Dual Diagnosis Capability in Addiction Treatment (DDCAT) Toolkit

Version 4.0

DDCAT

Dual Diagnosis Capability in Addiction Treatment Toolkit

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I. Introduction

Addiction treatment providers are continually challenged to improve services. Often, these challenges occur in a fiscal growth environment that is not only flat, but in most instances, declining. Over the past 15 years, there has been an increased awareness of the common presentation of persons with co-occurring mental health disorders in routine addiction treatment settings. Research results suggest that sequential treatment (treating one disorder first, then the other) and purely parallel treatment (treatment for both disorders provided by separate clinicians or teams who do not coordinate services) are not as effective as integrated treatment (Drake, O'Neal, & Wallach, 2008). National and state initiatives related to co-occurring disorders have been significant, stimulating considerable interest in providing better services for people with these challenges. Although clearly interested in improving existing services, addiction treatment providers have lacked pragmatic guidance on how to change. In 2005, the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT) published *Treatment Improvement Protocol 42* (or TIP 42) to respond to this need. However, providers continue to identify the need for specific benchmarks and related practical direction with which to plan and develop services.

In 2003 the Dual Diagnosis Capability in Addiction Treatment (DDCAT) index was created and field tested. Since 2004, we have been developing and implementing the index. The DDCAT, based on the American Society of Addiction Medicine's (ASAM) taxonomy of program dual diagnosis capability, has been subjected to a series of psychometric studies. The map below reflects the widespread implementation in various stages of the DDCAT as well as two parallel instruments, the Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) and Dual Diagnosis Capability in Health Care Settings (DDCHCS). The DDCAT, defined more fully below, guides both programs and system authorities in assessing and developing the dual diagnosis capacity of addiction treatment services (McGovern, Matzkin, & Giard, 2007).

States Utilizing the DDCAT/DDCMHT/DDCHCS Measure as of April 2011

WA, MT, ND, MN, WI, VT, ME, OR, ID, SD, NY, NH, MA, WY, MI, PA, RI, CT, NV, UT, CO, NE, IA, OH, NJ, DE, CA, KS, MO, IL, IN, WV, VA, AZ, NM, OK, KY, NC, DC, TN, TX, AR, MS, AL, GA, SC, LA, FL

Navajo Nation

■ States using DDCAT/DDCMHT/DDCHCS in 2011 (32 states, District of Columbia, and Navajo Nation)

☐ States
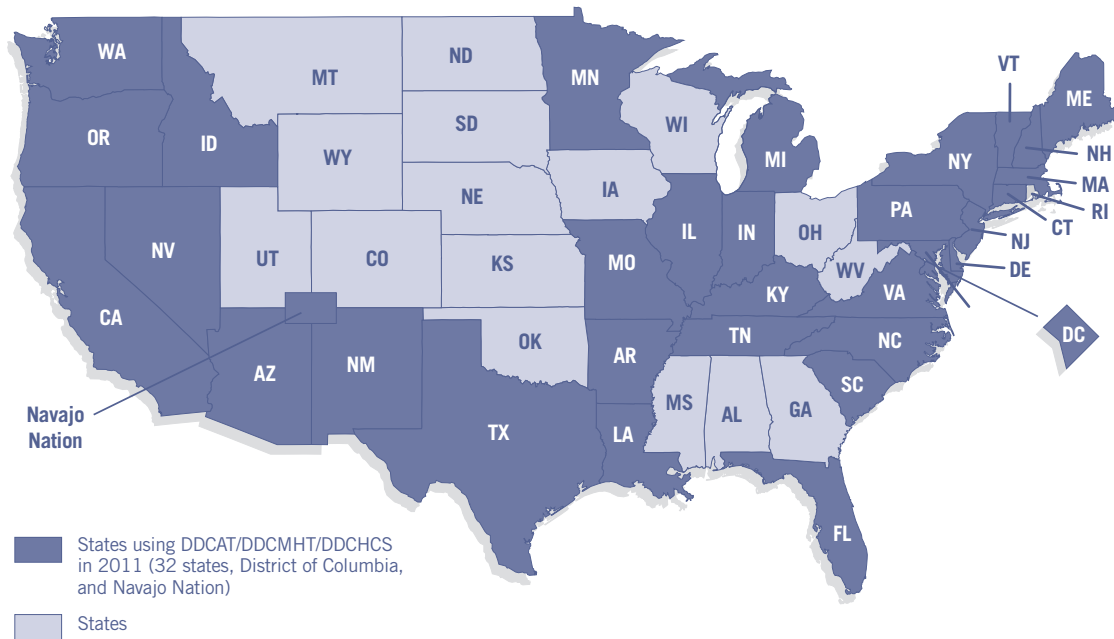
This toolkit emerges from these efforts. It is a response to numerous requests by community treatment providers for more specific guidance on how to enhance services based upon their current status. For programs that the DDCAT determines to offer services at an Addiction Only Services (AOS) level, this toolkit provides specific suggestions and examples from the field on how to reach Dual Diagnosis Capable (DDC) level services. Likewise, programs already assessed at the DDC level have asked for specific guidance on how to attain the Dual Diagnosis Enhanced (DDE) level. This toolkit responds to that request as well.

The motivation among addiction treatment providers to improve the quality of care offered to their patients is impressive if not inspirational. This toolkit was developed in direct response to addiction treatment programs at the "action" stage of readiness. The toolkit is designed to immediately offer practical tools and useable materials that will rapidly improve services to those programs with co-occurring disorders entrusted to their care.

A. Introduction to Co-occurring Disorders (COD) and Integrated Services

1. Literature Support and Report to Congress

Co-occurring mental health and substance use disorders are prevalent and difficult to treat. Although rates vary by disorder combinations and somewhat by study, epidemiological research has shown that a significant portion of the population experiences co-occurring disorders (Grant et al., 2004; Kessler et al., 1994, 1997; Regier et al., 1990). Moreover, the prevalence of co-occurring disorders is even higher in populations of individuals seeking mental health or substance abuse treatment (Grant et al., 2004; McGovern et al., 2006; Watkins et al., 2004). Furthermore, individuals with co-occurring mental health and substance use disorders have poorer outcomes, including higher rates of relapse, suicide, homelessness, incarceration, hospitalization, and lower quality of life (Compton et al., 2003; Wright, Gournay, Glorney, & Thornicroft, 2000; Xie, McHugo, Helmstetter, & Drake, 2005). Compounding the problem has been that, traditionally, mental health and addiction treatment have been separate systems with separate practitioners, and little crossover. Treatment was provided sequentially for the two types of disorders, and individuals were often told that they must deal with one disorder prior to entering treatment for the other. Care was not coordinated.

During the past 15 years, increasing attention has been given to the problem of co-occurring substance use and mental health disorders. In 2002, an important milestone in changing treatment for individuals with co-occurring disorders occurred with the release of the Substance Abuse and Mental Health Services Administration's Report to Congress on the *Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders*. Not only did the report highlight the significant portion of individuals in the

United States with co-occurring disorders and the poor treatment outcomes for these individuals, the report also discussed the lack of effective care available at the time. The report noted an increasing research base suggesting that coordinated and integrated care was effective, and that evidence-based treatment practices were being developed. Treatment research from both the mental health and substance abuse fields has shown that treatments aimed at addressing both disorders simultaneously are generally more effective than dealing with one disorder at a time (Drake et al., 2001; Mangrum, Spence, & Lopez, 2006; SAMHSA, 2002). In 2005, SAMHSA's Center for Substance Abuse Treatment (CSAT) released the *Substance Abuse Treatment for Persons With Co-Occurring Disorders, Treatment Improvement Protocol 42* (CSAT, 2005), which summarizes consensus and evidence-based practices for co-occurring disorders, including integrated psychiatric and addiction medication services, psychoeducation, counseling, and specialized peer recovery support groups for persons with co-occurring disorders.

The *Report to Congress* was also a call for treatment programs to develop increased capability to serve patients with co-occurring disorders, including increasing access to treatment and initial screening/assessment, stating "any door is the right door" (SAMHSA, 2002). Although not all addiction treatment programs need to have fully integrated services for co-occurring disorders, as suggested by the report, all programs may be expected to have some level of capability to address COD.

To classify the dual diagnosis capability of addiction treatment programs, the American Society of Addiction Medicine (ASAM) developed a taxonomy (ASAM Patient Placement Criteria 2nd Revision [ASAM-PPC-2R]; Mee-Lee et al., 2001). The taxonomy includes three categories of capability: Addiction Only Services (AOS), Dual Diagnosis Capable (DDC), and Dual Diagnosis Enhanced (DDE).

Generally, AOS programs do not accommodate individuals with mental health disorders; DDC programs accommodate individuals with mental health disorders that are relatively stable, and the programs address COD to some extent in policies, procedures, assessment, and programming. DDE programs accommodate individuals with even acute and unstable mental health disorders. The taxonomy provides a useful classification for capability, but needed a benchmark or fidelity measure to place addiction treatment programs within it.

2. Fidelity and Patient Outcomes

It was assumed that if shown new evidence about treatments that improve patient outcomes, treatment providers would rapidly implement such therapies. In reality, it is less than a straightforward process to use new information to shift routine practice and treatment services. The new field of implementation science focuses on the challenges of implementing evidence-based or expert consensus-based treatments. One component that supports implementation success is the observation by those who implement new treatments that their patients' outcomes are improved. Ironically, most implementation efforts do not include patient outcome tracking, meaning treatment providers do not see that the new treatment or services really do work better.

Another aspect of implementation pertains to fidelity or the adherence to the new practice guidelines or techniques. Simply saying that the new practice is being implemented is not adequate, so systematic observations of the implementation are often used to evaluate whether the practice is being implemented as designed. The research upon which the evidence for any practice has been established typically includes quality monitoring (i.e., integrity of the practice is verified). Therefore, the assumption is that to maximize the outcomes found in the research, real world providers should deliver the new therapy with fidelity.

In medical care, it has been demonstrated that if a new technique is not implemented with fidelity, the expected gain in improved patient outcomes is non-existent (Woolf

and Johnson, 2005). This also seems to be the case with behavioral treatments (Durlak and DuPre, 2008).

In reality, some adaptations will likely be needed to assimilate a new service or practice approach into any particular setting, culture, patient population and provider group. Nonetheless, fidelity or adherence to the original model is important. This finding has been established across a variety of interventions, including medical procedures, psychotherapy, addiction treatments, and behavioral therapies (McHugo et al., 1999; Schoenwald, Sheidow, & Letourneau, 2004).

3. Benchmark Measures

Several benchmark instruments have been developed to assess co-occurring capability or fidelity to specific co-occurring disorders treatments in mental health treatment programs. The Integrated Dual Disorders Treatment (IDDT) Fidelity Scale assesses fidelity to a specific evidence-based practice (Mueser et al., 2003; SAMHSA, 2003). Several more general agency self-assessment tools have been developed by Minkoff and Cline (2004) and Timko, Dixon, and Moos (2005).

What had been lacking in this area was an objective instrument for measuring co-occurring disorders capability within addiction treatment programs. Research has shown significant over-reporting of capability with self-assessments (e.g., Adams, Soumerai, Lomas, & Ross-Degnan, 1999). For example, McGovern et al. (2006) found that when asked to categorize their addiction treatment programs using the ASAM taxonomy (Mee-Lee et al., 2001), program directors and clinical staff showed less than 50 percent agreement, with program managers rating the program at a higher level of capability. Similarly, in a study of Australian treatment programs, Lee and Cameron (2009) found that programs over-rated their co-occurring services capability compared to presumably more objective external raters.

The DDCAT is a valid and reliable, objectively rated benchmark measure to assess capability of addiction treatment programs to provide services to individuals with co-occurring disorders.

4. Terminology and Acronyms

Co-occurring disorders is used to denote the status of having a substance use disorder and a psychiatric/mental health disorder.

Dual diagnosis (DD) refers to the same status defined by co-occurring disorders. Dual diagnosis is used in this manual to retain the language initially established by ASAM and the DDCAT Index.

Substance use disorders is used specifically to denote the broad range of substance use disorders within the DSM-IV that include the broad categories of substance use and substance-induced disorders.

Mental health disorders or **psychiatric disorders** are used to refer to other major psychiatric disorders besides the substance use disorders. Generally, this term refers to the mood disorders, anxiety disorders, thought disorders, adjustment disorders, and other disorders not substance related or induced by substances.

Addiction Only Services (AOS) is an ASAM-PPC-2R category referring to addiction treatment programs that do not accommodate individuals with mental health disorders.

Dual Diagnosis Capable (DDC) is an ASAM-PPC-2R category referring to addiction treatment programs that accommodate individuals with mental health disorders that are relatively stable. These programs address COD to some extent in policies, procedures, assessment, and programming.

Dual Diagnosis Enhanced (DDE) is an ASAM-PPC-2R category referring to addiction treatment programs that accommodate individuals with acute and unstable mental health disorders.

B. Description of the Index

The Dual Diagnosis Capability in Addiction Treatment Index—referred to as the DDCAT—is a benchmark instrument for measuring addiction treatment program services for persons with co-occurring mental health and substance use disorders (see the appendix for a copy of the instrument).

The DDCAT has been in development since 2003, and it is based upon a fidelity assessment methodology. Fidelity scale methods have been used to ascertain adherence to and competence in the delivery of evidence-based practices. This methodology has been used to assess mental health program implementation of the Integrated Dual Disorder Treatment (IDDT) model. IDDT is an evidence-based practice for persons with co-occurring disorders in mental health settings, and who suffer from severe and persistent mental illnesses (Mueser et

al., 2003). The DDCAT utilizes a similar methodology as the IDDT Fidelity Scale, but has been specifically developed for addiction treatment service settings. Until the DDCAT, addiction treatment services for co-occurring disorders were guided by an amalgam of evidence-based practices and consensus clinical guidelines.

The DDCAT evaluates 35 program elements that are subdivided into seven dimensions.

- The first dimension is **Program Structure**. This dimension focuses on general organizational factors that foster or inhibit the development of integrated treatment.
- **Program Milieu** is the second dimension, and it focuses on the culture of the program and whether the staff and physical environment

are receptive and welcoming to persons with co-occurring disorders.

- The third and fourth dimensions are referred to as the **Clinical Process** dimensions (**Assessment** and **Treatment**). These examine whether specific clinical activities achieve specific benchmarks for integrated assessment and treatment.

- The fifth dimension is **Continuity of Care**, which examines the long-term treatment issues and external supportive care issues commonly associated with persons who have co-occurring disorders.

- The sixth dimension is **Staffing**, which examines staffing patterns and operations that support integrated assessment and treatment.

- The seventh dimension is **Training**, which measures the appropriateness of training and supports that facilitate the capacity of staff to treat persons with co-occurring disorders.

The DDCAT draws heavily on the taxonomy of addiction treatment services outlined by the American Society of Addiction Medicine (ASAM) in the *ASAM Patient Placement Criteria Second Edition Revised* (ASAM-PPC-2R, 2001). This taxonomy provided brief definitions of Addiction Only Services (AOS), Dual Diagnosis Capable (DDC) and Dual Diagnosis Enhanced (DDE). The ASAM-PPC-2R provided brief descriptions of these services but did not advance operational definitions or pragmatic ways to assess program services. The DDCAT utilizes these categories and developed observational methods (fidelity assessment methodology) and objective metrics to ascertain the dual diagnosis capability of addiction treatment services for persons with co-occurring disorders: AOS, DDC, or DDE.

C. Development and Psychometric Studies

Development of the DDCAT began in 2003 by Dr. Mark McGovern, Associate Professor of Psychiatry at Dartmouth Medical School and member of The Dartmouth Psychiatric Research Center. The index was initially field-tested in Connecticut, Louisiana, and New Hampshire before widespread implementation in a number of states, Native American tribes, and internationally. DDCAT items and scoring anchors were revised in 2006 and 2011.

Investigations by the developers of the DDCAT and DDCMHT have found initial support for the psychometric properties of the measures. Studies assessing the DDCAT and DDCMHT indices' inter-rater reliability, internal consistency, convergent and discriminant validity, preliminary criterion validity, and sensitivity to change are summarized in the sections below.

1. Reliability

In terms of inter-rater reliability, in a study of seven programs and rater pairs in Missouri, Gotham, Haden, and Owens (2004) found a correlation coefficient of .76 (p < .01) and median kappa coefficient of .67 (p< .05) across all scales. Brown & Comaty (2007) reported an intra-class correlation coefficient of .84 (p<.001) across 35 program sites and five raters in Louisiana. With respect to internal consistency, Gotham, Claus, Selig, and Homer (2010) found the median dimension alpha coefficient to be .73, with a range across all 7 dimensions from .61 to .81.

2. Convergent and Discriminant Validity

Two studies of the DDCMHT's convergent and discriminant validity have been reported. The DDCMHT was compared with the IDDT Fidelity Scale, the latter designed for use in assessing implementation of IDDT for patients with severe mental illnesses and substance abuse-level disorders in community mental health settings. The DDCMHT total score was found positively correlated with the IDDT total score (.75; p<.01). The relationship between the IDDT total score and the DDCMHT dimension scores ranged from .53 to .68. Four (57 percent) of the 7 DDCMHT dimensions were significantly correlated with the IDDT total score (at p<.05), whereas 3 (43 percent) were not. Since the IDDT fidelity scale measures adherence to the IDDT approach, designed for different patients and settings, some correspondence, but not complete overlap with the DDCMHT was expected (Gotham et al., 2004). Gotham et al. (2008) also compared DDCMHT total scores (n=7) with the Organizational Readiness for Change Scale (Lehman et al., 2002). Using Cohen's (1987) classifications (correlation of .10 = small, .30 = medium, and .50 = large), 11 of the 18 Pearson correlation coefficients were large, and the remaining 9 were small or insignificant, suggesting that program dual diagnosis capability shares common but independent characteristics with organizational factors such as resources, staff, organizational climate, and overall needs and pressures. Both of these studies by Gotham et al. (2004; 2008) support the convergent and discriminant validity of the DDCMHT.

3. Criterion Related Validity

Two studies have shown that programs of differential dual diagnosis capacity (DDCAT assessed) have different types of patients accessing their services, as determined by standardized screening measures at admission and more severe and complex problems as measured at admission using the Addiction Severity Index (ASI). McGovern & Giard (2007) found that of 15 programs using the Mental Health Screening Form-III (MHSF-III) with new admissions, AOS programs (550 admissions) had significantly fewer co-occurring disorder positive (COD+)(69.1 percent) than DDC programs (n=36 admissions)(94.4 percent). These differences were also reflected in significant differences in average MHSF-III total scores (AOS Mean=3.39; SD=3.69) (DDC Mean=7.06; SD=3.86) (p<.001).

This finding was confirmed in data from 15 different addiction treatment programs that used the Modified MINI Screen (MMS) at admission. AOS programs (452 admissions) had fewer MMS identified COD+ patients (46.9 percent) vs. DDC programs (743 admissions) (52.5 percent). These differences were also found to be significant (AOS Mean=5.39; SD=5.13) (DDC Mean=6.57; SD=5.87) (p<.001). In a study of 391 admissions across 3 AOS programs and 112 admissions across 2 DDC programs, Mangrum (2007) found a similar trend. On the MINI Neuropsychiatric Interview (MINI), DDC patients were more likely diagnosed with bipolar, psychotic, dysthymia, and PTSD, whereas AOS patients were more likely positive for depression, obsessive-compulsive, and generalized anxiety disorders. DDC patients had significantly more problem days (p<.05) than AOS patients on the ASI scales of psychiatric, drug, alcohol, social, medical and employment domains. Both of these investigations find preliminary criterion validity for the DDCAT and also suggest the feasibility of using the MMS and MINI, based on patient screening and assessments within one week of admission, and by routine community counselors.

4. Sensitivity to Change

In a study of 16 addiction treatment programs assessed using the DDCAT at baseline and 9 months later, McGovern, Matzkin, et al. (2007) found the DDCAT sensitive to change. The programs received one of three "dual diagnosis enhancement strategies":

1) DDCAT assessment + feedback only (8 programs);

2) DDCAT assessment + feedback + training (4 programs); and

3) DDCAT assessment + feedback + training + implementation support (4 programs).

All three groups increased dual diagnosis capability over the 9 months, but the DDCAT assessment + feedback + training + implementation support group had significantly greater change overall (Kruskal-Wallis tests, p <.01).

Although programs were not randomized and were significantly different at baseline, this small study supports the application of the DDCAT to measure change. Other studies have also found effective program improvement efforts, as measured by the DDCAT, moderately predict baseline program organizational factors as assessed by the Organizational Readiness for Change scales (Gotham, Brown, Comaty, & McGovern, 2008) and leadership styles (Claus, Gotham, Harper-Chang, Selig, & Homer, 2007; Claus, 2008). These findings underscore the importance of gathering information about the implementation or change strategies used when conducting a repeated measures study using the DDCAT, and obtaining information about more generic organizational factors as potential correlates of baseline capacity or moderators of change over time. These findings were replicated and further enhanced by tracking implementation strategies in more recent research (McGovern, Lambert-Harris, McHugo, Giard & Mangrum, 2010).

D. Toolkit Organization

This toolkit is intrinsic to administering and scoring the DDCAT. Accordingly, toolkit suggestions are embedded within the context of each item's scoring. Each of the seven dimensions of the DDCAT is described and then each item is listed and the scoring procedure articulated.

Each item includes a section entitled "Item Response Coding," which provides descriptive anchors to assist scoring this scale item using the DDCAT rankings of 1-AOS, 3-DDC, and 5-DDE. In some cases descriptive anchors are available for scores of 2 and 4, when observations fall within intermediate ranges between the 1, 3, and 5 ratings. A section titled "Source" lists sources of the data to be considered in determining the score.

Corresponding to each item, the toolkit offers specific enhancement suggestions for AOS and DDC programs. Many of the suggestions throughout the toolkit are examples from actual treatment providers. A complete listing of the no and low cost suggestions is available below, as an appendix. Sample instruments, forms, and other resources that are mentioned in the discussions of each item are also available in the appendix section.

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II. Applications

The widespread use of the DDCAT and DDCMHT measures speaks to their appeal to the behavioral health community. The measures are pragmatic and relatively easy to use. A range of constituencies find the measure useful and a variety of implementations have occurred by system and regulatory agencies as well as treatment providers.

The sections below summarize examples of how the DDCAT and DDCMHT have been used to assess and guide quality improvement in program co-occurring capacity. In addition, descriptions are provided for applications in health services research and how families and individuals seeking services have used DDCAT summaries to make informed treatment choices.

A. System and Regulatory Agencies

As of 2010, over 30 state regulatory authorities, several large county governments, private treatment programs, and several nations are in various stages of implementation using the DDCAT and DDCMHT indices. Systems seek to obtain objective information about dual diagnosis capacity among the providers with whom they contract for services. In the absence of objective measures, the regulatory agency has only provider self-report or anecdote upon which to base their appraisal. Research has consistently shown that provider self-

assessment of dual diagnosis capability is of dubious validity, and often inflated (McGovern, Xie, et al., 2007; Lee & Cameron, 2009). For this reason, a standardized yardstick, such as the DDCAT or DDCMHT, enables the state or county authority to obtain an accurate and multi-dimensional picture of services within their jurisdiction. System agencies have found multiple uses for this information:

1) Developing a map of types of treatment agencies based upon dual diagnosis capability;

2) Examining variation in funded services by region, level of care, or type of agency;

3) Using the data to plan and implement standards for differential funding;

4) Using the data to plan and offer targeted training and technical assistance;

5) Assessing baseline capacity and then repeating assessments to measure the effectiveness of quality improvement efforts;

6) Featuring the information in grant applications to federal agencies;

7) Using the data to present to legislators; and

8) Linking the DDCAT and DDCMHT indicators to patient level outcomes.

B. Treatment Providers

The experience of treatment providers who have been assessed with the DDCAT is near universally positive. Concrete and practical guidance about policy, practice, and workforce development in the arena of co-occurring disorders has been lacking. For at least the past decade, treatment providers have been well aware of federal recommendations, such as SAMHSA's *Report to Congress*, the President's New Freedom Commission, and SAMHSA's TIP 42. Community treatment providers have also been highly motivated to address the issue and improve services for persons with co-occurring disorders already under their care. What have been missing are the concrete guidelines and benchmarks with which to do so.

Treatment providers have used the DDCAT and DDCMHT to assess their status on co-occurring capacity relative to established benchmarks on policy, practice, and workforce. Using this guide, many providers have identified target scores they wished to achieve on specific benchmarks, and then planned quality improvements in the intended direction. More generally, providers often want to operate at a certain level of overall capacity, such as DDC or DDE. Providers utilize the information from the DDCAT and DDCMHT to achieve concrete change to score at these levels. In some instances, having a DDE level program has been associated with increased reimbursement rates, whereas in the private sector, operating an objectively verified DDE program is used to negotiate with private payers and for marketing purposes.

Another application for treatment providers is the use of the measures to articulate specific training goals for programs and clinical staff members. Rather than a more global or vague approach to agency endorsed or funded training, specific clinical goals (e.g., facilitating a co-occurring disorders stage-wise group session) can lead to training exposure that staff members need. In fact, DDCAT and DDCMHT items pertain to the recommended basic co-occurring training for all staff (item VIIA) and specialized training for clinical staff (VIIB). These benchmarks sharpen the focus and create clarity for staff professional development plans.

Specifics on Implementing Change

The two sections above discuss how the DDCAT and DDCMHT may be used by system/regulatory agencies and treatment providers and in both instances those applications involve making changes at the system, agency, or program levels. The developing field of implementation science can contribute to the use of the DDCAT and DDCMHT. While a complete review of implementation science findings are beyond the scope of this toolkit, some general recommendations can be made.

Many programs and systems have obtained initial DDCAT assessments. Using these data as a "baseline" measure of co-occurring capability, the programs go on to develop co-occurring implementation plans akin to treatment plans. Such plans have similar ingredients to treatment plans in that they include goals, objectives, interventions, responsible persons, and projected target dates. Programs have used the DDCAT dimensions or domains at baseline to organize the list of goals, and then used the specific items in the DDCAT to define specific objectives. Interventions and the specific targets of change can be extracted directly from this toolkit. Thus the DDCAT can provide an addiction treatment program with a practical blueprint and tools to achieve increased capacity for co-occurring disorders. Since the measure can be re-administered, it can also be used to assess the success (or sustainability) of these changes.

In addition to a written implementation plan, other components of a change process that programs often find helpful include:

1) Identify a program "champion" or change agent;

2) Develop a steering committee;

3) Obtain training and technical assistance;

4) Ensure that clinical supervisors in the program are competent in the new skills being expected of clinicians/counselors and lead routine clinical supervision sessions (individual and group) to practice the new skills with staff;

5) Connect with other programs that have or are currently implementing the same kinds of changes, either individually or through a learning collaborative;

5) Track certain data elements that inform whether the service changes are happening and if they are improving patient outcomes; and

6) Conduct ongoing DDCAT assessments every 3 to 6 months during the first year of implementation, with annual reviews thereafter.

This change process, including a written implementation plan, is meant to be used in an ongoing iterative fashion; as initial goals and tasks are achieved, other goals and tasks can be added to the plan. For more information on implementation science, please see the References section.

C. Health Services Researchers

The availability of a program level measure of co-occurring capability has a variety of implications for organizational and clinical research. Descriptive research studies are now possible, such as in assessing variation in co-occurring capability across a specific region, or in comparing capacity in urban and rural areas, in mental health to addiction treatment programs, or hospital programs and free-standing clinics. Researchers are often interested in categorizing the characteristics or types of organizations within which multi-site clinical trials take place. This enables the researchers to either understand the potential study confounds due to site differences or to a priori use sites that have similar levels of co-occurring capacity to minimize this influence.

Researchers also are interested in the effectiveness of quality improvement or process improvement strategies. Such strategies may range from training in specific evidence-based practices, increased funding for certain services, Network for Improvement of Addiction Treatment (NIATx) approaches, or Plan-Do-Study-Act cycles. Using the DDCAT or DDCMHT as a pre-post implementation measure identifies changes in co-occurring capability over time.

A burning question remains for health services researchers: What is the relationship between program level measures of capability, such as the DDCAT or DDCMHT, and patient level outcomes, such as mental health symptom reduction, decreased substance use, medication compliance, or improved quality of life? Studies conducted under controlled conditions and of sufficient sample size are needed to address these questions.

D. Families and Individuals Seeking Services

Classifying programs as AOS, DDC, or DDE can help families and individuals seeking care for a co-occurring disorder. Since no current directory sorts programs by co-occurring capability, consumers may be misled by self-appraisals or marketing statements which lack objective or independent validation. A regional, statewide, or national directory would enable consumers to make informed treatment decisions based on preferences. Many patients and families with co-occurring disorders have had negative treatment experiences, in part due to the fact that they did not receive adequate or integrated care. Being able to confidently identify a program providing DDC or DDE services based on objective standards established by the DDCAT and DDCMHT would support persons and families struggling with co-occurring disorders as they make a courageous step towards professional help.

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III. Methodology

A. Observational Approach and Data Sources

The DDCAT uses observational methods to gather information about a program and rate its co-occurring capability. External raters make a site visit to an addiction provider, collecting data about the program from a variety of sources:

1) Ethnographic observations of the milieu and physical settings;

2) Focused but open-ended interviews of agency directors, clinical supervisors, clinicians, medication prescribers, support personnel, and patients; and

3) Review of documentation such as medical records, program policy and procedure manual, brochures, daily patient schedules, telephone intake screening forms, and other materials that may seem relevant.

Information from these sources is used to rate the 35 DDCAT Index items.

B. The Site Visit

The scheduling of the site visit is done in advance. Generally the site visit will take up to a half day or a full day. The time period is contingent on the number of programs within an agency that are being assessed, the number of assessors, and their experience with the DDCAT tool. Since the DDCAT is used to assess a program, rather than an entire agency, the raters pre-arrange what program or programs within the agency are to be assessed. Experience suggests that it may be possible to fully assess one program in approximately a half day. In a full day it may be possible to assess two to three programs within one agency, depending upon how closely their operations are related. It is important to allocate sufficient time to do the DDCAT assessment. This process typically becomes more efficient as the assessor gains experience, and when multiple assessors can share the site visit tasks.

The DDCAT process begins with identifying the appropriate contact person, usually the agency director or a designee. In a preliminary conversation, raters can define the scope of the assessment and clarify the time allocation requirements. At this time it is also be important to convey the purpose of the assessment and relay any implications of the data being collected. This process has been found to be most effective if

offered as a service to the agency—that is, to help the agency learn about its services to persons with co-occurring disorders, and to suggest practical strategies to enhance services if warranted. This sets an expectation of collaboration rather than evaluation and judgment, which will help the assessor elicit more accurate information.

Scheduling should include both an initial meeting and an "exit" feedback meeting with the agency director, and time for separate group interviews with the program clinical leaders and supervisors, select clinicians, and patient(s). Conducting separate interviews allows the assessor to identify different perspectives on the program's practices and procedures, and any discrepancies between what one group perceives and another experiences. Selected persons in these roles can be interviewed (i.e., not every supervisor, staff member or patient must be interviewed). More is always better, but reasonableness and representativeness should be the overarching goal.

This initial contact with the agency director is also a good opportunity to gather descriptive information about the program as listed on the DDCAT rating scale cover sheet. While this information is not necessary to score the DDCAT, it can be useful in tabulating or making comparisons of DDCAT scores, such as across regions or states, or by level of care, size, or funding source. The cover sheet offers the assessor an easy format for organizing basic information as well as providing a program with information about the data sources used and the assessment process

During the visit a tour of the program's physical site is essential. Agencies have experience doing this for other purposes, and it often serves not only as a way to observe the milieu, but also affords the assessor the opportunity to meet additional staff and have conversations along the way. There should also be some time allocated to review documents, such as brochures, policy and procedure manuals, patient activity schedules, and other pertinent materials. When possible, obtaining a copy of

any of these materials to review ahead of time will help save time at the visit. Lastly, enough time should be scheduled to review eight to 10 medical records, all for individuals identified as having co-occurring disorders. Ideally records should be for recently discharged patients, and representative of different clinicians.

It is important to allow time for the assessor to process and formulate the findings from the DDCAT assessment at the end of the visit. This may be a period of 15 to 30 minutes. During this time, the assessor considers DDCAT items that have not yet been addressed. He or she also considers how to provide preliminary feedback to the agency about the findings of the assessment. Missing information can most likely be gathered within the final meeting with the director or staff. If necessary, a follow-up call can be made after the visit if the assessor finds any data was overlooked.

The preliminary feedback or debriefing at the end of the DDCAT assessment is typically positive and affirming, and it emphasizes program strengths and themes from the assessment. The assessor is encouraged to consider the program's readiness to change and focus on addressing issues that have already been raised as areas of concern or desired change.

C. Cautions Regarding Self-Evaluation

The accuracy and usefulness of a DDCAT assessment is directly proportional to the objectivity of the assessor and her or his familiarity with the underpinning of each DDCAT item response coding. Experience has shown that self-assessors generally view their programs as more capable than they actually are (McGovern, Xie, et al., 2007), and that there is a high likelihood self-assessors will score their programs higher in all dimensions (often by a full point or more) than will an objective assessor (Lee and Cameron, 2009). This is not to say that self-assessment should not be attempted and cannot be done effectively.

The self-assessor's foremost task is to look with "fresh eyes" and ask all the questions necessary to base a score on facts, rather than on assumptions based on prior information or impressions. Agencies that choose to self-assess are encouraged to use their quality assurance staff, which due to the nature of their work can typically be more objective, and/or staff from a program other than the one being assessed. A team of two or more self-assessors is recommended in order to increase the opportunity to identify, discuss, and mitigate any inherent biases by scoring independently and coming to consensus when initial scores don't agree. Agencies may also want to explore reciprocal arrangements with other agencies to further minimize bias. The Louisiana Office of Behavioral Health conducted DDCAT assessments using a team that included their expert raters as well as staff from providers to be assessed; this meant that staff raters participated in assessing their own programs. Program staff's consistency with the expert raters was demonstrated by the fourth visit (i.e., the quality of assessment increases with practice) (Brown & Comaty, 2007).

A thorough understanding of the definition and item response coding for each DDCAT element is equally as important as objectivity. Louisiana found that the development of manuals enhanced ratings consistency. A recent study of dual diagnosis capability of residential substance abuse programs in Australia found that the self-assessors consistently did not read the DDCAT instructions, resulting in incorrect scores (Matthews, Kelly, & Deane 2011). Basing scores on the DDCAT tool's anchors alone often results in inaccurate ratings; the anchors serve only as a prompt for scoring, and they are not intended to be all-encompassing descriptors. This toolkit contains expanded definitions for many of the scores. It describes the essence and nuances of each element. Additionally, the guidance for programs wishing to increase their capability offers examples that can provide further clarity.

D. Training Program Quality Assurance Staff

It is recommended that programs intending to improve their co-occurring capability use both process and outcome measures to monitor and improve program quality over time. DDCAT baseline and follow-up assessments can be an integral element of such quality assurance efforts. Quality assurance staff not only may be more objective, but also are likely to have interviewing and chart review skills that will help ensure a competent assessment. Quality assurance staff who are trained to conduct DDCAT assessments can use them to measure progress toward implementation plan goals. The quality assurance staff can also assess and compare different programs within the agency.

E. Training Individuals to Conduct the Program Assessment

1. Didactic Training

Individuals who wish to conduct a DDCAT assessment can attain some proficiency through familiarizing themselves with the information in this toolkit. Some state agencies have offered workshops on the DDCAT. Other resources are listed in the References section.

Prior to a visit, some assessors have found it helpful to note on the scoring sheet the various sources for each item to cue them throughout the visit. They also develop separate lists of questions for each interview group that will elicit information necessary to score each item, in some cases organizing them by topic rather than by assessment dimension and element. Some have found it helpful to develop a brief checklist form to use as a guide when reviewing medical records. Samples of these are included as appendices to the Toolkit.

2. Shadowing

One of the best training methods is to shadow an experienced DDCAT assessor on a visit, preferably more than once. As mentioned above, practice has been shown to improve the quality of the assessment. Observing how the visit is organized, what the assessor looks for on the tour, the assessor's interview questions and techniques, how the assessor manages discrepancies in information, and the preliminary feedback session provides a model for the new assessor to emulate. Reviewing medical records, policies and procedure manuals, and other materials together offers an opportunity to learn how to obtain the desired information in a limited period of time. Individuals who train in this fashion are encouraged to score the assessment independently of the experienced assessor, and then compare and discuss the basis for each score, not just those that were scored differently.

3. DDCAT Vignette/Case Study

A vignette has been developed to help individuals practice evaluating information gathered at a DDCAT visit and scoring the assessment. The vignette briefly describes a DDCAT visit to a fictional addiction treatment program and the information gleaned from tour observations, staff and patient interviews, policy and procedures review, and medical record reviews. It is a composite of actual DDCAT visit interactions and observations, intended to give "the feel" of a visit, as well as a demonstration of how a visit might elicit some conflicting information. The vignette and scoring guide are included as appendices.

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IV. Scoring and Profile Interpretation

A. Scoring Each DDCAT Item

Each program element of the DDCAT is rated on a 1-to-5 scale.

- A score of 1 is commensurate with a program that is focused on providing services to persons with substance use disorders. This level, using ASAM language, is referred to on the DDCAT as Addiction Only Services (AOS).

- A score of 3 indicates a program that is capable of providing services to some individuals with co-occurring substance use and mental health disorders, but has greater capacity to serve individuals with substance use disorders. This level is referred to as being Dual Diagnosis Capable (DDC) by ASAM and on the DDCAT.

- A score of 5 designates a program that is capable of providing services to any individual with co-occurring substance use and mental health disorders, and the program can address both types of disorders fully and equally. This level is referred to as being Dual Diagnosis Enhanced (DDE) on the DDCAT.

- Scores of 2 and 4 are reflective of intermediary levels between the standards established at the 1-AOS, 3-DDC, and 5-DDE levels.

When rating a program on the DDCAT, it is helpful to understand that the objective anchors on the scale for each program element are based on the following factors:

1) The *presence or absence* of specific hierarchical or ordinal benchmarks: 1-AOS sets the most basic mark; a 3-DDC sets the mid-level mark; a 5-DDE sets the most advanced benchmark to meet. For example, the first Index element regarding the program's mission statement requires specific standards to be met in order to meet the minimum requirements for scoring at each of the benchmark levels (AOS, DDC, or DDE).

    -or-

2) The *relative frequency* of an element in the program, such as in the last Index element regarding clinical staff that have advanced training in integrated services. The rating 1-AOS sets a lower percentage of staff with required training, 3-DDC requires a moderate percentage, and 5-DDE requires the maximum percentage. Another way frequency may be determined is the degree to which the process under assessment is clinician-driven and variable or systematic and standardized. When processes are clinician-driven they are less likely to occur on a consistent basis and be incorporated into a program's routine practices.

    -or-

3) A combination of a presence of a hierarchical standard *and* the frequency at which these standards occur. In other words, in order to meet the criterion of 3 or 5 on a DDCAT item, a program must meet a specific qualifying standard. Also, the program must consistently maintain this standard for the majority of their patients (set at an 80 percent basis). For example, the program element regarding integrated assessment sets a qualifying standard for the type of assessment used *and* specifies the frequency with which the standard is routinely applied.

B. Scoring the DDCAT Index

Scoring the DDCAT will produce ratings on the seven dimensions and categorize the program as AOS, DDC or DDE. This is a simple way to indicate the co-occurring capacity of an agency's program.

The total score for the DDCAT and rank of the program overall is arrived at by:

1. Tallying the number of 1's, 2's, 3's, 4's, and 5's that a program obtained.

2. Calculating the following percentages:

   a) Percentage of 5's (DDE) obtained

   b) Percentage of 3's, 4's, and 5's (scores of 3 or greater) obtained

   c) Percentage of 1's and 2's obtained

3. Applying the following cutoffs to determine the program's DDCAT category:

   a) Programs are DDE if at least 80 percent of scores (i.e., 28 of the 35) are 5's

   b) Programs are DDC if at least 80 percent of scores are 3's or greater

   c) Programs are AOS if less than 80 percent of scores are 3's or greater

C. Creating Scoring Profiles

The dimension scores are the average scores of the items within each dimension. Dimension scores can be examined for relative highs and lows and may be connected with the agency's own readiness to address specific, if not all, areas. These averages can also be depicted on a chart (line graph) and presented as the program's profile. Horizontal lines can indicate points above or below the benchmark criteria (e.g., DDC) and this can serve as a visual aid in focusing the assessor and program leadership on both those dimensions that are strengths and areas for potential development. This bar graph can be very useful to guide feedback and for targeting program enhancement efforts. Lastly, the visual depiction can be enlightening if DDCAT assessments are conducted at two or more points in time. As a process or continuous quality improvement measure, the profile depicts change or stabilization by dimension.

D. Feedback to Programs

Feedback to programs based on their assessment is typically provided in two formats: verbal feedback and a written report.

First, at the end of the DDCAT site visit, agency directors and leadership may receive some preliminary verbal feedback. A suggestion is to focus on the strengths of the program and, where possible, join with those issues that have already been identified as quality improvement issues by the agency/program staff members themselves. This could be seen as a parallel to motivational interviewing techniques.

The second format is via written report, which can be structured in several different ways. The report may be in the form of a summary letter to the agency director or a more formal structured report. Regardless of the format, the feedback letter or report should include:

- a communication of appreciation;

- a review of what programs and sources of data were assessed;

- a summary of their scores, including their categorical rating of AOS, DDC, or DDE, and a graph from the Excel workbook that shows the seven dimension scores;

- an acknowledgment of relative strengths in existing services; and

- empathic and realistic suggestions of potential areas that can be targeted for enhancement.

Additional components that could be included in the report include:

- a graphical display of the program's overall and dimension scores compared to their region/county/state's overall averages;

- a discussion and graph showing the changes since baseline if the assessment is a follow-up.

Conversation and written summaries about dimensions, as well as themes across dimensions, are often the most useful ways for providers to consider where they are and where they want to go. The report may include specific recommendations (e.g., listing and describing specific screening measures to systematize screening for co-occurring disorders) or may mention only thematic areas of potential improvements.

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V. The DDCAT Index:
Scoring and Program Enhancement

I. Program Structure

IA. Primary focus of agency as stated in the mission statement. (If program has mission, consider program mission.)

Definition: Programs that offer treatment for individuals with co-occurring disorders should have this philosophy reflected in their mission statements.

Source: Agency or program brochure or in frames on walls of offices or waiting areas.

Item Response Coding: Coding of this item requires an understanding and review of the program's mission statement, specifically as it reflects a co-occurring disorders orientation.

- **Addiction Only Services = (SCORE-1):** *Addiction only.* The program has a mission statement that outlines its mission to be the treatment of a primary target population who are defined as individuals with substance use disorders only.

- **Dual Diagnosis Capable = (SCORE-3):** *Primary focus is addiction, co-occurring disorders are treated.* The program has a mission statement that identifies a primary target population as being individuals with substance use disorders, but the statement also indicates an expectation and willingness to admit individuals with a co-occurring mental health disorder and to address that disorder, at least within the context of addiction treatment. The term "co-occurring disorders" does not need to be used specifically in the mission statement.

An example of a mission statement that meets the DDC level would be one similar to the following. Note that a specific population is identified, but it also incorporates a willingness to treat the person comprehensively and provide the necessary arrays of services.

> "The mission of the Addiction Board is to improve the quality of life for adults and adolescent with addictive disorders. This is accomplished by ensuring access to an integrated network of effective and culturally competent behavioral health services that are matched to persons' needs and preferences; thus promoting consumer rights, responsibilities, rehabilitation, and recovery."

- **Dual Diagnosis Enhanced = (SCORE-5):** *Primary focus on persons with co-occurring disorders.* The program has a mission statement that identifies the program as being one that is designed to treat individuals with co-occurring disorders. The statement notes that the program has the combined capacity to treat both mental health and substance use disorders equally.

"The Behavioral Health Unit is a private, non-profit organization dedicated to providing services that support the recovery of families and individuals who experience co-occurring mental health and substance use disorders."

AOS PROGRAMS

Enhancing IA. Primary focus of agency as stated in the mission statement. (If program has mission, consider program mission.)

Programs scoring a 1 for this item likely have a more traditional mission statement, such as: "The North Side Alcohol and Drug Treatment Center is dedicated to assisting persons with alcohol and drug problems regain control over their lives."

Revising a mission statement is emblematic of a "sea change" in leadership philosophy and commitment even though the new mission statement may not directly or immediately affect the clinical practices at a program. Consider this subtle shift in the last phrase of the mission statement: "The North Side Alcohol and Drug Treatment Center is dedicated to assisting persons initiate a process of recovery from substance use and its associated problems."

A DDC mission statement is characterized by a clear willingness to treat individuals with COD. Often this is communicated in overarching terminology, such as "behavioral health" or "recovery." Here is an example: "The City Clinic is committed to offering a full range of behavioral health services to promote well-being and lifelong recovery."

DDC PROGRAMS

Enhancing IA. Primary focus of agency as stated in the mission statement. (If program has mission, consider program mission.)

DDC programs have scored a 3 on this item. It is likely that the mission statement reflects a program philosophy that recognizes comorbid mental health disorders as secondary to substance use disorders. A DDE program mission statement is characterized by an equivalent focus on substance use and mental health disorders. It will include the term "co-occurring disorders" or clearly encompass both mental health and addiction treatment services.

Some providers take issue with the "behavioral" terminology, arguing that it may connote a less than holistic (or perhaps mechanistic) approach to health care. Alternative terminology that embraces co-existing mental health and substance use disorders is also fitting.

IB. Organizational certification and licensure.

Definition: Organizations that provide integrated treatment are able to provide unrestricted services to individuals with co-occurring disorders. These organizations do so without barriers that have traditionally divided the services for mental health disorders from the services for substance use disorders. The primary examples of organizational barriers include licenses or certifications of clinics or programs that restrict the types of services that can be delivered.

Source: Interview with agency or program director or prior knowledge of applicable rules and regulations.

Item Response Coding: Coding of this item requires an understanding and review of the program's license or certification permit and specifically how this document might selectively restrict the delivery of services on a disorder-specific basis.

- **Addiction Only Services = (SCORE-1):** *Permits only addiction treatment.* The program's certification, licensure agreement or state permit restricts services to individuals with substance use disorders only.

- **(SCORE-2):** *Has no actual barrier, but staff report there to be certification or licensure barriers.*

The program's certification, licensure agreement or state permit is the same as described at the DDC level in that there are no restrictions in serving individuals with mental health disorders that co-occur with substance use disorders. But the staff and administrators report and perceive barriers in providing mental health services; thus the program operates in a manner consistent with AOS.

- **Dual Diagnosis Capable = (SCORE-3):** *Has no barrier to providing mental health treatment or treating co-occurring disorders within the context of addiction treatment.* The program's certification, licensure agreement or state permit identifies the target population to be individuals with substance use disorders but does **not** restrict the program from serving individuals with co-occurring mental health disorders. The program provides services in the context of addiction treatment licensure. It targets mental health problems in a general approach, for example, in the context of relapse prevention.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Is certified and/or licensed to provide both.* The program's certification, licensure agreement(s) or state permit(s) identifies the program as providing services for both mental health and substance use disorders.

AOS PROGRAMS

Enhancing IB. Organizational certification and licensure.

Programs at the AOS level often face legitimate certification or licensure restrictions. This restriction encumbers a program to provide treatment solely to persons who meet criteria for a substance use disorder. Even though many patients will have an active co-occurring mental health disorder, the program must declare the substance use disorder as primary if not singular.

Several practical strategies are possible to elevate a program to the DDC level. Some programs cite long-standing agency traditions to assert their inability to treat persons with co-occurring disorders. Regional, state, and funder policies must be verified so that restrictions, if they do exist, can be clearly determined. Some state authorities have made special allocations for persons with co-occurring disorders (i.e., substance use disorders with complications). Other programs have sought joint mental health licensure or hired licensed staff to bill for unbundled services. Finally, it is common and realistic for a program to provide services that generically target mental health problems within the context and scope of addiction treatment licensure.

DDC PROGRAMS

Enhancing IB. Organizational certification and licensure.

Programs at the DDC level with intentions to attain DDE on this item will likely need to acquire secondary or additional licensure or certification to provide mental health treatment services.

IC. Coordination and collaboration with mental health services.

Definition: Programs that transform themselves from ones that only provide services for substance use disorders into ones that can provide integrated services typically follow a pattern of staged advances in their service systems. The steps indicate the degree of communication and shared responsibility between providers who offer services for mental health and substance use disorders. The following terms are used to denote the stepwise advances and originate from SAMHSA's Co-Occurring Measure (2007).

Minimal coordination, consultation, collaboration, and **integration** are not discrete points, but bands along a continuum of contact and coordination among service providers. "Minimal coordination" is the lowest band along the continuum, and integration the highest band. Please note that these bands refer to *behavior*, not to organizational structure or location. "Minimal coordination" may characterize provision of services by two persons in the same agency working in the same building; "integration" may exist even if providers are in separate agencies in separate buildings.

Minimal coordination: "Minimal coordination" treatment exists if a service provider meets any of the following: (1) is aware of the condition or treatment but has no contact with other providers, or (2) has referred a person with a co-occurring condition to another provider with no or negligible follow-up.

Consultation: Consultation is a relatively informal process for treating persons with co-occurring disorders, involving two or more service providers. Interaction between or among providers is informal, episodic, and limited. Consultation may involve transmission of medical/clinical information, or occasional exchange of information about the person's status and progress. *The threshold for "consultation" relative to "minimal coordination" is the occurrence of any interaction between providers after the initial referral, including active steps by the referring party to ensure that the referred person enters the recommended treatment service.*

Collaboration: Collaboration is a more formal process of sharing responsibility for treating a person with co-occurring conditions, involving regular and planned communication, sharing of progress reports, or memoranda of agreement. In a collaborative relationship, different disorders are treated by different providers, the roles and responsibilities of the providers are clear, and the responsibilities of all providers include formal and planned communication with other providers. *The threshold for "collaboration" relative to "consultation" is the existence of formal agreements and/or expectations for continuing contact between providers.*

Integration: Integration requires the participation of substance abuse and mental health services providers in the development of a single treatment plan addressing both sets of conditions, and the continuing formal interaction and cooperation of these providers in the ongoing reassessment and treatment of the client. *The threshold for "integration" relative to "collaboration" is the shared responsibility for the development and implementation of a treatment plan that addresses the co-occurring disorder. Although integrated services may often be provided within a single program in a single location, this is not a requirement for an integrated system. Integration might be provided by a single individual, if s/he is qualified to provide services that are intended to address both co-occurring conditions.*

Source: Interviews with agency director, program clinical leaders, and clinicians. Some documentation may also exist (e.g., a memorandum of understanding).

Item Response Coding: Coding of this item requires an understanding of the service system and structure of the program, specifically with regard to the provision of mental health as well as addiction treatment services. An understanding of the SAMHSA terms defined above is also necessary. The DDCAT scoring directly corresponds to those definitions.

- **Addiction Only Services = (SCORE-1):** *No document of formal coordination or collaboration. Meets the SAMHSA definition of Minimal Coordination.*

- **(SCORE-2):** *Vague, undocumented, or informal relationship with mental health agencies, or consulting with a staff member from that agency. Meets the SAMHSA definition of Consultation.*

- **Dual Diagnosis Capable = (SCORE-3):** *Formalized and documented collaboration or collaboration*

with mental health agency. Meets the SAMHSA definition of Collaboration.

- **(SCORE-4):** *Formalized coordination and 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.* These programs have a system of care that meets the definition of collaboration and demonstrate an increased frequency of integrated elements. However, these elements are informal and not part of the defined program structure. Typical examples of activities that occur at this level would be informal staff exchange processes or case management on an as-needed basis to coordinate services.

- **Dual Diagnosis Enhanced = (SCORE-5):** *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.*

AOS PROGRAMS

Enhancing IC. Coordination and collaboration with mental health services.

AOS level programs either have no existing relationship or an informal one with the local mental health provider. Programs intending to achieve DDC status must develop more formalized procedures and protocols to coordinate services for persons with co-occurring disorders.

Staff at the North Shore Alcohol and Drug Treatment Center (NSADTC) often referred patients to the Lakeland Mental Health agency for psychiatric emergencies or for a medication evaluation if deemed appropriate. Psychiatric emergencies would occur one to two times per year, and would usually be dealt with by calling 911. A social worker at NSADTC who formerly worked at Lakeland was often asked

to contact his former colleagues so that patients might be evaluated within a more expedient time frame.

To become DDC, NSADTC initiated a series of meetings with Lakeland and the agencies composed a memorandum of understanding (MOU) that addressed admission, transfer and referral procedures (see the appendix for a sample MOU). Monthly meetings between program coordinators and designated intake clinicians were also initiated to review the protocol and discuss plans for common patients.

An AOS program moves from a loose and clinician-driven consultation model to a more formalized and collaborative one in order to become DDC.

ID. Financial incentives.

Definition: Programs that are able to merge funding for the treatment of substance use disorders with funding for the treatment of mental health disorders have a greater capacity to provide integrated services for individuals with co-occurring disorders.

Source: Interview with agency director, knowledge of regional rules and regulations.

Item Response Coding: Coding of this item requires an understanding of the program's current funding streams and the capacity to receive reimbursement for providing services for substance use and mental health disorders.

- **Addiction Only Services = (SCORE-1):** *Can only bill for addiction treatments or bill for persons with substance use disorders.* Programs can only get reimbursement for services provided to individuals with a primary substance use disorder. There is no mechanism for programs to be reimbursed for services provided to treat mental health disorders.

- **(SCORE-2):** *Could bill for either service type if substance use disorder is primary, but staff report* there to be barriers. OR: *Partial reimbursement for mental health services available.* The program's reimbursement codes allow for reimbursement as described in the DDC category, but the staff and administrators report and perceive barriers in getting reimbursed for mental health services; thus the program operates in a manner consistent with AOS.

- **Dual Diagnosis Capable = (SCORE-3):** *Can bill for either service type, however a substance use disorder must be primary.* Programs can be reimbursed for services provided to treat mental health and substance use disorders as long as the person being treated has a substance use disorder that is listed as primary.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Can bill for addiction or mental health treatments, or their combination and/or integration.* Programs can be reimbursed for services provided to treat both mental health and substance use disorders equally. There are no specific requirements for the individual to have a substance use disorder.

AOS PROGRAMS

Enhancing ID. Financial incentives.

Programs scoring at the AOS level typically cannot bill or receive reimbursement for any mental health services. AOS programs that have shifted to enhanced mental health services have been able to locate physicians or prescribers on whose behalf they can bill for unbundled services.

Another mechanism is to obtain contract or grant funding to provide adjunctive pharmacological or psychosocial services. An innovative methadone maintenance program secured additional county grant funding to provide psychiatric and mental health counseling for methadone patients with mental health problems. This additional funding from the county covered the human resources of a psychiatrist (.1 FTE) and a clinical social worker (.5 FTE).

DDC PROGRAMS

Enhancing ID. Financial incentives.

Programs scoring at the DDE level can bill or receive reimbursement for mental health services. This may include mechanisms for billing Medicaid, Medicare, third party insurance, or via state contracts or voucher programs.

The Good Neighbor Clinic, an outpatient addiction treatment program, arranged for their onsite consulting psychologist, Dr. Heinrich, to be able to bill Medicaid and Medicare as well as receive payment for services to indigent patients (via state funding) and for diagnostic and couples therapy services.

II. Program Milieu

IIA. Routine expectation of and welcome to treatment for both disorders.

Definition: Persons with co-occurring disorders are welcomed by the program or facility, and this concept is communicated in supporting documents. Persons who present with co-occurring mental health disorders are not rejected from the program because of the presence of this disorder.

Source: Observation of milieu and physical environment, including posters on walls in waiting rooms and group rooms, as well as interviews with clinical staff, support staff, and patients.

Item Response Coding: Coding of this item requires a review of staff attitudes and behaviors, as well as the program's philosophy reflected in the organization's mission statement and values.

- **Addiction Only Services = (SCORE-1):** *Program expects substance use disorders only, refers or deflects persons with mental health disorders or symptoms.* The program focuses on individuals with substance use disorders only and deflects individuals who present with any type of mental health problem.

- **(SCORE-2):** *Documented to expect substance use disorders only (e*.g., admission criteria, target population), but has informal procedure to allow some persons with mental health disorders to be admitted. The program generally expects to manage only individuals with substance use disorders, but does not strictly enforce the refusal or deflection of persons with mental health problems. The acceptance of persons with mental health disorders likely varies according to the individual clinician's competency or preferences. There is no formalized documentation indicating acceptance of persons with mental health disorders.

- **Dual Diagnosis Capable = (SCORE-3):** *Focus is on substance use disorders, but expects and accepts mental health disorders by routine and if mild and relatively stable as reflected in program documentation.* The program tends to primarily focus on individuals with substance use disorders, but routinely expects and accepts persons with mild or stable forms of co-occurring mental health disorders. This is reflected in the program's documentation and surroundings, (e.g., on walls and brochure racks).

- **(SCORE-4):** *Program formally defined like DDC, but clinicians and program informally expect and treat co-occurring disorders regardless of severity; not well documented.* The program expects and accepts individuals with co-occurring disorders regardless of severity, **but** this program has evolved to this level informally and does **not** have the supporting documentation to reflect this.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Clinicians and program expect and treat co-occurring disorders regardless of severity; well documented.* The program routinely accepts individuals with co-occurring disorders regardless of severity and has formally mandated this through its mission statement, philosophy, welcoming policy, and appropriate protocols.

AOS PROGRAMS

Enhancing IIA. Routine expectation of and welcome to treatment for both disorders.

AOS programs typically foster a more traditional ambiance and environment. This cultural "atmosphere" is focused on substance-related issues and recovery from addiction only. Often this focus hampers a dialogue or openness about mental health problems or concerns. This milieu may not enable a patient to inquire about the potential for recovery from co-occurring mental health disorders.

AOS programs seeking to become DDC must document, for example, in their admission criteria, that the program accepts individuals with mild or stable co-occurring mental health disorders. Programs can decrease the stigma and elevate the status of mental health disorders by providing in waiting areas brochures that describe mental health problems (e.g., depression) and recovery (e.g., Dual Recovery Anonymous brochures). These subjects can also be routinely raised in orientation sessions, community meetings, or family visits. These practices explicitly convey a welcoming and acceptance of persons with mental health disorders.

The cultural undercurrent to a DDC program enables persons with co-occurring mental health problems to feel "normal."

DDC PROGRAMS

Enhancing IIA. Routine expectation of and welcome to treatment for both disorders.

In order to become a DDE level program, DDC programs make a milieu or cultural shift to an equivalent focus on addiction and mental health disorders. Programs must document, for example, mission or philosophy statements, and admission criteria, their acceptance of individuals with co-occurring disorders regardless of severity. Patients in DDC programs will report that they are in treatment to get "clean and sober" but they can also readily talk about mental health problems and ask questions about emotional difficulties. Whereas patients in DDE programs are able to articulate that they have two (or more) co-occurring disorders and they are getting treatment for both (or all). They may contrast this with previous treatment experiences, and remark this is the first program that has addressed both at the same time. Patients also report no stigma or differential status associated with having a co-occurring disorder.

IIB. Display and distribution of literature and patient educational materials.

Definition: Programs that treat persons with co-occurring disorders create an environment which displays, distributes, and provides literature and educational materials that address both mental health and substance use disorders.

Source: Observation of milieu and physical settings, review of documentation of patient handouts, videos, brochures, posters and materials for patients and families that are available and/or used in groups. Patient interviews are also completed.

Item Response Coding: Coding this item depends on examination of the clinic environment and waiting areas. Specifically, the different types and displays of educational materials and public notices are considered.

- **Addiction Only Services = (SCORE-1):** *Addiction or peer support (e.g., AA) only. Materials that address substance use disorders are the only type that is routinely available.*

- **(SCORE 2):** *Available for both disorders, but not routinely offered or formally available.* Materials are available for both substance use and mental health disorders, but they are not routinely accessible or displayed equally. The majority of materials and literature are focused on substance use disorders.

- **Dual Diagnosis Capable = (SCORE-3):** *Routinely available for both mental health and substance use disorders in waiting areas, patient orientation materials and family visits, but distribution is less for mental health disorders.* Materials are routinely available for both substance use and mental disorders, and they are equally displayed. However, materials for mental health disorders are not equitably distributed by staff or the program.

- (SCORE 4): Routinely available for both mental health and substance use disorders with equivalent distribution.

- Dual Diagnosis Enhanced = (SCORE-5): Routinely and equivalently available for both disorders and for the interaction between both mental health and substance use disorders. Materials and literature address both substance use and mental disorders and also attend to concerns specific to co-occurring disorders, such as interactions of co-occurring disorders and the effects on psychological function, health, ability to find and keep a job, etc.

AOS PROGRAMS

Enhancing IIB. Display and distribution of literature and patient educational materials.

AOS programs display materials related to drug and alcohol problems. In some instances, AOS programs may display brochures and have handouts about sexually transmitted diseases, substance use during pregnancy, or transportation entitlements. To become DDC, a program must provide materials about co-occurring disorders, or specific common disorders such as depression, anxiety, and PTSD. These materials should be visible in waiting areas, in patient orientation packets or binders, and distributed during family visits.

Such materials are readily available from SAMHSA (www.samhsa.gov) and the National Institute of Mental Health (www.nimh.nih.gov). Many professional organizations (e.g., the American Psychiatric Association and American Psychological Association)

and pharmaceutical companies also provide excellent materials specific to certain co-occurring disorders.

Specific examples include:

A description of co-occurring disorders and guide to recovery suitable for the general public can be obtained from SAMHSA's National Clearinghouse for Alcohol and Drug Information: http://store.samhsa. gov/product/Overcoming-Substance-Use-and-Mental-Disorders/PHD1078.

Some states have a clearinghouse of materials. For example, the Connecticut Department of Mental Health and Addiction Services funds the Connecticut Clearinghouse that includes many audiovisual materials, books, curricula, and pamphlets on co-occurring disorders, available for providers to borrow or keep. Visit www.ctclearinghouse.org.

DDC PROGRAMS

Enhancing IIB. Display and distribution of literature and patient educational materials.

DDE level programs display and equivalently distribute materials related to substance use and mental health problems, and their interaction. These programs emphasize the common co-occurrence of the disorders and suggest a plan for recovery from both. In orientations to the program, psychoeducational sessions, and family sessions, materials about co-occurring disorders are routinely distributed.

North Shore Behavioral Health introduces the concept of mental health disorders to all patients in their addiction treatment intensive outpatient program. They distribute pamphlets and fact sheets that describe the expected occurrence rates for depression, bipolar disorder, anxiety disorders, and PTSD as well as signs, symptoms and treatments so that patients and families have realistic ideas about their prospects.

They also present information distinguishing drugs from medications, and discuss the challenges of co-occurring disorders in society and in attempting to affiliate with mutual self-help meetings.

DVDs that describe the causes and course of co-occurring disorders are available from a variety of publishers. Hazelden Publishing (www.hazelden.org) offers DVDs on adults with co-occurring disorders and adolescents with co-occurring disorders. These DVDs are brief (about 30 minutes) and targeted to patients and family members. These can serve to systematically raise awareness and promote discussion during treatment groups, family education or visit programs and result in educated consumers of addiction treatment services.

III. Clinical Process: Assessment

IIIA. Routine screening methods for mental health symptoms.

Definition: Programs that provide services to individuals with co-occurring disorders routinely and systematically screen for both substance use and mental health disorders. The following text box provides a standard definition of "screening" and originates from SAMHSA's Co-Occurring Measure (2007).

> **Screening:** The purpose of screening is to determine the **likelihood** that a person has a co-occurring substance use or mental disorder. The purpose is **not** to establish the presence or specific type of such a disorder, but to establish the need for an in-depth assessment. Screening is a formal process that typically is brief and occurs soon after the patient presents for services. There are three essential elements that characterize screening: intent, formal process, and early implementation.
>
> - **Intent:** Screening is intended to determine the possibility of a co-occurring disorder, not to establish definitively the presence, or absence, or specific type of such a disorder.
>
> - **Formal process:** The information gathered during screening is substantially the same no matter who collects it. Although a standardized scale or test need not be used, the same information must be gathered in a consistently applied process and interpreted or used in essentially the same way for everyone screened.
>
> - **Early implementation:** Screening is conducted early in a person's treatment episode. For the purpose of this questionnaire, screening would routinely be conducted within the first four visits or within the first month following admission to treatment.

Source: Interviews with program leadership and staff, observations of medical record (or electronic medical record system) or intake screening form packets.

Item Response Coding: Coding of this item requires the evaluation of screening methods routinely used in the program.

- **Addiction Only Services = (SCORE-1):** *Pre-admission screening based on patient self-report. Decision based on clinician inference from patient presentation or by history.* The program has essentially no screening for mental health disorders. On occasion, a program at this level offers a minimal screening for mental health disorders, which is based on the clinician's initial observations and/or impressions.

- **(SCORE-2):** *Pre-admission screening for symptom and treatment history, current medications, suicide/homicide history prior to admission.* The program conducts a basic screening for mental health problems prior to admission, **but** it is not a routine or standardized component of the evaluation procedures (occurs less than 80 percent of the time). At this level, the screen might include some symptom review, treatment history, current medications, and/or suicide/homicide history. Considerable variability across clinicians occurs at this level.

- **Dual Diagnosis Capable = (SCORE-3):** *Routine set of standard interview questions for mental health using generic framework, e.g., ASAM-PPC (Dimension III) or "biopsychosocial" data collection.* The program conducts a screening process with interview questions for mental health problems; it is incorporated into a more comprehensive evaluation procedure and it occurs routinely (at least 80 percent of the time). This screening is standardized in that it consists of a standard set of questions or items and a routine mental health status screening, including questions to assess risk of harm to self

or others. The format of the screening questions may be open-ended or discrete, but they are used consistently.

- **(SCORE-4):** *Screen for mental health symptoms using standardized or formal instruments with established psychometric properties.* The program conducts a systematic screening process that uses standardized, reliable and valid instrument(s) for screening mental health symptoms. This screening process is routinely used (at least 80 percent of the time).

- **Dual Diagnosis Enhanced = (SCORE-5):** *Screen using standardized or formal instruments for both mental health and substance use disorders with established psychometric properties.* The program conducts a systematic screening process which uses standardized, reliable, and validated instrument(s) for screening both substance use and mental health disorders. This screening process is routinely (at least 80 percent of the time) incorporated into the comprehensive evaluation procedures, and it is considered an essential component in directing the individual's care.

AOS PROGRAMS

Enhancing IIIA. Routine screening methods for mental health symptoms.

AOS programs typically attempt to capture or detect mental health problems via an initial phone interview. This interview typically asks about current and past medications, prior psychiatric hospitalizations, and if the caller ever received a mental health diagnosis. The responses may be used to refer a patient to a mental health treatment center and may not routinely trigger a mental health assessment.

In order to become DDC, AOS programs must extend this procedure to routinely screen for current and past mental health problems using a standard set of interview questions (such as to screen for mood, PTSD, or trauma symptoms), and a routine mental health status screening, including questions to assess risk of harm to self or others.

For more information on screening, an overview of screening and assessment produced by SAMHSA's Co-Occurring Center for Excellence is available. Screening, Assessment, and Treatment Planning for Persons with Co-Occurring Disorders is online at www.samhsa.gov/co-occurring/topics/screening-and-assessment/samsha-overview.aspx.

DDC PROGRAMS

Enhancing IIIA. Routine screening methods for mental health symptoms.

In order to achieve the DDE level, DDC programs institute standardized screening measures for both mental health and substance use disorders, and the measures are used routinely (with at least 80 percent of patients). Measures can screen for more general mental health symptoms and/or substance use, and some are sensitive to identifying specific mental health problems. Examples of some general measures include the Modified MINI Screen (MMS), Mental Health Screening Form-III , CAGE-AID, Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD), and the Global Appraisal of Individual Need (GAIN)

Short Screener (GAIN-SS). Measures with greater specificity to screen for the most prevalent mental health disorders are also recommended. These may include measures for depression (e.g., the Beck Depression Inventory), anxiety (e.g., the Beck Anxiety Inventory), PTSD (e.g., the Posttraumatic Stress Disorder Checklist), and social phobia (e.g., Social Interaction Anxiety Scale). Key to operating at the DDE level is the implementation and systematic application of a standardized (and psychometrically sound) screening measure(s). Examples of screening measures are included in the appendices.

IIIB. Routine assessment if screened positive for mental health symptoms.

Definition: Programs that provide services to persons with co-occurring disorders should routinely and systematically assess for mental health problems as indicated by a positive screen. The following text box provides a standard definition of "assessment" and originates from SAMHSA's Co-Occurring Measure (2007).

Assessment: An assessment consists of gathering information and engaging in a process with the patient that enables the provider to establish the presence or absence of a co-occurring disorder; determine the patient's readiness for change; identify patient strengths or problem areas that may affect the processes of treatment and recovery; and engage a person in the development of an appropriate treatment relationship. The purpose of the assessment is to establish (or rule out) the existence of a clinical disorder or service need and to work with the patient to develop a treatment and service plan. Although a diagnosis is often an outcome of an assessment, a formal diagnosis is **not** required to meet the definition of assessment, as long as the assessment establishes (or rules out) the existence of **some** mental health or substance use disorder.

Assessment is a formal process that may involve clinical interviews, administration of standardized instruments, and/or review of existing information. For instance, if reasonably current and credible assessment information is available at the time of program entry, the (full) process need not be repeated. There are two essential elements for the definition of assessment: establish or rule-out a co-occurring disorder (diagnosis) and use results of the assessment in the treatment plan.

Establish (rule-out) co-occurring disorder: The assessment must establish justification for services and yield sufficient information to determine or rule-out the existence of co-occurring mental health and substance use disorders. (A specific diagnosis is **not** required.)

Use results in the treatment plan: The assessment results must routinely be included in the development of a treatment plan.

Source: Interview with program leadership and staff, policy and procedure manual, and medical record.

Item Response Coding: Coding of this item requires the evaluation of the assessment methodology routinely used in the program or facility.

- **Addiction Only Services = (SCORE-1):** *Assessment for mental health disorders is not recorded in records.* There is no formal or standardized process that assesses for mental health disorders when such disorders are suspected within the program. At most, a program offers ongoing monitoring for mental health disorders when mental health disorders are suspected. In most cases, the ongoing monitoring is to determine appropriateness or exclusion from care.

- **(SCORE-2):** *Assessment for mental health disorders occurs for some patients, but is not routine or is variable by clinician.* This may include a more detailed biopsychosocial assessment or mental status exam, but it is clinician-driven. The program does not offer a standardized process to assess for mental health disorders, but there are variable arrangements for a mental health assessment that are provided based upon clinician preference and expertise.

- **Dual Diagnosis Capable = (SCORE-3):** *Assessment for mental health disorders is present, formal, standardized and documented in 50 to 69 percent of the records.* Formal mental health assessment, if necessary, typically occurs if there is a positive screen for mental health symptoms. The program has a formal policy and a regular mechanism for providing a formal mental health assessment as is necessary based on a positive screen. A formal mental health assessment is defined as a standardized set of elements or interview questions that assesses mental health concerns (current symptoms and chief complaints, past mental health history and typical course and effectiveness of previous treatment, mental health risk, etc.) in a comprehensive fashion. This level of mental health assessment requires the expertise of an individual who is capable of conducting such an evaluation, either by education, training, licensure, certification, or supervised experience. This could be done on site or off site with a formal relationship as documented in a memorandum of understanding, for example.

- **(SCORE-4):** *Assessment for mental health disorders is present, formal, standardized, and documented in 70 to 89 percent of the records.* This includes having a policy and capacity for formal mental health assessments, as defined above, following all positive mental health screens.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Assessment for mental health disorders is formal, standardized and integrated with assessment for substance use symptoms, and documented in at least 90 percent of the records.* The program provides standardized or formal integrated assessment to all individuals following all positive mental health screens per formal policy. An integrated assessment entails comprehensive assessment for both substance use and mental health disorders, which is conducted in a systematic, integrated, and routine manner by a competent provider.

AOS PROGRAMS

Enhancing IIIB. Routine assessment if screened positive for mental health symptoms.

DDC programs offer a mental health assessment to persons who are identified via screening, by history, or by observable behaviors. Such assessments are guided by the belief that there is a potential benefit for a mental health treatment (e.g., medication). DDC programs offer such assessments on site or off site with a formal relationship as documented in a MOU, for example, and these can be conducted on a routine, timely, and consistent basis.

The City Clinic provides a mental health assessment to patients who are identified by self-reports of mental health symptoms. This evaluation is performed by the consultant nurse practitioner who is at the program one day per week.

IIIC. Mental health and substance use diagnoses made and documented.

Definition: Programs serving persons with co-occurring disorders have the capacity to routinely and systematically diagnose both mental health disorders and substance use disorders.

Source: Interviews with staff, medical record/chart.

Item Response Coding: Coding of this item requires the review of diagnostic practices within the program.

- **Addiction Only Services = (SCORE-1):** *Mental health diagnoses are neither made nor recorded in records.* The program does not provide diagnoses for mental health disorders. In some cases, diagnoses of mental health disorders may be discouraged or not recorded.

- **(SCORE-2):** *Mental health diagnostic impressions or past treatment records are present in records, but the program does not have a routine process for making and documenting mental health diagnoses.* The program has a limited capacity to provide mental health diagnoses in an inconsistent capacity. At most, this service is provided occasionally or on an as needed basis.

- **Dual Diagnosis Capable = (SCORE-3):** *The program has a mechanism for providing diagnostic services*

in a timely manner. Mental health diagnoses are documented in 50 to 69 percent of the records. The program has established a formal mechanism for mental health diagnoses to be provided and documented. There is some variability in the program's capacity to do this, but these diagnostic services are provided with enough regularity to meet the needs of individuals with severe or acute mental health disorders.

- **(SCORE-4):** *The program has a mechanism for providing routine, timely diagnostic services.* Mental health diagnoses are documented in 70 to 89 percent of the records. Mental health diagnoses are more frequently recorded, but inconsistently; it is done if issues are identified in the assessment.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Comprehensive diagnostic services are provided in a timely manner.* Mental health diagnoses are documented in at least 90 percent of the records. Standard and routine mental health diagnoses are consistently made. The program has a formal mechanism to ensure a comprehensive diagnostic assessment for each individual, which ensures that mental health diagnoses, when warranted are consistently made and documented. Evidence supports that the full range of mental health diagnoses are provided.

AOS PROGRAMS

Enhancing IIIC. Mental health and substance use diagnoses made and documented.

AOS programs register only substance use disorder diagnoses in their medical record or patient chart. There are numerous reasons for this exclusive focus. To become DDC, however, AOS programs must follow the process from screening to assessment to a formal diagnosis minimally in relation to screening results/presenting problems. In those cases, this diagnosis must be regularly included in the program's documentation or electronic record. Including a problem (e.g., depression problem) or a rule out diagnosis (e.g., R/O dysthymia) is not acceptable at the DDC level.

DDC PROGRAMS

Enhancing IIIC. Mental health and substance use diagnoses made and documented.

DDC programs routinely provide comprehensive diagnostic services in a timely manner, with mental health diagnoses. These diagnoses are routinely reflected in medical records. To attain DDE level services, these diagnoses, when present, are more systematically and routinely ascertained. Further, they are observable in a sample of all records and all patients being treated. The diagnoses are specific, and include all five of the axes on the DSM-IV multi-axial system.

IIID. Mental health and substance use history reflected in medical record.

Definition: Biopsychosocial and other clinical assessment and evaluative processes routinely assess and describe past history and the chronological or sequential relationship between substance use and mental health disorders or problems.

Source: Medical record.

Item Response Coding: Coding of this item requires the review of documentation, specifically the protocols or standards in the collection of the individual's substance use and mental health history.

- **Addiction Only Services = (SCORE-1):** *Collection of substance use disorder history only.* The program does not utilize or promote standardized collection of mental health history and only collects substance use history on a routine basis.

- **(SCORE-2):** *Standard form collects substance use disorder history only. Mental health history collected inconsistently.* In addition to the routine collection of substance use history, the program encourages the collection of mental health history, but this history is neither structured nor incorporated into the standardized assessment process. The degree and variability in collection methods varies considerably by clinician preference and competency. If the program provides a means of collecting a formal mental health history (as set by the standard in DDC), the program does so only variably (less than 80 percent of the time).

- **Dual Diagnosis Capable = (SCORE-3):** *Routine documentation of both mental health and substance use disorder history in record in narrative section.* In the course of routine collection of substance use history, there is a routine narrative section in the record that discusses mental health history and this documentation occurs at least 80 percent of the time. This is evident in the records of the majority of individuals assessed, which document and discuss mental health histories. When applicable for an individual's history, narrative sections note even the absence of mental health related history.

- **(SCORE-4):** *Specific section in record dedicated to history and chronology of both disorders.*

- **Dual Diagnosis Enhanced = (SCORE-5):** *Specific section in record devoted to history and chronology of course of both disorders and the interaction between them is examined temporally.* The program has established a specific standardized section of the assessment that is devoted to both mental health and substance use histories, and this section also provides historical information regarding the interactions between these two disorders. The mental health history section is more structured and has specific content or elements that are to be covered in this section of the assessment, **and** this documentation is completed at least 80 percent of the time.

AOS PROGRAMS

Enhancing IIID. Mental health and substance use history reflected in medical record.

Although mental health and substance use disorders commonly interact, AOS programs typically document only a history of a patient's mental health disorder. However, assessing and diagnosing mental health disorders in addiction treatment are complicated by the effects of substances, from intoxication to craving to withdrawal to protracted withdrawal. The DSM-IV provides some guidelines in making differential diagnosis (substance-induced vs. independent disorders) and the Clinical Institute for Withdrawal Assessment (CIWA) assists in identifying the type and severity of withdrawal symptoms.

Programs at the DDC level typically gather information about a patient's substance use and mental health disorders in terms of ages of onset and course. This is recorded in the patient chart and typically documented as a narrative in a quasi-chronological format.

DDC PROGRAMS

Enhancing IIID. Mental health and substance use history reflected in medical record.

DDE programs recognize the complexity of the interaction of these disorders, and that only by conducting a longitudinal and systematic observation will the relationship between disorders be comprehended. DDE programs have specific and dedicated segments in their initial evaluation process to record dates of onset, course of illness, and the interaction between disorders during periods of abstinence, treatment, institutionalization, etc.

DDE programs recognize that the criteria in the DSM-IV necessitates a chronological and sequential review of symptoms in order to distinguish between substance-induced disorders (e.g., substance-induced mood disorder; substance-induced anxiety disorder, or substance-induced psychotic disorder) vs. independent mental health disorders (e.g., dysthymic disorder, panic disorder, or schizophrenia).

DDE programs do not rely on individual clinicians to probe these chronologies, but ensure consistency by formats within the medical record or electronic medical record. Time line follow-back (TLFB) calendars are a helpful tool to assess and document histories of substance use and mental health symptoms (see the appendix section). This temporal display illustrates the interplay between disorders, which may facilitate an appropriate treatment plan and effective relapse prevention strategies.

IIIE. Program acceptance based on mental health symptom acuity: low, moderate, high.

Definition: Programs offering services to individuals with co-occurring disorders use mental health symptom acuity or instability within the current presentation to assist with the determination of the individual's needs and appropriateness, and whether the program is capable of effectively addressing these needs.

Source: Interview with program leadership and staff, policy and procedure manual, and initial contact and/or referral form.

Item Response Coding: Coding of this item requires an understanding of clinical protocol for individuals who present with different levels of mental health symptom acuity (e.g., suicidality, dangerousness, agitation, self-regulatory capacity). The level of care capacities within the program must be taken into account when rating this item.

- **Addiction Only Services = (SCORE-1):** *Admits persons with no to low acuity.* The program cannot care for individuals who present with any level of mental health symptom acuity.

- **Dual Diagnosis Capable = (SCORE-3):** *Admits persons in program with low to moderate acuity, but who are primarily stable.* The program is capable of providing care to individuals who present with low to medium acuity of mental health symptoms; persons are primarily stable at present (i.e., no active suicidality, homicidality, and some capacity for self-regulation). These programs are able to plan for (i.e., advanced directives) and temporarily manage some crisis stabilization interventions with higher acuity mental health disorders, but tend to rely on linkages/referrals to mental health programs.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Admits persons in program with moderate to high acuity, including those unstable in their mental health disorder.* The program is capable of providing services to individuals who present with all ranges of mental health symptom acuity, including those with high acuity, whose present mental status may be severe or unstable. These programs have the capacity to provide comprehensive treatment in an integrated manner for these high-acuity individuals and are not dependent on a referral system with mental health services.

AOS PROGRAMS

Enhancing IIIE. Program acceptance based on mental health symptom acuity: low, moderate, high.

AOS programs routinely base admission decisions on mental health history (e.g., prior hospitalizations), the present diagnoses they carry (e.g., bipolar disorder), or medications (e.g., olanzapine). Even if persons with mental health disorders are presently stable, by virtue of their history, the AOS program will decline or defer admission. Determination of these patients' entry may be based upon clinical appropriateness ("We can't get their meds if they run out.") or milieu driven ("We don't want other patients to be distracted.") or staff driven ("We only have one person at this residential program here on nights and weekends.").

To be DDC, AOS programs must be able, within the capacity of their staff resources and level of care, to accept patients regardless of their history of mental health disorders, but more so based on their current level of acuity or stability (e.g., suicidality, homicidality, self-care, affective dysregulation, impulsivity). DDC programs accept patients regardless of their history of impairment, but who are primarily stable.

DDC PROGRAMS

Enhancing IIIE. Program acceptance based on mental health symptom acuity: low, moderate, high.

Within the constraints of clinical appropriateness by level of care to manage risk (inpatient hospital vs. outpatient), DDE programs will accept patients for treatment regardless of present acuity. DDC programs seeking to achieve this status should establish appropriate staff members, protocols for patient monitoring and observation, and clear crisis and emergency procedures.

Mental health acuity must be assessed in the DDE program using routine protocols and procedures (and qualified staff to do so). The DDE program accepts patients regardless of acuity (i.e., patients do not need to be stable for admission). DDE programs that are unable to offer a complete continuum of care have established and can demonstrate strong collaborative arrangements with mental health providers.

IIIF. Program acceptance based on severity and persistence of mental health disability: low, moderate, high.

Definition: Programs offering services to individuals with co-occurring disorders use the severity and persistence of disability related to the mental health disorders:

- As an indicator to assist with the determination of the individual's needs, and

- As an indicator whether the program is capable of effectively addressing these needs.

Source: Interviews with program leadership and staff, policy and procedure documentation, and mission statement.

Item Response Coding: Coding of this item requires an understanding of clinical protocol for individuals who present with different levels of severity and persistence of mental health disorder.

- **Addiction Only Services = (SCORE-1):** *Admits persons in program with no to low severity and persistence of mental health disability.* The program can only provide care to individuals who present with no to low levels of persistence of mental health disability. These individuals are defined as those who have no or a very limited history of functional impairment (e.g., person's capacity to manage relationships, job, finances, and social interactions) as a result of a mental health disorder. Persons with a history of severe and persistent mental illnesses, as well as persons with histories of psychiatric hospitalization or extended ambulatory treatments episodes, would be deflected from this type of program.

- **Dual Diagnosis Capable = (SCORE-3):** *Admits persons in program with low to moderate severity and persistence of mental health disability.* The program can only provide care to individuals who present with low to moderate severity and persistence of mental health disability. These individuals are defined as those who have mild to moderate histories of functional impairment as a result of a mental health disorder. In this case, there may be some substantial history of recurrence in the mental health disorder, and/or there has been evidence of continued impairment in at least one functional area. Persons with Axis I mood, anxiety or posttraumatic stress disorders, or Axis II disorders might be more typically served by this program. Individuals with higher severity and persistence of mental health problems are directed toward services in a mental health service program, or they may be at risk for a premature discharge from this program.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Admits persons in program with moderate to high severity and persistence of mental health disability.* The program can provide care to individuals who present with moderate to high severity and persistence of mental health disability. These individuals are often characterized as having chronic, potentially lifelong, functional impairment as a result of a mental health disorder, including persons with severe and persistent mental illnesses. In this case, there may be a significant history of multiple recurrences in the mental health disorder, and/or there has been evidence of continued impairment in several functional areas. DDE programs are able to comprehensively manage the complex treatment needs of these individuals.

AOS PROGRAMS

Enhancing IIIF. Program acceptance based on severity and persistence of mental health disability: low, moderate, high.

AOS programs intending to be at the DDC level will need to accept patients for services who have histories and/or current mental health diagnoses that may be associated with moderate severity and impairment. These diagnostic categories may include: mood, anxiety, PTSD, Axis II disorders, as well as persons with schizophrenia or bipolar disorders. DDC programs will often accept persons who are stable with a non-severe mental illness type. This may be commonly known as a person from Quadrant III (see the Quadrant Model of Co-occurring Disorders, SAMHSA's *Report to Congress*, 2002, which is online at http://www.samhsa.gov/reports/congress2002/).

Programs clearly operating at the DDC level routinely accept persons with bipolar disorder and less often persons with psychotic spectrum disorders, even with current stable clinical status.

DDC PROGRAMS

Enhancing IIIF. Program acceptance based on severity and persistence of mental health disability: low, moderate, high.

DDC programs who seek DDE level on this item will extend their program acceptance to patients in both Quadrant III (mood, anxiety, PTSD, less severe Axis II disorders) and Quadrant IV (schizophrenia, bipolar disorder, schizoaffective disorder) on a more routine basis. Integrated with Item IIIE, these liberal program acceptance policies are based upon clinical appropriateness and not just an unrealistic willingness to accept all patients at admission. DDE programs must have a clear capacity to effectively treat persons of high levels of severity of mental health disability and high levels of acuity.

IIIG. Stage-wise assessment.

Definition: For individuals with substance use and mental health disorders, the assessment of readiness for change for both disorders is essential to the planning of appropriate services. Although the stages of change model has been more traditionally associated with treatment for substance use disorders, assessment of motivational stages across the individual's identified areas of need (including both substance use and mental health) is a more comprehensive approach. Doing so helps to more strategically and efficiently match the individual to appropriate levels of service intensities.

Source: Interviews with program staff, medical records.

Item Response Coding: Coding of this item requires an understanding of the assessment procedures used in the determination of the stages of change or a similar model to systematically determine treatment readiness or motivation.

- **Addiction Only Services = (SCORE-1):** *Not assessed or documented.* The program does not have an established protocol within the evaluative procedures that assesses or documents motivation (stage of change or stage of treatment).

- **(SCORE-2):** *Assessed and documented variably by individual clinician.* The program has an informal, non-standardized process to assess motivation (stage of change or stage of treatment) or the program has encouraged the use of a protocol that assesses motivation, but the process is irregularly used (less than 80 percent of the time).

- **Dual Diagnosis Capable = (SCORE-3):** *Clinician assessed and routinely documented, focused on substance use motivation.* The program has a routinely used assessment protocol that incorporates an assessment of motivation (stage of change or stage of treatment) and documents this consistently (at least 80 percent of the time).

- **(SCORE-4):** *Formal measure used and routinely documented but focusing on substance use motivation only.*

- **Dual Diagnosis Enhanced = (SCORE-5):** *Formal measure used and routinely documented, focus on both substance use and mental health motivation.* The program has a routinely used assessment protocol that incorporates standardized instrument(s) to assess and document motivation (stage of change or stage of treatment), for substance use and for mental health.

AOS PROGRAMS

Enhancing IIIG. Stage-wise assessment.

Assessing stages of patient motivation has added a new level of clinical sophistication to addiction treatment in recent years. As evidence-based practices, motivational interviewing (MI) and motivational enhancement therapies (MET) depend on a careful assessment of patient motivation. A variety of models have been developed to conceptualize motivation to change a specific problem (e.g., cocaine dependence or panic attacks) or motivation to attend treatment. For AOS programs to achieve DDC, they must have identified a patient's level of motivation at the initial assessment.

At a DDC program, clinicians routinely focus on and document patient motivation related to substance use disorders. Mental health disorders are not prioritized or may be variably documented. This assessment may focus on readiness to change or treatment motivation, and they may use motivational assessment methods or measures that are well established in the scientific literature (see the appendix section for examples of these instruments). A global rating in a medical record (precontemplation, contemplation, preparation, action, and maintenance) is also possible.

DDC PRGRAMS

Enhancing IIIG. Stage-wise assessment.

DDC programs intending to become DDE will have made a transition from labeling motivation to a more formal, systematic, and complete effort to assess motivation. This can include the routine incorporation of the well-established self-report measures (URICA, SOCRATES) and/or clinician-completed measure (SATS). It may also include training staff to develop ratings on the ASAM-PPC-2R Treatment Acceptance/Resistance Dimension (Dimension IV). Motivation to change both mental health and addiction problems is routinely documented.

DDE programs can also use clinician ratings on motivation to address any perceived self-efficacy for both substance use and mental health problems. These are incorporated as general clinical ratings at the end of the assessment protocol, or in some cases, a presentation of a two-sided "motivational ruler" to a patient for their own ratings of motivation and efficacy. The specific wording can vary, but a simple example follows:

On a 10-point scale, how much do you want to change your substance use now?

Not at all   **1**--**10** Totally

On a 10-point scale, how sure are you that you will be able to make this change?

Not at all   **1**--**10** Totally

On a 10-point scale, how much to you want to change your mental health problem?

Not at all   **1**--**10** Totally

On a 10-point scale, how sure are you that you will be able to make this change?

Not at all   **1**--**10** Totally

Variants on this approach include an emphasis on "want help" vs. the desire to change.

The stage of change model has been criticized for its cognitive emphasis, so other approaches include more of a behavioral focus ("What steps are you willing to take?)," and incorporate clinician ratings demonstrating evidence for the patient's behavioral commitment to change.

IV. Clinical Process: Treatment

IVA. Treatment Plans.

Definition: In the treatment of individuals with co-occurring disorders, the treatment plans indicate that both the mental health disorder as well as the substance use disorder will be addressed.

Source: Review of treatment plans.

Item Response Coding: Coding of this item requires an understanding of the program's treatment planning process as well as any standardized procedures and formats used in treatment planning.

- **Addiction Only Services = (SCORE-1):** *Address addiction only (mental health not listed).* Within the program, the treatment plans focus exclusively on substance use disorders.

- **(SCORE-2):** *Variable by individual clinician (i.e., plans vaguely or only sometimes address co-occurring mental health disorders).* Within the program, the treatment plans for individuals with co-occurring disorders do not often or specifically address the mental health disorders while the substance use disorders are more comprehensively targeted. The variability is likely due to individual clinician preferences/competencies or resource/time constraints.

- **Dual Diagnosis Capable = (SCORE-3):** *Plans routinely address both disorders although substance use disorders are addressed as primary, mental health as secondary with generic interventions.* Within the program, the treatment

plans of individuals with co-occurring disorders routinely (at least 80 percent of the time) address both the substance use and mental health disorders, although the treatment planning for the substance use disorders tends to be more specific and targeted. Mental health disorders are regularly addressed, albeit in a somewhat non-specific fashion and often within the framework of substance use relapse prevention.

- **(SCORE-4):** *Plans routinely address substance use and mental health disorders; equivalent focus on both disorders; some individualized detail is variably observed.* Within the program, the treatment plans of individuals with co-occurring disorders routinely consider both the substance use and mental health disorders equivalently. However, individualized objectives and interventions specific to each disorder are not consistently incorporated.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Plans routinely address both disorders equivalently and in specific detail; interventions in addition to medication are used to address mental health disorders.* Within the program, the treatment plans of individuals with co-occurring disorders consistently (at least 80 percent of the time) and equivalently address both substance use and mental health disorders with clear, specific, measurable objectives and individualized interventions that systematically target symptoms of the specific disorders. Additionally, the interventions used by the program include both psychosocial and pharmacological treatments.

AOS PROGRAMS

Enhancing IVA. Treatment plans.

Treatment planning is the culmination of a process of assessment and the interaction between the program and the patient. Goals agreed to by both, using a shared decision-making approach, are generally agreed to be most associated with success, as illustrated by the research on therapeutic alliance in psychotherapy. AOS programs, whether by screening, assessment, or even diagnosis, may identify mental health problems, but routinely do not address the same mental health problems in the treatment plan.

To score at the DDC level, these mental health disorders need to be identified, targeted by at least generic treatment interventions, and monitored for treatment response. Interventions may include feelings or anger management groups, or a referral to an outside provider for medication and/or medication management to manage psychiatric symptoms. Although substance use problems may continue to be the major focus of the treatment plan, mental health problems and disorders are increasingly listed.

DDC PROGRAMS

Enhancing IVA. Treatment plans.

In order for DDC programs to transition to DDE on this item, there must be a documented and equivalent focus on treatment planning for both substance use and mental health disorders. A review of records finds this to be normative, and interventions are targeted, generally "in house." The objectives are clear, measurable, and specific (vs. generic) for problems related to each disorder. One defining characteristic of the DDE program is the use of interventions in addition to medications to address and leverage a mental health disorder. These interventions are identified

and connected with treatment plan goals. Interventions may be associated with specific staff members who will deliver them and monitor patient progress.

Joan T's treatment plan identified her problems with prescription narcotics and PTSD. In addition to a series of goals and interventions associated with opioid dependence disorder, the goal for her PTSD was also specified and included reduction in re-experiencing and avoidance symptoms as objectives, and cognitive behavioral therapy as the intervention.

IVB. Assess and monitor interactive courses of both disorders.

Definition: In the treatment of persons with co-occurring disorders, the continued assessment and monitoring of substance use and mental health disorders as well as the interactive course of the disorders is necessary.

Source: Medical records.

Item Response Coding: Coding for this item requires an understanding of the program's process and procedures for monitoring co-occurring disorders.

- **Addiction Only Services = (SCORE-1):** *No attention or documentation of progress with mental health problems.* Within the program, treatment monitoring and documentation reflect a focus on substance use disorders only.

- **(SCORE-2):** *Variable reports of progress on mental health problems by individual clinicians.* Within the program, treatment monitoring of co-occurring mental health problems is conducted inconsistently, largely depending on clinician preference/competence as well as staff resources.

- **Dual Diagnosis Capable = (SCORE-3):** *Routine clinical focus in narrative (treatment plan review or progress note) on mental health problem change; description tends to be generic.* Treatment monitoring for individuals with co-occurring disorders routinely (at least 80 percent of the time) reflects a clinical focus on changes in mental health symptoms, **but** this monitoring tends to be a basic, generic, or qualitative description within the record.

- **(SCORE-4):** *Treatment monitoring and documentation reflecting equivalent in-depth focus on both disorders is available but variably used.* Treatment monitoring and documentation sometimes reflect a more systematic and equally in-depth focus on changes in the symptoms of both mental health and substance use disorders, although this is done variably (less than 80 percent of the time).

- **Dual Diagnosis Enhanced = (SCORE-5):** *Treatment monitoring and documentation routinely reflects clear, detailed, and systematic focus on change in both substance use and mental health disorders.* Treatment monitoring and documentation routinely (at least 80 percent of the time) reflect a systematic and in-depth focus on changes in the symptoms of both mental health and substance use disorders.

AOS PROGRAMS

Enhancing IVB. Assess and monitor interactive courses of both disorders.

Data obtained on this item flow from the assessment process, in particular item IIID: Mental health and substance use history reflected in medical record.

In AOS level services, the chronologies of the disorders are not well documented during the assessment, so treatment is not likely to anticipate the exacerbation or diminution of psychiatric symptoms with abstinence.

DDC programs have attempted to record these chronologies in the assessment, as well as monitor mental health symptom change in early addiction treatment experiences. They may assist patients in preparing for changes (e.g., the return of social phobia symptoms after benzodiazepine and alcohol use are discontinued). DDC programs may also be prepared to rapidly intervene by initiating pharmacotherapy. The DDC record captures the ebbs and flows of both substance use and mental health symptoms.

DDC PROGRAMS

Enhancing IVB. Assess and monitor interactive courses of both disorders.

DDE programs improve on DDC services by the use of more systematic tracking and monitoring of patient symptoms during treatment, and correlation with abstinence or continued use. DDE programs have a medical record structured so that these changes can be regularly observed and recorded. DDE records consistently have documentation of progress or deterioration on both substance use and mental health domains. For example, clinician and/or patient use of time line follow-back (TLFB) calendars are likely to be used by DDE programs (see the appendix for an example).

Many programs will admit and treat patients with less than one month since their last substance use. Also, many of these same patients will have never had a period of one month of abstinence. Monitoring mental health symptoms during the course of treatment will provide essential diagnostic and treatment planning data. Substance-induced disorders and independent mental health disorders can be differentiated during this assessment period. Programs can anticipate different treatment approaches accordingly.

IVC. Procedures for mental health emergencies and crisis management.

Definition: Programs that treat individuals with co-occurring disorders use specific clinical guidelines to manage crisis and mental health emergencies, according to documented protocols.

Source: Interviews with clinicians, policy and procedure manual.

Item Response Coding: Coding of this item requires an understanding of a program's specific clinical protocols used to manage mental health crises or concerns. Consider the program's level of care when coding, meaning that the criteria are met as could be expected from the program's level of care (e.g., programs do not need to be residential/inpatient setting to score a 5).

- **Addiction Only Services = (SCORE-1):** *No guidelines conveyed in any manner.* The program has no written clinical guidelines for mental health emergencies, **and** the majority of staff has no general understanding of any unwritten crisis/emergency management procedures for such situations.

- **(SCORE-2):** *Verbally conveyed in-house guidelines.* The program staff is able to communicate a good general understanding of emergency procedures for crisis situations associated with mental health concerns, although there are no written guidelines. Automatically calling 911 or emergency personnel is not considered acceptable general internal procedure for the management of such crises. A general understanding would include the concept that there is a need to globally assess the risk/crisis and a basic understanding of available options for intervention based on the assessment.

- **Dual Diagnosis Capable = (SCORE-3):** *Documented guidelines: referral or collaborations (to local mental health agency or emergency department).* The program has some written guidelines for mental health crisis/emergency management that include a standard risk assessment that captures mental health emergencies. The written guidelines also

define the available intervention strategies that are matched to the assessed risk. Most of these strategies will include linkage with other providers or entities. An essential aspect of intervention strategies for this level is a formalized arrangement with collaborative entities like mental health clinics or the mental health unit of a hospital emergency department to assist in the management of these crisis situations. Staff is thoroughly familiar with guidelines and collaboration agreements.

- **(SCORE-4):** *Variable use of documented guidelines, formal risk assessment tools and advance directives for mental health crisis and substance use relapse.* The program has detailed written guidelines for in-house crisis/emergency management that are designed to provide consistent risk assessment and interventions to maintain individuals within the program when possible. However, these guidelines are not routinely followed, as evidenced by variable staff competency to use them. This inconsistency is likely due to individual staff preferences/competencies or training resource constraints.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Routine capability, or a process to ascertain risk with ongoing use of substances and/or severity of mental health symptoms; maintain in program unless commitment is warranted.* The program has explicit and thoroughly written guidelines for comprehensive mental health crisis/emergency management that outline explicit in-house procedures, including the completion of advance directives pertaining to mental health crisis and substance use relapse with every patient, use of a formal risk assessment tool, and expected intervention strategies matched to assessed risk. These guidelines are designed to maintain individuals within the program, unless the severity of the circumstance warrants alternative placement. This means that the program is capable of ongoing risk assessment and management of persons with interacting and exacerbating symptoms. Staff expects crisis/emergency situations, and is thoroughly familiar with and adheres to the guidelines.

AOS PROGRAMS

Enhancing IVC. Procedures for mental health emergencies and crisis management.

AOS programs often have undocumented, informal, outdated, or loose arrangements for dealing with mental health emergencies. Often, by deferring admission of cases of even moderate risk, these events are kept to a minimum. Calling 911 is often the only plan given such an event.

DDC level programs have more formalized and documented guidelines and staff can clearly articulate the policy in place. Emergencies may be a more common occurrence. The response to emergencies and crises is typically characterized by a more formalized relationship with the local mental health agency or the mental health emergency service of the nearby hospital. This is a significant upgrade in capability from an internal or familiar relationship with paramedics or the local hospital emergency department staff. Mental health advance directives may be offered to patients to complete as an option upon intake.

DDC PROGRAMS

Enhancing IVC. Procedures for mental health emergencies and crisis management.

DDC programs have more thorough and articulated emergency and crisis intervention plans, expect events to occur more regularly, and have protocols in place so that the emergency or crisis does not result in referral or linkage issues. DDE programs can and do evaluate the nature and level of emergency they may be able to handle in house, and have clearer documented guidelines and a formal risk assessment tool, staff training in risk management and assessment and, if possible, a review of current staffing patterns. Mental health advance directives are completed with every patient upon intake to prepare for any mental health crises and substance use relapse they may have during their treatment episode.

Under no circumstances should the DDC program overextend its clinical capability in this area solely for the purposes of perceived enhancement of services. Taking on more clinical risk must be carefully planned and prepared for in protocol, staffing, and prudence.

IVD. Stage-wise treatment.

Definition: Within programs that treat individuals with co-occurring disorders, ongoing assessment of readiness to change contributes to the determination of continued services which appropriately fit that stage in terms of treatment content, intensity, and utilization of outside agencies.

Source: Interviews with clinicians, review of treatment plans/reviews and progress notes.

Item Response Coding: Coding of this item requires an understanding of the program's protocol for the continued assessment and monitoring of the individual as well as whether the stages of change assessment is part of this continued follow-up. Note: Programs that do not routinely assess the stage of motivation in the initial assessment will likely not consistently address this issue during the course of treatment.

- **Addiction Only Services = (SCORE-1):**
  Not assessed or explicit in treatment plan.
  The program does not monitor motivational stages in an ongoing fashion throughout treatment.

- **(SCORE-2):** *Stage of change or motivation documented variably by individual clinician in treatment plan.* The program assesses and documents stages of motivation/ change on an inconsistent and informal basis throughout the course of treatment. This is largely driven by clinician preference or competence.

- **Dual Diagnosis Capable = (SCORE-3):** *Stage of change or motivation for substance use issues routinely incorporated into individualized plan, but no specific stage-wise treatments.* The program has endorsed the concept of ongoing stage of change assessment and has inserted this into clinical procedures related to substance use disorders. The program routinely (at least 80 percent of the time) assesses and documents stage of change related to substance use issues throughout the treatment course, **but** treatments do not reflect these ongoing stage-wise assessments. This mismatch is often due to the generic application of core services or the placement of individuals into service tracks as opposed to an individualized approach.

- **(SCORE 4):** *Stage of change or motivation routinely incorporated into individualized plan; general awareness of adjusting treatments by substance use stage or motivation only.* There is some evidence that the program considers individual stage of change or motivation in delivering treatments for substance use disorders throughout the course of treatment, but this is done variably (less than 80 percent of the time). Stage of readiness related to mental health disorders is typically not assessed and/or not incorporated into treatment planning.

- **Dual Diagnosis Enhanced = (SCORE-5):**
  Stage of motivation routinely incorporated into individualized plan, and formally prescribed and delivered stage-wise treatments for both substance use and mental health issues. The program regularly assesses and documents stage of change or motivation for both substance use and mental health disorders throughout the course of treatment, **and** specific stage-wise treatments for both disorders are routinely provided (at least 80 percent of the time) to individuals based on these re-assessments.

AOS PROGRAMS

Enhancing IVD. Stage-wise treatment.

Data obtained on this item flow from the assessment process, in particular item IIIG: Stage-wise assessment.

AOS programs may not assess stage of motivation upon admission, and are therefore even less likely to do so during treatment. Individual clinicians may understand the dynamic nature of motivation, in terms of its non-linearity and difficulty assessing its verbalized, inferred, and behavioral components.

DDC programs routinely assess and document stages of motivation for substance use issues on an ongoing basis during the course of treatment, but do so in a way that is fairly general, and which may not be closely linked to intervention choice. DDC programs are "stage aware" and sometimes modify treatments accordingly if only informally. For example, instead of working with a patient as if she is at the relapse prevention stage, by recognizing she is at the precontemplative/comtemplative stage interventions

may be more appropriate to the extent they are motivational enhancement strategies, engagement of significant others in treatment planning, or even psychoeducational in nature. DDC programs do not routinely assess stage of readiness related to mental health issues or deliver stage-wise mental health treatments.

Free resources to assess and build motivational interviewing skills are available. Clinical vignettes used to train clinicians on MI principles are available at http://adai.washington.edu/instruments/VASE-R.htm.

Implementing and maintaining this evidence-based practice can be supported by strong clinical supervision. Supervisory tools for enhancing MI proficiency are available at http://www.attcnetwork.org/explore/priorityareas/science/blendinginitiative/miastep/product_mate.rials.asp

DDC PROGRAMS

Enhancing IVD. Stage-wise treatment.

DDE programs extend beyond DDC by more routinely and reliably assessing and using stage of motivation for both substance use and mental health issues during the course of treatment, and especially during treatment or level of care transitions (see the appendix for examples of stagewise assessment instruments). Stage is directly correlated to the treatment plan objectives and interventions, and drives the particular approach used by clinicians in individual and group sessions and even determines level of care. Differential motivation to address substance use and mental health disorders is addressed.

A residential program has operationalized the ASAM Dimension IV (Treatment Acceptance or Resistance) and reduces the length of stay based upon stage of readiness assessed at two-week intervals. Ratings of precontemplative or contemplative stages result in earlier transitions to an intensive outpatient level of care. This conserves a more expensive resource (residential services) and enables patients at preparation, action, or relapse prevention stages more access.

The Bay Park House implemented the following stage-wise assessment and treatment protocol. Motivational rulers for both mental health and substance use problems were used: Motivation for Change, 1-10 scale: "How motivated are you to change?"; Efficacy, 1-10 scale: "How sure are you that you can make the change?" Responses to these rulers were used to determine the relative importance and risk of substance use vs. mental health issues, and Bay Park House uses these to assign clients to different groups.

IVE. Policies and procedures for medication evaluation, management, monitoring, and compliance.

Definition: Programs that treat individuals with co-occurring disorders are capable of evaluating medication needs, ensuring access to a prescriber when needed, coordinating and managing medication regimens, monitoring for adherence to regimens, and responding to any challenges or difficulties with medication compliance, as documented in policy/procedure.

Source: Interviews (preferably with a prescriber), policy and procedure manual, and medical records.

Item Response Coding: Coding of this item requires an understanding of the program's medication management policies and procedures as well as an understanding of the prescribers' job description.

- **Addiction Only Services = (SCORE-1):**
  Patients on medication routinely not accepted. No capacities to monitor, guide prescribing, or provide psychotropic medications during treatment. The program does not admit individuals who have been prescribed medications. The program has no capacity to manage, monitor, or prescribe medications to individuals.

- **(SCORE-2):** *Certain types of medication are not acceptable, or patient must have own supply for entire treatment episode. Some capacity to monitor psychotropic medications.* The program does **not** have the capacity to prescribe. The program has a very limited capacity to accept and monitor individuals who take medications. Frequently, the program has restrictions on the type of medications that it can manage, or the program requires the individual to have a sufficient supply of their medications in order to be accepted into the program.

- **Dual Diagnosis Capable = (SCORE-3):** *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. The program maintains written policies and guidelines for prescribing medications for individuals with co-occurring disorders in treatment. **And:** The program has a formalized mechanism for accessing the services of a prescriber, who is at least a consultant to the program.

- **(SCORE-4):** *Clear standards and routine for medication prescriber who is also a staff member. Routine access to prescriber and guidelines for prescribing in place. The prescriber may periodically consult with other staff regarding medication plan and recruit other staff to assist with medication monitoring.* The program maintains written standards and guidelines for prescribing and monitoring medications for individuals with co-occurring disorders. **And:** The program retains a staff person(s) who is a prescriber and is competent in the pharmacotherapy of mental health disorders, but the prescribing staff member(s) is **not** fully integrated into the treatment team. This prescribing staff member is frequently perceived as providing an adjunctive service to the program and tends to function in an independent fashion.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Clear standards and routine for medication prescriber who is also a staff member. Full access to prescriber and guidelines for prescribing in place. The prescriber is on the treatment team and the entire team can assist with monitoring.* The program maintains standards and guidelines for prescribing medications to individuals with co-occurring disorders. **And:** The program retains a staff person(s) who is a prescriber competent in the pharmacotherapy of mental health disorders and is fully integrated into the program's treatment team. The prescriber does **not** provide services in an isolated or independent manner or as an external, add-on service. The prescriber is an active member of the treatment program, involved in treatment planning and administrative decisions.

AOS PROGRAMS

Enhancing IVE. Policies and procedures for medication evaluation, management, monitoring and compliance.

Data obtained on this item are related to the staffing dimension, in particular item VIA: Psychiatrist or other physician or prescriber of psychotropic medications. Programs that do not have an onsite prescriber will not have formal policies and procedures to guide prescribing within the program.

AOS programs typically have no patients who are on medication or have very informal undocumented policies about what medications are appropriate. AOS programs moving toward DDC will need to have a prescriber, at least on a contractual basis, develop clearer medication policies and protocols,

and likely will increase the range of acceptable medications. Medications may be kept in a secure, locked storage area, and be self-administered but observed. Medications may be brought in by a patient, and there is some access to the program's prescriber who can renew or give a new prescription during treatment. Medications are monitored, primarily by the prescriber, and necessary adjustments can be made; such protocols are formalized. DDC programs document the use of medications and the patient's compliance with them, and this is evident in the patient medical record.

DDC PROGRAMS

Enhancing IVE. Policies and procedures for medication evaluation, management, monitoring and compliance.

DDE programs generally are capable of accepting patients on most psychotropic medications, which may also extend to medications for other problems: STDs, HIV, chronic pain, hepatitis C, and hypertension. The program has policies which address the use of benzodiazepines or other potentially addictive medications.

The DDE program has the capacity to evaluate existing, and initiate new, pharmacotherapies for either or both the substance use and mental health disorders. Further, the DDE level program may have the capacity

to aggressively treat patients who are actively using substances or patients using medications for medical or mental health problems with abuse liability (e.g., narcotics, anxiolytics), by more frequent contact, stringent toxicological monitoring, and behavioral contracting. These protocols are well developed, and the medication response is consistently well documented in the patient record. As a treatment team member, the prescriber informs the team about the medication plan and the entire team can assist with monitoring.

IVF. Specialized interventions with mental health content.

Definition: Programs that treat individuals with co-occurring disorders utilize specific therapeutic interventions and practices that target specific mental health symptoms and disorders. There is a broad array of such interventions and practices that can be effectively integrated into treatment. Some interventions can be generically applied by programs. These interventions might include stress management, relaxation training, anger management, coping skills, assertiveness training, and problem solving. In some cases, addiction treatment programs may already use some of these techniques in the treatment of substance use disorders. More advanced interventions that could be applied to persons with co-occurring disorders include adaptations of evidence based addiction treatments (e.g., brief motivational or cognitive behavioral therapies, to target specific disorders such as PTSD, depression, anxiety disorders, and Axis II disorders.

This DDCAT item pertains to psychosocial or behavioral interventions for persons with co-occurring disorders in addiction treatment settings. Frequently, providers wish to focus on medications as the primary option for treatment of the mental health disorder. Medications can be FDA-approved medications for the most common disorders in addiction treatment (mood, anxiety, PTSD, bipolar disorder). However, these disorders are at least if not more responsive to psychosocial/behavioral interventions in terms of clinical efficacy and durability of response. Accordingly, this is an opportunity for addiction treatment providers, with and without medication resources, to develop or enhance services along these lines.

DDC programs will typically incorporate generic interventions for co-occurring disorders in group, individual and psycho-educational formats. However, DDE programs will also routinely adapt psychological/behavioral therapies for addiction disorders for use with patients with co-occurring mental health disorders, delivering therapies in a targeted and systematic (manual-guided) fashion. DDE programs also attempt to implement the available integrated treatments for persons with co-occurring disorders (e.g., Seeking Safety, Dialectical Behavior Therapy—Substance Abuse, or other integrated therapies for co-occurring disorders). There are presently few such treatments, although many are in the development and testing stages.

Source: Interviews with clinicians and patients, review of treatment plans, progress notes, group schedule and group curriculum, and observation of group.

Item Response Coding: Coding of this item requires an understanding of the program's interventions for individuals with co-occurring disorders that focus on mental health concerns, symptoms, and disorders.

- **Addiction Only Services = (SCORE-1):** *Not addressed in program content.* The program services do not include the incorporation of therapeutic interventions intended to specifically address mental health concerns, symptoms, or disorders.

- **(SCORE-2):** *Based on judgment by individual clinician; variable penetration into routine services.* The program inconsistently provides generic interventions for mental health concerns. The variability is secondary to the judgment or expertise of the individual clinician.

- **Dual Diagnosis Capable = (SCORE-3):** *In program format as generalized intervention, (e.g., stress management) with penetration into routine services. Routine clinician adaptation of an evidence based addiction treatment (e.g., MI, CBT, Twelve-Step Facilitation).* The program is able to routinely incorporate (at least 80 percent of the time) mental health interventions for individuals with co-occurring disorders. This is translated to mean that the individuals with co-occurring disorders who are treated within the program almost always receive treatment interventions that specifically target mental health problems. **And:** The type of interventions at this level is not usually individualized but instead tends to be of a more broadly applicable, generic, and less resource intensive. Some clinicians may adapt evidence-based addiction treatments to include some general interventions for mental health disorders.

- **(SCORE-4):** *Some specialized interventions by specifically trained clinicians in addition to routine generalized interventions.* The program

meets the standards set at DDC, **and** the program shows some movement toward the DDE level by having some clinicians who offer components of more specialized interventions for specific mental health disorders.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Routine mental health symptom management groups; individual therapies focused on specific disorders; systematic adaptation of an evidence based addiction treatment (e.g., MI, CBT, Twelve Step Facilitation).* The program routinely (at least 80 percent of the time) provides targeted mental health interventions that are individualized to the disorder. This is translated to mean that individuals with co-occurring disorders almost always receive skilled interventions specific to their mental health problems. The mental health interventions at this level are characterized as being comprised of a full array of services types, including integrated treatments for co-occurring disorders or adaptations of evidence-based addiction treatments.

AOS PROGRAMS

Enhancing IVF. Specialized interventions with mental health content.

As the previous item pertains to pharmacological interventions for mental health disorders in addiction treatment, this item pertains to psychosocial interventions. These interventions do not necessarily require a licensed or certified mental health professional to deliver. However, they do require a trained clinician or counselor, who may also have additional certifications, or has attended workshops and received supervision in therapies with that particular co-occurring disorder (e.g., borderline personality disorder) or has had good training in cognitive behavioral therapy.

AOS programs tend to address the mental health problem as a side effect of basic addiction treatment: reviewing relapse triggers may touch on negative mood associated with depression; bringing a patient to a mutual peer support meeting may help with social anxiety disorder; or "working the steps" may soften the rough edges of a personality disorder. To be DDC level, however, the program must address the mental health disorder more intentionally, and explicitly. In DDC programs, this may be accomplished through use of generic interventions such as stress management or coping skills groups, in addition to adaptation of cognitive behavioral therapy (e.g., for substance use, feelings or anger management groups, and individual counseling). The application of these treatments to patients is likely more clinician- vs. program-driven.

It is reasonable for DDC providers to make adaptations to evidence-based practices for substance use disorders in order to apply them to mental health disorders. Although the terminology and definition of "evidence-based" is not consistent or regulated (McGovern & Carroll, 2003), the guide offers resources for manualized approaches that at least have an evidence-base. SAMHSA has been making some strides in creating a National Registry of Evidence-Based Programs and Practices. This effort is in its early stages and far from the level of detail, protocol, and

sophistication needed for a comparison with the FDA-approval process used for pharmacological agents.

Recommendations for evidence-based addiction treatments that may be adapted for persons with co-occurring disorders can be obtained for free from the following websites:

National Institute on Drug Abuse Therapy Manuals (www.nida.nih.gov/DrugPages/Treatment.html)

1. Cognitive-Behavioral Approach
2. Community Reinforcement Approach
3. Individual Drug Counseling
4. Group Drug Counseling
5. Brief Strategic Family Therapy

National Institute on Alcohol Abuse and Alcoholism Therapy Manuals
(http://pubs.niaaa.nih.gov/publications/match.htm)

1. Twelve Step Facilitation Therapy
2. Motivational Enhancement Therapy
3. Cognitive Behavioral Coping Skills Therapy

SAMHSA Youth Treatment Manuals
(http://kap.samhsa.gov/products/manuals/cyt/index.htm)

1. Motivational Enhancement Therapy/Cognitive Behavioral Therapy – 5 Sessions
2. Motivational Enhancement Therapy/Cognitive Behavioral Therapy – 7 Sessions
3. Family Support Network Therapy
4. Assertive Community Reinforcement Approach
5. Multidimensional Family Therapy

SAMHSA Specialized Manuals
(http://kap.samhsa.gov/products/manuals)

1. Therapeutic Community for Residential Programs
2. Matrix Model for Intensive Outpatient Programs
3. Anger Management Groups

DDC PROGRAMS

Enhancing IVF. Specialized interventions with mental health content.

DDE programs will have specialized and targeted interventions and psychosocial treatments for patients with co-occurring disorders. Often, these approaches are specific manual-guided treatments for diagnosed disorders: Seeking Safety for PTSD, Dialectical Behavior Therapy - Substance Abuse for borderline personality disorder; Integrated Group Therapy for bipolar disorder or Modified Therapeutic Community (MTC) for antisocial personality disorders.

Training is widely available in the approaches noted above, and in some regions certified trainers and supervisors exist. Often DDE programs recognize the need for specifically targeted treatments for the most prevalent disorders (those related to mood, anxiety, PTSD) and address this within the context of individual psychotherapy, or a well-delivered cognitive behavioral therapy group that targets both the substance use and the mental health disorder at the same time. These latter approaches are most typical of DDE programs, due to program size, staff resources, and the unnecessary burden of multiple manuals specific for each disorder. However, regardless of the approach used, DDE programs ensure that clients with co-occurring disorders receive treatments that specifically address their mental health disorder.

For the DDE programs, links are provided to resources that either have been tested or documented for persons with co-occurring disorders. A list of evidence-based practices and empirically supported practices for mental health disorders are beyond the scope of this toolkit. A general principle seems to be emerging from the research, however. Much like the finding that the FDA-approved medication for the mental health disorder is indicated for persons with co-existing substance use disorders, it also seems apparent that cognitive behavioral therapies for those conditions are likewise routinely effective. More research is needed to substantiate this finding. But studies with PTSD (Hien et al., 2004), depression (Brown et al., 2001), social phobia (Randall et al., 2001) and other diagnostically heterogeneous groups (McEvoy & Nathan., 2007) support CBT as a generically effective treatment.

The Toolkit references provide several specific citations for studies and manuals related to the most common disorders: mood, anxiety (including PTSD and social phobia) and Axis II disorders. Presently, several interventions are in the investigational stage, including group therapy for co-occurring bipolar disorder and substance use (Roger Weiss, Harvard-McLean Hospital), and PTSD and substance use (Denise Hien, City University of New York; Mark McGovern, Dartmouth Medical School).

The following is an excellent reference for cognitive behavioral therapy groups for depression, anxiety disorders, and dual disorders, with additional chapters on youth, elders, and Latino group approaches: White JR, Freeman AS. Cognitive-behavioral group therapy for specific problems and populations. Washington DC: American Psychological Association, 2002).

SAMHSA's National Registry of Evidence Based Programs and Practices for Co-Occurring Disorders (http://nrepp.samhsa.gov/)

1. Dialectical Behavioral Therapy
2. Multisystemic Family Therapy
3. Seeking Safety
4. Trauma Empowerment and Recovery Model

The Hazelden Co-Occurring Disorders Program for adults with co-occurring disorders in addiction treatment can be obtained at www.hazelden.org. It includes a stage-based curriculum that combines evidence-based motivational enhancement therapy, cognitive behavioral therapy, and twelve-step facilitation, as well as a cognitive behavioral therapy curriculum specifically adapted for individuals with co-occurring disorders. Hazelden Publications also has a series on adolescent co-occurring disorders, with group curriculum on substance use and anxiety disorder, mood disorder, attention deficit/hyperactivity disorder, conduct disorder, oppositional defiant disorder, adjustment disorder, and anger. There is no information about the evidence base for these materials, but they are also available at this link.

IVG. Education about mental health disorders, treatment, and interaction with substance use disorders.

Definition: Programs that offer treatment to individuals with co-occurring disorders provide education about mental health and substance use disorders, including treatment information and the characteristics, features, and interactive course of both types of disorders.

Source: Interviews with staff and patients, review of schedules of psycho-educational groups, group curriculum, and progress notes.

Item Response Coding: Coding of this item requires an understanding of the program's educational components that address mental health disorders.

- **Addiction Only Services = (SCORE-1):** *Not offered.* The program does not offer education about mental health disorders and treatment, or the interaction with substance use disorders.

- **(SCORE-2):** *Generic content, offered variably or by clinician judgment.* The program may occasionally offer education about mental health disorders and mental health treatment, but such programming tends to focus on these issues as they relate to substance use disorders and concerns (e.g., within the context of substance use relapse prevention).

- **Dual Diagnosis Capable = (SCORE-3):** *Generic content, routinely delivered in individual and/ or group formats.* The program routinely (at least 80 percent of the time) provides to all patients general education about mental health disorders, mental health treatment, and its interaction with substance use disorders and treatment. Examples

include a general orientation to co-occurring disorders, educational lectures about mental health disorders and symptoms, and educational lectures about the connections between mental health symptoms and substance use, as well as the appropriate use of psychotropic medications (medications are not drugs). These are lectures designed to inform and are not designed to treat.

- **(SCORE-4):** *Specific content for specific co-morbidities; variably offered in individual and/ or group formats.* The program variably provides information about a patient's specific mental health disorder(s), including symptoms, treatment, and interaction with substance use disorders and treatment. This is primarily driven by individual clinician preference or competence.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Specific content for specific co-morbidities; routinely offered in individual and/or group formats.* The program regularly offers a combination of general education components to all patients as described at the DDC level. The program also has incorporated more individualized instruction (at least 80 percent of the time) that addresses specific issues within mental health disorders. Instruction addresses mental health treatment and its interaction with substance use disorders and treatment and their relation to specific needs of the persons in treatment. Examples might include topics such as interaction between alcohol and marijuana use and social anxiety. These instructional sets tend to be more in-depth and they are designed to address specific needs and risks of individuals in treatment.

AOS PROGRAMS

Enhancing IVG. Education about mental health disorders, treatment, and interaction with substance use disorders.

It is widely believed in medical care that educating patients about the nature and treatment of their disease will improve compliance. It may also increase the likelihood of positive outcomes. A longstanding tradition in addiction treatment is the didactic presentation of a variety of aspects to the disease of addiction, the effect on the family, and the role of mutual self-help groups in long-term recovery. AOS programs may continue with this tradition without much attention to prevalence and the importance of mental health disorders among addicted persons, and their influence on outcomes.

DDC programs routinely offer all patients basic information about mental health disorders through general lectures, group therapy or community meetings, family sessions, and/or through individual sessions. These services are offered in a fairly generic format that is systematically delivered as part of a protocol. They include some effort to have individuals verbalize their diagnosis, understand the current treatments, express the risks in not following through with treatments (in terms of their abstinence from substance use), and have some understanding of the role of the family (including inheritability issues) in both the mental health and substance use disorders. The program may offer a medication group where the differences between drugs and medications are discussed, and the role of medication in self-help recovery traditions is explored. These efforts are a substantial improvement over the lack of attention paid to the common mental health disorders by AOS programs.

DDC PROGRAMS

Enhancing IVG. Education about mental health disorders, treatment, and interaction with substance use disorders.

DDE programs, in contrast to DDC programs, deliver didactic and specific informational material to patients about co-occurring disorders in a systematic, individualized manner. These may be via informational sessions about the specific disorder or the dynamics of co-occurring disorders, or in individual counseling sessions. These efforts are delivered routinely in the program schedule, and a strong emphasis is placed on the patient understanding that they have two disorders, that these disorders interact, that there are treatments for each (and both), that long term compliance is essential, and that recovery with both is possible.

The materials available for these didactics are carefully prepared, used by the program (not just one or two clinicians) and are part of a protocol and treatment plan. Materials are available online from SAMHSA, the National Institute of Mental Health (NIMH), and the Center for Mental Health Services. For example, NIMH provides a detailed booklet on depression for clients. It describes symptoms, causes, and treatments, with information on getting help and coping (2000): http://www.nimh.nih.gov/health/publications/depression/index.shtml.

Hazelden offers free fact sheets and educational handouts at www.cooccurring.org/public/handouts.page. Hazelden Publications has also produced DVDs for adults with co-occurring disorders and adolescents with co-occurring disorders. Both are 30 minutes in length and can be viewed by patients individually or in groups. These can be used for educational purposes and also to initiate a discussion specific to their co-occurring disorder.

IVH. Family education and support.

Definition: Programs that offer treatment to individuals with co-occurring disorders provide education and support to family members regarding co-occurring disorders. This includes treatment information and the characteristics and features of both types of disorders. This is offered to educate collaterals about realistic expectations, the interactive course of the disorders, and the positive prospects for recovery. It is also designed to provide a supportive environment for family members to address specific concerns and be involved in the individual's treatment planning as necessary. Family education and support can occur in individual or group formats. Family is broadly defined to include any significant others and members of support systems.

Source: Interviews with clinicians and patients, schedule of group therapies and support groups, and review of treatment plans and progress notes.

Item Response Coding: Coding of this item requires an understanding of the program's educational and supportive components for the family or significant others that address co-occurring disorders.

- **Addiction Only Services = (SCORE-1):** *For substance use disorders only, or no family education at all.* The program may provide education and support to family members, but the focus tends to be only on substance use disorders.

- **(SCORE-2):** *Variably or by clinician judgment.* The program sometimes provides educational groups or support to families regarding mental health disorders and may at times address mental health questions if raised. These services are informally conducted and usually depend on the competency and preference of the treating clinician.

- **Dual Diagnosis Capable = (SCORE-3):** *Mental health issues routinely but informally, incorporated into family education or support sessions. Available as needed.* The program offers a more formalized mechanism that routinely offers general educational groups and support to families of individuals with co-occurring mental health disorders. These groups tend to focus on information and issues related to substance use disorders. General information about co-occurring mental health disorders, while not in any formal curriculum, is consistently included. While this service might be regularly accessed, it would not be considered to be a standard part of the routine program format.

- **(SCORE-4):** *Generic group on site for families on substance use and mental health disorders, variably offered. Structured group with more routine accessibility.* The program has established family education and support groups that intentionally address both substance use and mental health disorders. **And:** The program makes some effort to incorporate these family groups more regularly into the treatment interventions but this occurs less than 80 percent of the time.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Routine and systematic co-occurring disorder family group integrated into standard program format. Accessed by families of the majority of patients with co-occurring disorders.* The program routinely provides education and support groups to families of individuals with co-occurring disorders on specific disorder co-morbidities and their interactions. **And:** the provision of this service is considered a standard part of the treatment interventions, with the majority of families and/or members of support systems of individuals with co-occurring disorders regularly participating in these activities.

AOS PROGRAMS

Enhancing IVH. Family education and support.

The AOS program seeking to attain DDC status on this item will need to include many of the same ingredients from item IVG (Education about substance use disorders, treatment, and interaction with mental health disorders), but directed towards family members. Addiction treatment programs vary in the inclusion of family members in services. "Family" has been broadened to include any significant others and members of support systems, and it is understood to be a major support or risk factor in ongoing recovery. For this reason, in times past, family members were excluded from treatment. Many evidence-based practices for substance use disorders are family or couples formats, and it is now widely believed that including family members will augment outcomes. AOS programs may educate families about addiction and recovery, with a singular focus on substance issues. Al-Anon may be introduced.

DDC programs take the time, either through individual family sessions, or by using a segment in multi-family groups (which are often required in order to visit the identified patient) to present the co-morbid mental health disorder as a complicating factor in recovery. The importance of medications to manage the mental health disorder may be emphasized. Advanced DDC programs may begin to discuss familial and genetic predispositions, medications vs. drugs and mutual support organizations for family members. These are not protocol driven and are more so driven by individual clinicians, particularly ones with an emphasis on family systems or therapies.

DDC PROGRAMS

Enhancing IVH. Family education and support.

DDE programs routinely offer services to family members or significant others of people with substance use, mental health and co-occurring disorders. Services in DDE programs involve systematic and protocol driven didactics and materials, as well as an individualized presentation of the interactive risks of co-occurring disorders, in terms of etiology, course, compliance and recovery. Educational materials are routinely distributed to family members and significant others. They learn about both (or more) disorders that their loved one is and will be dealing with. Careful discussions about drugs vs. medications, chronic vs. acute care models, and the importance of family support are routinely conducted, and information is routinely provided about mutual support resources for family members.

SAMHSA's Family Psychoeducation Toolkit may be helpful in implementing family education and support programming. You can find it online at http://store. samhsa.gov/product/Family-Psychoeducation-Evidence-Based-Practices-EBP-KIT/SMA09-4423.

Hazelden Publications has also produced a DVD series for adults with co-occurring disorders and adolescents with co-occurring disorders. Both are 30 minutes in length and can be viewed by families individually or in multi-family groups. These can be used for educational purposes and also to initiate a discussion specific to the co-occurring disorder of their family member. The Hazelden Co-Occurring Disorders Program also includes educational resources and a family curriculum. Hazelden is online at www.hazelden.org.

IVI. Specialized interventions to facilitate use of peer support groups in planning or during treatment.

Definition: Addiction treatment programs that offer treatment to individuals with co-occurring disorders provide assistance in developing a support system through peer recovery support groups. Individuals with mental health symptoms and disorders often face additional barriers in linking with peer recovery support groups. These individuals may require additional assistance such as being referred/ accompanied/ introduced to peer recovery support groups by clinical staff, designated liaisons, or mutual aid group peer volunteers. Additional interventions may be required to help individuals find peer support groups with accepting attitudes toward people with co-occurring disorders and toward the use of psychotropic medication.

Source: Interviews with clinicians and patients, schedule or calendar of available peer recovery support groups, and review of treatment plans and progress notes.

Item Response Coding: Coding of this item requires an understanding of the mechanism through which individuals, specifically those with co-occurring disorders, are linked with peer recovery support groups.

- **Addiction Only Services = (SCORE-1):** *No interventions used to facilitate use of either addiction or mental health peer support.* The program does not encourage and does not offer a mechanism to encourage or link individuals with co-occurring mental health disorders to peer support groups.

- **(SCORE-2):** *Used variably or infrequently by individual clinicians for individual patients, mostly for facilitation to addiction peer support groups.* The program sometimes offers assistance or

support to individuals with co-occurring mental health disorders in linking with appropriate peer support groups. This is usually the result of clinician's judgment or preference.

- **Dual Diagnosis Capable = (SCORE-3):** *Generic format on site, but no specific or intentional facilitation based on mental health disorders. More routine facilitation to addiction peer support groups (e.g., AA, NA).* The program routinely encourages the use of peer support groups for patients with co-occurring disorders. While the mechanisms tend to be general and not specific to the individual, they are consistently used. Examples of this include providing individuals with a schedule of peer support groups or making some initial contacts made on their behalf. This is considered to be a standard aspect of the program and occurs at least 80 percent of the time.

- **(SCORE-4):** *Variable facilitation targeting specific co-occurring needs, intended to engage patients in addiction peer support groups or groups specific to both disorders (e.g., DRA, DTR).* Individualized facilitation, including to peer support groups specifically for patients with co-occurring disorders occurs, but is only occasionally documented in charts.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Routine facilitation targeting specific co-occurring needs, intended to engage patients in addiction peer support groups or groups specific to both disorders (e.g., DRA, DTR).* The program systematically advocates for the use of peer support groups with their patients who have co-occurring disorders. Treatment plans and/or progress notes indicate that linkage with self-help groups is regularly discussed with patients. Specialized assistance in making this linkage attempts to proactively

plan for potential barriers or difficulties that the patient might experience in the peer support group environment. Examples of individualized approaches to linking a patient with peer support group include the following: (1) identifying a liaison, who assists the individual in transitioning to the group; (2) consultation with the peer recovery support group on behalf of the individual regarding specialized mental health needs of the individual; (3) an onsite "transition group" with specific mutual aid group members who have some willingness to discuss co-occurring mental health problems pertaining to use of the peer support group in the community; and (4) assisting individuals to identify specific strategies to help them connect with peer support groups. This specialized support to the individual is a standard part of program activities.

AOS PROGRAMS

Enhancing IVI. Specialized interventions to facilitate use of peer support groups in planning or during treatment.

Involvement with mutual support groups, including twelve-step groups, is associated with long-term recovery and positive life change. These groups typically embrace a chronic disease model that understands addiction as a lifelong vulnerability, offer a fellowship of non-using peers, provide an explanatory model with suggested steps for change, and do not collect dues or fees. There is some evidence to suggest persons with co-occurring disorders have difficulty affiliating and participating in addiction peer support groups. Double Trouble in Recovery, Dual Recovery Anonymous, and other groups have been developed to address this challenge. These groups have had varying degrees of success. Addiction twelve-step groups may be optimal, since they have more members with significant periods of sobriety, have clearer guidelines about operations (traditions), and there are more available meetings in the community.

AOS programs typically do not offer special services to bridge the person with a co-occurring disorder into addiction peer support. DDC programs, by identifying the mental health problem, will individualize the referral to mutual peer recovery support groups. The DDC program presents generic information through individual sessions, group sessions, or in-house meetings to help a person with a co-occurring disorder learn how to join and participate (and presumably benefit) from these groups. At the DDC level, these efforts are not systematic, but are more driven by individual clinicians, many of whom have a personal or working understanding of how certain groups in the community tolerate persons with mental health disorders, and to what degree.

There are two manualized evidence-based versions of facilitation of the connection with peer group support in the community. Although neither of these approaches specifically addresses co-occurring mental health barriers, they can be adapted for this purpose:

National Institute on Drug Abuse (NIDA) Therapy Manuals for Individual Drug Counseling and Group Drug Counseling

(www.nida.nih.gov/DrugPages/Treatment.html)

National Institute on Alcohol Abuse and Alcoholism (NIAAA) Therapy Manual for Twelve-Step Facilitation Therapy

(http://pubs.niaaa.nih.gov/publications/match.htm)

Hazelden Publications has also produced a 30-minute DVD (Introduction to Twelve Step Groups) and a manual based on the NIAAA Twelve Step Facilitation Outpatient Program. Hazelden products are available for purchase at www.hazelden.org.

DDC PROGRAMS

Enhancing IVI. Specialized interventions to facilitate use of peer support groups in planning or during treatment.

In contrast to DDC programs, DDE programs may have co-occurring recovery groups on site, and will systematically address the possible difficulties of specific co-occurring disorders. These may include helping a person with depression learn about the role of medications in recovery and how to (or not) discuss medicines in groups. Staff may help a person with social phobia gradually approach a group, first by attending smaller groups, then by showing up earlier and staying later to minimize public speaking anxiety yet being able to meet others. Other assistance may include helping a person with PTSD find meetings without members who may trigger her re-experiencing symptoms. These interventions may be conducted within the context of a co-occurring disorder group, and may feature counselors attending meetings with patients in order to facilitate affiliation. DDE programs document the various strategies used to help people connect with peer support groups to share across all staff and retain the knowledge when staff turnover occurs.

Dual Recovery Anonymous groups (http://www.draonline.org/) and Double Trouble in Recovery groups (http://nrepp.samhsa.gov/ViewIntervention.aspx?id=13) are the most common self-help groups designed specifically for people with co-occurring disorders.

In the absence of dual recovery groups, DDE programs use intentional and routine facilitation approaches to AA and NA groups for medication, anxiety, avoidance, sponsorship, and speaking challenges common among persons with co-occurring disorders.

IVJ. Availability of peer recovery supports for patients with co-occurring disorders.

Definition: Addiction programs that offer treatment to individuals with a co-occurring mental health disorder encourage and support the use of peer supports and role models that include consumer liaisons, alumni groups, etc. Assistance is provided to individuals in developing a support system that includes the development of relationships with individual peer supports (in addition to peer support groups described in the previous item.) For the purpose of this item, peer is defined as a person with a co-occurring disorder.

Source: Interviews with clinicians and patients, review of treatment plans, calendar of available peer recovery supports, understanding of onsite peer recovery supports, consumer liaisons, and alumni staff.

Item Response Coding: Coding of this item requires an understanding of the availability of co-occurring disorders-specific peer supports and role models.

- **Addiction Only Services = (SCORE-1):** *Not present, or if present not recommended.* The program does not support or guide individuals with co-occurring mental health disorders toward peer supports or role models with co-occurring disorders.

- **(SCORE-2):** *Off site, recommended variably.* The program may occasionally offer referrals to offsite peer supports, primarily individuals with substance use disorders. This is largely dependent on the providers' preferences and knowledge of the available individual supports in the area.

- **Dual Diagnosis Capable = (SCORE-3):** *Off site and facilitated with contact persons or informal matching with peer supports in the community, some co-occurring focus.* The program routinely (at least 80 percent of the time) attempts to refer and link individuals with co-occurring mental health disorders to peer supports and role models located off site, some of whom have co-occurring disorders. This is considered a standard support service that can be offered to individuals, but it is not incorporated into treatment planning.

- **(SCORE-4):** *Off site, integrated into plan, and routinely documented with co-occurring focus.* The program routinely (at least 80 percent of the time) integrates off site peer recovery supports into the treatment plan for individuals with co-occurring mental health disorders. Utilization of recovery supports is considered a part of standard programming, and treatment plans consistently reflect the utilization of these peer recovery supports.

- **Dual Diagnosis Enhanced = (SCORE-5):** *On site, facilitated and formally integrated into program (e.g., alumni groups); routinely used and documented with co-occurring focus.* The program routinely supports the use of peer supports and role models for individuals with co-occurring disorders, developing these peer supports on site. Treatment plans consistently document the utilization of these recovery supports.

AOS PROGRAMS

Enhancing IVJ. Availability of peer recovery supports for patients with CODs.

An AOS score on this item is highly associated with a program's score on the previous item (IVI. Specialized interventions to facilitate use of peer support groups in planning or during treatment.). AOS programs make no specialized effort to link persons to support group meetings, and likewise there is no effort to connect current patients to persons with co-occurring disorders who are in recovery.

DDC programs often have staff members who make special introductions to individuals from the community who are in recovery. DDC programs may have staff members who are in personal recovery who attempt to "match" patients with temporary sponsors based upon aspects of mental health disorders commonality. These efforts are typically clinician-driven and not a routine aspect of a protocol designed to link peers who may identify with one another on common co-occurring disorder bases.

DDC programs intentionally and routinely encourage the use of peer supports, but not in a particularly formalized way.

DDC PROGRAMS

Enhancing IVJ. Availability of peer recovery supports for patients with CODs.

In order for DDC programs to achieve DDE status on this item, they must develop clearer systems and protocols for matching patients with peer mentors or supports. These mentors or supports are matched based upon the likelihood of identification on mental health disorders in their background, and the need to learn how to live with both disorders. This matching is protocol-driven rather than clinician-instigated, with the use of volunteer boards, program alumni, the twelve-step hospital and institution committees, volunteer peer recovery specialists, or bridging the gap groups.

The City Clinic has responded to this crucial issue through the establishment of weekly "bridge" groups, co-led by recovering volunteers and a staff member. A segment of the group is dedicated to co-occurring mental health issues with the goal being the development of individual peer support relationships.

A key feature in the DDE program is creating peer support connections on site and having a formal protocol to insure the ongoing availability of these supports.

V. Continuity of Care

VA. Co-occurring disorder addressed in discharge planning process.

Definition: Programs that offer treatment to individuals with a co-occurring mental health disorder develop discharge plans that include an equivalent focus on needed follow-up services for both mental health and substance use disorders.

Source: Discharge plans, memoranda of understanding.

Item Response Coding: Coding of this item requires an understanding of the key elements considered in the documented discharge plan of individuals with co-occurring mental health symptoms.

- **Addiction Only Services = (SCORE-1):** *Not addressed.* Within the program, the discharge plans of individuals with co-occurring disorders routinely focus on substance use disorders only and do not address mental health concerns.

- **(SCORE-2):** *Variably addressed by individual clinicians.* Within the program, the discharge plans of individuals with co-occurring disorders occasionally address both the substance use and mental health disorders, with the substance use disorder taking priority. The variability is typically due to individual clinician judgment or preference.

- **Dual Diagnosis Capable = (SCORE-3):** *Co-occurring disorder systematically addressed as secondary in planning process for offsite referral.* Within the program, the discharge plans of individuals with co-occurring disorders routinely (at least 80 percent of the time) address both the substance use and mental health disorders, but the substance use disorder takes priority and is likely to continue

to be managed within the program's overall system of care or by the next addiction treatment provider. Follow-up mental health services are managed through an offsite linkage (e.g., for medication management), and are often generically addressed as part of the relapse (substance) prevention plan.

- **(SCORE-4):** *Some capacity (less than 80 percent of the time), to plan for integrated follow-up (i.e., equivalently address both substance use and mental health disorders as a priority).* Discharge plans occasionally include appropriate follow-up services for both disorders equally. The variability is secondary to the judgment or expertise of the individual clinician.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Both disorders seen as primary with confirmed plans made for onsite follow-up, or documented arrangements for offsite follow-up; at least 80 percent of the time.* Within the program, the discharge plans of individuals with co-occurring disorders routinely (at least 80 percent of the time) address both the substance use and mental health disorders. **And:** Both disorders are considered a priority, with equivalent emphasis placed on ensuring appropriate follow-up services for each disorder. The program/agency may have the capacity to continue management and support of both disorders in-house or have a formalized agreement with a mental health clinic to provide the needed services. In the case of discharge, appropriate services are identified to address both disorders. Referrals are routinely made, confirmed, and documented in the discharge plan. The program has specific protocols that guide the discharge process.

AOS PROGRAMS

Enhancing VA. Co-occurring disorder addressed in discharge planning process.

Since AOS programs often have not listed the co-existing mental health disorder or problem on the treatment plan, it may not be a subject for intentional discharge planning. In order to achieve DDC status, the AOS program must make a more deliberate plan for post-discharge and consider the influence of the co-occurring disorders on one another. DDC programs will conceptualize the substance use disorder as primary, but will underscore the importance of treatments for the mental health disorder (pharmacological and psychosocial) and will make discharge plans accordingly.

Consultative relationships (see Program Structure items) at a minimum are particularly important here, since successful linkage is predicated on a close relationship and clear referral protocol shared by providers. Programs that admit from and discharge back to wide geographic areas may not have these relationships with every provider, but every effort is made to formally arrange services prior to discharge.

The discharge process, in considering both disorders, retains a largely clinician-driven rather than protocol driven format.

DDC PROGRAMS

Enhancing VA. Co-occurring disorder addressed in discharge planning process.

DDE programs have an equivalent focus on discharge planning for both substance use and psychiatric disorders. Treatment providers and interventions, medications and dose, recovery supports, and relapse risks for both disorders are well described and documented. The DDE medical record has a systematic approach to the discharge process, resulting in a systematic rather than clinician-driven document.

The Miracles detoxification program transfers men from a clinically managed setting to an affiliated

addiction treatment program that has a collaborative agreement with a local mental health clinic. Miracles' staff arranges for the initial appointment prior to discharge, and a primary care giver accompanies the patient to the first appointment. Upon discharge from detoxification services, a patient has already visited the outpatient program (which offers addiction and mental health treatment) and has met his counselor. This has improved linkage to both programs and appropriately addresses both substance use and mental health problems.

VB. Capacity to maintain treatment continuity.

Definition: When programs address the continuum of treatment needs for individuals with co-occurring disorders, there should be a formal mechanism for providing ongoing needed mental health follow-up. Best practice indicates that mental health concerns are followed-up and monitored in a manner that is integrated with substance use follow-up. The program emphasizes continuity of care within the program's scope of practice but if a linkage with another level of care is necessary it sets forth the expectation that treatment continues indefinitely with a goal of illness management.

Source: Interview with clinicians, medical records, and policy and procedure manual.

Item Response Coding: Coding of this item requires an understanding of the continuity of care available for the continued treatment and monitoring of mental health disorders in conjunction with substance use disorders. Outpatient programs, or programs in an agency with an outpatient component, will have a greater capacity to provide ongoing follow-up services, even if linkage with another level of care is necessary. Inpatient or residential programs that stand alone, or serve a large geographic area, may not have this option.

- **Addiction Only Services = (SCORE-1):** *No mechanism for managing ongoing care of mental health needs when addiction treatment program is completed.* With regard to treatment continuity, the program's system of care may offer follow-up care for substance use disorders only, and there is no internal mechanism for providing any follow-up care, support, or monitoring of mental health disorders. Follow-up mental health treatment is referred to an offsite provider without any formal consultation or collaboration. Programs at this level may discharge individuals for mental health symptoms or relapse to substance use with minimal expectation or preparation for returning to services.

- **(SCORE-2):** *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.* With regard to treatment continuity, the program's system of care is similar to that of an AOS system, **but** there are individual clinicians who are competent and willing to provide some increased follow-up care for co-occurring mental health disorders.

- **Dual Diagnosis Capable = (SCORE-3):** *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.* With regard to treatment continuity, the program's system of care has the capacity to provide continued monitoring/support for mental health disorders in addition to any regularly provided follow-up care for substance use disorders until the patient is systematically linked to mental health services off site through collaborative efforts. The program does not routinely discharge a patient for substance use relapse or mental health symptoms, but instead reviews on a case by case basis with the goal of maintaining the individual in treatment when possible; if referral to another level of care is necessary, the program ensures a rapid return for a new episode of program services when indicated.

- **(SCORE-4):** *Formal protocol to manage mental health needs indefinitely, but variable documentation that this is routinely practiced, typically within the same program or agency.* With regard to treatment continuity, the program's system of care has the capacity to provide continued monitoring and treatment for mental health disorders in addition to any regularly provided follow-up care for substance use disorders but use of this continuum is inconsistently documented.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Formal protocol to manage mental health needs indefinitely and consistent documentation that this is routinely practiced, typically within the same program or agency.* With regard to treatment continuity, the program's system of care has the capacity to monitor and treat both mental health disorders and substance use disorders over an extended or indefinite period. Onsite clinical recovery check-ups may be an annual or more frequent option in this type of program. The program, within its scope of practice, treats substance use relapse and exacerbation of mental health symptoms on an individualized basis and maintains individuals in treatment whenever possible. If referral to another level of care is necessary, the program ensures a rapid re-admission when indicated.

AOS PROGRAMS

Enhancing VB. Capacity to maintain treatment continuity.

AOS programs may discharge persons with co-occurring disorders who exhibit mental health symptoms, or who relapse or "slip" in substance use. In order to achieve DDC status, AOS programs will need to develop increased clinical flexibility to explore the exacerbation of mental health symptoms (and deliver treatments) or relapse to substances (and consider the potential for a "therapeutic" approach to relapse). These shifts in protocol must not exceed the program's capability in level of care. DDC programs will evaluate the mental health problem, and if it is sufficiently stable they will retain the patient in the current program. If a referral is required (preferably within the same agency or to a mental health agency with which there is a memorandum of understanding), they will accept the patient back once stabilized.

Likewise, within the constraints particular to level of care and patient safety, relapse to substances may be approached from the context of an exacerbation of symptoms, potentially managed within the program, or once stabilized, not a barrier to immediately accepting the patient back.

Outpatient DDC programs have the capacity to treat both disorders (substance use and psychiatric) for an extended if not open-ended period of time. Residential DDC programs strive to maintain patients with co-occurring disorders within their agency (if they offer a comprehensive array of services) or link to follow-up services through a collaborative relationship with the local mental health provider.

DDC PROGRAMS

Enhancing VB. Capacity to maintain treatment continuity.

DDE programs recognize the chronic nature of addiction and the majority of co-existing mental health disorders. DDE programs, in contrast to DDC, are typically able to provide in-house or within-agency services that promote a patient experience of a seamless process. Patients understand and can verbalize that this is a program that may be in position to continue with them for the foreseeable future if not indefinitely. DDE programs do not see the addiction as primary, but rather maintain continuity for both disorders in an equivalent fashion.

VC. Focus on ongoing recovery issues for both disorders.

Definition: Programs that offer services to individuals with co-occurring disorders support the use of a recovery philosophy (vs. symptom remission only) for both substance use as well as mental health disorders.

Source: Interviews with clinicians and patients, document review (mission statement, brochure, policy and procedure manual), and review of treatment plans.

Item Response Coding: Coding of this item requires an understanding the program's philosophy and how the concept of recovery (vs. remission) is used in the treatment and planning of both substance use and mental health disorders.

- **Addiction Only Services = (SCORE-1):** *Not observed.* The program embraces the philosophy of recovery for substance use disorders only. Mental health recovery is not incorporated.

- **(SCORE-2):** *Individual clinician determined.* The program embraces the philosophy of recovery for substance use disorders only, **but** there are individual clinicians who use recovery philosophy when planning services for mental health disorders as well.

- **Dual Diagnosis Capable = (SCORE-3):** *Routine focus is on recovery from addiction, mental health issues are viewed as potential relapse issues only.* The program systematically embraces the philosophy of recovery for substance use disorders and also includes a recovery philosophy for co-occurring mental health disorders, but primarily as it impacts the recovery from the substance use disorder. For example, a mental health disorder is perceived as a recovery issue in terms of its probability of leading to substance use relapse if not appropriately treated. Medication compliance may be conceptualized as part of generic wellness and positive lifestyle change.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Routine focus on addiction recovery and mental health illness management and recovery, both seen as primary and ongoing.* The program embraces the philosophy of hope and recovery equivalently for both substance use and mental health disorders, and articulates specific goals for persons to achieve and maintain recovery that include both mental health and substance use objectives.

AOS PROGRAMS

Enhancing VC. Focus on ongoing recovery issues for both disorders.

AOS programs will typically focus on recovery from alcohol or drug addiction. Emphasis will be placed on those traditional approaches that have been found to be effective: aftercare, twelve-step group affiliation, finding a sponsor, working the steps, and remaining abstinent one day at a time. Although these processes are in fact associated with long-term positive outcomes, for the person with a co-occurring mental health disorder, another disease and recovery process will need to be embraced.

DDC programs add to the recovery path outlined above with some emphasis on how mental health problems complicate or are a risk factor to one's recovery from substances. This may include the importance of medication compliance, attendance at therapy sessions for cognitive behavioral therapy, or perhaps staying connected to the community mental health center's case management staff members.

DDC PROGRAMS

Enhancing VC. Focus on ongoing recovery issues for both disorders.

Whereas the DDC level program recognizes recovery from substance use as primary and mental health disorders as complicating factors, the DDE level program recognizes the process of recovery for both disorders. The DDE program may utilize the concepts of twelve-step recovery to advance the principles necessary for lifelong illness management. The DDE program will also augment these steps and concepts with mental health recovery literature (from NAMI) or by implementing the Illness Management and Recovery strategy (from SAMHSA): http://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/SMA09-4463

The key is that recovery from both disorders is seen as equivalent and interactive, and that the prospects are positive. The similarity, in terms of the distinction between symptom remission and recovery, is imparted in the DDE program.

Recovery for both addiction and mental illness is seen as a positive lifestyle change and personal transformation. Recovery extends well beyond simple symptom remission or the absence of something negative. Instead, recovery embraces a new life filled with hope, promise, and opportunity.

VD. Specialized interventions to facilitate use of community-based peer support groups during discharge planning.

Definition: Programs that offer services to individuals with co-occurring disorders anticipate difficulties that the individuals might experience when linking or continuing with peer recovery support groups in the community. Thus these programs provide the needed assistance to support this transition beyond active treatment.

Source: Interviews with clinicians and patients, review of progress notes, discharge procedures.

Item Response Coding: Coding of this item requires an understanding of peer support groups within the program's continuum of services and the systems for facilitating the connection with groups in the community. Note: Some programs have difficulty with specialized interventions to facilitate the use of peer support groups while the individual is in treatment. These programs will likely have difficulty meeting this goal when the individual is discharged.

- **Addiction Only Services = (SCORE-1):** *No interventions made to facilitate use of either addiction or mental health peer support groups upon discharge.* The program does not advocate or assist with linking individuals with co-occurring disorders to peer support groups beyond recommendations, assignments, meetings lists, and suggestions to "work the steps" and/or "find a temporary sponsor."

- **(SCORE-2):** *Used variably or infrequently by individual clinicians for individual patients, mostly for facilitation to addiction peer support groups upon discharge.* The program does not advocate or generally assist with linking persons with co-occurring disorders with peer support groups or document any such attempts. However, there is some indication that it may happen as a result of clinician judgment or preference. A connection specific to co-occurring disorders may be variably developed.

- **Dual Diagnosis Capable = (SCORE-3):** *Generic, but no specific or intentional facilitation based on mental health disorders.* More routine facilitation to addiction peer support groups (e.g., AA, NA) upon discharge. The program facilitates the process of linking individuals with co-occurring disorders to peer support groups at discharge. This is not a systematic part of standard discharge planning but occurs with some frequency. Interventions might include providing a list of addiction peer support meetings that are more tolerant of individuals with co-occurring disorders, linking women with PTSD to women's AA meetings, and thoroughly discussing medications vs. drugs, including how to talk at NA meetings about medications and how to find a receptive sponsor.

- **(SCORE-4):** *Assertive linkages and interventions variably made targeting specific co-occurring needs to facilitate use of addiction peer support groups or groups specific to both disorders (e.g., DRA, DTR) upon discharge.* The program sometimes facilitates the process of assertively matching individuals with co-occurring disorders to peer support groups at discharge. This is not a part of standard discharge planning but occurs with increasing frequency (at least 50 percent of the time).

- **Dual Diagnosis Enhanced = (SCORE-5):** *Assertive linkages and interventions routinely made targeting specific co-occurring needs to facilitate use of addiction peer support groups or groups specific to both disorders (e.g., DRA, DTR) upon discharge.* The program routinely recognizes the difficulties of individuals with co-occurring disorders in linking or continuing with peer recovery support groups. It routinely (at least on a 80 percent basis) facilitates this process of assertively matching individuals to these groups at discharge. This may be a component of the program's continuity of care policy, and it may include directed introductions to recovering individuals from the community, accompanying patients to meetings in the community, or enabling patients to attend in-house mutual aid meetings on site indefinitely.

AOS PROGRAMS

**Enhancing VD. Specialized interventions to facilitate
use of community-based peer support groups during discharge planning.**

Item IVI. (Specialized interventions to facilitate use of peer support groups in planning or during treatment) describes the benefits of specialized interventions to facilitate the use of peer recovery support groups for persons with co-occurring disorders during treatment. This item is an extension of this line of clinical reasoning through the discharge and future of the patient. AOS programs have not made specialized interventions up to this point. Nonetheless, many patients will have successfully linked with mutual aid groups. Many patients will have only linked to the degree it satisfies program requirements, and once these are lifted the patient may no longer attend or benefit. Other patients will attend, but not participate.

This may be helpful in fostering remission, but not in the possible lifestyle and psychological changes (transformations) that a person who participates fully can more likely expect.

DDC programs have made efforts to match the patient with community support groups, with a plan to foster the connection and deepen the patient's relationships with other non-using people. Further, these social connections serve as mentors or role models, who can guide the newcomer on a course of recovery. DDC programs note this in the discharge planning process, and perhaps offer the patient the opportunity to return for alumni events.

DDC PROGRAMS

**Enhancing VD. Specialized interventions to facilitate
use of community-based peer support groups during discharge planning.**

The DDE program expands on the usual practices of the DDC program on this item by an increase in systematization and a more protocol-driven (vs. clinician-driven) process. DDE programs ensure the introductions of current patients to peer recovery support group members with an eye toward matching. Peers will have accompanied patients to meetings in the community until sufficient linkage and comfort has been verified, and they may offer in-house Dual

Recovery Anonymous or twelve-step meetings that patients can attend as alumni indefinitely.

Since co-occurring recovery peer support groups are less available in some areas, DDE programs insure smooth linkage and integration with more traditional and readily available community peer support groups, such as Alcoholics Anonymous and Narcotics Anonymous where appropriate.

VE. Sufficient supply and compliance plan for medications is documented.

Definition: Programs that serve individuals with a co-occurring mental health disorder have the capacity to assist these individuals with psychotropic medication planning, prescription and medication access and monitoring, and prescribing sufficient supplies of medications at discharge.

Source: Interviews with clinicians and prescriber, discharge procedures, and review of discharge plans.

Item Response Coding: Coding of this item requires an understanding of the program's prescribing guidelines for individuals with co-occurring disorders at discharge. Note: Programs that have difficulty providing pharmacotherapy for co-occurring mental health disorders while the individual is in treatment will likely have difficulty providing this service at discharge.

- **Addiction Only Services = (SCORE-1):** *No medications in plan.* When an individual with a co-occurring mental health disorder is discharged, the program does not offer any accommodations with regard to medication planning or supplies other than recommending the individual consult with a prescriber or making an appointment on her/his behalf.

- **(SCORE-2):** *Variable or undocumented availability of 30-day supply to next appointment off site.* When an individual with a co-occurring mental health disorder is discharged, the program may prescribe a 30-day supply of medication to "bridge" the individual until his/her next appointment. This is not a consistent or documented program practice.

- **Dual Diagnosis Capable = (SCORE-3):** *Routine 30-day or supply to next appointment off site. Prescription and confirmed appointment documented.* When an individual with a co-occurring mental health disorder is discharged, the program has the capacity to provide for medication planning and prescribes a 30 day or short-term supply until the individual can be linked for follow-up prescriptions at an external site. The follow-up appointment is arranged and confirmed by the program with some exchange of information to the referral site, and the appointment and bridge prescription are documented in the chart.

- **(SCORE- 4):** *Maintains medication management in program/agency until admission to next level of care at different provider (e.g., 45 to 90 days). Prescription and confirmed admission documented.* The program meets the standards set at DDC **and** has the capacity to prescribe a longer-term "bridge" supply of medication.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Maintains medication management in program with provider.* When an individual with a co-occurring mental health disorder is discharged, the program/agency has the capacity to provide continued medication management including prescribing within the program/agency structure for an indefinite period.

AOS PROGRAMS

Enhancing VE. Sufficient supply and compliance plan for medications is documented.

AOS programs are likely not in position to prescribe a supply of medication, but they do encourage linkage, collaboration or consultation with the local mental health provider. DDC programs may have continued or initiated psychotropic medication and a sufficient short-term supply of medication—necessary until the next level of care or provider is reached—is prescribed at discharge. This procedure is documented and a collaborative arrangement with the next level of care provider ensures acknowledgement and successful linkage.

DDC PROGRAMS

Enhancing VE. Sufficient supply and compliance plan for medications is documented.

In contrast to DDC programs, DDE programs will maintain prescribing relationships with patients for the foreseeable future. Inpatient or residential DDE programs that are time-limited will be more closely integrated with the next level of care, often within the same agency, than are DDC providers. Medication is seen to be one key part of an overall strategy of dual recovery and illness management.

VI. Staffing

VIA. Psychiatrist or other physician or prescriber of psychotropic medications.

Definition: Programs that offer treatment to individuals with co-occurring disorders offer pharmacotherapy for both mental health and substance use disorders through the services of prescribing professionals. These programs may have a formal relationship with a psychiatrist, physician, or nurse practitioner (or other licensed prescriber) who works with the clinical team to increase medication compliance, to decrease the use of potentially addictive medications such as benzodiazepines, and to offer medications such as disulfiram, naltrexone, or acamprosate that may help to reduce addictive behavior.

Source: Interviews with program director and clinical staff (and prescriber if possible)

Item Response Coding: Coding of this item requires an understanding of the specific competencies of the prescribing professional and his or her level of involvement with the clinical treatment team.

- **Addiction Only Services = (SCORE-1):** *No formal relationship with a prescriber for this program.* The program has no formal relationship with a prescriber and cannot prescribe or provide medication services to individuals.

- **(SCORE-2):** *Consultant or contractor off site.* The program has an arrangement with a prescriber as a consultant or as an offsite provider.

- **Dual Diagnosis Capable = (SCORE-3):** *Consultant or contractor on site.* The program has an arrangement with a prescriber who is experienced and competent to prescribe medications for mental health disorders, as either a consultant or contractor who provides prescribing services on site but who is not a member of the program's clinical staff (i.e., is only available for direct patient care).

- **(SCORE-4):** *Staff member, present on site for clinical matters only.* The program has a prescriber who is experienced and competent to prescribe medications for mental health disorders as an onsite staff member to provide specific clinical duties, but who does not routinely participate in the organized activities of a clinical team. At this level, this prescriber may be accessed by staff on a limited basis, but this is not routine.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Staff member, present on site for clinical, supervision, treatment team, and/or administration.* The program has a prescriber, who is experienced and competent to prescribe medications for mental health disorders, as an onsite staff member. **And:** This prescribing staff member is also an active participant in the full range of the program's clinical activities, is an integral member of the clinical team, and may serve in a key clinical decision-making or supervisory role.

AOS PROGRAMS

Enhancing VIA. Psychiatrist or other physician or prescriber of psychotropic medications.

Many addiction treatment providers consider this item to be pivotal. Having access to a psychiatrist, physician, or other prescriber can leverage a program from AOS to DDC, and is associated with many other items on the DDCAT. Yet, many programs do have physician coverage, and based upon the role of the physician within the agency, policies for clinical practice, traditions, and patient admission criteria, a program may still be AOS, even with physician coverage.

AOS programs typically do not have a formal relationship with a prescriber. They must refer patients in need of medication or medication evaluations to a prescriber outside the program. DDC programs have contracted with a consultant prescriber who can evaluate and treat patients on site. These contracted arrangements may be inadequate to cover the needs of all patients, but most patients can be initiated on medication when indicated. The DDC program consultant prescriber is typically available for circumscribed clinical duties only.

DDC PROGRAMS

Enhancing VIA. Psychiatrist or other physician or prescriber of psychotropic medications.

Whereas the DDC program prescriber is focused on clinical and patient management responsibilities, the DDE prescriber has taken on a more expanded role. The time allocated for patient care, either during no shows or by arrangement, can be augmented if the prescriber can meet with staff, either individually or in team meetings. To the extent the prescriber can act in a clinical leadership capacity, a teaching and supervision role, the program may enhance its dual diagnosis capability. These relationships are best if formalized and recognized. We have also seen prescribers who are unofficial leaders and do so by example.

In order to become DDE, Deerpath Associates decided to ask their nurse practitioner to attend their weekly clinical team meetings. These meetings occurred every Wednesday morning from 9:00 to 10:30. The nurse practitioner agreed to attend the meetings which cut down on the amount of time staff needed to contact her by e-mail or phone to discuss shared patient issues, but also created an opportunity for her to educate staff, supervise and lead. Staff appreciated this new relationship and the nurse practitioner became more of a leader in the program.

VIB. Onsite clinical staff members with mental health licensure (doctoral or masters level), competency or substantive experience.

Definition: Addiction treatment programs that offer treatment to individuals with co-occurring disorders employ clinical staff with expertise in mental health to enhance their capacity to treat the complexities of mental health disorders that co-occur with substance use disorders.

Source: Interview with leadership and clinicians, review of staff composition.

Item Response Coding: Coding of this item requires an understanding of the program's clinical staff composition, particularly the number of licensed, certified and/or competent mental health staff (e.g., LCSW, LPC, LMFT, licensed psychologist, psychiatrist, APRN, or others with education and experience equivalent to a master's degree). In addition, professionals need at least two years of supervised experience in assessing and treating patients with co-occurring disorders, to the point where certification or autonomy has been achieved and competence established. Competence is defined as a demonstrated capability to assess and diagnose mental health disorders, determine treatment needs including appropriate level of care, prevent and manage mental health crises, and deliver mental health treatments. Clinical staff are so defined if they carry a caseload, conduct individual or group sessions, or provide clinical supervision or medication management.

- **Addiction Only Services = (SCORE-1):** *Program has no staff who is licensed as mental health professionals or has had substantial experience sufficient to establish competence in mental health treatment.* The program has no staff members with specific expertise or competencies in the provision of services to individuals with mental health disorders.

- **(SCORE-2):** *1 to 24 percent of clinical staff have either a license in a mental health profession or substantial experience sufficient to establish competence in mental health treatment.* The program has **less than 25 percent** of clinical staff with specific expertise or competencies in the provision of services to individuals with mental health disorders.

- **Dual Diagnosis Capable = (SCORE-3):** *25 to 33 percent of clinical staff has either a license in a mental health profession or substantial experience sufficient to establish competence in mental health treatment.* The program has **at least 25 percent** of clinical staff with specific expertise or competencies in the provision of services to individuals with mental health disorders.

- **(SCORE-4):** *34 to 49 percent of clinical staff has either a license in a mental health profession or substantial experience sufficient to establish competence in mental health treatment.* The program has **at least 34 percent** of staff with specific expertise or competencies in the provision of services to individuals with mental health disorders.

- **Dual Diagnosis Enhanced = (SCORE-5):** *50 percent or more of clinical staff have either a license in a mental health profession or substantial experience sufficient to establish competence in mental health treatment.* The program has **at least 50 percent** of clinical staff with specific expertise or competencies in the provision of services to individuals with mental health disorders.

AOS PROGRAMS

Enhancing VIB. Onsite clinical staff with mental health licensure (doctoral or masters level), competency or substantive experience.

The AOS program intending to become DDC is challenged to provide an increasing array of services in-house. Some addiction clinicians can and will obtain additional training and certification to be able to deliver psychosocial treatments and assessments to persons with co-occurring disorders in addiction settings. DDC programs have sought to increase the number of mental health educated and trained (if not licensed and certified) clinicians who have demonstrated competence in assessing and treating mental health disorders. A DDC program may have about 25 percent of staff in this category. The DDC program moving in this direction must be careful not to reduce its capability to effectively treat substance use disorders by enhancing its capacity to treat mental health problems. Thus in hiring mental health trained clinicians, those with complementary addiction treatment education and/or experience should be the top priority.

DDC PROGRAMS

Enhancing VIB. Onsite clinical staff with mental health licensure (doctoral or masters level), competency or substantive experience.

DDC programs wishing to achieve DDE status will make a more definitive practice of hiring and staffing the program with personnel who can deliver mental health treatments and who are capable of assessing mental health disorders. Reaching DDE status on this criterion may also involve the inclusion of staff members who are educated in mental health-related fields (e.g., social work, psychology, counseling) upon which addiction treatment expertise will be built in apprenticeship learning models. In DDE programs at least half of the clinical staff has mental health expertise.

VIC. Access to mental health clinical supervision or consultation.

Definition: Programs that offer treatment to individuals with a co-occurring mental health disorder provide formal mental health supervision by a licensed professional (i.e., LCSW, LPC, LMFT, licensed psychologist, psychiatrist, APRN) for both trained providers of mental health services who are unlicensed or who have insufficient competence or experience in the treatment setting, and licensed providers who are developing fidelity to evidence-based practices.

Source: Interview with clinical supervisors, staff composition.

Item Response Coding: Coding of this item requires an understanding of the program's supervision structure, e.g., frequency, duration, supervision "tree," etc., specifically the credentials/qualifications of those individuals who provide supervision for mental health services.

- **Addiction Only Services = (SCORE-1):** *No access.* The program does not have the capacity to provide supervision for mental health services.

- **(SCORE-2):** *Consultant or contractor off site, variably provided.* The program provides a very limited form of mental health supervision that is informal, irregular, and largely undocumented. This service is typically offered through an offsite consultant or only in emergent situations on site.

- **Dual Diagnosis Capable = (SCORE-3):** *Provided as needed or variably on site by consultant, contractor or staff member.* Informal process. The program has the capacity to offer mental health supervision on site to staff on a semi-structured basis. Supervision at this level tends to be focused primarily on case disposition or crisis management issues.

- **(SCORE-4):** *Routinely provided on site by staff member.* The program offers regular supervision for mental health services through an onsite supervisor, which includes some in-depth learning of assessment and treatment skill development and may include activities such as rating forms, review of audiotape sessions, or group observation, **but** this supervision is **not** formally or consistently documented.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Routinely provided on site by staff member and focuses on in-depth learning.* The program has the capacity to offer a structured and regular supervision for mental health services on site and there is evidence that the supervision is focused on in-depth learning of assessment and treatment skill development, which includes use of at least one of the following activities: fidelity rating forms, review of audiotape sessions, or group observation, **and** documentation is available that demonstrates these activities and regularly scheduled supervision periods occur.

AOS PROGRAMS

Enhancing VIC. Access to mental health clinical supervision or consultation.

AOS programs may not have access to mental health consultation or supervision by a licensed professional. In order to become DDC on this item, mental health supervision must be provided. This supervision is typically scheduled either on an individual or group basis, and mental health treatments are encouraged and reviewed. Often the focus in this supervision is on diagnosis, appropriate referral to the prescriber for medication, development of empathy, and the management of countertransference issues. The supervision, although present in DDC programs, may tend to take on a crisis management or disposition "laundry list" vs. in-depth quality.

DDC PROGRAMS

Enhancing VIC. Access to mental health clinical supervision or consultation.

DDE programs have recognized the value of clinical supervision in promoting staff satisfaction, ensuring quality care, and in promoting the installation of evidence-based practices. DDE programs offer regular individual and/or group supervision (no more time allocated than DDC) but deliberately focus the supervision on in-depth learning of clinical practices. These practices may include manual-guided therapies in which the agency has just received training (e.g., Integrated Cognitive Behavioral Therapy [ICBT], Seeking Safety, or DBT-S). Supervision is not confused with caseload review or with discussing administrative issues. The focus is dedicated to clinical process.

An LCSW attended a series of local workshops on cognitive behavioral therapy for mood and anxiety disorders. Through the regional Addiction Technology Transfer Center the professional was able to arrange to be supervised by phone over the course of a year. The agency supported his efforts to acquire this skill since they conceptualized it as an evidence-based practice for which their state agency was beginning to require implementation. He then found that he could use it in his supervision of the addiction counseling staff members, as well as in his individual and group supervision sessions with them. He used both therapy rating forms (he obtained in the workshop) and audiotape recordings of sessions to help the counselors learn how to do cognitive behavioral therapy.

Research on the supervision process is underway, including motivational interviewing approaches to the process itself. A suggested resource for clinical supervision is SAMHA's Technical Assistance Publication 21-A: Competencies for Substance Abuse Treatment Clinical Supervisors, which is online at http://store.samhsa.gov/product/TAP-21A-Competencies-for-Substance-Abuse-Treatment-Clinical-Supervisors/SMA08-4243.

VID. Case review, staffing or utilization review procedures emphasize and support co-occurring disorder treatment.

Definition: Programs that offer treatment to individuals with a co-occurring mental health disorder conduct co-occurring disorder-specific case reviews or engage in a formal utilization review process of co-occurring disorder cases in order to continually monitor the appropriateness and effectiveness of services for this population.

Source: Interview with clinicians, agency documents.

Item Response Coding: Coding of this item requires an understanding of the program's formal process for reviewing mental health issues, specifically the cases of individuals with co-occurring disorders.

- **Addiction Only Services = (SCORE-1):** *Not conducted.* The program has no protocols to review the cases of individuals with co-occurring mental health disorders through a formal case or utilization review process.

- **(SCORE-2):** *Consultant or contractor off site, variably provided.* The program has an offsite consultant who occasionally conducts reviews of the cases of individuals with co-occurring mental health disorders. It appears to be a largely unstructured and informal process, and documentation may not be available.

- **Dual Diagnosis Capable = (SCORE-3):** *Documented, on site, and as needed coverage of co-occurring issues.* The program has a regular procedure for reviewing the cases of individuals with co-occurring mental health disorders through a case or utilization review process by an onsite supervisor. This process is a regular procedure within the program that allows for a general review of patient progress on mental health problems. Documentation supports the consideration of co-occurring disorders services within this process (e.g., weekly staffings).

- **(SCORE-4):** *Documented, routine, but not systematic coverage of co-occurring issues.* The program routinely conducts case reviews of individuals with co-occurring mental health disorders. Reviews are documented, and the program may use a standard format that includes general categories related to co-occurring mental health issues. However, there is no systematic or in-depth evaluation of specific interventions for co-occurring disorders.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Documented, routine and systematic coverage of co-occurring issues.* The program has a routine, formalized protocol that ensures the cases of all patients are comprehensively reviewed in a process that consistently reviews and focuses on co-occurring mental health disorders. This process takes a patient-centered approach that allows for a systematic and critical review of targeted interventions for co-occurring disorders in order to determine appropriateness or effectiveness, and the process may include the patient. Documentation of this formalized process is available.

AOS PROGRAMS

Enhancing VID. Case review, staffing or utilization review procedures emphasize and support co-occurring disorder treatment.

While AOS programs may focus on the achievement of recovery-oriented goals or in compliance with policy, DDC programs attend to the status and progress with the co-occurring disorder in case review, staffing disposition or team meetings. DDC programs review the patient's progress with medications, ability to talk about his/her mental health issues in group, progress with significant others, and the status of these issues in mutual support group affiliation and ongoing recovery. The DDC program tends to review these issues in a general way and on as an as-needed basis.

DDC PROGRAMS

Enhancing VID. Case review, staffing or utilization review procedures emphasize and support co-occurring disorder treatment.

DDC programs review patient progress on mental health problems in a general and variable way. DDE programs do so consistently and in a systematic way. This is accomplished by standard case review forms that a transcriber completes during team or utilization review meetings. In addition to drug related issues and addiction recovery progress, mental health disorders are evaluated with precision and reliability. One program uses Beck Depression Inventory and Posttraumatic Stress Disorder Checklist scores to ascertain patient status upon admission and at two-week reviews. Another residential program lists mental health disorders and designates clinically responsible parties. These clinicians then report on patient progress (per treatment plan) at each weekly team meeting. The DDE program is characterized by routine, systematic, and protocol-driven case review of co-occurring problems.

One indicator of Alphabet Clinic's DDE level of service is their staff familiarity with the scores of the screening measures used to describe initial mental health problem symptom severity. All staff members know the scales on the MINI and the Beck Depression Inventory, and they know how to interpret the clinical importance of scores at the mild, moderate, or severe level. In another program, clinicians in case review meetings call out the latest screening measure scores and stage of change for both mental health and substance use for every patient discussed, not just those they are concerned about.

VIE. Peer/Alumni supports are available with co-occurring disorders.

Definition: Programs that offer treatment to individuals with co-occurring mental health disorders maintain staff or a formalized relationship with volunteers who can serve as co-occurring disorders peer/alumni supports.

Source: Interviews with clinicians and patients, staff and volunteer composition.

Item Response Coding: Coding of this item requires an understanding of the program's staff composition and the availability of staff or volunteers as peer/alumni supports, specifically the presence of individuals in recovery from co-occurring disorders.

- **Addiction Only Services = (SCORE-1):**
  Not available. The program offers neither onsite staff volunteers nor offsite linkages with either alumni or peer recovery supports with co-occurring disorders.

- **(SCORE-2):** *Available, with co-occurring disorders, but as part of the community. Variably referred by individual clinician.* Referrals are made secondary to clinician knowledge and judgment.

- **Dual Diagnosis Capable = (SCORE-3):** *Available, with co-occurring disorders, but as part of community. Routine referrals made through clinician relationships or more formal connections such as peer support service groups (e.g., AA Hospital and Institutional Committees or NAMI).* The program provides offsite linkages with peer/alumni supports on a consistent basis.

- **(SCORE-4):** *Available on site, with co-occurring disorders, either as paid staff, volunteers, or program alumni. Variable referrals made.* The program has developed onsite peer recovery supports, although referrals are not routinely made.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Available on site, with co-occurring disorders, either as paid staff, volunteers, or program alumni. Routine referrals made.* The program maintains a network of staff or volunteers on site who can provide peer/alumni support. Referrals are routinely made, and clinicians have developed relationships with the peer supports that facilitate strategic matching of patients and peers. The program has a formal protocol to ensure the ongoing availability of these supports.

AOS PROGRAMS

Enhancing VIE. Peer/Alumni supports are available with co-occurring disorders.

This item closely corresponds to item IVJ: Availability of peer recovery supports for patients with co-occurring disorders. AOS programs approach this issue in a less intentional and less individualized fashion. In order to become DDC, the AOS program must consider being more targeted in trying to match persons with specific co-morbidities with peer role models. The use of alumni, volunteers, or even carefully supervised recovering staff members may be one way to accomplish this. The key is to enable the patient with a co-occurring disorder to recognize that he or she is not alone in having a co-occurring disorder, and that someone who has been successful can assist them in navigating and connecting with mutual peer support groups in the community.

DDC programs typically will build upon these peer support connections off site and within the community.

The Pottsville Hospital was approached by the three members of the district AA Hospital and Institution Committee. They wanted to "put on" meetings for the patients at the hospital with alcohol problems and hold the meetings in the hospital cafeteria on Friday evenings. The Pottsville Hospital evening intensive outpatient program director felt that adding this component to his Monday through Thursday treatment services would be an excellent new feature to his program. Informally, he has gotten to know some of the "regulars" at the meeting, so he has mentioned to patients he knows have mental health problems to look for specific regulars at the Friday night meetings. He bases these "matches" on his awareness of their empathy for certain types of people based on their own experience.

DDC PROGRAMS

Enhancing VIE. Peer/Alumni supports are available with co-occurring disorders.

DDE programs capitalize on a network of community volunteers, alumni, recovering staff and others, both to serve as onsite recovery supports with co-occurring disorders, and to strategically and routinely connect persons with co-occurring disorders with identifiable others who can facilitate the affiliation with mutual self-help groups. DDE programs utilize traditional twelve-step group mechanisms, peer led Illness Management and Recovery groups, staff and volunteer co-led Bridge groups, and open alumni and Dual Recovery meetings held on site. Programs have wrestled with HIPAA, confidentiality, patient safety, and integrity of milieu challenges. All have agreed these challenges were worth the benefits in facilitating patients' connections to recovering peers.

City Center methadone maintenance clinic has developed an onsite peer program. Selected patients with more than two years of successful treatment in the clinic are included in new staff orientation trainings on substance use and mental health disorders. These Peer Recovery Specialists have an office, meet individually with other patients referred by staff, and participate in weekly staff meetings. The program has intentionally recruited individuals with co-occurring disorders to be Peer Recovery Specialists.

The key difference in the DDE program is that this occurs on site, and the program clinicians are more closely connected with the peer group volunteers, alumni, or members of the community. This connection is often reinforced by monthly meetings to talk about issues from clinical to administrative.

VII. Training

VIIA. All staff members have basic training in attitudes, prevalence, common signs and symptoms, detection and triage for co-occurring disorders.

Definition: Programs that provide treatment to individuals with co-occurring mental health disorders ensure **all** staff who have contact with patients have basic training in co-occurring disorders. For the purpose of this item, basic training minimally includes understanding one's own attitudes, the prevalence of co-occurring disorders and their screening and assessment, common signs and symptoms of these disorders, and triage/brief interventions and treatment decision-making. Staff includes positions such as outpatient receptionists and intake workers, as well as residential third shift and weekend staff.

Source: Interviews with clinical leadership and clinicians, review of strategic training plan and staff training records

Item Response Coding: Coding of this item requires an understanding of the program's requirements for basic skills and training with regard to co-occurring disorders, and knowledge of the number of staff who have completed this training.

- **Addiction Only Services = (SCORE-1):** *No staff have basic training (0 percent trained).* The program's staff has no training and is not required to be trained in basic co-occurring issues.

- **(SCORE-2):** *Variably trained, no systematic agency training plan or individual staff member election (1 to 24 percent of staff trained).* The program encourages basic co-occurring disorders training but has not made this a part of their strategic training plan. A portion of the program's staff are trained as a result of management's encouragement or individual staff interest.

- **Dual Diagnosis Capable = (SCORE-3):** *Certain staff trained, encouraged by management and with systematic training plan (25 to 50 percent of staff trained).* The program's strategic training plan requires basic training in co-occurring disorders for certain staff. **And:** At least 25 percent of all program staff is trained in attitudes, prevalence, screening and assessment, common signs and symptoms, and triage/brief interventions and treatment decision-making for co-occurring disorders.

- **(SCORE-4):** *Many staff trained and monitored by agency strategic training plan (51 to 79 percent of staff trained).* The program's strategic training plan requires the majority of staff to have basic training in co-occurring disorders. **And:** The majority of staff is trained. The program uses the plan to monitor the number of staff who is trained and to ensure they receive ongoing co-occurring disorders training, typically at least annually.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Most staff trained and periodically monitored by agency strategic training plan (80 percent or more of staff trained).* The program's strategic training plan requires all staff to have basic training in co-occurring disorders. **And:** At least 80 percent of all staff is trained in attitudes, prevalence, screening and assessment, common signs and symptoms, and triage and treatment decision-making for co-occurring disorders. The program periodically monitors the number of staff members who are trained and uses the strategic training plan to ensure that this number is maintained despite staff turnover.

AOS PROGRAMS

Enhancing VIIA. All staff has basic training in attitudes, prevalence, common signs and symptoms, detection and triage for co-occurring disorders.

Research into the successful adoption of new technologies has generally found that training alone is of limited value in sustaining change in practice or behavior. Training is the principal mechanism to impart new information, and a necessary step toward practice change. AOS program staff members have variable exposure to information about co-occurring disorders, and about the prevalence of mental health disorders already under their auspices.

DDC programs have made commitments to have certain staff trained in basic issues pertaining to co-occurring disorders: attitudes, prevalence, screening and assessment, common signs and symptoms, triage/brief interventions, and treatment decision making. These trainings might be strategically directed using existing training budgets or release time, and are incorporated into a training plan. The need for this basic training is not just for designated clinical staff, but beneficial for all persons who come in professional contact with patients. Residential program aides are often neglected in training programs, and these individuals provide hours of direct service. As an example of how to incorporate this into existing structures, one program provides nine in-service training sessions a year and has committed 1/3 of these to co-occurring disorders. They include all staff from clinical supervisors to residential aides to front office administrative support staff.

DDC level programs, as part of a strategic training plan, have an increasing number of staff members who are trained in understanding their attitudes, the prevalence, screening, assessment, common signs and symptoms, and triage/brief interventions and therapeutic needs of persons with co-occurring disorders.

An excellent introduction to the topic of workforce development can be found in the SAMHSA Co-Occurring Center for Excellence (COCE) Workforce Development and Training: Technical Assistance (TA) Report for the Co-Occurring State Incentive Grants (COSIGS) September 9, 2005, Updated June 2008, available at http://homeless.samhsa.gov/(S(mizsnr455dukej55bgx342z4))/ResourceFiles/4xcn5gxr.pdf.

DDC PROGRAMS

Enhancing VIIA. All staff members have basic training in attitudes, prevalence, common signs and symptoms, screening and assessment for psychiatric symptoms and disorders.

Whereas DDC programs have focused on training certain staff on basic issues pertaining to co-occurring disorders, the DDE program has all or almost all staff trained in basic issues as a result of a regularly monitored implementation of its strategic training plan. Much like a DDC level program, administrators strategically direct staff training and incorporate the cost of doing so into existing allocations wherever possible.

In contrast to the DDC program, the DDE program intentionally plans and ensures that at all times at least 80 percent of staff are trained in basic issues related to co-occurring disorders.

VIIB. Clinical staff members have *advanced* specialized training in integrated psychosocial or pharmacological treatment of persons with co-occurring disorders.

Definition: Programs that offer treatment to individuals with co-occurring disorders ensure clinical staff has advanced specialized training to increase the needed capacity to provide co-occurring disorders treatment within the program and create a "no wrong door" experience for patients. This aspect of training is incorporated into the program's strategic training plan. For the purpose of this item, advanced specialized training in integrated treatment minimally includes knowledge of specific therapies and treatment interventions for individuals with co-occurring disorders, assessment and diagnosis, and basic knowledge of pharmacological interventions for co-occurring disorders. Clinical staff is defined as those staff who carry a caseload, conduct individual or group sessions, or provides clinical supervision or medication management.

Source: Interviews with executive director, clinical leadership and clinicians, review of strategic training plan and staff training records

Item Response Coding: Coding of this item requires an understanding of the program's requirements for advanced specialized training in co-occurring disorders, and knowledge of the numbers of staff who have completed this training.

- **Addiction Only Services = (SCORE-1):** *No clinical staff have advanced training (0 percent trained).* The program has no staff with advanced specialized training in integrated treatment of co-occurring disorders and does not require this training.

- **(SCORE-2):** *Variably trained, no systematic agency training plan, or individual staff member election (1 to 24 percent of clinical staff trained).* A portion of the program's clinical staff have advanced

specialized training in integrated treatment of co-occurring disorders. This is either encouraged by management or the result of individual staff interest, but this is not a part of the program's strategic training plan.

- **Dual Diagnosis Capable = (SCORE-3):** *Certain staff trained, encouraged by management and with systematic training plan (25 to 50 percent of clinical staff trained).* The program's strategic training plan requires advanced specialized training in integrated treatment of co-occurring disorders for certain staff. **And:** At least 25 percent of clinical staff is trained in specific therapies and treatment interventions, assessment and diagnosis, and pharmacological interventions for co-occurring disorders.

- **(SCORE-4):** *Many staff trained and monitored by agency strategic training plan (51 to 79 percent of clinical staff trained).* The program's strategic training plan requires the majority of clinical staff to have advanced specialized training in co-occurring disorders. **And:** The majority of staff is trained. The program uses the plan to monitor the number of staff who is trained.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Most staff trained and periodically monitored by agency strategic training plan (80 percent or more of clinical staff trained).* The program's strategic training plan requires advanced specialized training in integrated treatment for co-occurring disorders for all clinical staff. **And:** At least 80 percent of all clinical staff is trained in specific therapies and treatment interventions, assessment and diagnosis, and pharmacological interventions for co-occurring disorders. The program periodically monitors the number of staff who is trained and uses the strategic training plan to ensure that this number of trained staff is maintained despite staff turnover.

AOS PROGRAMS

Enhancing VIIB. Clinical staff members have advanced specialized training in integrated psychosocial or pharmacological treatment of persons with co-occurring disorders.

This item reviews the overall training profile of the staff working within a program. AOS programs may not have an overall training strategy and have developed no particular mechanism to track or direct staff needs for training or training actually received. The DDC program has made some effort to organize this critically important and common competency support. DDC programs aim to have 25 to 50 percent of staff with advanced specialized training in integrated treatment for individuals with co-occurring disorders, including knowledge of specific therapies and treatment interventions, assessment and diagnosis, and basic knowledge of pharmacological interventions. This item does not have to be cost-intensive but can require an organization to be more intentional and strategic in the use of its training dollars and time allocations.

An excellent introduction to the topic of workforce development can be found in the SAMHSA Co-Occurring Center for Excellence (COCE) Workforce Development and Training: Technical Assistance (TA) Report for the Co-Occurring State Incentive Grants (COSIGS) September 9, 2005, Updated June 2008, available at http://homeless. samhsa.gov/(S(mizsnr455dukej55bgx342z4))/ ResourceFiles/4xcn5gxr.pdf

DDC PROGRAMS

Enhancing VIIB. Clinical staff members have advanced specialized training in integrated psychosocial or pharmacological treatment of persons with co-occurring disorders.

DDE programs make a substantial investment in creating a "no wrong door" experience for patients. They do this at the program level, and with respect to staff competency, attempt to do this at the individual clinician level. Thus any clinician in a DDE program will respond to a patient with a co-occurring disorder with a similarly open framework. In the DDE program, at least 80 percent of staff will have advanced specialized training if not expertise in integrated treatment of co-occurring disorders. An agency strategic training plan allows program administrators to coordinate the delivery of needed training and may undergird the delivery and fidelity of specific integrated services.

Dual Diagnosis Capability
in Addiction Treatment
(DDCAT) Toolkit
Version 4.0

VI. Epilogue

Both the DDCAT and DDCMHT are designed to be practical measures of program level capacity to address co-occurring substance use and mental health disorders. The intent is for them to be used to improve services for persons and families who suffer from these disorders. These individuals and families are beleaguered by the challenges confronting them with the severity of symptoms associated with these disorders. They should not have to confront barriers and confusion in accessing care. The DDCAT and DDCMHT provide objective, standardized and comparable benchmarks and categorizations of addiction and mental health treatment services and programs. This information can go far to provide consumers with a guide to make informed choices about where to seek treatment.

The DDCAT and DDCMHT are relatively straightforward measures to use. With this toolkit, and the indexes, you can probably proceed with reasonable skill and confidence in assessing services. On the one hand, we support your initiative in doing so. On the other hand, we appreciate the benefits of consultation with others with experience in the administration, scoring, interpretation of findings, and the use of the data for quality improvement efforts. The choice is yours.

Our mission is to improve the chances for recovery among persons with co-occurring substance use and mental health disorders. Their chances are less than average. With the encouragement and pragmatic guidance that the DDCAT and DDCMHT measures provide those who deliver treatment, we hope their chances improve.

Dual Diagnosis Capability in Addiction Treatment (DDCAT) Toolkit

Version 4.0

VII. Appendices

A. Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index Version 4.0

DDCAT — 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= 3rd 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 (MH) services
____Mix of addiction & MH services
____General health services
____Hospital

Size of program

____# of admissions/last fiscal year
____Capacity (highest # serviceable)
____Average length of stay (in days)
____Planned length of stay (in days)
____# of unduplicated clients/year

Agency type

____Private
____Public
____Non-Profit
____Government operated
____Veterans Health Administration

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
    & SU disorders
____HIV/AIDs
____Gay & lesbian
____Seniors/Elders
____Pregnant/post-partum
____Women
____Residential setting for patients
    and their children
____Men
____DUI/DWI
____Criminal justice clients
____Adult General

DDCAT — 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 and 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 mental health agency, 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 and 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 bill 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 mental health services available.	Can bill for either service type; however, a substance use disorder must be primary.		Can bill for addiction or mental health treatments, or their combination and/or integration.

Table Header Key	
1-AOS	Addiction Only Services
3-DDC	Dual Diagnosis Capable
5-DDE	Dual Diagnosis Enhanced

DDCAT — Rating Scale

	1 – AOS	2	3 – DDC	4	5 – DDE
II. Program Milieu					
IIA. Routine expectation of and welcome to treatment for both disorders.	Program expects substance use disorders only; refers or deflects persons with mental health disorders or symptoms.	Documented to expect substance use disorders only (e.g., admission criteria, target population), but has informal procedure to allow some persons with mental health disorders to be admitted.	Focus is on substance use disorders, but accepts mental health disorders by routine and if mild and relatively stable as reflected in program documentation.	Program formally defined like DDC but clinicians and program informally expect and treat co-occurring disorders regardless of severity, not well documented.	Clinicians and program expect and treat co-occurring disorders regardless of severity, 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.	Routinely available for both mental health and substance use disorders in waiting areas, patient orientation materials and family visits, but distribution is less for mental health disorders.	Routinely available for both mental health and substance use disorders with equivalent distribution.	Routinely and equivalently available for both disorders and for the interaction between mental health and substance use disorders.
III. Clinical Process: Assessment					
IIIA. Routine screening methods for mental health 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 and treatment history, current medications, suicide/homicide history prior to admission.	Routine set of standard interview questions for mental health using a generic framework, e.g., ASAM-PPC (Dimension III) or "Biopsychosocial" data collection.	Screen for mental health symptoms using standardized or formal instruments with established psychometric properties.	Screen using standardized or formal instruments for both mental health and substance use disorders with established psychometric properties.
IIIB. Routine assessment if screened positive for mental health symptoms.	Assessment for mental health disorders is not recorded in records.	Assessment for mental health disorders occurs for some patients, but is not routine or is variable by clinician.	Assessment for mental health disorders is present, formal, standardized, and documented in 50-69% of the records.	Assessment for mental health disorders is present, formal, standardized, and documented in 70-89% of the records.	Assessment for mental health disorders is formal, standardized, and integrated with assessment for substance use symptoms, and documented in at least 90% of the records.

DDCAT — Rating Scale

	1−AOS	2	3−DDC	4	5−DDE
IIIC. Mental health and substance use diagnoses made and documented.	Mental health diagnoses are neither made nor recorded in records.	Mental health diagnostic impressions or past treatment records are present in records but the program does not have a routine process for making and documenting mental health diagnoses.	The program has a mechanism for providing diagnostic services in a timely manner. Mental health diagnoses are documented in 50-69% of the records.	The program has a mechanism for providing routine, timely diagnostic services. Mental health diagnoses are documented in 70-89% of the records.	Comprehensive diagnostic services are provided in a timely manner. Mental health diagnoses are documented in at least 90% of the records.
IIID. Mental health 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 record dedicated to history and chronology of both disorders.	Specific section in record devoted to history and chronology of both disorders and the interaction between them is examined temporally.
IIIE. Program acceptance based on mental health 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 mental health disorder.
IIIF. Program acceptance based on severity and persistence of mental health disability: low, moderate, high.	Admits persons in program with no to low severity and persistence of mental health disability.		Admits persons in program with low to moderate severity and persistence of mental health disability.		Admits persons in program with moderate to high severity and persistence of mental health disability.
IIIG. Stage-wise assessment.	Not assessed or documented.	Assessed and documented variably by individual clinician.	Clinician assessed and routinely documented, focused on substance use motivation.	Formal measure used and routinely documented but focusing on substance use motivation only.	Formal measure used and routinely documented, focus on both substance use and mental health motivation.

DDCAT — Rating Scale

	1 – AOS	2	3 – DDC	4	5 – DDE
IV. Clinical Process: Treatment					
IVA. Treatment plans.	Address addiction only (mental health not listed).	Variable by individual clinician, i.e., plans vaguely or only sometimes address co-occurring mental health disorders.	Plans routinely address both disorders although substance use disorders addressed as primary, mental health as secondary with generic interventions.	Plans routinely address substance use and mental health disorders; equivalent focus on both disorders; some individualized detail is variably observed.	Plans routinely address both disorders equivalently and in specific detail; interventions in addition to medication are used to address mental health disorders.
IVB. Assess and monitor interactive courses of both disorders.	No documentation of progress with mental health disorders.	Variable reports of progress on mental health disorder by individual clinicians.	Routine clinical focus in narrative (treatment plan review or progress note) on mental health disorder change; description tends to be generic.	Treatment monitoring and documentation reflecting equivalent in-depth focus on both disorders is available but variably used.	Treatment monitoring and documentation routinely reflects clear, detailed, and systematic focus on change in both substance use and mental health disorders.
IVC. Procedures for mental health 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 emergency department).	Variable use of documented guidelines, formal risk assessment tools, and advance directives for mental health crisis and substance use relapse.	Routine capability, or a process to ascertain risk with ongoing use of substances and/or severity of mental health symptoms; maintain in program unless commitment is warranted.
IVD. Stage-wise treatment.	Not assessed or explicit in treatment plan.	Stage of change or motivation documented variably by individual clinician intreatment plan.	Stage of change or motivation routinely incorporated into individualized plan, but no specific stage-wise treatments.	Stage of change or motivation routinely incorporated into individualized plan; general awareness of adjusting treatments by substance use stage or motivation only.	Stage of change or motivation routinely incorporated into individualized plan; formally prescribed and delivered stage-wise treatments for both substance use and mental health disorders.

DDCAT — Rating Scale

	1−AOS	2	3−DDC	4	5−DDE
IVE. Policies and procedures for medication evaluation, management, monitoring, and compliance.	Patients on medication routinely not accepted. No capacities to monitor, guide prescribing or provide psychotropic medications during treatment.	Certain types of medication are not acceptable, or patient 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 prescribing are provided. Monitoring of the medication is largely provided by the prescriber.	Clear standards and routine for medication prescriber who is also a staff member. Routine access to prescriber and guidelines for prescribing in place. The prescriber may periodically consult with other staff regarding medication plan and recruit other staff to assist with medication monitoring.	Clear standards and routine for medication prescriber who is also a staff member. Full access to prescriber and guidelines for prescribing in place. The prescriber is on the treatment team and the entire team can assist with monitoring.
IVF. Specialized interventions with mental health content.	Not addressed in program content.	Based on judgment by individual clinician; variable penetration into routine services.	In program format as generalized intervention (e.g., stress management) with penetration into routine services. Routine clinician adaptation of an evidence-based addiction treatment (e.g., MI, CBT, Twelve-Step Facilitation).	Some specialized interventions by specifically trained clinicians in addition to routine generalized interventions.	Routine mental health symptom management groups; individual therapies focused on specific disorders; systematic adaptation of an evidence-based addiction treatment (e.g., MI, CBT, Twelve-Step Facilitation).
IVG. Education about mental health disorders, treatment, and interaction with substance use disorders.	Not offered.	Generic content, offered variably or by clinician judgment.	Generic content, routinely delivered in individual and/or group formats.	Specific content for specific co-morbidities; variably offered in individual and/or group formats.	Specific content for specific co-morbidities; routinely offered in individual and/or group formats.
IVH. Family education and support.	For substance use disorders only, or no family education at all.	Variably or by clinician judgment.	Mental health disorders routinely, but informally incorporated into family education or support sessions. Available as needed.	Generic family group on site on substance use and mental health disorders, variably offered. Structured group with more routine accessibility.	Routine and systematic co-occurring disorders family group integrated into standard program format. Accessed by families of the majority of patients with co-occurring disorders.

DDCAT — Rating Scale

	1 – AOS	2	3 – DDC	4	5 – DDE
IVI. Specialized interventions to facilitate use of peer support groups in planning or during treatment.	No interventions used to facilitate use of either addiction or mental health peer support.	Used variably or infrequently by individual clinicians for individual patients, mostly for facilitation to addiction peer support groups.	Generic format on site, but no specific or intentional facilitation based on mental health disorders. More routine facilitation to addiction peer support groups (e.g., AA, NA).	Variable facilitation targeting specific co-occurring needs, intended to engage patients in addiction peer support groups or groups specific to both disorders (e.g., DRA, DTR).	Routine facilitation targeting specific co-occurring needs, intended to engage patients in addiction peer support groups or groups specific to both disorders (e.g., DRA, DTR).
IVJ. Availability of peer recovery supports for patients with co-occurring disorders.	Not present, or if present not recommended.	Off site, recommended variably.	Off site and facilitated with contact persons or informal matching with peer supports in the community, some co-occurring focus.	Off site, integrated into plan, and routinely documented with co-occurring focus.	On site, facilitated and integrated into program (e.g., alumni groups); routinely used and documented with co-occurring focus.
V. Continuity of Care					
VA. Co-occurring disorders addressed in discharge planning process.	Not addressed.	Variably addressed by individual clinicians.	Co-occurring disorders systematically addressed as secondary in planning process for off site referral.	Some capacity (less than 80% of the time) to plan for integrated follow-up, i.e., equivalently address both substance use and mental health disorders as a priority.	Both disorders seen as primary, with confirmed plans for on-site follow-up, or documented arrangements for off-site follow-up; 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 documentation that this is routinely practiced, typically within the same program or agency.	Formal protocol to manage mental health needs indefinitely and consistent documentation that this is routinely practiced, typically within the same program or agency.
VC. Focus on ongoing recovery issues for both disorders.	Not observed.	Individual clinician determined.	Routine focus is on recovery from addiction; mental health symptoms are viewed as potential relapse issues only.		Routine focus on addiction recovery and mental health management and recovery; both seen as primary and ongoing.

DDCAT — Rating Scale

	1–AOS	2	3–DDC	4	5–DDE
VD. Specialized interventions to facilitate use of community-based peer support groups during discharge planning.	No interventions made to facilitate use of either addiction or mental health peer support groups upon discharge.	Used variably or infrequently by individual clinicians for individual patients, mostly for facilitation to addiction peer support groups upon discharge.	Generic, but no specific or intentional facilitation based on mental health disorders. More routine facilitation to addiction peer support groups (e.g., AA, NA) upon discharge.	Assertive linkages and interventions variably made targeting specific co-occurring needs to facilitate use of addiction peer support groups or groups specific to both disorders (e.g., DRA, DTR) upon discharge.	Assertive linkages and interventions routinely made targeting specific co-occurring needs to facilitate use of addiction peer support groups or groups specific to both disorders (e.g., DRA, DTR) upon discharge.
VE. Sufficient supply and compliance plan for medications is documented.	No medications in plan.	Variable or undocumented availability of 30-day or supply to next appointment off-site.	Routine 30-day or supply to next appointment off-site. Prescription and confirmed appointment documented.	Maintains medication management in program/agency until admission to next level of care at different provider (e.g., 45-90 days). Prescription and confirmed admission documented.	Maintains medication management in program with provider.
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 or substantive experience.	Program has no staff who are licensed as mental health professionals or have had substantial experience sufficient to establish competence in mental health treatment.	1-24% of clinical staff have either a license in a mental health profession or substantial experience sufficient to establish competence in mental health treatment.	25-33% of clinical staff have either a license in a mental health profession or substantial experience sufficient to establish competence in mental health treatment.	34-49% of clinical staff have either a license in a mental health profession or substantial experience sufficient to establish competence in mental health treatment.	50% or more of clinical staff have either a license in a mental health profession or substantial experience sufficient to establish competence in mental health treatment.
VIC. Access to mental health clinical supervision or consultation.	No access.	Consultant or contractor off site, variably provided.	Provided as needed or variably on site by consultant, contractor or staff member.	Routinely provided on site by staff member.	Routinely provided on site by staff member and focuses on in-depth learning.

DDCAT — Rating Scale

	1 – AOS	2	3 – DDC	4	5 – DDE
VID. Case review, staffing or utilization review procedures emphasize and support co-occurring disorder treatment.	Not conducted.	Variable, by off site consultant, undocumented.	Documented, on site, and as needed coverage of co-occurring issues.	Documented, routine, but not systematic coverage of co-occurring issues.	Documented, routine, and systematic coverage of co-occurring issues.
VIE. Peer/Alumni supports are available with co-occurring disorders.	Not available.	Available, with co-occurring disorders, but as part of the community. Variably referred by individual clinicians.	Available, with co-occurring disorders, but as part of the community. Routine referrals made through clinician relationships or more formal connections such as peer support service groups (e.g., AA Hospital and Institutional committees or NAMI).	Available on site, with co-occurring disorders, either as paid staff, volunteers, or program alumni. Variable referrals made.	Available on site, with co-occurring disorders, either as paid staff, volunteers, or program alumni. Routine referrals made.
VII. Training					
VIIA. All staff members have basic training in attitudes, prevalence, common signs and symptoms, detection and triage for co-occurring disorders.	No staff have basic training (0% trained).	Variably trained, no systematic agency training plan or individual staff member election (1-24% of staff trained).	Certain staff trained, encouraged by management and with systematic training plan (25-50% of staff trained).	Many staff trained and monitored by agency strategic training plan (51-79% of staff trained).	Most staff trained and periodically monitored by agency strategic training plan (80% or more of staff trained).
VIIB. Clinical staff members have advanced specialized training in integrated psychosocial or pharmacological treatment of persons with co-occurring disorders.	No clinical staff have advanced training (0% trained).	Variably trained, no systematic agency training plan or individual staff member election (1-24% of clinical staff trained).	Certain staff trained, encouraged by management and with systematic training plan (25-50% of clinical staff trained).	Many staff trained and monitored by agency strategic training plan (51-79% of clinical staff trained).	Most staff trained and periodically monitored by agency strategic training plan (80% or more of clinical staff trained).

Site Visit Notes

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** _____

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** _____

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" 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) _____

B. Frequently Asked Questions (FAQ)

1) Can I use the DDCAT to rate my whole agency?

The DDCAT is intended to rate an individual program. Using the DDCAT to produce a single agency-level rating is **not** recommended. If the entire agency is scored, the rater is forced to consider practices that differ and diverge across multiple programs, usually resulting in scores that are not meaningful or helpful. An examination of separate capability ratings across multiple programs within an agency, however, can assist leadership in understanding variations in agency practice patterns. Such variation may be intentional, but also may signal the need to initiate quality improvement activities to establish consistency across programs within an agency.

2) What do the DDCAT results tell me?

The DDCAT results will tell you the level of co-occurring capability in a program. Each of the 35 items in the DDCAT is scored on a 1 to 5 scale, with 5 reflecting the highest co-occurring capability. An average score is obtained for each of the seven domains in the DDCAT. An overall score ranks the program at the Addiction Only Services (AOS), Dual Diagnosis Capable (DDC), or Dual Diagnosis Enhanced (DDE) level.

3) Is the DDCAT a psychometrically valid instrument?

Yes. Please see the Psychometric Studies section and the journal articles by McGovern et al. (2007) and Gotham et al. (2010) listed in the appendix.

4) Is there an easy way to do the scoring?

Yes. An Excel workbook (available for download) accepts DDCAT item scores and calculates the program's average domain scores, an overall average score, and the categorical rank (i.e., AOS, DDC, or DDE). In addition, the workbook creates several graphic displays.

5) Who can administer the DDCAT?

Behavioral health professionals can be trained to administer the DDCAT by others with experience doing these assessments. Training typically involves a didactic component, one or more observations of an assessment, and practice with supervision and feedback.

6) How long does it take to do a DDCAT assessment?

Typically, a DDCAT assessment takes from four to eight hours. Requesting documents for review in advance of the visit can reduce the amount of time required at the program location. The number of charts reviewed can also impact the length of the visit.

B. Frequently Asked Questions (FAQ)

7) Can I ask programs to rate themselves on the DDCAT?

It is not recommended that programs use the DDCAT to rate themselves. Bias in DDCAT self-ratings has been documented, with higher self-rated scores observed compared to ratings by an external assessor (e.g., Lee & Cameron, 2009; please see the References section). Research also documents a "learning curve" before raters consistently and accurately use this measure (Brown & Comaty, 2007). The DDCAT items and anchors can generate valuable discussion among staff and provide the basis for programs to increase their co-occurring capability.

8) What is the incentive for programs to participate in a DDCAT assessment?

Each program receives concrete feedback on its co-occurring capability as expressed by its policies, assessment and treatment services, staffing, and training, combined with information on how to increase that capability. Increased co-occurring capability may lead to improved services for clients. Given widespread expectations for programs to improve their performance in co-occurring disorders, programs find the DDCAT assessment and results valuable. Some state or regional funding agencies offer financial incentives for achieving a DDC or DDE rating.

9) How long does it take a program to improve their scores on the DDCAT?

It depends. As described in the Applications section, a comprehensive implementation plan based on the results of an initial DDCAT can facilitate change by including targeted strategies for change, identifying persons responsible for leading each task, and setting target dates for completion. Other components of a successful change process often include an overall "champion" or change agent for the program, a steering committee to support the efforts over time, targeted training and technical assistance, connections with peers (i.e., other programs) also working on these kinds of changes for support and lessons learned, and ongoing quality assurance (e.g., semi-annual or annual follow-up DDCAT assessments).

10) How can I find out more about how others are using the DDCAT?

Dr. Mark McGovern of Dartmouth Medical School, the primary author of the DDCAT, chairs the national DDCAT/DDCMHT Collaborative, which meets monthly by conference call to discuss ways that states and programs are using the DDCAT to improve their policies and practices. He can be reached at mark.p.mcgovern@dartmouth.edu if you are interested in joining the Collaborative.

C. No or Low Cost Enhancements to Increase Co-Occurring Capability

Program Structure

IA.   Revise mission statement to include focus on co-occurring disorders.

IC.   Develop formal memorandum of understanding with a mental health program.

Program Milieu

IIA.   Revise materials and procedures to welcome individuals with co-occurring disorders.

IIB.   Display/distribute free educational materials about mental health/co-occurring disorders.

Assessment

IIIA.   Implement free standardized mental health and substance use screening measures.

IIIB.   Implement a standard set of mental health bio-psychosocial assessment questions.

IIID.   Implement a standard section of the assessment to capture mental health history.

IIIG.   Assess patients' stage of change for both their substance use and mental health problems.

Treatment

IVA.   Include mental health related interventions in treatment plans.

IVB.   Observe and document changes in mental health and substance use symptoms over time.

IVC.   Implement guidelines and advance directives for mental health emergencies.

IVD.   Adjust objectives and interventions to match persons' stages of change.

IVG.   Incorporate free mental health/COD curricula into program services.

IVH.   Implement family education/support group with co-occurring curricula.

IVI.   Assertively link patients to peer support groups welcoming to co-occurring issues.

IVJ.   Incorporate program alumni and other peer supports with COD into program.

Continuity of Care

VA.   Implement discharge procedures that plan for mental health and substance use services.

VC.   Focus on ongoing recovery from both disorders.

VD.   Assertively link patients to peer support groups welcoming to COD upon discharge.

Staffing

VID.   Implement routine case reviews that support co-occurring disorder treatment.

VIE.   Include peers with co-occurring disorders on-site as paid or volunteer staff.

Training

VII .   Implement training plan that routinely includes basic training on co-occurring disorders.

D. The Site Visit

DDCAT — Multiple Chart Review Form

SECTION	DDCAT ITEM	#1	#2	#3	COMMENTS/NOTES
Intake, Screening, Biopsycho-Social	IIIA. Mental health screening				
	IIIB. Assessment if positive screen				
	IIIC. Mental health and substance use diagnoses made				
	IIID. MH & SA history reflected in medical record.				
Treatment Plan	IIIG. Stage-wise txt assessed/affect treatment planning				
	IVA. Treatment plans address both disorders				
	IVD. Stage-wise treatment				
Progress Notes	IC. Coordination and collaboration with SA or MH services				
	IVB. Assess monitor interactive courses of both disorders				
	IVF. Specialized interventions with mental health content				
	IVG. Education about mental health disorders				
	IVH. Family education part of treatment interventions				
	IVI. Specialized interventions to use peer support groups				
Discharge Planning & Plan	VA. COD addressed in discharge planning process.				
	VB. Capacity to maintain treatment continuity				
	VC. Focus on ongoing recovery issues for both disorders				
	VD. Facilitation to self-help COD support groups at d/c				
	VE. Sufficient supply of meds, confirmed follow-up appt				

DDCAT — Agency Director/Program Director/Clinical Director Questions

IA	**What is the agency/program mission statement? (get copy or view on website ahead of time)**
IB	**What license(s) does your program have? MH? SA? Both?** Is lack of MH licensure a real barrier to providing services to individuals with COD? A perceived barrier?
IC	**How and where are MH services provided? Through relationship w/MH provider or integrated w/single tx plan?** Type of relationship: Minimal Coordination? Consultation? Collaboration? Collaboration w/some informal integration? Formal/documented?
ID	**Do billing structures limit or incentivize provision of services for persons with COD?** Can program bill for both SA/MH tx? Must SUD be "primary"?
IIA	**What patients are expected and welcome? What percent of your patients have COD MH disorders?**
IIB	**What kind of literature/educational materials is provided to patients?** SA? MH? Equal? Info on interaction? Routine? Is literature distributed in waiting areas? Orientation packets? Posters? Handouts? Videos?
IIIA	**What type of MH screening occurs?** Self-report pre-admission? Basic pre-admission screen? Standard set of MH questions? Routine standard/formal instrument for MH? Routine standard/formal instrument for MH and SA? Measure(s) used:
IIIB	**What is the process for following up on a positive MH screen? Type of assessment?** Detailed bio-psychosocial questions or mental status? Formal, standardized, assessment? Integrated MH/SUD assessment? Variable? If necessary? Routine for all positive screens? Documented? Conducted onsite?
IIIC	**Are psychiatric diagnoses made at the program? By whom? Documented in chart?**
IIIE	**Are there any admission limitations re: symptom acuity?** Need to be primarily stable? Can be moderate to high acuity, even unstable?
IIIF	**Does the program have any admission limitations re: symptom severity?** No severity of persistence of disability? Low to moderate (e.g. Quadrant III: Axis I mood, anxiety, PTSD or Axis II)? High (e.g. Quadrant IV: bipolar disorder, schizoaffective disorder, schizophrenia)?
IIIG	**Does the program assess stages of change?** For both MH and SA? Formal measure? Documented in chart? Where? Measure(s) used:
IVD	**Do you monitor motivational stages ongoing throughout treatment? Use and match stage-wise treatments to individuals?** Some examples:
IVC	**Does the program have any procedures for psychiatric emergencies and crisis management?** Just call 911? Written guidelines including a standard risk assessment that captures MH emergencies and identifies intervention strategies? Formal arrangement w/MH clinic to help manage crisis situations? In-house crisis management standards/guidelines, goal to maintain individual in program? All staff competent to use in-house procedures?
IVE	**Does the program accept individuals on medications? Does program have ability to prescribe?** Any medications restricted? Individual must bring own supply? Written policies/procedures for prescribing/monitoring medications for COD? Program has some access to prescriber (consultant)? Routine access to staff prescriber, not fully integrated into tx team? Full access to staff prescriber, fully integrated into tx team? Medication monitoring done by prescriber? With some staff assistance? Entire team can assist?

IVF	**Does the program use any specific therapeutic interventions/practices that target specific MH symptoms and disorders?** Generic interventions (e.g. stress mgmt, coping skills)? Generic adaptation of EBP addiction tx (MI, CBT, TSF)? Systematic (e.g. manualized) adaptation of EBP addiction tx for specific disorders? Integrated EBP for COD (e.g. Seeking Safety, DBT-S)? Individual clinician driven or routine part of program? Examples of interventions:
IVG	**Does the program provide education about MH disorders, tx, and interaction w/SUD?** Generic content tx (e.g. general orientation, education re: MH symptoms, appropriate use of psychotropic meds, interaction of MH and SA)? Specific content for specific co-morbidities? Variably offered? Routinely offered? To all patients? Curriculum used? Give example(s):
IVH	**Does the program provide any education on COD to family members?** (*Note:* "Family" can be broadly interpreted.) No family education? SUD only? MH and SUD? MH routinely but informally incorporated into family education/support sessions? Generic group on site addresses MH and SUD, not regularly incorporated into tx interventions? COD family education/support group standard part of tx? Majority of families participate?
IVI	**Does the program assist individuals with COD to develop a support system through self-help groups?** Variable interventions, mostly to addiction peer support groups? Generic on-site format, no intentional facilitation based on MH disorders? Variable facilitation to use addiction or COD peer support groups, targeting specific COD needs (e.g. identify a liaison, individualize referral to particular groups, help w/how to (or not) discuss meds in groups)? Specific on-site format targeting MH needs?
VD	**Does the program offer specialized interventions to facilitate use of community-based peer support groups during discharge planning?** Variable, interventions mostly to addiction peer support groups (e.g. meeting lists, suggestions to "work the steps")? Generic on-site format, routine facilitation (e.g. meeting lists, making initial contacts), but not based on MH disorders? Variable assertive linkages, targeting MH needs, to addiction or COD peer support groups (e.g. help w/how to (or not) discuss meds in groups, help person w/PTSD find meetings w/out members who may trigger her re-experiencing symptoms, help person w'/social anxiety find a small group)? Routine assertive linkages targeting MH needs? In-house mutual self-help meetings? Examples:
IVJ	**Does the program match patients with individual peer supports and role models? Peer is person w/COD?** Off site? On site? Variable? Standard part of programming? Documented in treatment plan?
VIE	**Does the program maintain staff, or formal arrangement w/volunteers, in recovery from COD who can serve as peer/alumni supports?** In community, variable referrals? In community, routine linkages made? On site, variable referrals? On site, routine matching? Formal protocol to insure ongoing on site supports?
VC	**What is the program's recovery philosophy (vs. symptom remission only)?** SUD only? SUD and MH depending on clinician? Routine SUD, MH viewed as potential relapse issue? Equal focus on both SUD/MH? Symptom remission? SUD and MH seen as part of generic wellness, process of recovery and positive prospects for both?
VE	**Does the program help with medication planning/prescription/access at discharge?** Variable/undocumented 30-day supply? Routine 30-day or supply to next appointment? Maintains med management in program/agency until admission to next level of care? Prescription & confirmed admission documented? Maintains medication management in program/agency?
VIA	**Does the program have a formal relationship with a prescriber?** Off-site consultant/contractor? On-site medical/contractor who prescribes? Member of staff, clinical matters only? Staff member who routinely participates in team activities and serves in clinical decision-making or supervisory role?

VIB	**What's the percent of clinical staff with MH license/competency/substantive MH experience? (see toolkit for definition of competency)** None? 1-24%? 25-33%? 43-49%? 50%?
VIC	**Does the program have access to licensed MH supervisor or consultant?** Variable off-site supervision? As needed on site? Routine on-site supervision by staff member? Primary focus on case disposition and crisis management? Focus on in-depth learning?
VID	**Does the program conduct case/utilization reviews to monitor appropriateness/effectiveness of services for patients w/COD?** Documented? Formal protocol? Off site consultant? Routine? On site procedure, general COD coverage PRN? General review of patients with COD? Focus on targeted interventions for COD?
VIIA	**What percent of ALL staff have basic training in attitudes, prevalence, common signs & symptoms, detection & triage for COD?** None? 1-24%? 25-50%? 51-79%? 80%+? Systematic training plan that includes this training? Monitored by plan?
VIIB	**What percent of CLINICAL staff have advanced specialized training in integrated psychosocial or pharmacological tx of persons w/COD?** None? 1-24%? 25-50%? 51-79%? 80%+? Systematic training plan that includes this training? Monitored by plan?

DDCAT — Clinician Interviews

IC	**How and where are MH services provided? Through relationship w/MH provider or integrated w/single tx plan?** Type of relationship: Minimal Coordination? Consultation? Collaboration? Collaboration w/some informal integration? Formal/documented?
IIA	**What patients are expected and welcome? What percent of your patients have COD MH disorders?**
IIB	**What kind of literature/educational materials is provided to patients?** SA? MH? Equal? Info on interaction? Routine? Is literature distributed in waiting areas? Orientation packets? Posters? Handouts? Videos?
IIIE	**Are there any admission limitations re: symptom acuity?** Need to be primarily stable? Can be moderate to high acuity, even unstable?
IIIF	**Does the program have any admission limitations re: symptom severity?** No severity of persistence of disability? Low to moderate (e.g. Quadrant III: Axis I mood, anxiety, PTSD or Axis II)? High (e.g. Quadrant IV: bipolar disorder, schizoaffective disorder, schizophrenia)?
IIIG	**Do you assess stage of change?** For both MH and SA? Formal measure? Documented in chart? Where? Measure(s) used:
IVD	**Do you monitor motivational stages ongoing throughout treatment?** Use and match individuals to stage-wise treatments? Give me some examples:
IVC	**Does the program have any procedures for psychiatric emergencies and crisis management?** Just call 911? Written guidelines including a standard risk assessment that captures MH emergencies and identifies intervention strategies? Formal arrangement w/MH clinic to help manage crisis situations? In-house crisis management standards/guidelines, goal to maintain individual in program? All staff competent to use in-house procedures?
IVF	**Does the program use any specific therapeutic interventions/practices that target specific MH symptoms and disorders?** Generic interventions? (e.g. stress mgmt, coping skills)? Generic adaptation of EBP addiction tx (MI, CBT, TSF)? Specialized (e.g. manualized) interventions for specific disorders? Systematic adaptation of EBP addiction tx? Integrated EBP for COD? Individual clinician driven or routine part of program? Examples of interventions:
IVG	**Does the program provide education about MH disorders, tx, and interaction w/SUD?** Generic content? Specific content for specific co-morbidities? Variably offered? Routinely offered? To all patients? Curriculum used? Give example(s):
IVH	**Does the program provide any education on COD to family members?** (Note: "Family" can be broadly interpreted.) No family education? SUD only? MH and SUD? MH routinely but informally incorporated into family education/support sessions? Generic group on site addresses MH and SUD, not regularly incorporated into tx interventions? COD family group standard part of tx? Majority of families participate?
IVI	**Do you assist individuals with COD to develop a support system through self-help groups?** Variable interventions, mostly to addiction peer support groups? Generic on-site format, no intentional facilitation based on MH disorders? Variable facilitation to use addiction or COD peer support groups, targeting specific COD needs (e.g. identify a liaison, individualize referral to particular groups, help w/how to (or not) discuss meds in groups)? Specific on-site format targeting MH needs?

VD	**Do you offer specialized interventions to facilitate use of community-based peer support groups during discharge planning?**
	Variable interventions, mostly to addiction peer support groups (e.g. meeting lists, suggestions to "work the steps")?
	Generic on-site format, no intentional facilitation based on MH disorders?
	Variable assertive linkages, targeting MH needs, to addiction or COD peer support groups (e.g. woman w/PTSD linked to women's AA meeting)? Routine assertive linkages targeting MH needs? In-house mutual self-help meetings? Examples:
IVJ	**Do you match patients with *individual* peer supports and role models? Peer is person w/COD?**
	Off site? On site? Variable? Standard part of programming? Documented in treatment plan?
VIE	**Does program maintain staff, or formal arrangement w/volunteers, in recovery from COD who can serve as peer/alumni supports?**
	In community, variable referrals? In community, routine linkages made
	On site, variable referrals? On site, routine matching? Formal protocol to insure ongoing on site supports?
VC	**What is the program's recovery philosophy (vs. symptom remission only)?**
	SUD only? SUD and MH depending on clinician? Routine SUD, MH viewed as potential relapse issue? Equal focus on both SUD/MH?
	Symptom remission? SUD and MH seen as part of generic wellness, process of recovery and positive prospects for both?
VE	**Does program help with medication planning/prescription/access at discharge?**
	Variable/undocumented 30-day supply? Routine 30-day or supply to next appointment?
	Maintains med management in program/agency until admission to next level of care? Prescription & confirmed admission documented?
	Maintains medication management in program/agency?
VIA	**(If program has a prescriber on site) Do you have access to the prescriber to discuss patients?**
	Prescriber only provides prescribing services? Limited access? Prescriber is member of treatment team?
VIB	**Please describe your license and/or mental health experience/expertise?**
VIC	**Do you receive supervision from a licensed MH supervisor or consultant?**
	Variable, off-site? As needed, on site? Routine, on-site?
	Primary focus on case disposition and crisis management? Focus on in-depth learning?
VID	**Does the program conduct case/utilization reviews to monitor appropriateness/effectiveness of services for patients w/COD?**
	Documented? Formal protocol? Off site consultant? Routine?
	On site procedure, general COD coverage PRN? General review of patients with COD? Focus on monitoring targeted interventions for COD?

DDCAT — Consumer Interview Questions

IIA	Did you feel welcomed when you came to this agency for treatment?
IIB	Have you received any materials about substance abuse and/or mental health issues? SA ? MH ? Equal? Info on interaction? Routine?
IVE	If you are on medications for a mental health issue, does the program prescribe them? If not, where do you get them? Do providers communicate?
IVF	Does program offer any groups related to emotional or mental health issues? E.g. anger management group? Seeking Safety?
IVG	Does program or your counselor provide general education about MH disorders, tx, and interaction w/substance use disorders and tx (e.g. general orientation, education re: MH symptoms, appropriate use of psychotropic meds, interaction of MH and SA? Anything specific to any emotional or mental health issue you may have?
IVH	Does program provide any education on COD to family members? Regular support/ed group? Incorporated into recovery planning? Majority of families participate? ("Family" can be broadly interpreted.)
IVI	Does program assist you in developing a support system through self-help groups? Does the program talk about issues someone with a mental health issue might have in some groups, and how to manage them (e.g. how to (not to) talk about meds at a meeting)? Does the program make any special linkages or make some intros on a person's behalf depending on a person's issues? (e.g. small group if have social anxiety).
IVJ	Does program match clients with peer (a person w/a COD) supports and role models, e.g. consumer liaisons, alumni groups? On site or off?
VC	Does program talk about recovery for both SA and MH issues (vs. symptom remission only)? Are both SA and MH seen as part of wellness, or is MH just a complicating factor of SA?
VD	Does program link to self help groups at discharge? Recommendations, meeting lists and suggestions to "work the steps"? Or link/match to specific groups relative to MH issues? Have on site ongoing alumni group or DRA group?
VIE	Does program have staff or volunteers who are open about having a mental health issue that you can talk with? Part of community, i.e. of-site linkages or H&I committee connection? Provided consistently? Or present on-site, i.e. program maintains staff or volunteers on site?

E. Training Raters to Conduct DDCAT Assessments

Dual Diagnosis Capability in Addiction Treatment (DDCAT) Scoring Scenario

Recovery Depot is housed in a modest brick building next to the local health clinic. The waiting room is light and airy with comfortable furniture. One wall is covered with a large poster of the Twelve Steps and there are racks of AA and NA materials and meeting schedules, along with pamphlets on HIV/AIDS, and state employment and financial assistance services. A bulletin board has an announcement for a Community for Addiction Recovery sober dance, and a local Dual Recovery Anonymous meeting. A framed mission statement near the receptionist says "Recovery Depot is committed to the belief that recovery from addiction is possible through treatment and education of individuals and their families."

The Program Director describes the program as a "typical" outpatient program. She says that RD is licensed to provide substance abuse outpatient services, and is funded primarily by state grants and fee-for-service contracts. The clinic offers individual treatment, and a number of different groups including relapse prevention, anger management, stress reduction, women's group, a Seeking Safety group, and a weekly "Coffee Club" group for individuals who are mandated to treatment by the criminal justice system, many of whom are not sure they have a substance abuse problem.

The interview with the Program Director indicates that individuals are referred by the health clinic, other agencies, the court, or are self-referrals. An initial screening is done by phone or in person that ascertains if the person has had prior substance abuse treatment, their last use, drug of choice, etc. She gives the assessors a copy of the program's bio-psychosocial evaluation which is done on intake. It includes a brief mental status section, along with a series of questions about both substance use and treatment histories, and similar questions about mental health symptoms and treatment. The form also asks if the individual is currently on any psychiatric medications, and if so, which ones.

The Program Director estimates that 15% of the program's 160 clients have co-occurring disorders. When asked if there are any admission restrictions, she says that program policies require individuals to have a primary substance use disorder for licensing and billing reasons. However, while it is not in writing, she says the program will admit individuals with a co-occurring mental health disorder if they are stable on their medications. The policies exclude sex offenders or anyone requiring pain medication. There are no other medication restrictions, although the Program Director says the program generally doesn't work well with individuals with psychotic disorders and does keep an eye out for medications that would indicate this. These individuals are referred to the local mental health clinic. Individuals who are suicidal or homicidal are likewise not admitted.

When asked about any specialized interventions for individuals with co-occurring disorders, the Program Director says that the Seeking Safety group has been very successful, and receives regular referrals from the local women's center. The Program Director is also very excited because two of her staff just completed a half day workshop in Motivational Interviewing, and the agency is hosting an on-site training on depression next month, offered free by the health clinic's APRN. When asked more about staff training, she indicates that salaries are low, so training is a benefit the program supports. There is no set program training plan, but the

Program Director has to approve any training request. Staff typically is allowed to choose whatever training they want to go to. The Program Director stated that two of the four counselors with prior experience in mental health programs have a very good understanding of co-occurring disorders and typically sign up for new co-occurring trainings provided at the mental health center. One of these counselors leads the Seeking Safety group. When asked if the program's intake and clerical staff have basic training in co-occurring disorders the Program Director states that hasn't really been necessary since they don't treat clients.

The Program Director indicates that she provides weekly individual supervision to each of the four full-time counselors, and meets as needed with several per diem clinicians. The Program Director is a LCSW; two counselors have a Certified Addiction Counselor Credential from the State Certification Board and are working on completing their college degrees. One counselor is an LPC, and one is an LADC with a Master's Degree in Psychology. The latter two are new hires. Both of these have several years of counseling experience in mental health clinics, one of which specialized in treating co-occurring disorders.

The Program Director reports the program contracts for three hours a week with a psychiatrist who also works at a nearby mental health clinic. The assessors have the opportunity to speak with her briefly. She says she does psychiatric evaluations and will prescribe psychiatric medications on a limited basis if a client does not have a prescriber, as well as write a one-month "bridge" prescription to insure the client has enough medications at discharge to last until a follow-up appointment with a mental health provider. When asked if the program has any medication policies or guidelines, she reports not being aware of any, although she has been asked to careful about prescribing any benzodiazepines. She also mentions that the program has a good working relationship with the local health clinic's APRN who will renew prescriptions as needed.

When asked about mental health emergencies or crises, the Program Director reports they seldom occur. However, 911 would be called if it appeared any client was becoming symptomatic or decompensating. She notes that, if a client had to be hospitalized, Recovery Depot would close the case and refer him/her to the mental health clinic for more appropriate care on discharge.

The Program Director gives the assessors a tour of the program, and points out a large group room which she says is used for open AA meetings on Tuesdays and Saturday mornings. Everyone in the program is required to go to 12-step meetings in addition to their outpatient sessions. When asked about the local Dual Recovery Anonymous meeting flyer in the reception area, she is unfamiliar with it, but says the staff probably knows about it. There are no particular efforts to link individuals with co-occurring disorders to particular groups, but everyone is given a meeting list and encouraged to keep trying different meetings until they find one that works for them.

As the assessors enter one of the group rooms, several people are leaving. The Program Director introduces one as a Big Brother, a former client who volunteers weekly to come to the Coffee Club group to share his experiences and encourage the group members to stay with treatment. The Program Director explains that the program started the Big Brothers and Sisters project with one volunteer three years ago and it has grown to a formal volunteer program overseen by one of the counselors. The "Bigs" regularly attend the on-site AA meetings and the counselor frequently will introduce a client to a Big Brother or Sister so the client will know someone at the meeting ahead of time. The Big Brothers/Sisters also take turns leading a monthly program alumni group for individuals who want to stay in touch with the program for ongoing support, and routinely are invited to share their experiences in the relapse prevention groups. When asked later, the Program Director says the Big Brother she introduced is one of three who have co-occurring mental health disorders and are very open

about it, which is why the program actively recruited them. They go regularly to the local mental health clinic where they were referred after completing the Recovery Depot program.

When meeting with two of the counselors, the assessors ask how many clients have co-occurring disorders. They reply that the majority of the clients do, although most do not have anything so significant that it impedes their participation in the program. Since it is an addiction program, formal screening for mental health issues is rarely done and no mental health diagnoses are made. However, if it seems that an individual's mental health issues are a potential relapse risk, he/she is referred to the contracted psychiatrist for further evaluation. The psychiatrist will leave the counselor a note as to the outcome of the evaluation, and is available by phone if there are any questions.

When asked about supervision, the clinicians smile and say regular supervision sessions are often pre-empted by the Program Director's administrative duties. They are quick to add that her door is always open and she makes herself readily available when they are struggling or "stuck" regarding next steps with a client whom they suspect is using again or who is refusing to accept a follow-up referral to the mental health clinic, for example. Weekly staff meetings however are always held. Typically several clients from each counselor's caseload are reviewed, any legal or other updates given, general progress on treatment plan goals is reviewed, and discharge plans gone over. Usually the need for a referral to the psychiatrist or mental health clinic is discussed if individual client symptoms or behavior indicates a possible need. A review form is completed for each client's file for those clients reviewed, including any referrals, and this becomes a tickler to insure referrals are followed up on at the next staff meeting. When asked about psychiatric emergencies or crises, both counselors indicate they have never seen a program policy, but common sense would dictate calling 911. They are not aware of any formal policy with either the mental health or local health clinics, but indicate that they have good

relationships with particular staff at each and are usually able to get referrals seen relatively quickly. They insure referred clients sign a release of information so that staff can confirm this.

When asked if they assess for stage of change, one clinician references the recent Motivational Interviewing training and says he's decided to start using the stages of change in his work with some clients. The other indicates that he works mostly with the Coffee Club group and other individuals referred by the courts, so there is no need since all of them are at the stage of thinking they have no problem.

Both counselors are familiar with local 12-step groups, and indicate that most are tolerant of individuals on psychiatric medications. Neither does any specific linking of clients to specific groups or individuals, but one counselor says he's referred a couple of his clients who have bi-polar disorder to the local hospital's Bi-Polar Disorder Support Group. One counselor emphasizes that the linkage with 12-step groups is important, especially at discharge, because after discharge the clients no longer have access to their counselor for support.

A review of five client charts of discharged clients with co-occurring disorders indicates that the mental health section of the bio-psychosocial evaluation is rarely filled in completely, sometimes not at all; this is the case even in two charts where the evaluation reported the individual was taking several psychotropic medications. Treatment plan goals for substance use problems are comprehensive and individualized. Treatment plans in four charts include a mental health problem framed as a relapse prevention issue with goals to obtain a psychiatric evaluation and maintain medication compliance. Overall, progress notes indicate a lot of work on relapse prevention, and some education about addiction takes place. Several of the charts have documentation for anger and stress management groups, and another client attended Seeking Safety groups. All of the discharge plans include recommendations to regularly attend AA/NA meetings, obtain a sponsor,

and attend the program's monthly alumni group. Two discharge plans document confirmation of a follow-up appointment at the local mental health clinic for medication management, as well as a one-month refill from the part-time psychiatrist. One counselor's notes indicates he worked with two of the clients on identifying when they felt anxious or depressed, and teaching them some coping skills to help manage their symptoms, e.g. breathing exercises, journaling, etc. He also helped them identify the relationship of their drug and alcohol use to their mental health symptoms and noncompliance with medication. These were not areas identified on their treatment plans, however.

Three clients volunteer to be interviewed together. They all report they are happy with the program, and the staff is great. Two of them share they have mental health problems. One of these clients had been diagnosed in a prior program with PTSD and she finds the Seeking Safety group very helpful. The other has seen the program's psychiatrist and reports being been diagnosed with depression. He goes to the nearby health clinic to receive his medication. He has gotten some information from the health clinic, but reports wanting to know more about side effects, and is having trouble sleeping. All three report that they can talk with their counselors about anything in their individual counseling sessions, but two say their counselors can really only listen to them as they don't have a lot of information/knowledge about mental health issues. The clients all indicate that mental health issues are rarely discussed in group sessions, except for the Seeking Safety group. One states that he had never shared with the two other clients that he'd been diagnosed with depression, even though they are in the same group. When asked about family involvement, two report that their families had attended one of the Family Orientation groups the program offers every other month. The group provided a lot of information about addiction and relapse, and ways to be supportive of a family member in recovery. They clients state they felt much supported by their families' participation.

DDCAT — Case Study Scoring Key

Domain/Item	Comments
Program Structure	
IA. Mission Statement	**Score 1:** The mission statement addresses addiction only.
IB. Organizational Certification and Licensure	**Score 3:** The program is licensed to provide substance abuse services. However, treatment plans list mental health problems in the context of relapse prevention, i.e. there is no barrier to providing mental health services within the context of addiction treatment.
IC. Collaboration with Mental Health Services	**Score 2:** Staff has limited interaction with the contracted psychiatrist (only available by phone). The program has no formal agreement with the mental health clinic, but there is follow-up to insure successful referral (meets SAMHSA definition of consultation).
ID. Financial Incentives	**Score 1:** The program can only bill for services for individuals with a primary substance use disorder.

Clarifying point:

- If the agency can identify funding for co-occurring or mental health services, or is able to bill for mental health services they provide as long as the client has a substance use disorder, then score 3. |
Program Milieu	
IIA. Routine Expectation and Welcoming	**Score 2:** Program Director says 15% of clients have co-occurring disorders; however the counselors report the majority do. Program policies and procedures do not address admission of individuals with co-occurring mental health disorders, and waiting room décor and materials are primarily addiction focused. Clients interviewed state that mental health issues are rarely discussed in group sessions, only individual sessions.
IIB. Display and Distribution of Literature	**Score 1:** The waiting area displays primarily addiction-related materials. The DRA notice on bulletin board is the only visible item related to a co-occurring mental health disorder. One counselor provides some information about mental health issues and one Seeking Safety group offered. However, educational materials about mental health disorders are not made available.
Assessment	
IIIA. Routine Screening Methods for mental Health Symptoms	**Score 2**: The biopsychosocial assessment has substance use and mental health history sections, but the mental health section is not always completed.

Clarifying point:

- If the program's biopsychosocial assessment includes a standard set of questions to screen for mental health problems, and these are questions are routinely asked and responses are documented, then score 3. |
IIIB. Routine Assessment if Screened Positive	**Score 2:** The program does not routinely screen (see IIIA) or assess for mental health problems; if a client's mental health symptoms seem a potential relapse risk the client is referred to the contracted psychiatrist for evaluation.
IIIC. Mental Health and Substance Use Diagnoses	**Score 1:** No mental health diagnoses are made.
IIID. Mental Health and Substance Use History Reflected in Record	**Score 2:** The clinicians do not consistently complete the mental health history questions on the biopsychosocial assessment.
IIIE. Program Acceptance Based on Psychiatric Symptom Acuity	**Score 1:** An individual's symptoms must be stable in order to be admitted.

DDCAT — Case Study Scoring Key

Domain/Item	Comments
IIIF. Program Acceptance Based on Severity of Persistence and Disability	**Score 3:** The program admits individuals with bi-polar disorder and PTSD, e.g., but does not admit individuals with psychotic or other more serious mental health disorders.
IIIG. Stage-wise Assessment	**Score 1:** One staff member "has decided" to start assessing stage of change after attending a recent Motivational Interviewing training, i.e. program does not require it. The other has inaccurate understanding of how to assess stage of change, i.e. he assumes that if an individual is mandated to treatment he/she cannot be in a contemplation or action stage. Clarifying point: • If the program encourages clinicians to use a protocol to assess stage of change, but not all clinicians use it on a regular basis, then score 2.
Treatment	
IVA. Treatment Plans	**Score 3:** Treatment plans routinely (80% of the plans reviewed) address both disorders, but primary focus is on substance use issues. Mental health problems are typically listed as a relapse prevention issue with general goals
IVB. Assess and Monitor Interactive Courses of Both Disorders	**Score 2:** One counselor is charting the progress his client is making on managing her mental health symptoms.
IVC. Procedures for Mental Health Emergencies and Crisis Management	**Score 1:** The program has no policies and procedures; staff usually calls 9-1-1.
IVD. Stage-wise Treatment	**Score 1:** Since the program does not have a mechanism to assess stage of change, treatment plans do not reflect state-wise treatments. The program offers the Coffee Club for individuals who may not be sure if they have a substance use problem, but it is only open to individuals mandated to treatment.
IVE. Policies and Procedures for Medication Management	**Score 2:** A contract is in place with a psychiatrist who prescribes on site, and there are no medication restrictions except for pain medications. However, the program has no written policies and guidelines for prescribing medications to clients with co-occurring disorders. Clarifying point: • If the program has access to a prescriber, and has written policies and guidelines to guide the prescribing, then score 3.
IVF. Specialized Interventions with Mental Health Content	**Score 3:** The program offers anger management and stress reduction groups (generalized interventions), one counselor is helping client's deal with their symptoms (symptom management) in individual sessions, one is starting to use motivational interviewing, and Seeking Safety Group is offered. Chart review indicates that most clients are receiving a generic mental health intervention.
IVG. Education about Mental Health Disorder, Treatment, and Interaction with Substance Use Disorders	**Score 2:** Variable by clinician, i.e. one counselor is educating his clients about symptom management and providing education regarding the relationship of substance use to mental health symptoms and medication noncompliance. Two of the three clients interviewed state their counselors do not provide mental health education.
IVH. Family Education and Support	**Score 1:** The program's family group is focused only on addiction information.

DDCAT — Case Study Scoring Key

Domain/Item	Comments
IVI. Interventions to Facilitate Use of Peer Support Groups	**Score 3:** The program routinely encourages the use of self-help groups (a program requirement), offers several on site, and provides general interventions to use peer support groups, e.g. meeting lists and introductions to some of the Big Brother/Sister volunteers who attend the on-site groups.
IVJ. Availability of Peer Recovery Supports with Co-occurring Disorders	**Score 3:** Big Brothers/Sisters are incorporated on-site in Coffee Club, Relapse Prevention, Alumni, and self-help groups. Three with co-occurring disorders have been intentionally recruited. Linkage to peers is not documented on treatment plans. Clarifying point: • If utilization of on-site peer supports is incorporated into treatment plans, then score 5.
Continuity of Care	
VA. Co-occurring Disorders Addressed in Discharge Planning	**Score 2:** Two of the five discharge plans (less than 80%) included a referral to the local mental health clinic for medication management. The two clients had the same counselor, i.e. variability due to individual clinician judgment or preference.
VB. Capacity to Maintain Treatment Continuity	**Score 1:** One of the counselors stated clients no longer have access to their counselor after discharge. Follow-up referrals are made to the local mental health clinic, but there is no formal agreement. Program Director stated a client's case would be closed and the client referred to the mental health clinic (rather than be re-admitted to Recovery Depot once stabilized) if the client had to be hospitalized for mental health reasons.
VC. Focus on Ongoing Recovery Issues for Both Disorders	**Score 3:** Treatment plans focus on recovery from addiction, view mental health issues as potential relapse risk and include general goal of maintaining medication compliance.
VD. Specialized interventions to Facilitate Use of Community-Based Peer Support Groups During Discharge Planning	**Score 2:** The program doesn't provide any specialized interventions other than recommendations to attend meetings and obtain a sponsor after discharge. Clarifying point: • If counselors and client interviews, or medical record documented general interventions such as guidance for talking about medications at 12-step meetings or recommendations of meetings welcoming to individuals with co-occurring disorders, e.g., then score 3.
VE. Sufficient Supply and Compliance Plan for Medication	**Score 2:** Consulting psychiatrist will write bridge prescriptions at discharge to insure client has enough medications until first appointment post-discharge. However, it appears this is not a consistent (or consistently documented) practice because only two of the five charts reviewed documented confirmed follow-up appointment and 30-day bridge prescription in two charts. Clarifying point: • If two or three of the other charts reviewed indicated that the client did not need ongoing medication management or mental health follow-up, or that the client refused a referral to the mental health clinic, then score 3.
Staffing	
VIA. Psychiatrist/ Prescriber of Psychotropic Medications	**Score 3:** Consulting psychiatrist works at local mental health clinic (i.e. is competent to prescribe medications for mental health disorders), is not a staff member, only provides evaluations and prescribing on site, and is only available to staff by phone or communicates via note to staff.

DDCAT — Case Study Scoring Key

Domain/Item	Comments
VIB. On Site Clinical Staff with Mental Health Licensure, Competency or Substantive Experience	**Score 5:** 3 of 5 staff (4 counselors and Program Director) meet criteria = 60%. Three staff includes 1 LPC with several years experience in a mental health clinic, 1 LADC with a Master's in Psychology and several years experience in a mental health clinic, and Program Director w/LCSW. Clarifying point: • If per diem staff works routinely, i.e. not just coverage for vacations, etc., then reviewers should inquire about their qualifications/competency.
VIC. Access to Mental Health Supervision or Consultation	**Score 3:** Weekly clinical supervision is provided by the Program Director who is an LCSW. Supervision is often pre-empted by her administrative duties, but she has an "open door policy," i.e. as needed supervision, mostly for crisis/problem management.
VID. Case Review, Staffing or Utilization Review Emphasizes and Supports Co-occurring Disorder Treatment	**Score 3:** Regular procedure @ weekly staff meetings allows discussion of co-occurring disorder issues. Case dispositions and symptoms/behaviors that prompt the need for referral to the psychiatrist are discussed, as well as general progress toward treatment plan goals, but not specific mental health treatments/interventions. Meetings are documented. Clarifying point: • Given that treatment plans for individuals with co-occurring disorders routinely include general mental health goals such as obtaining a psychiatric evaluation and maintaining medication compliance, a review of progress toward treatment plan goals would touch on diagnosis, progress with medication compliance, etc.
VIE. Peer/Alumni Supports Available with COD	**Score 5:** The program has a formal, on-site volunteer network of former clients in recovery (Big Brothers and Big Sisters) that lead a monthly alumni group. The program has intentionally recruited three volunteers with co-occurring disorders. Discharge plans document routine referrals to the on-site alumni group. Clarifying point: • If there is no protocol to insure peer supports are maintained as part of this network, then score 4.
Training	
VIIA. All Staff Members Have Basic Training in COD	**Score 2:** There is no strategic training plan, staff typically goes to whatever training they want to, non-clinical staff isn't considered to need training, and some staff is trained as result of their own interest. Clarifying point: • Reviewers would want to ask more specifics about the experience/training of the two staff with prior mental health clinic experience, but for this exercise it is assumed their background includes the basic training required in this item.
VIIB. Clinical Staff Members Have Advanced Specialized Training in Integrated Treatment of COD	**Score 2:** There is no strategic training plan. Two counselors have several years of experience at a mental health clinic, one specializing in co-occurring disorders treatment. Clarifying point: • Reviewers would want to ask more specifics about the experience/training of the two staff with prior mental health clinic experience, but for this exercise it's assumed their background includes the advanced training required in this item.

F. Sample Memorandum of Understanding

Between

[mental health program]

and

[addiction treatment program]

The purpose of this Memorandum of Understanding (MOU) is to clarify agreements between _____ and _____. These agreements form the basis to provide comprehensive and integrated treatment to people with co-occurring disorders. This MOU covers arrangements for mental health and addiction treatment services.

Principles of recovery-oriented, co-occurring enhanced care that we agree to adhere to in the delivery of concurrent services:

Roles and responsibilities are defined as follows:

[define for each organization]

Referral Protocol

[referral protocol between agencies is described]

Addiction Treatment Services

___ will provide the following services:

Intake and admission procedures:

Mental Health Services

___ will provide the following services:

Intake and admission procedures:

Both parties agree to the responsibilities and procedures stated above. This agreement will be in effect/valid through FY ___ and FY ___ and will be reviewed and/or amended every 6 months. Any changes to this MOU will be made with the approval of both parties.

In the event of termination of this MOU, each party should give or be given a 30-day notice.

G. Screening for Mental Health and Substance Use Disorders

Modified MINI Screen (MMS)

Mental Health Screening Form-III (MHSF-III)

CAGE-Adapted to Include Drugs (CAGE-AID)

Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD)

Posttraumatic Stress Disorder Checklist

Social Interaction Anxiety Scale

Modified MINI Screen (MMS)

Introduction

In this program, we help people with all their problems—their addictions and emotional problems. Our staff is ready to help you to deal with any problems you may have, but we can do this only if we are aware of the problems.

Section 1

Section A

1. Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks? YES _____   NO_____

2. In the past two weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time? YES _____   NO_____

3. Have you felt sad, low or depressed most of the time for the last two years? YES _____   NO_____

4. In the past month did you think that you would be better off dead or wish you were dead? YES _____   NO_____

5. Have you ever had a period of time when you were feeling 'up', hyper or so full of energy or full of yourself that you got into trouble, or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol). YES _____   NO_____

6. Have you ever been so irritable, grouchy or annoyed for several days, that you had arguments, verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or overreacted, compared to other people, even when you thought you were right to act this way? YES _____   NO_____

Section B

7. Have you had one or more occasions when you felt intensely anxious, frightened, uncomfortable or uneasy even when most people would not feel that way? Did these intense feelings get to be their worst within 10 minutes? (If "yes" to both questions, answer "yes", otherwise check "no.") YES _____   NO_____

8. Do you feel anxious, frightened, uncomfortable or uneasy in situations where help might not be available or escape might be difficult? Examples include: ___being in a crowd, ___standing in a line, ___being alone away from home or alone at home, ___crossing a bridge, ___traveling in a bus, train or car? YES _____   NO_____

9. Have you worried excessively or been anxious about several things over the past 6 months? (If you answered "no" to this question, please skip to Question 11.) YES _____   NO_____

10. Are these worries present most days?　　　　　　　　　YES _____　NO_____

11. In the past month, were you afraid or embarrassed when others were watching you or when you were the focus of attention? Were you afraid of being humiliated? Examples include: ___speaking in public, ___eating in public or with others, ___writing while someone watches, ___being in social situations.　　　　　　　　　　　YES _____　NO_____

12. In the past month, have you been bothered by thoughts, impulses, or images that you couldn't get rid of that were unwanted, distasteful, inappropriate, intrusive, or distressing? Examples include: ___Were you afraid that you would act on some impulse that would be really shocking? ___Did you worry a lot about being dirty, contaminated or having germs? ___Did you worry a lot about contaminating others, or that you would harm someone even though you didn't want to? ___Did you have any fears or superstitions that you would be responsible for things going wrong? ___Were you obsessed with sexual thoughts, images, or impulses? ___Did you hoard or collect lots of things? ___Did you have religious obsessions?　　　　　　　　YES _____　NO_____

13. In the past month, did you do something repeatedly without being able to resist doing it? Examples include: ___washing or cleaning excessively; ___counting or checking things over and over; ___repeating, collecting, or arranging things; ___other superstitious rituals.　　　　　　YES _____　NO_____

14. Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? Examples include: ___serious accidents; ___sexual or physical assault; ___terrorist attack; ___being held hostage; ___kidnapping; ___fire; ___discovering a body; ___sudden death of someone close to you; ___war; ___natural disaster.　　　　　　　　　　　　YES _____　NO_____

15. Have you re-experienced the awful event in a distressing way in the past month? Examples include: ___dreams; ___intense recollections; ___flashbacks; ___physical reactions.　　　　　　　　　　YES _____　NO_____

Modified MINI Screen (MMS)

16. Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you? YES _____ NO_____

17. Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could actually read someone's mind or hear what another person was thinking? YES _____ NO_____

18. Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self? Or, have you ever felt that you were possessed? YES _____ NO_____

19. Have you ever believed that you were being sent special messages through the TV, radio, or newspaper? Did you believe that someone you did not personally know was particularly interested in you? YES _____ NO_____

20. Have your relatives or friends ever considered any of your beliefs strange or unusual? YES _____ NO_____

21. Have you ever heard things other people couldn't hear, such as voices? YES _____ NO_____

22. Have you ever had visions when you were awake or have you ever seen things other people couldn't see? YES _____ NO_____

_____ **Screened positive for a mental health problem**

- **Total score of 6 or higher on the Modified MINI   – OR –**

- **Question 4 = yes (suicidality)   – OR –**

- **Question 14 AND 15 = yes (trauma)**

Instructions

In this program, we help people with all their problems, not just their addictions. This commitment includes helping people with emotional problems. Our staff is ready to help you deal with any emotional problems you may have, but we can do this only if we are aware of the problems. Any information you provide to us on this form will be **kept in strict confidence**. It will not be released to any outside person or agency **without your permission**. If you do not know how to answer these questions, ask the staff member giving you this form for guidance. Please note, each item refers to your **entire life history**, not just your current situation, this is why each questions begins – "Have you **ever**…"

1. Have you **ever** talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem? YES _____ NO_____

2. Have you **ever** felt you needed help with your emotional problems, or have you had people tell you that you should get help for you emotional problems? YES _____ NO_____

3. Have you **ever** been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem? YES _____ NO_____

4. Have you **ever** been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons? YES _____ NO_____

5. Have you **ever** heard voices no one else could hear or seen objects or things which others could not see? YES _____ NO_____

6. a) Have you **ever** been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or had thought about killing yourself? YES _____ NO_____

   b) Did you **ever** attempt to kill yourself? YES _____ NO_____

7. Have you **ever** had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed? YES _____ NO_____

8. Have you **ever** experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help? YES _____ NO_____

9. Have you **ever** given in to an aggressive urge or impulse, on more than one occasion that resulted in serious harm to others or led to the destruction of property? YES _____ NO_____

10. Have you **ever** felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior? YES _____ NO_____

11. Have you **ever** experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner?   YES _____   NO_____

12. Was there **ever** a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in a lot of exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up?   YES _____   NO_____

13. Have you **ever** had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything?   YES _____   NO_____

14. Have you **ever** had spells or attacks when you suddenly felt anxious, frightened, and uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint?   YES _____   NO_____

15. Have you **ever** had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very ridgid schedule of daily activities from which you could not deviate.   YES _____   NO_____

16. Have you **ever** lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling?   YES _____   NO_____

17. Have you **ever** been told by teachers, guidance counselors, or others that you have a special learning problem?   YES _____   NO_____

_____

Print client's name:

Program to which client will be assigned: _____

Name of admissions counselor: _____ Date: _____

Reviewer's comments: _____

_____ **Screened positive for a mental health problem**

- **At least one "yes" response to questions 3 – 17 on the MHSF-III**

CAGE-Adapted to Include Drugs (CAGE-AID)

1. Have you ever felt you should **C**ut down on your drinking or drug use?

    Drinking: YES _____   NO _____

    Drug Use: YES _____   NO _____

2. Have people **A**nnoyed you by criticizing your drinking or drug use?

    Drinking: YES _____   NO _____

    Drug Use: YES _____   NO _____

3. Have you ever felt bad or **G**uilty about your drinking or drug use?

    Drinking: YES _____   NO _____

    Drug Use: YES _____   NO _____

4. Have you ever had a drink or used drugs first thing in the morning
   to steady your nerves or to get rid of a hangover (**E**ye opener)?

    Drinking: YES _____   NO _____

    Drug Use: YES _____   NO _____

____ **Screened positive for a substance use problem**

- **Total score of 1 or greater on the CAGE-AID**

Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD)

I'm going to ask you a few questions about your use of alcohol and other drugs during the past 6 months. **During the past 6 months…**

1. Have you used alcohol or other drugs (such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants)? YES _____ NO_____

2. Have you felt that you use too much alcohol or other drugs? YES _____ NO_____

3. Have you tried to cut down or quit drinking or using drugs? YES _____ NO_____

4. Have you gone to anyone for help because of your drinking or drug use? YES _____ NO_____

5. Have you had any health problems? For example, have you:

___ had blackouts or other periods of memory loss?

___ injured your head after drinking or using drugs?

___ had convulsions, delirium tremens (DTs)?

___ had hepatitis or other liver problems?

___ felt sick, shaky, or depressed when you stopped?

___ felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs?

___ been injured after drinking or using?

___ used needles to shoot drugs?

Give a "YES" answer if at least one of the eight presented items is marked YES _____ NO_____

6. Has drinking or other drug use caused problems between you and family or friends? YES _____ NO_____

7. Has your drinking or other drug use caused problems at school or work? YES _____ NO_____

8. Have you been arrested or had other legal problems (such as bouncing bad checks, driving while intoxicated, theft, or drug possession)? YES _____ NO_____

9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs? YES _____ NO_____

10. Are you needing to drink or use drugs more and more to get the effect you want? YES _____ NO_____

11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs? YES _____ NO_____

12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone?   YES _____   NO_____

13. Do you feel bad or guilty about your drinking or drug use?   YES _____   NO_____

The next questions are about your lifetime experiences.

14. Have you **ever** had a drinking or other drug problem?   YES _____   NO_____

15. Have any of your family members **ever** had a drinking or drug problem?   YES _____   NO_____

16. Do you feel that you have a drinking or drug problem **now**?   YES _____   NO_____

_____ **Screened positive for a substance use problem**

- **Questions 1 and 15 are not scored**

- **Score of 5 or higher on the SSI-AOD measure**

Traumatic Life Events Inventory and Post-Traumatic Stress Disorder Checklist

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event, **circle one or more** of the numbers to the right to indicate that: (a) **it happened to you personally**, (b) **you witnessed it** happen to someone else, (c) you learned about it **happening to someone close to you**, (d) you're **not sure** if it fits, or (e) it **doesn't apply** to you.

Be sure to **consider your entire life** (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Not sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)	0	1	2	3	4
2. Fire or explosion	0	1	2	3	4
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)	0	1	2	3	4
4. Serious accident at work, home, or during recreational activity	0	1	2	3	4
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)	0	1	2	3	4
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)	0	1	2	3	4
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)	0	1	2	3	4
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)	0	1	2	3	4
9. Other unwanted or uncomfortable sexual experience	0	1	2	3	4
10. Combat or exposure to a war-zone (in the military or as a civilian)	0	1	2	3	4
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)	0	1	2	3	4
12. Life-threatening illness or injury	0	1	2	3	4
13. Severe human suffering	0	1	2	3	4
14. Sudden, violent death (for example, homicide, suicide)	0	1	2	3	4
15. Sudden unexpected death of someone close to you	0	1	2	3	4
16. Serious injury, harm, or death you caused to someone else	0	1	2	3	4
17. Any other very stressful event or experience	0	1	2	3	4

Traumatic Life Events Inventory and Post-Traumatic Stress Disorder Checklist

If an event listed on the previous page **happened to you** or you **witnessed it**, please complete the items below. If more than one event happened, please choose the one that is **most troublesome to you now**.

The event you experienced was_____
                                       (Event)

_____ on _____
                                                (Date)

Instructions

Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, then **circle** one of the numbers to the right to indicate how much you have been **bothered** by the problem **in the past month**.

Bothered by	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated disturbing memories, thoughts or images of the stressful experience?	1	2	3	4	5
2. Repeated, disturbing dreams of the stressful experience?	1	2	3	4	5
3. Suddenly acting or feeling as if the stressful experience were happening again? (As if you were reliving it?)	1	2	3	4	5
4. Feeling very upset when something reminded you of the stressful experience?	1	2	3	4	5
5. Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of the stressful experience?	1	2	3	4	5
6. Avoiding thinking about or talking about the stressful experience or avoiding having feelings related to it.	1	2	3	4	5
7. Avoiding activities or situations because they remind you of the stressful experience?	1	2	3	4	5
8. Trouble remembering important parts of the stressful experience?	1	2	3	4	5
9. Loss of interest in activities that you used to enjoy?	1	2	3	4	5
10. Feeling distant or cut off from other people?	1	2	3	4	5
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?	1	2	3	4	5

Bothered by	Not at all	A little bit	Moderately	Quite a bit	Extremely
12. Feeling as if your future will somehow be cut short?	1	2	3	4	5
13. Trouble falling or staying asleep?	1	2	3	4	5
14. Feeling irritable or having angry outbursts?	1	2	3	4	5
15. Having difficulty concentrating?	1	2	3	4	5
16. Being "super-alert" or watchful or on guard?	1	2	3	4	5
17. Feeling jumpy or easily startled?	1	2	3	4	5

SCORING

1) Was the person exposed to at least one event that involved actual or threatened death or serious injury, or threat to physical integrity of self or others?

   YES   **NO**

2) Did the person respond with intense fear, helplessness or horror?

   YES   **NO**

3) Score of 44 or more? (add up all 17 items on the second page)

   YES   **NO**

If YES to all, PTSD: **YES**   **NO**

Total Score: _____

Social Interaction Anxiety Scale

Instructions

In this section, for each item, please circle the number to indicate the degree to which you feel the statement is characteristic or true for you. The rating scale is as follows:

0 = **Not at all** characteristic or true of me.

1 = **Slightly** characteristic or true of me.

2 = **Moderately** characteristic or true of me.

3 = **Very** characteristic or true of me.

4 = **Extremely** characteristic or true of me

Characteristic	Not at all	Slightly	Moderately	Very	Extremely
1. I get nervous if I have to speak with someone in authority (teacher, boss).	0	1	2	3	4
2. I have difficulty making eye contact with others.	0	1	2	3	4
3. I become tense if I have to talk about myself or my feelings.	0	1	2	3	4
4. I find it difficult to mix comfortably with the people I work with.	0	1	2	3	4
5. I find it easy to make friends my own age.	0	1	2	3	4
6. I tense up if I meet an acquaintance in the street.	0	1	2	3	4
7. When mixing socially, I am uncomfortable.	0	1	2	3	4
8. I feel tense when I am alone with just one person.	0	1	2	3	4
9. I am at ease meeting people at parties, etc.	0	1	2	3	4
10. I have difficulty talking with other people.	0	1	2	3	4
11. I find it easy to think of things to talk about.	0	1	2	3	4
12. I worry about expressing myself in case I appear awkward.	0	1	2	3	4
13. I find it difficult to disagree with another's point of view.	0	1	2	3	4
14. I have difficulty talking to attractive persons of the opposite sex.	0	1	2	3	4
15. I find myself worrying that I won't know what to say in social situations.	0	1	2	3	4

Social Interaction Anxiety Scale

Characteristic	Not at all	Slightly	Moderately	Very	Extremely
16. I am nervous mixing with people I don't know well.	0	1	2	3	4
17. I feel I'll say something embarrassing when talking.	0	1	2	3	4
18. When mixing in a group, I find myself worrying I will be ignored.	0	1	2	3	4
19. I am tense mixing in a group.	0	1	2	3	4
20. I am unsure whether to greet someone I know only slightly.	0	1	2	3	4

SCORING

Total Score: _____

Reserve Items: 5, 9, 11

Interpretation:

34+ Social Phobia is probable.

43+ Social Anxiety is probable.

H. Measuring Motivation for Change and Motivation for Treatment

University of Rhode Island Change Assessment (URICA)

Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES)

Substance Abuse Treatment Scale (SATS)

URICA (Long Form)
(University of Rhode Island Change Assessment)

This questionnaire is to help us improve services. Each statement describes how a person might feel when starting therapy or approaching problems in their lives. Please indicate the extent to which you tend to agree or disagree with each statement. In each case, make your choice in terms of how you feel right now, not what you have felt in the past or would like to feel. For all the statements that refer to your "problem," answer in terms of what you write on the "PROBLEM" line below. And "here" refers to the place of treatment or the program.

There are FIVE possible responses to each of the items in the questionnaire:

1 = Strongly Disagree   2 = Disagree   3 = Undecided   4 = Agree   5 = Strongly Agree

1. As far as I'm concerned, I don't have any problems that need changing.

2. I think I might be ready for some self-improvement.

3. I am doing something about the problems that had been bothering me.

4. It might be worthwhile to work on my problem.

5. I'm not the problem one. It doesn't make much sense for me to be here.

6. It worries me that I might slip back on a problem I have already changed, so I am here to seek help.

7. I am finally doing some work on my problem.

8. I've been thinking that I might want to change something about myself.

9. I have been successful in working on my problem but I'm not sure I can keep up the effort on my own.

10. At times my problem is difficult, but I'm working on it.

11. Being here is pretty much a waste of time for me because the problem doesn't have to do with me.

12. I'm hoping this place will help me to better understand myself.

13. I guess I have faults, but there's nothing that I really need to change.

14. I am really working hard to change.

15. I have a problem and I really think I should work at it.

16. I'm not following through with what I had already changed as well as I had hoped, and I'm here to prevent a relapse of the problem.

17. Even though I'm not always successful in changing, I am at least working on my problem. ❑

18. I thought once I had resolved my problem I would be free of it, but sometimes I still find myself struggling with it. ❑

19. I wish I had more ideas on how to solve the problem. ❑

20. I have started working on my problems but I would like help. ❑

21. Maybe this place will be able to help me. ❑

22. I may need a boost right now to help me maintain the changes I've already made. ❑

23. I may be part of the problem, but I don't really think I am. ❑

24. I hope that someone here will have some good advice for me. ❑

25. Anyone can talk about changing; I'm actually doing something about it. ❑

26. All this talk about psychology is boring. Why can't people just forget about their problems? ❑

27. I'm here to prevent myself from having a relapse of my problem. ❑

28. It is frustrating, but I feel I might be having a recurrence of a problem I thought I had resolved. ❑

29. I have worries but so does the next guy. Why spend time thinking about them? ❑

30. I am actively working on my problem. ❑

31. I would rather cope with my faults than try to change them. ❑

32. After all I had done to try to change my problem, every now and again it comes back to haunt me. ❑

Scoring

Precontemplation items	1, 5, 11, 13, 23, 26, 29, 31
Contemplation items	2, 4, 8, 12, 15, 19, 21, 24
Action items	3, 7, 10, 14, 17, 20, 25, 30
Maintenance items	6, 9, 16, 18, 22, 27, 28, 32

Personal Drinking Questionnaire (SOCRATES 8A)

Instructions

Please read the following statements carefully. Each one describes a way that you might (or might not) feel about your drinking. For each statement, circle one number from 1 to 5, to indicate how much you agree or disagree with it right now. Please circle one and only one number for every statement.

1 – No! Strongly Disagree
2 – No. Disagree
3 - ? Undecided or Unsure
4 – Yes Agree
5 - YES! Strongly Agree

1. I really want to make changes in my drinking.	1 2 3 4 5
2. Sometimes I wonder if I am an alcoholic.	1 2 3 4 5
3. If I don't change my drinking soon, my problems are going to get worse.	1 2 3 4 5
4. I have already started making some changes in my drinking.	1 2 3 4 5
5. I was drinking too much at one time, but I've managed to change my drinking.	1 2 3 4 5
6. Sometimes I wonder if my drinking is hurting other people.	1 2 3 4 5
7. I am a problem drinker.	1 2 3 4 5
8. I'm not just thinking about changing my drinking, I'm already doing something about it.	1 2 3 4 5
9. I have already changed my drinking, and I am looking for ways to keep from slipping back to my old pattern.	1 2 3 4 5
10. I have serious problems with drinking.	1 2 3 4 5
11. Sometimes I wonder if I am in control of my drinking.	1 2 3 4 5
12. My drinking is causing a lot of harm.	1 2 3 4 5
13. I am actively doing things now to cut down or stop drinking.	1 2 3 4 5
14. I want help to keep from going back to the drinking problems that I had before.	1 2 3 4 5
15. I know that I have a drinking problem.	1 2 3 4 5
16. There are times when I wonder if I drink too much.	1 2 3 4 5
17. I am an alcoholic.	1 2 3 4 5
18. I am working hard to change my drinking.	1 2 3 4 5
19. I have made some changes in my drinking, and I want some help to keep from going back to the way I used to drink.	1 2 3 4 5

NH-Dartmouth Psychiatric Research Center – Version date: January 22, 2002

Client Name _____

Date of Rating _____

Substance Abuse Treatment Scale

Instructions

This scale is for assessing a person's stage of substance abuse treatment, not for determining diagnosis. The reporting interval is the last **six months**. If the person is in an institution, the reporting interval is the time period prior to institutionalization.

1. **Pre-engagement:** The person (not client) does not have contact with a case manager, mental health counselor, or substance abuse counselor, and meets criteria for substance abuse or dependence.

2. **Engagement:** The client has had only irregular contact with an assigned case manager or counselor, and meets criteria for substance abuse or dependence.

3. **Early Persuasion:** The client has regular contacts with a case manager or counselor, continues to use the same amount of substances or has reduced substance use for less than 2 weeks, and meets criteria for substance abuse or dependence.

4. **Late Persuasion:** The client has regular contacts with a case manager or counselor, shows evidence of reduction in use for the past 2 to 4 weeks (fewer substances, smaller quantities, or both), but still meets criteria for substance abuse or dependence.

5. **Early Active Treatment:** The client is engaged in treatment and has reduced substance use for more than the past month, but still meets criteria for substance abuse of dependence during this period of reduction.

6. **Late Active Treatment:** The person is engaged in treatment and has not met criteria for substance abuse or dependence for the past 1 to 5 months.

7. **Relapse Prevention:** The client is engaged in treatment and has not met criteria for substance abuse or dependence for the past 6 to 12 months.

8. **In Remission or Recovery:** The client has not met criteria for substance abuse or dependence for more than the past year.

I. Tracking Changes in Substance Use and Mental Health

30-Day Timeline Follow Back Calendar of Substance Use and Mental Health Symptoms

For substance abuse entries: note substance and how much used
For mental health entries: note symptoms experienced and intensity on scale of 1 to 10

Sun	Mon	Tues	Wed	Thurs	Fri	Sat
Alc: _____ Drugs: _____ MH: _____	Alc: _____ Drugs: _____ MH: _____	Alc: _____ Drugs: _____ MH: _____	Alc: _____ Drugs: _____ MH: _____	Alc: _____ Drugs: _____ MH: _____	Alc: _____ Drugs: _____ MH: _____	Alc: _____ Drugs: _____ MH: _____
Alc: _____ Drugs: _____ MH: _____	Alc: _____ Drugs: _____ MH: _____	Alc: _____ Drugs: _____ MH: _____	Alc: _____ Drugs: _____ MH: _____	Alc: _____ Drugs: _____ MH: _____	Alc: _____ Drugs: _____ MH: _____	Alc: _____ Drugs: _____ MH: _____
Alc: _____ Drugs: _____ MH: _____	Alc: _____ Drugs: _____ MH: _____	Alc: _____ Drugs: _____ MH: _____	Alc: _____ Drugs: _____ MH: _____	Alc: _____ Drugs: _____ MH: _____	Alc: _____ Drugs: _____ MH: _____	Alc: _____ Drugs: _____ MH: _____
Alc: _____ Drugs: _____ MH: _____	Alc: _____ Drugs: _____ MH: _____	Alc: _____ Drugs: _____ MH: _____	Alc: _____ Drugs: _____ MH: _____	Alc: _____ Drugs: _____ MH: _____	Alc: _____ Drugs: _____ MH: _____	Alc: _____ Drugs: _____ MH: _____
Alc: _____ Drugs: _____ MH: _____	Alc: _____ Drugs: _____ MH: _____	Alc: _____ Drugs: _____ MH: _____	Alc: _____ Drugs: _____ MH: _____	Alc: _____ Drugs: _____ MH: _____	Alc: _____ Drugs: _____ MH: _____	Alc: _____ Drugs: _____ MH: _____

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