DUAL DIAGNOSIS CAPABILITY IN ADDICTION TREATMENT (DDCAT) *VERSION 2.4*
Mental Health version rev. 2/21/06 by Heather Gotham, Rev. 4/15/06 by Jessica Brown

RATING SCALE COVER SHEET

Date: ___________ Rater(s): ____ Time Spent: ____________________

Agency Name: ____

Program Name: ____

Program Type(s): ____ Level of Care: _____________________________

Address: ____

Contact Person: ____ (Title: ____)

Telephone: ___________________________; FAX: ________________________; Email: ______________________________________

Sources used:

_____ Chart Review | _____ Agency brochure review | _____ Program manual review

_____ Team meeting observation | _____ Supervision observation | _____ Observe group/individual session

_____ Interview with Program Director | _____ Interview with Clinicians | _____ Interview with clients (#: _________)

_____ Interview with other service providers (Specify: _______________________________) | _____ Physical site tour/observation

Total # of sources used: _______

Notes:

Abbreviations: MHOS=mental health only services, DDC=dual diagnosis capable, DDE=dual diagnosis enhanced, MH=mental health, MHD=mental health disorders, SU=substance use, SUD=substance use disorders

	1 MHOS	2	3 DDC	4	5 DDE
I. PROGRAM STRUCTURE					
IA. Primary treatment focus as stated in mission statement.	Mental health Only		Primary focus is mental health, co-occurring disorders are treated		Primary focus on dual-diagnosis patients.
IB. Organizational certification & licensure.	Permits only mental health treatment	Has no actual barrier, but staff report there to be certification or licensure barriers.	Has no barrier to providing addiction treatment		Is certified and/or licensed to provide both
IC. Coordination and collaboration with addiction services.	No document of formal coordination or collaboration.	Vague, undocumented, or informal relationship with addiction agencies, or consulting with a staff member from that agency.	Formalized and documented coordination or collaboration with addiction agency.	Formalized coordination & collaboration, and the availability of case management staff, or staff exchange programs (variably used)	Most services integrated within the existing program, or routine use of case management staff or staff exchange programs.
ID. Financial incentives.	Can only bill for mental health treatments or for persons with mental health disorders.		Can bill for either service type, however, mental health must be primary.		Can bill for addiction or mental health treatments, or the combination and/or integration.

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II. PROGRAM MILIEU					
IIA. Routine expectation of and welcome to treatment for both disorders	Expect MHDs only, refer or deflect SUDs. CODs not expected, nor plans documented.	Documented to expect MHDs only, but will not deflect SU disorders.	Expect MHDs, and accept SUDs by routine and if relatively stable.	Clinicians and program expects and treats both disorders, not well documented.	Documented in mission statement, or program philosophy.
IIB. Display and distribution of literature and patient educational materials.	Mental health only	Available for both disorders but not routinely offered or formally available.	Available for both mental health & substance use disorders.		Available for the interaction between both mental health and substance use disorders.
III. CLINICAL PROCESS: ASSESSMENT					
IIIA. Routine screening methods for substance use disorders	Pre-admission screening based on patient self-report: Decision based on clinician inference from patient presentation or history.	Pre-admission screening for substance use & treatment history,	Clinicians have routine set of standard interview questions using generic framework: Level of Care or Biopsychosocial data collection.		Standardized or formal instruments with established psychometric properties.
IIIB. Routine assessment if screened positive for substance use	Ongoing monitoring for appropriateness or exclusion from program	More detailed assessment of SU, each clinician driven	Formal assessment on site by SU professional as necessary		Standardized or formal integrated assessment is routine in all cases.

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III. CLINICAL PROCESS: ASSESSMENT					
IIIC. Substance use and mental health diagnoses made and documented.	SU diagnoses are not made or recorded	SU diagnoses made occasionally. Clinician driven	Formal process to make SU diagnoses more routine, recorded in chart. (Variable).		Standard & routine SU diagnoses made.
IIID. Substance use and mental health history reflected in medical record.	Not present	Variable by individual clinician.	Routine documentation in record in narrative section.		Specific section in record devoted to history and chronology of course of both disorders.
IIIE. Service matching based on SU symptom acuity: low, moderate, high.	Can provide care to persons with no to low acuity.		Can provide care to persons with low to moderate acuity, but primarily stable.		Can provide care to persons with moderate to high acuity, including those who have not quit
IIIF. Service matching based on severity of persistence and disability of SU: low, moderate, high.	Can provide care to persons with no to low severity of persistence of disability		Can provide care to persons with low to moderate severity.		Can provide care to persons with moderate to high severity
IIIG. Stage-wise treatment-initial.	Not assessed or documented.	Assessed & documented variably by individual clinician	Clinician assessed and documented routinely, used in planning.		Formal measure used, & integrated in treatment planning

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IV. CLINICAL PROCESS: TREATMENT					
IVA. Treatment plans.	Address MH only (addiction not listed)	Variable by individual clinician	MH primary, SU as secondary	Systematic focus available but variably used.	Address both as primary, both listed in plan
IVB. Assess and monitor interactive courses of both disorders.	No attention or documentation of progress with SU problems	Variable by individual clinician reports of progress on SU problems (acknowledge up front, then no more)	Clinical focus in narrative on SU problem change	Systematic focus is available but variably used.	Clear, detailed, and systematic focus on change in both SU and MH
IVC. Procedures for intoxicated/high clients, detox, and relapse or active users.	Few documented or explicit in-house guidelines	Explicit or verbally conveyed in-house guidelines.	Explicit or documented guidelines: Referral or collaborations (to local SU agency or E/R)		Routine capability, or a process to ascertain risk of ongoing use of substances: Maintain in program unless higher level of care is warranted
IVD. Stage-wise treatment-ongoing.	Not assessed or explicit in plan.	Documented variably by individual clinician	Individualized plan, no specific stage-wise treatments.		Formally prescribed stage-wise treatments.

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IV. CLINICAL PROCESS: TREATMENT					
IVE. Policies and procedures for medication evaluation, management, monitoring and compliance for individuals with active SUDs as well as the use of medications for SUDs.	Patients with active SU on taking meds for SUD not manageable within program	Certain types of meds for SUD are not managed within program but can be monitored. Might work in conjunction with off-site addictions specialist to manage.	Capable of managing patients with active SU or taking medications for SUDs. Formal mechanism to regularly access services of prescriber who is competent in addictions.	Provider competent in addictions is a staff member. Clear standards for SU related medication issues are available.	Provider competent in addictions is a staff member and present on treatment teams or administration. Clear standards and for SUD related medication issues are available.
IVF. Specialized interventions with SUD content.	Not addressed in program content	Based on judgment by individual clinician	In program format as generalized intervention, often more generic and broadly applicable	Some specialized interventions offered by specifically trained clinicians.	Comprehensive array of specialized interventions focused on SUD
IVG. Education about SUD & treatment; interaction with MH & treatment.	None	Variably	Present in generic format and content.		Present specific content for specific disorder comorbidities.
IVH. Family education and support.	For MH only, or minimal to no family involvement	Variably offered for SUD or based on individual clinical judgment	Access regularly offered. Often through collaborative agreement with SU therapist	More of a standard treatment option for families but not fully integrated into program format.	Routine COD family group integrated into standard program format by staff member.

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IV. CLINICAL PROCESS: TREATMENT					
IVI. Specialized interventions to facilitate use of COD self-help groups.	Not present.	Used variably by individual clinicians.	Present, generic format on site.		Specific to need of COD groups, special programs on site.
IVJ. Peer recovery supports for patients with CODs.	Not present, not recommended.	Off site, recommended variably	Present, off site and facilitated with contact persons	Off site, integrated into plan.	Present, on site, facilitated and integrated into program (e.g. alumni groups)

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V. CONTINUITY OF CARE					
VA. Co-occurring disorder addressed in discharge planning process.	Not addressed	Variably addressed by individual clinicians.	COD systematically addressed as secondary in planning process for off site referral		Both disorders seen as primary, and plans made and insured, on site, or by arrangement - off site.
VB. Capacity to maintain treatment continuity	Referral for SU treatments off site upon discharge	Variably addressed by individual clinicians	Documented monitoring of SUD		Monitoring and ongoing treatment of SUD
VC. Focus on ongoing recovery issues for both disorders.	No	Individual clinician determined.	Primary MH, SUD as potential relapse issue only.		Focus on recovery from both disorders, both primary and ongoing.
VD. Facilitation of self-help support groups for COD is documented.	No	Rarely, but addressed by individual clinicians	Yes, variably but not routine or systematic		Yes, routine and systematic
VE. Sufficient supply and compliance plan for SUD medications is documented.	No medications in plan.		Yes, 30-day or supply to next appointment off-site.		Maintains medication management in program with provider after d/c.

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VI. STAFFING					
VIA. Psychiatrist or prescriber competent in treatment of addictions	No formal relationship with program.	Consultant or contractor off-site.	Consultant or contractor for on-site.	Staff member, present on-site for clinical matters only	Staff member, present on- site for clinical, supervision, treatment team, and/or administration.
VIB. On-site staff with addiction certification/ expertise.	No formal relationship with program.	Less than 25% of staff members are.	At least 25% of staff members are.		At least 50% of staff members are.
VIC. Access to addiction supervision or consultation.	No	Yes, off-site by consultant, undocumented.	Yes, on-site, documented PRN.	Yes, on-site undocumented regular supervision sessions.	Yes, on-site, documented regular supervision sessions for clinical matters.
VID. Supervision, case management or utilization review procedures emphasize and support COD treatment.	No	Variable, by off-site consultant, undocumented.	Yes, on-site, documented PRN and with COD issues.		Yes. Documented, routine and systematic coverage of COD issues.
VIE. Peer/Alumni supports are available with COD.	No		Present, but as part of community.		Present, on site.

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VII. TRAINING					
VIIA. Basic training in COD includes: prevalence, common signs & symptoms, screening and assessment for SU symptoms and disorders.	Not trained in basic skills.	Variably trained, not documented as part of systematic training plan, but encouraged by management.	Trained in basic skills per agency strategic training plan.	Trained in these skills per agency strategic training plan, and also have some specialized training in treatment approaches	Trained in these skills per agency strategic training plan, and also have staff trained in specialized treatment approaches as part of plan.
VIIB. Staff are cross-trained in mental health and substance use disorders, including pharmacotherapy	Not trained, or not documented.	Less than 33% trained.	At least 50% trained	At least 75% are trained	At least 90% are trained.

ADDITIONAL SITE VISIT NOTES:

DDCAT-MENTAL HEALTH VERSION PROGRAM SUMMARY SCORE SHEET (*VERSION 2.4*)

Program: ______________________________ **Date of Review:** ______________
Level of care: ______________________________
Reviewer(s): ______________________________

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** __________