

DUAL DIAGNOSIS CAPABILITY IN ADDICTION TREATMENT (DDCAT) *VERSION 2.4*

RATING SCALE COVER SHEET

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

Agency Name: _____

Program Name: _____

Program Type(s): _____ **ASAM-PPC-2R 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: AOS=addiction only services, DDC=dual diagnosis capable, DDE=dual diagnosis enhanced, MH=mental health, MHD=mental health disorders, SU=substance use, SUD=substance use disorders

DUAL DIAGNOSIS CAPABILITY IN ADDICTION TREATMENT PROGRAMS (DDCAT) VERSION 2.4

SCORING MANUAL

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

	1 AOS	2	3 DDC	4	5 DDE
II. PROGRAM					
IIA. Routine expectation of and welcome to treatment for both disorders	Expect SUDs only, refer or deflect MH. CODs not expected, nor plans documented.	Documented to expect SUDs only, but will not deflect MH disorders.	Expect SUDs, and accept MH 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.	Addiction or self-help 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 psychiatric symptoms	Pre-admission screening based on patient self-report: Decision based on clinician inference from patient presentation or by history.	Pre-admission screening for symptom & treatment history, current medications, suicide/homicide history prior to admission.	Clinicians have routine set of standard interview questions using generic framework: ASAM-PPC or “Biopsychosocial” data collection.		Standardized or formal instruments with established psychometric properties.
IIIB. Routine assessment if screened positive for psychiatric symptoms	Ongoing monitoring for appropriateness or exclusion from program	More detailed biopsychosocial assessment, mental status exam, each clinician driven	Formal assessment on site by MH professional as necessary		Standardized or formal integrated assessment is routine in all cases.

	1 AOS	2	3 DDC	4	5 DDE
III. CLINICAL PROCESS: ASSESSMENT					
IIIC. Psychiatric and substance use diagnoses made and documented.	Psychiatric diagnoses are not made or recorded	Off site MH professional may make diagnosis, and then is recorded.	MH professional makes diagnosis, recorded in chart. (Variable).		Standard & routine diagnoses made by MH professional staff member.
IIID. Psychiatric and substance use 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 psychiatric 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 who are primarily stable.		Can provide care to persons with moderate to high acuity, including those unstable in their psychiatric condition.
IIIF. Service matching based on severity of persistence and disability: 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

	1 AOS	2	3 DDC	4	5 DDE
IV. CLINICAL PROCESS: TREATMENT					
IVA. Treatment plans.	Address addiction only (MH not listed)	Variable by individual clinician	SUDs addressed as primary, MH as secondary	Systematic focus in 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 MH problems	Variable by individual clinician reports of progress on MH problems	Clinical focus in narrative on MH problem change	Systematic focus in available but variably used.	Clear, detailed, and systematic focus on change in both SUDs and MH
IVC. Procedures for psychiatric emergencies and crisis management.	Few documented or explicit in-house guidelines	Explicit or verbally conveyed in-house guidelines.	Explicit or documented guidelines: Referral or collaborations (to local MH agency or E/R)		Routine capability, or a process to ascertain risk with ongoing use of substances: Maintain in program unless commitment is warranted
IVD. Stage-wise treatment-ongoing.	Not assessed or explicit in plan.	Documented variably by individual clinician	Individualized plan, no specific stage-wise treatments.		Formally prescribed stage-wise treatments.

	1 AOS	2	3 DDC	4	5 DDE
IV. CLINICAL PROCESS: TREATMENT					
IVE. Policies and procedures for medication evaluation, management, monitoring and compliance.	Patients on meds routinely not accepted	Certain types of meds are not acceptable. Or must have own supply for entire treatment episode	Present, coordinated medication policies for consultant provider.	Clear standards and routine for medicating provider who is also a staff member.	Clear standards and routine for medicating provider who is also a staff member and present on treatment teams or administration.
IVF. Specialized interventions with mental health content.	Not addressed in program content	Based on judgment by individual clinician	In program format as generalized intervention, e.g. stress management	Some specialized interventions by specifically trained clinicians.	MH symptom management groups; Individual therapies focused on specific disorders.
IVG. Education about psychiatric disorder & its treatment, and interaction with substance use & its treatment.	No	Variably	Present in generic format and content.		Present specific content for specific disorder comorbidities.
IVH. Family education and support.	For alcohol or drug problems only	Variably or by individual clinical judgment	Consultant or collaborative agreement with therapist for SUDs and MH onsite group	Generic group on site for families on SUDs and MH issues, variably offered by staff member.	Routine COD family group integrated into standard program format by staff member.

	1 AOS	2	3 DDC	4	5 DDE
IV. CLINICAL PROCESS: TREATMENT					
IVI. Specialized interventions to facilitate use of 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)

	1 AOS	2	3 DDC	4	5 DDE
V. CONTINUITY					
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 mental health treatments off site upon discharge	Variably addressed by individual clinicians	Documented monitoring of psychiatric conditions.		Monitoring and ongoing treatment of psychiatric conditions.
VC. Focus on ongoing recovery issues for both disorders.	No	Individual clinician determined.	Primary SUDs, MH 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 medications is documented.	No medications in plan.		Yes, 30-day or supply to next appointment off-site.		Maintains medication management in program with provider.

	1 AOS	2	3 DDC	4	5 DDE
VI. STAFFING					
VIA. Psychiatrist or other physician.	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 mental health licensure (doctoral or masters level).	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 mental health 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.

	1 AOS	2	3 DDC	4	5 DDE
VII. TRAINING					
VIIA. Basic training in prevalence, common signs & symptoms, screening and assessment for psychiatric symptoms and disorders.	Not trained in basic skills.	Variably trained, not documented as part of systematic training plan, but encouraged by management.	Trained in basic skills per agency strategic training plan.	Trained in these skills per agency strategic training plan, and also have some 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 pharmacotherapies.	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:

DUAL DIAGNOSIS CAPABILITY IN ADDICTION TREATMENT (DDCAT) 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 _____