The Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index

A Toolkit for enhancing

ADDICTION ONLY SERVICE (AOS) PROGRAMS

And

DUAL DIAGNOSIS CAPABLE (DDC) PROGRAMS

Version 3.2-CT
January 2010

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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 decade, there has been an increased awareness of the common presentation of persons with co-occurring psychiatric disorders in routine addiction settings. National and state initiatives have been significant, and have stimulated considerable interest in providing better services for co-occurring disorders. Although clearly interested in doing so, addiction treatment providers have lacked pragmatic guidance on how to improve existing services. The Substance Abuse and Mental Health Services Administration (SAMHSA) has generated two volumes within the Treatment Improvement Protocol (TIP) series (TIP Series #9 and #42) to respond to this need. However, providers continue to identify the need for practical guidance and/or specific benchmarks with which to plan and develop services. Over the past six years, we have been developing and implementing the Dual Diagnosis Capability in Addiction Treatment (DDCAT) index. The DDCAT, based on the American Society of Addiction Medicine's (ASAM's) taxonomy of program dual diagnosis capability, has been subjected to a series of psychometric studies, and has been implemented in a number of state systems including, Connecticut, Missouri, Louisiana, Texas and Indiana. The DDCAT, defined more fully below, has served to guide both programs and system authorities in assessing and developing the dual diagnosis capacity of addiction treatment services (McGovern et al, 2007).

This toolkit grows out of these efforts and 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 will provide 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 provides for DDC programs as well.

The motivation among addiction treatment providers to improve the quality of care offered to their patients is impressive if not inspirational.

We developed this toolkit in direct response to addiction treatment programs at the "Action" stage of readiness. This is the stage at which most addiction treatment providers find themselves. The toolkit is designed to immediately offer practical tools and useable materials that will rapidly improve services to those persons with co-occurring disorders entrusted to their care.

Program and system leaders who may be interested in assessing their stage of readiness might consider the measurement tools from the Institute for Behavioral Research at Texas Christian University (www.ibr.tcu.edu), particularly the Organizational Readiness for Change (ORC) index (Lehman et al, 2002).

As with any change initiative, it is important to consider goals, resources and barriers, and the degree to which there is a common mission among all whom are involved. An agency leader may be able to understand these issues, coalesce and inspire an organization forward. Leadership is key to the success of any organizational change effort.

What is the DDCAT?

The DDCAT is an acronym for the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index, and is a fidelity instrument for measuring addiction treatment program services for persons with co-occurring (i.e., mental health and substance use related) disorders (see Appendix A for a copy of the instrument). The DDCAT Index has been in development since 2003, and is based upon the fidelity assessment methodology described below. 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 programs implementation of the Integrated Dual Disorder Treatment (IDDT). 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 are guided by an amalgam of evidence-based practices and consensus clinical guidelines.

Over the past 2-3 years, the term of "co-occurring disorder" (COD) has gradually come to replace the vernacular of "dual diagnosis." In this manual the terminology will be synonymous. In order to remain consistent with the DDCAT author, the dual diagnosis terminology will be used in discussing the specifics of the DDCAT items. When discussing issues broadly, however, the use of co-occurring disorders will be used.

The DDCAT evaluates 35 program elements that are subdivided into 7 dimensions. The first dimension is ***Program Structure***; this dimension focuses on general organizational factors that foster or inhibit the development of COD treatment. ***Program Milieu*** is the second dimension, and this dimension focuses on the culture of program and whether the staff and physical environment of the program are receptive and welcoming to persons with COD. The third and fourth dimensions are referred to as the ***Clinical Process*** dimensions (***Assessment*** and ***Treatment***), and these examine whether specific clinical activities achieve specific benchmarks for COD 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 COD. The sixth dimension is ***Staffing***, which examines staffing patterns and operations that support COD 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 COD.

The DDCAT Index 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.

The methodology of the DDCAT

The DDCAT uses observational methods. This involves a site visit of an addiction treatment agency by "objective" assessors. The assessors strive to collect data about the programs services 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, support personnel, and clients; and
3) Review of documentation such as medical records, program manuals, brochures, daily patient schedules, telephone intake screening forms, and other materials that may seem relevant.

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

Arranging and conducting the site visit

The scheduling of the site visit is done in advance of the actual visit. 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 unit of DDCAT assessment is at the level of the program not the entire agency. Therefore a site visit to an agency will need to pre-arrange what program or programs within that agency are to be assessed. Experience tells us that it may be possible to fully assess one program within one agency in approximately a half day. In a full day it may be possible to assess two to three programs within one agency. In a full day it may also be possible to assess one program in one agency and another program in a different agency in the second part of the day. It is important to allocate sufficient time to do the DDCAT assessment. This process typically becomes more efficient as the assessor gains experience.

The DDCAT process begins with the advance scheduling, usually with the Agency Director or her/his designate. It is important at this interaction to define the scope (program vs. agency) of the assessment, and clarify the time allocation requirements. At this time it will 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, i.e. to help the agency learn about it's services to persons with co-occurring disorders, and to suggest practical strategies to enhance services if warranted. This sets an expectation of collaboration vs. evaluation and judgment.

The scheduling should include an initial meeting with the agency director, time for interviews with the program clinical leaders and supervisors, select clinicians, and client(s). Selected persons in these roles can be interviewed, but not every supervisor, staff member or client must be interviewed. More is always better, but reasonableness and representativeness should be the overarching goal. During the visit a "tour" of the program's physical site is essential. Agencies have experience doing this for other purposes and this 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, medical records, policy & procedure manuals, patient activity schedules and other pertinent materials.

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, and 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.

The preliminary feedback at the end of the DDCAT assessment is typically positive and affirming and emphasizes program strengths and themes from the assessment. The assessor is encouraged to consider a motivational interviewing or stage of readiness for change model and focus on addressing issues that have already been raised as areas of concern or desired change.

After the visit, the assessor will score the DDCAT index, and may choose to write a letter or summary report to the agency director. Again, emphasizing strengths is encouraged, and capitalizing on areas of readiness will likely be the most valuable change suggestion for the agency. The use of graphic figures that plot the 7 dimension scores (with horizontal lines indicating the benchmarks for AOS, DDC or DDE services) has been very useful to guide feedback, conversation and target program enhancement efforts. The DDCAT data can be aggregated for program planning, system planning, and serve as the basis for strategic training, resource allocation, service collaboration and change measurement, with repeated evaluations over time.

Scoring the DDCAT

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 related disorders, referred to by ASAM and in the DDCAT as "Addiction Only Services" (AOS). A score of 3 is meant to be indicative of a program that is capable of providing services to some individuals with co-occurring substance related and mental health disorders but has greater capacity to serve individuals with substance related disorders. This level is referred to as being Dual Diagnosis Capable (DDC) by ASAM and on the DDCAT. A score of 5 is commensurate with a program that is capable of providing services to any individual with co-occurring substance related 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 either:

(1) The *presence or absence* of specific hierarchical or ordinal benchmarks, i.e. 1-AOS sets the most basic mark, a 3-DDC sets at a mid-level mark, and 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 a single standard, i.e. based on having a certain frequency of an element in the program such as staff that are cross-trained in COD services. 1-AOS sets a lower percentage of required cross-trained staff, 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.

-or-

(3) A combination of the presence of 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 and the program must consistently maintain this standard for the majority of their clients (set at an 80% basis). For example, program elements regarding COD screening and assessment typically set a qualifying standard for the type of screen or assessment used –AND- specify that the standard is routinely applied (at least on an 80% of the time).

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, & 5's (scores of 3 or greater) obtained
   c) Percentage of 1's obtained

3. Apply the following cutoffs to determine the program's DDCAT category:
   a) Programs are Dual Diagnosis Enhanced if 80% of scores are 5's
   b) Programs are Dual Diagnosis Capable if 80% of scores are 3's or greater
   c) Programs are Addiction Only Services if 80% of scores are 1's

4. Use the mean scores of the individual items within each dimension to develop a program profile and target areas of relative strength and targets for potential enhancement efforts.

Organization of the Manual and Toolkit

This toolkit is intrinsic to the DDCAT manual. Accordingly, the toolkit suggestions are imbedded within the context of the manual and it's scoring. Each of the seven dimensions of the DDCAT are 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, but this is not

always the case and depends on the item definition. The option of scoring a 2 or 4 on any given item is designed to give the rater some flexibility in scoring when observations do not provide sufficient information to decide whether an item clearly meets the requirements for scoring a 1 or 3, or a 3 or 5, respectively.

Corresponding to each item, the toolkit offers specific suggestions for that item to AOS and DDC programs in a text box. Whenever possible, and with appropriate permission given, actual treatment providers practices will be noted as illustrations. Further editions of this manual are envisioned, and exclusively using actual treatment provider examples is a goal. Also when possible, specific materials will be included for providers to use in their programs. These materials are included in the Appendix. Future editions of this toolkit will also likely feature an expanded Appendix with an accumulation of exemplar materials that are being used in the field and which providers are willing to share with one another.

Terminology and Acronyms

The term "co-occurring disorders" and its corresponding acronym (COD) are used in this text to denote the status of having a combination of substance related and other psychiatric disorders.

The DSM-IV specifies and defines substance related disorders, including for example dependence, abuse and substance induced disorders. All other psychiatric disorders, independent of substance related disorders will be designated in this manual as either psychiatric disorders or mental health disorders.

In addition, it is important to denote that the term "dual diagnosis" also refers to the same status defined in COD and continues to be used in this manual at times in the fidelity index itself to retain the language initially established by ASAM and the DDCAT Index versions.

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

The term "mental health disorders" is used to globally refer to other major psychiatric disorders besides the substance related disorders. Generally, this term refers to the mood disorders, anxiety disorders, thought disorders, adjustment disorders, and other disorders not substance related or induced.

Your program's DDCAT Profile and Interpretation

At the end of the DDCAT assessment you will receive a DDCAT Profile. This profile depicts your program's scores relative to the AOS, DDC and DDE criteria overall, and for each of the seven dimensions. You may choose to interpret the DDCAT Profile by identifying dimensions you feel reflect your best work. You may choose to focus on dimensions that are relatively lower than other dimensions. These may be areas for quality improvement initiatives. We recognize that some of these dimensions, for example Program Structure or

Staffing, may involve financial issues. For other dimensions, for example Training or Assessment, few if any costs to change are involved. We encourage you to examine your DDCAT Profile, identify those dimensions you wish to address, and consider using this toolkit to inform the process. A DDCAT assessment can then be conducted at a later date to measure your change efforts.

Using the DDCAT for continuous quality improvement

Using the DDCAT to both plan and measure the outcome of continuous quality improvement activities is a valuable feature to its implementation in programs and systems. Research is presently underway to evaluate the relative effectiveness of strategies and approaches to making change in addiction treatment programs' capacities to treat persons with co-occurring disorders.

Many programs and systems have obtained initial DDCAT assessments and then using these data as "baseline", go on to develop change 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. Various examples of these change plans are available from the authors.

Programs have used the DDCAT dimensions 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. And, since it can be re-administered, it can also be used to measure the success (or sustainability) of these changes.

The DDCAT Index: Item Definitions, Source for Data, and Scoring

I. PROGRAM STRUCTURE

IA. Primary treatment focus as stated in mission statement.

Definition:
Programs that offer treatment for individuals with COD should have this philosophy reflected in their mission statements.

Source: Program brochure, manuals, 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 COD 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 related 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 related disorders but the statement also indicates an expectation and willingness to admit individuals with and address their co-occurring mental health 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 might meet the DDC level would be one similar to the following where 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 COD, in that the program has the combined capacity to treat both mental health and substance related 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 illness and substance use disorders."

AOS PROGRAMS

Enhancing IA. Primary treatment focus as stated in mission statement.

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

Although mission statements may not translate into actual practice in any given treatment program or organization, a change in a mission statement is emblematic of a "sea change" in leadership philosophy and commitment. A subtle shift in the last phrase of the NSADTC mission statement to: "The North Side Alcohol and Drug Treatment Center (NSADTC) is dedicated to assisting persons initiate a process of recovery from substance use and its associated problems" is an example.

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" and/or "recovery." An example may be: "The New London Clinic is committed to offering a full range of behavioral health services to promote well being and lifelong recovery."

This change would begin to position the AOS program as DDC.

DDC PROGRAMS

Enhancing IA. Primary treatment focus as stated in mission statement

DDC programs have scored a 3 on this item. It is likely that the mission statement reflects a program philosophy that recognizes comorbid psychiatric problems, but probably as secondary to substance-related disorders. A DDE program mission statement is characterized by an equivalent focus on substance use and psychiatric problem and will include the term "co-occurring disorders" or clearly include MH and SA services.

Some providers take issue with the "behavioral" terminology, and argue that it may connote a less than holistic (or perhaps mechanistic) approach to health care. Alternative terminology that can embrace co-existing mental health and addictive problems are also possible.

1B. Organizational certification & licensure.

Definition:
Organizations that provide integrated COD treatment are able to provide unrestricted services to individuals with COD without barriers that have traditionally divided the services for mental health disorders from the services for substance related 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 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 licensure agreement or state permit restricts services to individuals with substance related disorders only.

- ***(SCORE-2):*** Has no actual barrier, but staff report there to be certification or licensure barriers. The program's certification or 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 related disorders. BUT the staff and administrators report and perceive there to be barriers; and 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 or licensure agreement or state permit identifies the target population to be individuals with substance related 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 services licensure and targets psychiatric 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 or licensure agreement(s) or state permit(s) identifies the program as a facility that provides services for both mental health and substance related disorders.

AOS PROGRAMS

Enhancing IB. Organizational certification and licensure

Programs at the AOS level have scored either a 1 or 2 on this item. Most frequently this is due to a program's legitimate certification or licensure restrictions. This encumbers a program to provide solely to persons who meet criteria for a substance use disorder. Even though up to 80% of such persons will likely have a co-occurring psychiatric disorder, the program must declare the substance use disorder as primary if not singular. Some programs have "spoken" mythologies but non-reality based constraints of their inability to treat persons with co-occurring disorders. Two practical strategies are possible to elevate to DDC level services. First, actual state and regional policies must be verified so that restrictions, if they do exist, can be encountered as reality-based. Some state authorities have considered making special allocations for persons with co-occurring disorders (i.e. substance use disorders with complications). Other programs have sought either joint mental health licensure or hired or enabled licensed staff to bill for unbundled services. Finally, it is common and realistic for a program to provide services in the context of addiction services licensure that target psychiatric problems in a general approach and with treatment individualized accordingly.

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 services.

IC. Coordination and collaboration with mental health services.

Definition:
Programs that transform themselves from ones that only provide for substance related disorders into ones that can provide integrated COD 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 related disorders. The following terms are used to denote the stepwise advances and were provided 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.*

<u>Source</u>: Interviews with Agency Director, program clinical leaders, clinicians. Some documentation may also exist.

<u>Item Response Coding</u>: 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 substance related services. An understanding of the SAMHSA defined terms regarding this issue is also necessary; these definitions of "minimally coordinated," "consultative," "collaborative," and "integrated services" are provided above. The DDCAT scoring directly corresponds to the SAMHSA definitions on the previous page.

- ***Addiction Only Services = (SCORE-1):*** No document of formal coordination or collaboration. Programs that have a system of care that meets the SAMHSA definition of "Minimal Coordination" only.

- ***(SCORE-2):*** Vague, undocumented, or informal relationship with MH agencies, or consulting with a staff member from that agency. Programs that have a system of care that meets the SAMHSA definition of "Consultation."

- ***Dual Diagnosis Capable = (SCORE-3):*** Formalized and documented collaboration with mental health agency. Programs that have a system of care that meets the SAMHSA definition of "Collaboration."

- ***(SCORE-4):*** Formalized 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." Programs which have a system of care that meets the definition of "Collaboration" AND demonstrate an increased frequency of integrated elements although these elements are informal and not part of the defined program structure. Typical examples of activities that occur at this level would be to have informal staff exchange processes or the use of case management on a prn basis to coordinate services.

- ***Dual Diagnosis Enhanced = (SCORE-5):*** A single treatment plan addresses both sets of conditions. Most services are integrated within the existing program or through routine use of case management staff or staff exchange programs. Programs that have a system of care that meets the SAMHSA definition for "Integration."

AOS PROGRAMS

Enhancing IC. Coordination and collaboration with mental health services

AOS level programs either have no existing or a rather informal relationship 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.

The North Shore Alcohol and Drug Treatment Center (NSADTC) generally referred patients to the Lakeland Mental Health agency for psychiatric emergencies or for a medication evaluation if deemed appropriate. Psychiatric emergencies would occur 1-2 times per year, and would usually be dealt with by calling the local 9-1-1 line. A social worker at NSADTC, who formerly worked at Lakeland, was often asked to call to squeeze in the most "needy" of potential medication patients, so that they might be evaluated within a more expedient time frame (less than the typical 45 day wait).

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 Appendix B for a sample MOU outline). 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.

DDC PROGRAMS

Enhancing IC. Coordination and collaboration with mental health services.

Programs at the DDC level on this item will need to develop more integrated services in order to score at the DDE level. Integration can be accomplished at the program level by providing all services "in house" so patients may obtain one-stop services. Integration can also be accomplished at the system level where programs are so closely connected either by common policies, electronic medical record systems or other lines so that integration occurs across agencies. Coordination or consultation between programs is not sufficient for integration. Integration is characterized by mental health and addiction service provision by one or more providers that is seamless from the client's perspective.

Integration within a program can exist for both outpatient and residential levels of care.

ID. Financial Considerations

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

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 related disorders and mental health disorders.

- ***Addiction Only Services = (SCORE-1):*** Can only bill for addiction treatments or for persons with substance use disorders. Programs can only get reimbursement for services provided to individuals with a primary substance related 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 disorders primary, but staff report there to be barriers. –OR- Partial reimbursement for MH services available. The program's reimbursement codes allow for reimbursement as described in the DDC category BUT the staff and administrators report and perceive there to be barriers in getting reimbursed for mental health services; and thus the program operates in a manner consistent with AOS.

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

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

AOS PROGRAMS

Enhancing ID. Financial considerations

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. The methadone maintenance program at Comprehensive Options for Drugs and Alcohol (CODA) in Portland Oregon secured additional county grant funding to provide psychiatric and mental health counseling for methadone clients with mental health problems. This additional funding from the Multinomah County Board covered the human resources of a psychiatrist (.1 FTE) and a clinical social worker (.5 FTE).

DDC PROGRAMS

Enhancing ID. Financial considerations

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/Medicare as well as receive payment for services to indigent patients (state funding) for his diagnostic and couples therapy services.

II. PROGRAM MILIEU

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

Definition:
Persons with COD 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, interview with clinical staff, support staff and clients.

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

- ***Addiction Only Services = (SCORE-1):*** Expects substance use disorders only, refer or deflect persons with mental health disorders or symptoms. The program focuses on individuals with substance related 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 problems to be admitted. The program generally expects to manage only individuals with substance related disorders but does not strictly enforce the refusal/ 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 not a formalized documentation indicating acceptance of persons with mental health concerns.

- ***Dual Diagnosis Capable = (SCORE-3):*** Focus is on substance use disorders but expects and accepts mental health disorders by routine if mild and relatively stable; reflected in program documentation. The program tends to primarily focus on individuals with substance related 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, for example on walls and brochure racks.

- ***(SCORE-4):*** Program formally defined like DDC but clinicians and program informally expects and accepts COD's regardless of severity. The program expects and accepts individuals with CODs 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 accept COD's regardless of severity, well documented. The program routinely accepts individuals with CODs 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 edges out the possibility of a dialogue or openness about psychiatric problems or concerns. This milieu may not enable a patient to inquire about the potential for recovery from psychiatric disorders also.

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 psychiatric disorders by providing in waiting areas brochures that describe psychiatric problems (e.g. depression). Also these subjects can be routinely raised in orientation sessions, community meetings, "rap" sessions, or family visits. Doing so explicitly conveys a welcoming and acceptance of persons with psychiatric concerns or disorders.

The cultural undercurrent to a DDC program enables persons with co-occurring psychiatric 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 equivalence in focus on addiction and mental health disorders. Programs must document, for example, mission or philosophy statements, and admission criteria, their acceptance of individuals with COD 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 a dual disorder, or two (or more) 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. <u>Display and distribution of literature and patient educational materials.</u>

<u>Definition</u>:
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.

<u>Source</u>:
Observation of milieu and physical settings, review of documentation of patient handouts, videos, brochures, posters and materials for clients and families that are available and/or used in groups.

<u>Item Response Coding</u>:
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 under consideration.

- ***<u>Addiction Only Services = (SCORE-1):</u>*** Addiction or peer support (e.g. AA) only. Materials that address substance related disorders are the only type made routinely available.

- ***<u>(SCORE 2):</u>*** Available for both disorders but not routinely offered or formally available. Materials are available for both substance related and mental health disorders but they are not routinely accessible or displayed in an equitable fashion. The majority of materials and literature are focused on substance related disorders.

- ***<u>Dual Diagnosis Capable = (SCORE-3):</u>*** Materials and information for both substance use and mental health disorders are made routinely available ,but distribution is less for mental health problems.

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

- ***<u>Dual Diagnosis Enhanced = (SCORE-5):</u>*** Available for the interaction between both mental health and substance use disorders. Materials and literature address both substance related and mental health disorders, treatments including medications, and also attend to COD-specific concerns 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 (STDs), 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.

These materials are available from the SAMHSA (www.samhsa.gov) and National Institute of Mental Health (NIMH) (24Hwww.nimh.nih.gov) websites, and many professional organizations (e.g. American Psychiatric Association; American Psychological Association) and pharmaceutical companies also provide excellent materials specific to certain diagnostic groups.

Some specific examples include:

SAMHSA's National Clearinghouse for Alcohol and Drug Information:
"Overcoming substance use and mental disorders: A guide to recovery from co-occurring disorders". This pamphlet describes what co-occurring disorders are, provides symptoms of a co-occurring disorder, and offers resources for finding the right help.
25Hhttp://store.health.org/catalog/productDetails.aspx?ProductID=16849

Some states may also have their own clearinghouse of materials. For example, the Connecticut Department of Mental Health and Addiction Services funds the Connecticut Clearinghouse that includes many audiovisuals, books, curricula, and pamphlets on co-occurring disorders, available for providers to borrow or keep.
26Hhttp://www.ctclearinghouse.org/

Another resource is the University of South Florida's Co-Occurring Disorders Treatment Manual and Workbook. A free download is available.
27Hhttp://mhlp.fmhi.usf.edu/web/mhlp/CDTManual.pdf and
28Hhttp://mhlp.fmhi.usf.edu/web/mhlp/CDTWorkbook.pdf

DDC PROGRAMS

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

DDE level programs display and distribute equal numbers of materials related to substance and mental health problems, as well the interaction between mental health and substance use disorders. These programs will emphasize the common co-occurrence of dual 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 psychiatric disorders to all patients in their addiction treatment intensive outpatient program (IOP). 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 dual disorders in society and in attempting to affiliate with mutual self-help meetings.

DVDs are available from Hazelden Publishing (0Hwww.hazelden.org) on a) Adults with Co-Occurring Disorders, and b) 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. In addition, Hazelden has a series of DVD's on addiction and specific mental health disorders, and the Co-Occurring Program includes educational handouts on specific mental health disorders as well as a DVD on co-occurring disorders specifically for families.

Another resource is The Basics – A Curriculum for Co-Occurring Psychiatric and Substance Disorders – Second Edition by Rhonda McKillip, M.Ed., LMHC, MAC, CCDCIII, CDP. Available at: 1Hhttp://mckillipbasics.com

III. CLINICAL PROCESS: ASSESSMENT

IIIA. Routine screening methods for psychiatric symptoms

Definition:
Programs that provide services to individuals with COD routinely and systematically screen for both substance related 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 health 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 client 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 (4) visits or within the first month following admission to treatment.

Source:
Interviews, observations of medical record (or electronic medical record (EMR) 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 psychiatric problems. 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 & treatment history, current medications, suicide/homicide history prior to admission. The program conducts a basic screening for psychiatric problems prior to admission BUT is not a routine or standardized component of the evaluation procedures (occurs less than 80% 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 MH using generic framework, e.g. ASAM-PPC (Dimension III) or "Biopsychosocial" data collection. The program conducts a screening process with interview questions for psychiatric problems, which is incorporated into a more comprehensive evaluation procedure, and occurs routinely (at least 80% of the time). This screening is standardized in that it consists of a standard set of questions or items. The format of the screening questions may be open-ended or discrete but they are used consistently.

  (SCORE-4): Screen for mental health problems using standardized formal instruments with established psychometric properties routinely (at least 80& of the time).

- ***Dual Diagnosis Enhanced = (SCORE-5):*** 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 related and mental health disorders, AND this screening process is routinely (at least 80% of the time) incorporated into the comprehensive evaluation procedures; and is considered an essential component in directing the individual's care.

AOS PROGRAMS

Enhancing IIIA. Routine screening methods for psychiatric symptoms

AOS programs typically attempt to capture or detect psychiatric problems via an initial phone interview. This may be attempted by inquiring about current and past medications, prior psychiatric hospitalizations, and if the caller ever received a "mental health" diagnosis. Some AOS programs extend this procedure to include clinician-driven questions at intake, broadly under the concept or rubric of a "biopsychosocial" assessment.

In order to become DDC, the AOS program must at least incorporate a routine set of specific questions (such as to screen for mood, PTSD, or trauma symptoms), and a routine mental status screening, including questions to assess risk of harm to self or others.

For more information on screening, you can access this paper produced by SAMHSA's Co-Occurring Center for Excellence (COCE):
Screening, Assessment, and Treatment Planning for Persons with Co-Occurring Disorders:
2Hhttp://coce.samhsa.gov/cod_resources/PDF/ScreeningAssessment%28OP2%29.pdf

It may be appropriate for some programs to only conduct screening for problems and not to deliver treatments. This circumstance may be found in primary health care settings or certain detoxification programs. The model found useful for service settings such as these is the Screening, Brief Intervention and Referral to Treatment (SBIRT). SBIRT has been found effective in primary healthcare settings in reducing substance-related problems and trauma symptoms, either via brief intervention or more effective linkage to other providers. For more information about SBIRT: http://sbirt.samsha.gov

DDC PROGRAMS

Enhancing IIIA. Routine screening methods for psychiatric symptoms

In order to achieve DDE level, DDC programs institute standardized screening measures for both mental health and substance related disorders and used routinely with at least 80% of clients.. Measures can screen for more general psychiatric symptoms and/or substance use, and some are sensitive to identifying specific psychiatric problems. Examples of some general measures include the Modified MINI Screen (MMS), Mental Health Screening Form-III , CAGE-AID, Simple Screening Instrument for Alchol 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 psychiatric disorders are also recommended. These may include measures for depression (e.g. Beck Depression Inventory), anxiety (e.g. Beck Anxiety Inventory), PTSD (e.g. 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). See Appendix C for copies of each of the screening measures mentioned here.

IIIB. Routine assessment if screened positive for psychiatric symptoms

Definition:
Programs that provide services to persons with COD should routinely and systematically assess for psychiatric 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 client that enables the provider to establish the presence or absence of a co-occurring disorder; determine the client's readiness for change; identify client 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 client 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 results of assessment are used in 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.]

Results used in treatment plan. The assessment results must routinely be included in the development of a treatment plan.

Source: Interview, Policy and Procedure Manual, 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):*** Ongoing monitoring for appropriateness or exclusion from program. There is no formal or standardized process that assesses for psychiatric disorders when such disorders are suspected within the program. At most, a program offers on-going 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):*** More detailed biopsychosocial assessment, mental status exam, each 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):*** Formal mental health assessment, if necessary, typically occurs if positive screen for MH symptoms. The program has a formal policy and a regular mechanism for providing a formal mental health assessment if 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 heath concerns (current symptoms and chief complaints, past MH 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 onsite or offsite with a formal relationship as documented in a MOU, for example.

- ***(SCORE-4):*** Policy and onsite capacity for formal mental health assessments, as defined above, following all positive MH screens.

- ***Dual Diagnosis Enhanced = (SCORE-5):*** Standardized or formal instruments for both mental health and substance use disorders with established psychometric properties. The program provides on-site *standardized* or formal integrated assessment to all individuals following all positive MH screens per formal policy. An integrated assessment entails comprehensive assessment for both substance related and mental health disorders, which are conducted in a systematic, integrated, and routine manner by a competent provider. .

AOS PROGRAMS

Enhancing IIIB. Routine assessment if screened positive for psychiatric 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 onsite or offsite with a formal relationship as documented in a MOU, for example, and these can be conducted on a routine and consistent basis. The assessments themselves need not be overly formalized, however, consistency across clinicians would be insured if they were.

The New London Clinic provides a mental health assessment to patients who are identified as "in need" of a psychiatric evaluation. This evaluation is performed by the consultant nurse practitioner who is at the program one day per week.

DDC PROGRAMS

Enhancing IIIB. Routine assessment if screened positive for psychiatric symptoms

To achieve a DDE level on this item, DDC programs must institute a systematic mental health assessment for all cases. This is based on the clear expectation that all patients entering the treatment will have a co-occurring psychiatric disorder. A DDE program will conduct these assessments in a consistent manner across clinicians. This can either be accomplished by an electronic clinical decision support tool (EMR), or a semi-structured clinical interview (GAIN, Addiction Severity Index (ASI), Structured Clinical Interview for DSM-IV-TR (SCID)), or another well-defined and thorough protocol developed by the program.

IIIC. Psychiatric 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 related disorders.

Source: Medical record (or EMR).

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

- ***Addiction Only Services = (SCORE-1):*** Psychiatric diagnoses are not made or recorded. The program does not provide diagnoses for psychiatric disorders. In some cases, diagnoses of mental health disorders may be discouraged or not recorded.

- ***(SCORE-2):*** Mental health diagnostic impressions made and recorded variably. 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):*** Mental health diagnosis variably recorded in chart (i.e. only for those with acute or severe mental health disorders). A 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):*** Mental health diagnosis more frequently recorded, but inconsistently; done if issues identified in assessment.

- ***Dual Diagnosis Enhanced = (SCORE-5):*** Standard and routine mental health diagnoses consistently made. A program has a formal mechanism to ensure a comprehensive assessment to each individual that results in a mental health diagnosis, if warranted; thus ensuring that mental health diagnoses are consistently made and documented. Evidence supports that the full range of mental health diagnoses are provided.

AOS PROGRAMS

Enhancing IIIC. Psychiatric and substance use diagnoses made and documented

AOS programs only register a substance use disorder diagnosis 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 (e.g. R/O dysthymia) are not acceptable at the DDC level.

DDC PROGRAMS

Enhancing IIIC. Psychiatric and substance use diagnoses made and documented.

DDC programs already can provide mental health diagnoses. These diagnoses are reflected in a sample of 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. <u>Psychiatric and substance use history reflected in clinical record</u>

Definition:
COD assessment and evaluative processes routinely assess and describe past history and the chronological or sequential relationship between substance related and psychiatric 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):*** 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; not included in assessment process. In addition to the routine collection of substance use history, the program encourages the collection 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 (<80% of the time).

- ***Dual Diagnosis Capable = (SCORE-3):*** Routine documentation of both mental health and substance use disorder history in record in narrative section; lack of mental health history also noted. 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% of the time. This would be evident in the records of the majority of individuals assessed which would document and discuss mental health histories; even for those individuals without mental health histories there would be a narrative section where the absence of mental health related history is noted.

- ***(SCORE-4):*** Specific and structured section in recorded dedicated to history and chronology of course 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 abuse 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% of the time.

AOS PROGRAMS

Enhancing IIID. Psychiatric and substance use history reflected in medical record

Assessing and diagnosing psychiatric 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 have narrative documentation of the substance use and psychiatric disorders in terms of ages of onset, the course of the psychiatric disorders during active substance use or periods of abstinence, and the course of the substance use during treatments or remission of the mental health disorder. This is recorded in the client chart and typically documented as a narrative in a quasi-chronological format.

DDC PROGRAMS

Enhancing IIID. Psychiatric 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. DDC 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 program 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 psychiatric disorders (e.g. dysthymic disorder, panic disorder, or schizophrenia).

DDE programs do not rely on individual clinicians to probe these chronologies, but insure consistency by formats within the medical record or EMR. Time line follow-back (TLFB) calendars are a helpful tool to assess and document histories of substance use and psychiatric symptoms (see Appendix D).

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

Definition:
Programs offering services to individuals with CODs use psychiatric 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, policy & procedure manual, 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 psychiatric 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 psychiatric 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 psychiatric 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 psychiatric condition. The program is capable of providing services to individuals who present with all ranges of psychiatric symptom acuity including those with high-acuity, whose present mental status may be severe or psychiatrically 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 psychiatric symptom acuity: low, moderate, high

AOS programs routinely base admission decisions on psychiatric history (e.g. prior hospitalizations), the present diagnoses they carry (e.g. bipolar disorder), or medications (e.g. olanzapine). Even if persons with psychiatric 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 psychiatric disorders, but more so based on the level of acuity or stability (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 psychiatric 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. For DDC programs seeking to achieve this status, having appropriate staff members, protocols for patient monitoring and observation, and clear crisis and emergency procedures, all are imperative. Outpatient programs may find this to be easier to achieve than residential or certain inpatient settings.

The key is that present acuity must be assessed in the DDE program, and that there are 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.

IIIF. <u>Program acceptance based on severity of persistence and psychiatric disability: low, moderate, high</u>.

<u>Definition</u>:
Programs offering services to individuals with CODs use severity as defined by the diagnosis, persistence, and disability as an indicator to assist with the determination of the individual's needs and whether the program is capable of effectively addressing these needs.

<u>Source</u>: Interviews, policy & procedure documentation, mission statement.

<u>Item Response Coding</u>:
Coding of this item requires an understanding of clinical protocol for individuals who present with different levels of persistence of mental health disability.

- ***<u>Addiction Only Services = (SCORE-1):</u>*** Admits persons in program with no to low severity or persistence of disability. The program can only provide care to individuals who present with no to low levels of persistence of mental health disability. Individuals with no to low persistence of disability are defined as those who have no or a very limited history of functional impairment (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.

- ***<u>Dual Diagnosis Capable = (SCORE-3):</u>*** Admits persons in program with low to moderate severity. The program can only provide care to individuals who present with low to moderate severity and persistence of psychiatric impairment and disability. Individuals with low to moderate persistence of disability are defined as those who have mild to moderate histories of functional impairment as a result of a psychiatric disorder. In this case, there may be some substantial history of recurrence in the psychiatric disorder, and/or there has been evidence of continued impairment in at least one functional area (person's capacity to manage relationships, job, finances, and social interactions). 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 persistency of mental health problems are directed toward services in a mental health service program or may be at risk for a premature discharge from this program.

- ***<u>Dual Diagnosis Enhanced = (SCORE-5):</u>*** Admits persons in program with moderate to high severity. The program can provide care to individuals who present with moderate to high severity or persistence of mental health disability. Individuals with high persistence of disability 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 (person's capacity to manage relationships, job, finances, and social interactions). DDE programs are able to comprehensively manage the complex treatment needs of these individuals.

AOS PROGRAMS

Enhancing IIIF. Program acceptance based on severity of persistence and psychiatric 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 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 Report to Congress, 2002). 3Hhttp://alt.samhsa.gov/reports/congress2002/chap1nasmhpd.htm#fig1.1

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

DDC PROGRAMS

Enhancing IIIF. Program acceptance based on severity of persistence and psychiatric 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 psychiatric disability (DDCAT IIIF) and high levels of acuity (DDCAT IIIE).

IIIG. <u>Stage-wise treatment: Initial Assessment</u>.

Definition:
For individuals with substance related and mental health disorders, the assessment of readiness for change for both disorders is essential to the planning of appropriate services. The stages of change model has its origin in fostering intentional behavior changes and has therefore been used readily in the addiction field; assessment of motivational stages across the individual's identified areas of need (including both substance related and mental health) is a more comprehensive approach and helps to more strategically and efficiently match the individual to appropriate levels of service intensities.

Source: Interview, medical records (EMR).

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 the stages of motivation for change.

- ***(SCORE-2):*** Assessed and documented variably by individual clinician. The program has an informal, non-standardized process to assess/label the stages of change. –OR- The program has encouraged the use of a protocol that assesses/labels the stages of change BUT the process is irregularly used (less than 80% of the time).

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

- ***(SCORE-*4):** Formal measure used and routinely documented but focusing on substance use disorders 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 for the stage of change that incorporates the use of a standardized instrument to assess and document stages of motivation for change. There is an effort at this level to measure differential motivation across the different areas of need for an individual.

AOS PROGRAMS

Enhancing IIIG. Stage-wise treatment-initial assessment

Assessing stages of patient motivation has added a new level of clinical sophistication to addiction treatment in recent years. Motivational interviewing (MI), motivational enhancement therapies (MET) are arguably evidence-based practices, and depend on a careful assessment of patient motivation. A variety of models have been developed to conceptualize the stages. All have advantages relative to the traditional bifurcation of motivation into two categories: "ready" or "not ready." For AOS programs to achieve DDC, they must have some notation of motivational stage at the initial assessment. This assessment can draw from the terminology of the motivational assessment models that are well established in the scientific literature (see Appendix E for a copy of these instruments).

A global rating in a medical record is also possible: Precontemplative, Contemplative, Preparation, Action, and Maintenance.

DDC PRGRAMS

Enhancing IIIG. Stage-wise treatment-initial

DDC programs intending to become DDE will have made a transition from the labeling of motivational stage to a more systematic effort to assess it. This can include incorporation of the well-established self-report measures (URICA, SOCRATES) and/or clinician-completed measure (SATS) or training staff to develop ratings on the ASAM-PPC-2R Treatment Acceptance/Resistance Dimension (Dimension IV).

University of Rhode Island Change Assessment (URICA):
20Hhttp://www.uri.edu/research/cprc/Measures/urica.htm

Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES):
21Hhttp://pubs.niaaa.nih.gov/publications/Assesing%20Alcohol/InstrumentPDFs/62_SOCRATE.pdf
22Hhttp://casaa.unm.edu/inst/SOCRATESv8.pdf

Substance Abuse Treatment Scale (SATS):
23Hhttp://www.cmha-edmonton.ab.ca/sats.pdf

In DDE programs these measures and ratings are systematically gathered, routinely recorded in patient medical records, and made explicit to work collaboratively with patients as they enter into the therapeutic relationship.

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 2-sided "motivational ruler" to a patient for their own ratings of motivation and efficacy. The specific wording can vary, but a simple example is:

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. Also, 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

IV.A. Recovery Plans.

Definition:
In the treatment of individuals with CODs, the recovery plans indicate that both the psychiatric disorder as well as the substance related disorder will be addressed.

Source: Medical record.

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

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

- ***(SCORE-2):*** Variable by individual clinician. Within the program, the recovery plans for individuals with CODs vaguely or only sometimes address co-occurring mental health disorders while the substance related disorders are more comprehensively targeted. The irregularity is likely due to individual clinician preferences/competencies or resource/time constraints.

- ***Dual Diagnosis Capable = (SCORE-3):*** Substance use disorders addressed as primary, mental health as secondary. Within the program, the recovery plans of individuals with COD routinely (at least 80% of the time) address both the substance related and mental health disorders, although the recovery planning for the substance related disorders tends to be more specific and targeted. Mental health concerns are regularly addressed albeit in a somewhat non-specific fashion.

- ***(SCORE-4):*** Systematic focus is available but variably used. Within the program, the recovery plans of individuals with CODs meet all the requirements for DDC. –AND- There is evidence that some recovery plans consider both the substance related and mental health disorders equivalently and in some individualized detail, although this is not done regularly (less than an 80% of the time).

- ***Dual Diagnosis Enhanced = (SCORE-5):*** Address both as primary, both listed in plan consistently. Within the program, the recovery plans of individuals with CODs regularly (at least 80% of the time) and equivalently address both substance related and mental health disorders equivalently and in specific detail as indicated by clear, objective, measurable objectives for both substance use and mental health disorders.

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. The best example of this is the research on therapeutic alliance in psychotherapy. AOS programs, whether by screening, assessment or even diagnosis, identify psychiatric problems, and will routinely leave these same psychiatric problems out of the treatment plan.

To score at the DDC level, these psychiatric problems need to be identified, and then targeted by at least generic treatment interventions, and then monitored for treatment response. Although substance use problems may continue to be the major focus of the treatment plan, psychiatric 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 psychiatric disorders. A review of records finds this to be normative, and interventions are targeted, generally "in house." In the case of both disorders as problems, the objectives are clear, measurable and specific (vs. generic). One defining characteristic of the DDE program is the use of interventions in addition to medications to address and leverage a psychiatric problem. These interventions may be identified when connect with treatment plan goals, and 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 posttraumatic stress disorder. 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.

IV B. <u>Assess and monitor interactive courses of both disorders</u>.

<u>Definition</u>:
In the treatment of persons with CODs, the continued assessment and monitoring of substance related and mental health disorders as well as the interactive course of the disorders is necessary.

<u>Source</u>: Medical record.

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

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

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

- ***<u>Dual Diagnosis Capable = (SCORE-3):</u>*** Clinical focus in narrative (treatment plan or progress note) on mental health problem change. Within the program, treatment monitoring for individuals with CODs regularly (at least an 80% of the time) reflect a clinical focus on changes in mental health problems –BUT- This monitoring tends to be a basic, generic or qualitative description within the record.

- ***<u>(SCORE-4)</u>*:** Systematic focus is available, but variably used. Within the program, the DDC standard has been attained and there is also evidence that treatment monitoring and documentation reflect a more systematic and equally in-depth focus on both mental health and substance related disorders, although this is done on an irregular basis (less than 80% of the time).

- ***<u>Dual Diagnosis Enhanced = (SCORE-5):</u>*** Clear, detailed, and systematic focus on change in both substance use and mental health disorders. Within the program, treatment monitoring regularly (at least 80% of the time) reflects a detailed, systematic and in-depth focus on both mental health and substance related concerns. –AND- This continued monitoring is documented in a standardized fashion within the record.

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-Psychiatric 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, and monitor psychiatric symptom change in early addiction treatment experiences. They may assist patients in preparing for this (e.g. the return of social phobia symptoms after benzodiazepine and alcohol 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 psychiatric 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 correlated with abstinence or continued use). DDE programs have a medical record structure 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 Appendix D).

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 months of abstinence. Monitoring psychiatric symptoms during the course of treatment will provide essential diagnostic and treatment planning data. Substance induced disorders and independent psychiatric disorders can be differentiated during this assessment period, and can anticipate different treatment approaches accordingly.

IV C. <u>Procedures for psychiatric emergencies and crisis management</u>.

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

Source: Interviews.

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.

- ***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 have no general understanding of any unwritten crisis/emergency management procedures for such situations.

- ***(SCORE-2):*** Verbally conveyed in-house guidelines. The program staff are able to communicate a good general understanding of emergency procedures for crisis situations associated with mental health concerns, although there are no written guidelines. Calling 911 or emergency personnel would not be considered an 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 ER). The program has some written guidelines for mental health crisis/emergency management that includes 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. Some of these strategies will include linkage with other providers or entities. An essential aspect of intervention strategies for this level often includes a formalized arrangement with collaborative entities like mental health clinics to assist in the management of these crisis situations.

- ***Dual Diagnosis Enhanced = (SCORE-5):*** Routine capability, or a process to ascertain risk with ongoing use of substances and/or severity of psychiatric symptoms using formal risk assessment tools; maintain in program unless commitment is warranted. The program has explicit and thoroughly written guidelines for comprehensive mental health crisis/emergency management that outlines explicit guidelines that can be conducted in-house, including the completion of advance directives pertaining to psychiatric crisis and substance use relapse. 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 on-going risk assessment and management of persons with interacting and exacerbating symptoms.

AOS PROGRAMS

Enhancing IVC. Procedures for psychiatric emergencies and crisis management

AOS programs often have undocumented, informal outdated or loose arrangements for dealing with psychiatric emergencies. Often, by deferring admission to cases of even moderate risk, these events are kept to a minimum. Calling 9-1-1 is often THE plan given such an event.

Whereas DDC level programs have more formalized and documented guidelines. Emergencies are a more common occurrence. Staff can clearly articulate the policy in place. The response to emergencies and crises is typically characterized by a more formalized relationship with the local mental health agency or the psychiatric 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. Psychiatric advance directives may be offered to patients to complete as an option upon intake.

DDC PROGRAMS

Enhancing IVC. Procedures for psychiatric emergencies and crisis management

DDE 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. DDC programs can 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. Psychiatric advance directives are completed with every patient upon intake to prepare for any psychiatric 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.

IV D. Stage-wise treatment ongoing.

Definition:
Within programs that treat individuals with COD, 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, medical records.

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.

- ***Addiction Only Services = (SCORE-1):*** Not assessed or explicit in treatment plan. The program does not monitor motivational stages in an on-going fashion throughout treatment. Programs that do not regularly assess the stage of motivation in the initial assessment, will likely not consistently address this issue during the course of treatment.

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

- ***Dual Diagnosis Capable = (SCORE-3):*** Stage of motivation for both substance use and mental health issues routinely incorporated into individualized plan, but no specific stage-wise treatments. The program has endorsed the concept of regularly assessing stages of change and has inserted this into clinical procedures. The program regularly (at least 80% of the time) assesses and documents stages of change throughout the treatment course. BUT treatments may not regularly reflect these on-going stage-wise treatments. 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 motivation routinely incorporated into individualized plan, and some individualized treatment related to an individual's stage of readiness on substance use motivation only.

- ***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 uses stage of change throughout treatment. Motivational stages are regularly re-assessed and documented. -AND- Specific stage–wise treatments are regularly provided to individuals based on these re-assessments i.e. the standards of DDC are met; and in addition, there is an effort to fully utilize this information to match the individual to the appropriate stage-specific services.

AOS PROGRAMS

Enhancing IVD. Stage-wise treatment

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

AOS programs may not assess stage of motivation upon admission, and are therefore even less likely to do so during treatment. Clinicians 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 motivational stage during treatment and sometimes make modifications of treatments accordingly. 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 document stages of motivation on an ongoing basis, 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 tend to adjust treatment accordingly if only informally.

DDC PROGRAMS

Enhancing IVD. Stage-wise treatment-ongoing

DDE programs extend beyond DDC by more routinely and reliably assessing stage of motivation during treatment, and especially during treatment or level of care transitions (see Appendix E for stage assessment instruments). Stage is directly correlated to the treatment plan, and drives the particular approach used by clinicians in individual, group and even determine level of care.

A residential program in Portland Oregon has operationalized the ASAM Dimension IV (Treatment Acceptance or Resistance) and reduces the length of stay based upon stage of readiness assessed at 2-week intervals. Ratings of precontremplative 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.

DDE programs also assesses differential motivation to address substance use and motivation to address psychiatric problems.

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 X?; 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 to substance use vs. mental health issues, and Bay Park House uses these to assign to different groups.

IV E. <u>Policies and procedures for medication evaluation, management, monitoring, and adherence</u>

Definition:
Programs that treat individuals with COD 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 adherence, as documented in policy/procedure.

Source: Interviews (preferably with the prescriber), policy & procedure manual.

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 medications routinely not accepted. No capacities to monitor, guide, 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 medications are not acceptable. Or 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 policies and guidelines for prescribing medications for individuals with COD 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 medicating provider who is also a staff member. Regular access to prescriber and guidelines for prescribing in place. The prescriber might more regularly consult with other staff regarding medication plan and recruit other staff to assist with medication monitoring. The program maintains standards and guidelines for prescribing and monitoring medications to individuals with COD. –AND- The program retains staff person(s) who are prescribers but these prescribing staff members are **<u>not</u>** fully integrated into the treatment team. These prescribing staff members are frequently perceived as providing an adjunctive service to the program and tend to function in an independent fashion.

- ***<u>Dual Diagnosis Enhanced = (SCORE-5):</u>*** Clear standards and routine for medicating provider who is also a staff member and present on treatment teams or administration. Full access to prescriber with appropriate prescribing guidelines in place. As a treatment team member, the prescriber informs the team about the medication plan and the entire team can assist with monitoring. The program maintains standards and guidelines for prescribing medications to individuals with COD. –AND- The program retains a staff person(s) who is a prescriber 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 recovery planning and administrative decisions.

AOS PROGRAMS

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

AOS programs may either 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 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/or there is access to a prescriber who can renew or give a new prescription during treatment. Medications are monitored 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 adherence

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, hypertension). The DDE program has the capacity to evaluate existing, and initiate new, pharmacotherapies. It may do so for either or both the substance use and psychiatric 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 psychiatric 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.

IV F. Specialized interventions with mental health content.

Definition:
Programs that treat individuals with COD utilize specific therapeutic interventions and practices that target specific mental health symptoms and disorders. There is a broad array of interventions and practices that can be effectively integrated into the treatment of individuals with co-occurring disorders that target mental health symptoms and disorders. Some interventions can be generically applied to programs; these interventions might include stress management, relaxation training, anger management, coping skills, assertiveness training, and problem solving, etc. [In some cases, addiction treatment programs may already use some of these techniques in the treatment of substance related disorders.] Other more advanced mental health interventions that could be applied to persons with CODs include brief motivational or cognitive behavioral therapies that 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 psychiatric condition. 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 make co-occurring disorder adaptations to standard addiction treatment practices for group, individual and psycho-educational formats. DDE programs will typically adapt psychological/behavioral therapies for psychiatric disorders for patients in addiction treatment programs. DDE programs also attempt to implement the available evidence-based treatments for persons with co-occurring disorders. There are presently few such treatments, although many are in the development and testing stages. More research is needed in this field and as findings are revealed, and results of interventions documented, this toolkit will be revised with more specific suggestions.

Source:
Interviews with staff and clients, review of recovery 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 COD 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; irregular penetration into routine services. The program irregularly provides generic interventions for psychiatric concerns. The irregularity 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); more regular penetration into routine services. Routine clinician adaptation of an evidence based addiction treatment (e.g., MI, CBT, TSF). The program is able to routinely incorporate (at least 80% of the time) mental health interventions for individuals with CODs. This is translated to mean that the COD individuals treated within the program almost always receive treatment interventions that specifically target mental health problems. –AND- The type of interventions at this level tends to be of a more broadly applicable, generic type and less resource intensive.

- ***(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 offering some components of more individualized interventions for mental health disorders that can be offered with some regularity.

- ***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, TSF). The program routinely (at least 80% of the time) provides targeted mental health interventions that are individualized to the disorder. –AND- These mental health interventions at this level are characterized as being comprised of a full array of services types including (1) more generic, broadly applicable services in addition to (2) more individualized and skilled interventions that target specific mental health disorders.

AOS PROGRAMS

Enhancing IVF. Specialized interventions with mental health content

As the previous item pertains to pharmacological interventions for psychiatric 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. They do however, require a trained clinician, 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 psychiatric 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 sand down the rough edges of a personality disorder. To be DDC level however, the program must address the psychiatric problem more intentionally, and explicitly. In DDC programs, this may be accomplished thru generic interventions such as cognitive behavioral therapy 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.

We recommend that DDC providers make adaptations to evidence-based practices for substance use disorders. Although the terminology and definition of "evidence-based" is not consistent or regulated (McGovern & Carroll, 2003), we offer 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 need 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:

NIDA Therapy Manuals (4Hwww.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

NIAAA Therapy Manuals (5Hhttp://pubs.niaaa.nih.gov/publications/match.html):
1. Twelve Step Facilitation Therapy
2. Motivational Enhancement Therapy
3. Cognitive Behavioral Coping Skills Therapy

SAMHSA Youth Treatment Manuals (6Hwww.samhsa.gov/cyt)
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 (7Hhttp://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 (DBT-S) for borderline personality disorder; Integrated Group Therapy for bipolar disorder, or Modified Therapeutic Community (MTC) for antisocial personality disorders. Training is widely available in these approaches, and in some regions, certified trainers and supervisors exist. Often DDE programs recognize the need for specifically targeted treatments for the most prevalent disorders (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 psychiatric 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.

For the DDE programs, we provide links to resources for programs for persons with co-occurring disorders 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 problems 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 psychiatric disorder is indicated for persons with co-existing substance use problems, 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 (Hein 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 references provided at the end of the toolkit provide several specific citations for specific 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), PTSD and substance use (Denise Hein, Columbia University School of Social Work; Mark McGovern, Dartmouth Medical School). This toolkit will be updated as this research is completed.

White JR, Freeman AS. Cognitive-behavioral group therapy for specific problems and populations. Washington DC: American Psychological Association, 2002). (8Hwww.apa.org). An excellent reference for CBT groups for depression, anxiety disorders, dual disorders, with additional chapters on youth, elders and Latino group approaches.

SAMHSA's National Registry of Evidence Based Programs and Practices for Co-Occurring Disorders (9Hhttp://nrepp.samhsa.gov/)

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

For information about an approach to co-occurring disorders in residential treatment, based upon an adaptation of the therapeutic community model: Modified Therapeutic Community (MTC): 10Hwww.ndri.org

Hazelden Publications 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 can be obtained at 11Hwww.hazelden.org. The Hazelden Co-Occurring Disorders Program for adults with co-occurring disorders in addiction treatment is also available at this link.

IV G. <u>Education about psychiatric disorder and its treatment, and interaction with substance use and its treatment</u>.

Definition:
Programs that offer treatment to individuals with COD provide education about mental health and substance related disorders, including treatment information and the characteristics and features of both types of disorders as well as the interactive course of the disorders.

Source:
Interviews with staff and clients, 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):*** None. The program does not offer education about mental health disorders and treatment, or the interaction with substance related disorders.

- ***(SCORE-2):*** Variably offered. The program may irregularly offer education about mental health disorders, mental health treatment, but such programming tends to focus on these issues as it relates to substance related disorders and concerns.

- ***Dual Diagnosis Capable = (SCORE-3):*** Present in general format and content, and delivered in individual and/or group formats. The program routinely (at least 80% of the time) provides general education about mental health disorders, mental health treatment, and its interaction with substance related disorders and treatment. Examples include a general orientation to CODs, 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.

- ***Dual Diagnosis Enhanced = (SCORE-5):*** Present specific content for specific disorder comorbidities and delivered in individual and/or group formats. The program regularly offers a combination of general education components as described at the DDC level and also has incorporated more individualized instruction that address specific issues within mental health disorders, mental health treatment, or its interaction with substance related disorders and treatment as they relate 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 are designed to address specific needs and risks of individuals in treatment.

AOS PROGRAMS

Enhancing IVG. Education about psychiatric disorder and its treatment, and interaction with substance use and its treatment

It is widely believed in medical care that educating patients about the nature and treatment of their disease will improve compliance and likely 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 the fact of the prevalence and importance of psychiatric disorders among addicted persons, and their influence on outcomes.

DDC programs offer information about psychiatric disorders through general lectures, group therapy or community meetings, family sessions and/or through individual sessions. These efforts are a substantial improvement over the attention paid to the common psychiatric problems by AOS programs. These services may include some effort to have people be able to verbalize their diagnosis, understand the current treatments, express the risks in not following through with treatments in terms of their abstinence of substance use, and lastly have some understanding of the role of the family (including inheritability issues) in both the psychiatric and substance use disorders. DDC programs may offer didactics on co-occurring disorders, or perhaps one medication group for patients on medication, where the differences between drugs and medications are discussed, and the role of medication in self-help recovery traditions are explored. The DDC program offers these services in a fairly generic format, and is frequently driven by the interests of individual clinicians, rather than systematically delivered in a protocol.

DDC PROGRAMS

Enhancing IVG. Education about psychiatric disorder and its treatment, and interaction with substance use and its treatment

DDE programs, in contrast to DDC programs, deliver didactic and informational material to patients about co-occurring disorders in a systematic, individualized manner. These may be via informational about the specific disorder or the dynamics of co-occurring disorders. 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), 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. These materials are available from the SAMHSA, NIMH and CMHS websites. 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): 12Hwww.nimh.nh.gov.publicat/nimhdepression.pdf

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 patient individually or in groups. These can be used for educational purposes and also to initiate a discussion specific to their specific co-occurring disorder. The Hazelden Co-Occurring Disorders Program also includes educational resources. 13Hwww.hazelden.org

IV.H. Family education and support.

Definition:
Programs that offer treatment to individuals with COD provide education and support to the individuals' family members (or significant others) regarding CODs, including treatment information and the characteristics and features of both types of disorders in order to educate collaterals about realistic expectations and the interactive course of the disorders.

Source: Interview.

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 alcohol/drug problems only or no family participation at all. The program may provide education and support to family members and significant others but the focus tends to be only on substance related disorders.

- ***(SCORE-2):*** Variably or by individual clinical judgment. The program irregularly provides educational groups or support to families regarding mental health disorders and may at times address psychiatric issues if raised. These services are informally conducted and provided on an as needed basis. These offerings usually depend on the competency and preference of the treating provider.

- ***Dual Diagnosis Capable = (SCORE-3):*** Mental health issues regularly, 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. While this service might be regularly accessed, this service 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 issues, variably offered and/or structured group with more routine accessibility. The program meets the criteria for DDC in that it has established a core of routinely offered educational groups and support to families of individuals with co-occurring mental health disorders; and in addition, this program has made efforts to incorporate this more regularly into the interventions and recovery planning process.

- ***Dual Diagnosis Enhanced = (SCORE-5):*** Routine and systematic COD family group(s) integrated into standard family format. Accessed by majority of families with COD family member. The program routinely provides education, support and skill building groups to families of individuals with co-occurring disorders. –AND- The provision of this service is considered a standard part of the treatment intervention with families and members of support systems regularly participating in these activities. This means that a majority of the families of individuals with COD participate 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 IVG 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 other(s), and are 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). These sessions and groups often present the comorbid psychiatric problem as a complicating factor in recovery. The importance of medications to manage the psychiatric problem 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 but 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 offer services to family members or significant others of people with addictive, psychiatric 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. Materials are routinely distributed to family members and significant others. They learn about both (or more) disorders that their identified patient 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.

SAMHSA's Family Psychoeducation Toolkit may be helpful in implementing family education and support programming:
14Hhttp://www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/family/

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 in individually or in multifamily groups. These can be used for educational purposes and also to initiate a discussion specific to the co-occurring disorder of their family member. (www.hazelden.org)

<u>IV.I. Specialized interventions to facilitate use of (COD) self-help groups.</u>

Definition:
Substance abuse programs that offer treatment to individuals with COD provide assistance to individuals in developing a support system through self-help groups. Individuals with mental health symptoms and disorders often face additional barriers in linking with self-help groups and require additional assistance such as being referred/ accompanied/ introduced to self-help groups by clinical staff, designated liaisons, or mutual self-help group peer volunteers. Specific issues related to the use of pharmacotherapy by individuals with COD also require additional education and guidance with regard to linking with self help groups.

Source: Interview, schedule or calendar of available self-help groups, recovery plans.

Item Response Coding:
Coding of this item requires an understanding of the mechanism through which individuals, specifically those with CODs, are linked with self-help groups.

- ***Addiction Only Services = (SCORE-1):*** None used to facilitate either use of 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 self-help groups.

- ***(SCORE-2):*** Used variably by, or infrequently by, individual clinicians, for individual patients, mostly for facilitation of addiction peer support groups. The program irregularly offers assistance or support to individuals with co-occurring mental health disorders in linking with appropriate self-help groups. This is usually the result of clinician's judgment or preference.

- ***Dual Diagnosis Capable = (SCORE-3):*** Present, generic format on-site, but no specific or intentional facilitation based on mental health problems. More routine facilitation of traditional addiction peer support groups (e.g., AA, NA). The program supports that their providers routinely encourage the use of self-help groups for their clients with co-occurring mental health disorders. While the mechanisms to do this tend to be general and not specific to the individual, they are regularly used. Examples of this might be to provide the individuals with a schedule of self-help groups and some initial contacts made on behalf of the individual. This is considered to be a standard aspect of the program and occurs at least 80% of the time.

- ***(SCORE-4):*** Present, but variable facilitation to peer support groups targeting specific mental health issues, either to traditional peer support groups or those specific to co-occurring disorders (e.g., DRA, DTR, etc). Individualized facilitation occurs but is irregularly documented in charts.

- ***Dual Diagnosis Enhanced = (SCORE-5):*** Routine and specific to need of persons with co-occurring disorders, special programs onsite, routinely targeted to specific issues, either to traditional peer support groups or those specific to co-occurring disorders (e.g., DRA, DTR, etc.). The program systematically advocates for the use of self-help groups with their clients who have co-occurring disorders. Recovery plans indicate that linkage

with self-help groups is regularly discussed with clients. Specialized assistance in making this linkage attempts to proactively plan for potential barriers or difficulties that the client might experience in the self-help group environment. Examples of individualized approaches to linking a client with a traditional self-help group or one specific to co-occurring disorders include the following: (i) identifying a liaison, who assists the individual in transitioning to the group, (ii) consultation with the self-help group on behalf of the individual regarding specialized mental health needs of the individual, (iii) an onsite "transition group" with specific mutual self-help group members who have some willingness to discuss co-occurring mental health problems pertaining to use of the self-help group in the community. This specialized support to the individual is a standard part of program activities, is documented in individuals' charts, and occurs regularly (at least 80% of the time).

AOS PROGRAMS

Enhancing IVI. Specialized interventions to facilitate use of self-help groups

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, they offer a fellowship of non-using others, they provide an explanatory model with suggested steps for change, and there are no dues or fees. There is some evidence to suggest persons with co-occurring disorders have difficulty affiliating and participating in traditional peer support groups. Double trouble, dual recovery anonymous and other groups have been developed to address this challenge. These groups have had varying degrees of success. The more traditional 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 traditional peer support. DDC programs, by identifying the psychiatric problem, will individualize the referral to mutual self-help groups. The DDC program through individual sessions, through group sessions or through in-house meetings may help a person with a co-occurring disorder learn how to join and participate (and presumably benefit) from these groups. 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 psychiatric problems, 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 psychiatric barriers, they can be adapted for this purpose:

NIDA Therapy Manuals for Individual Drug Counseling and Group Drug Counseling:
(15Hwww.nida.nih.gov/DrugPages/Treatment.html)

NIAAA Therapy Manual for Twelve-Step Facilitation Therapy (TSF):
(16Hhttp://pubs.niaaa.nih.gov/publications/match.html)

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

DDC PROGRAMS

Enhancing IVI. Specialized interventions to facilitate use of self-help groups

In contrast to DDC programs, DDE programs may have dual 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; helping 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; 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 self-help groups to share across all staff and retain the knowledge when staff turnover occurs.

Dual Recovery Anonymous groups (17Hhttp://www.draonline.org/) and Double Trouble in Recovery groups (18Hhttp://www.doubletroubleinrecovery.org/) 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 & NA groups for medication, anxiety, avoidance, sponsorship, and speaking challenges common among persons with co-occurring disorders.

IV.J. Peer recovery supports for persons with co-occurring disorders.

Definition:
Substance abuse 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. Substance abuse programs that offer treatment to individuals with COD provide assistance 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: Interview, listing/ calendar of available peer recovery supports, understanding of on-site peer recovery supports, consumer liaisons, and alumni staff

Item Response Coding:
Coding of this item requires an understanding of the availability of COD-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 for COD individuals.

- ***(SCORE-2)***: Off-site, recommended variably. The program may irregularly offer referrals to off-site peer support groups; this is largely dependent on the providers' preferences and knowledge of the available peer support groups in the area.

- ***Dual Diagnosis Capable = (SCORE-3):*** Present, offsite and facilitated with contact persons or informal matching with peer supports in the community, some co-occurring focus. The program routinely (at least 80% of the time) attempts to refer and link individuals with co-occurring mental health disorders to peer supports and role models located off-site. This is considered a standard support service that can be offered to individuals.

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

- ***Dual Diagnosis Enhanced = (SCORE-5):*** Present, onsite, facilitated and 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 through the development of these peer supports on-site. Recovery plans consistently document the utilization of these recovery supports.

AOS PROGRAMS

Enhancing IVJ. Peer recovery supports for persons with CODs

AOS programs' score on this item is highly associated with their score on the previous item (IV.I). AOS programs make no specialized effort to link persons to support group meetings, and likewise there is no effort to connect persons with co-occurring disorders who are in recovery with current patients. DDC programs often have staff members who make special introductions to individuals from the community who either attend or organize meetings on site at the program. DDC programs may have staff members who are in personal recovery who attempt to "match" patients with temporary sponsors based upon aspects of psychiatric 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 use this intentionally but not in a particularly formalized way.

DDC PROGRAMS

Enhancing IVJ. Peer recovery supports for persons 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 psychiatric disorders in their background, and the need to learn how to live with both disorders. This matching is more so protocol driven (vs. clinician driven), with the use of volunteer boards, program alumni, the twelve step hospital and institution committees (HIC) or bridging the gap groups.

The establishment of weekly "Bridge" groups, co-led by recovering volunteers and a staff member is the way the New London Clinic has responded to this crucial issue.
. A segment of the group is dedicated to co-occurring psychiatric issues with the goal being the development of individual peer support relationships.
A key feature in the DDE program is creating peer support connections onsite.

V. CONTINUITY OF CARE

V.A. 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 psychiatric and substance related disorders.

Source: Medical record.

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 psychiatric symptoms.

- ***Addiction Only Services = (SCORE-1):*** Not addressed. Within the program, the discharge plans of individuals with CODs routinely focus on substance related 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 CODs irregularly address both the substance related and mental health disorders. The irregularity 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 CODs routinely (at least 80% of the time) address both the substance related and mental health disorders BUT the substance related disorder takes priority and is likely to continue to be managed within the overall system of care while the follow-up mental health services are managed through an off-site linkage, or are generically addressed as part of the relapse (substance) prevention plan.

- ***(SCORE-4):*** Within the program, the discharge plans of individuals with CODs demonstrate some capacity, although it is irregular (less than 80% of the time), to plan for integrated follow-up as outlined in DDE (i.e., equivalently address both the substance related and mental health disorders as a priority).

- ***Dual Diagnosis Enhanced = (SCORE-5):*** Both disorders seem primary and plans made and insured, onsite, or by arrangement – offsite, at least 80% of the time. Within the program, the discharge plans of individuals with CODs routinely (at least 80% of the time) address both the substance related and psychiatric disorders. –AND- Both disorders are considered a priority with equivalent emphasis placed on ensuring appropriate follow-up services for both disorders. This program may have the capacity to continue management and support of both disorders in-house or have a formalized agreement with mental health clinics to provide the needed services.

AOS PROGRAMS

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

Since AOS programs often have not listed the co-existing psychiatric 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 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 psychiatric disorder (pharmacological and psychosocial) and will make discharge plans accordingly. Collaborative relationships (see Program Structure items) are particularly important here, since successful linkage is predicated on a close relationship and clear protocol shared by providers. The discharge process, in considering both disorders, retains a largely clinician-driven vs. 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 on 63rd Street detoxification program transfers men from their clinically-managed setting to an affiliated addiction treatment program and a coordinated local mental health clinic. Miracles' staff arrange for the initial appointment prior to discharge and a primary care giver accompanies the patient to the first appointment. When they are discharged from detoxification services, they have already been at their outpatient program (for addiction and mental health) and met their counselor. This has improved linkage to both programs and addresses both substance use and mental health problems with equivalence.

V.B. Capacity to maintain treatment continuity.

Definition:
There should be a formal mechanism for providing on-going needed mental health treatment 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 at the agency with a goal of illness management in a "clinical home."

Source: Interview, medical record

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 related disorders.

- ***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 related 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 off-site provider without any formal consultation or collaboration. Programs at this level may discharge individuals for psychiatric symptoms or non-adherence 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 related disorders either ongoing or until the client is systematically linked to mental health services off site through collaborative efforts and is insured a rapid return for a new episode of program services when indicated.

- **(SCORE-4):** Formal protocol to manage mental health needs indefinitely, but variable documented evidence that this is routinely practiced, typically within the same program or agency.

- ***Dual Diagnosis Enhanced = (SCORE-5):*** Formal protocol to manage mental health needs indefinitely and consistent documented evidence 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 related disorders over an extended or indefinite period. On site clinical recovery check-ups may be an annual option in this type of program.

AOS PROGRAMS

Enhancing VB. Capacity to maintain treatment continuity

AOS programs may discharge persons with co-occurring disorders who become symptomatic psychiatrically, 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 psychiatric 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 psychiatric problem and if sufficiently stable will retain the patient in the current program, and if a referral is required (preferably within the same agency or to a mental health agency with which there is a memorandum of understanding), 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, the patient is accepted 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 with 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 psychiatric disorders co-existing with them. DDE programs, in contrast to DDC, are typically able to provide in house or in 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.

V.C. Focus on ongoing recovery issues for both disorders.

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

Source: Interview, document review (mission statement, brochure, policy & procedure manual).

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 related and psychiatric disorders.

- ***Addiction Only Services = (SCORE-1):*** No. The program embraces the philosophy of recovery for substance related disorders only; mental health recovery is not incorporated.

- ***(SCORE-2):*** Individual clinician determined. The program embraces the philosophy of recovery for substance related disorders only, similar to that of an AOS system. BUT there are individual clinicians who use recovery philosophy when planning services for mental health related 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 related disorders but also includes a recovery philosophy for co-occurring mental health disorders, but primarily as it impacts the recovery from the substance related disorder. For example, mental health concerns are perceived as a recovery issue in terms of its probability of leading to relapse of the substance related disorder if not appropriately treated, or mental health issues 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 recovery equivalently for both substance related and mental health disorders, and articulates specific goals for persons to achieve and maintain recovery that includes 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 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 psychiatric 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 CBT, or perhaps staying close 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 psychiatric issues 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:
19Hhttp://www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/illness/

The key is that recovery from both disorders is seen as equivalent, interactive and the prospects 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. Both go well beyond simple symptom remission or the absence of something negative. Instead it embraces a new life filled with hope, promise and opportunity.

V.D. Facilitation of self-help support groups for COD is documented

Definition:
Programs that offer services to individuals with COD anticipate difficulties that the individuals with COD might experience when linking or continuing with self-help support groups and thus provide the needed assistance to support this transition beyond active treatment.

Source: Interview, medical record.

Item Response Coding:
Coding of this item requires an understanding of self-help support groups within the program's continuum of services and the systems for facilitating the connection with mutual self-help groups in the community.
Note: Programs having difficulty with the facilitation of self-help groups while the individual was in treatment, will also likely have difficulty meeting this when the individual is discharged.

- ***Addiction Only Services = (SCORE-1):*** No. The program does not advocate or assist with linking individuals with COD to self-help support groups beyond recommendations, assignments, meetings lists, and suggestions to "work the steps' and/or "find a temporary sponsor."

- ***(SCORE-2):*** Rarely, but addressed by individual clinicians. The program does not advocate or generally assist with linking COD persons with self help recovery groups or documents any such attempts. However, there is some indication that it may happen as a result of clinician judgment or preference. A COD specific connection may be variably developed.

- ***Dual Diagnosis Capable = (SCORE-3):*** Yes, variable, but not routine or systematic focus on co-occurring disorders peer support community connection (engagement in meetings or functions off-site). The program facilitates the process of linking individuals with COD to self-help recovery groups at discharge. This is not a systematic part of standard discharge planning but occurs with some frequency. For example, 1) women with PTSD are linked to women's AA meetings; 2) a thorough discussion of medications vs. drugs takes place, including how to talk at NA meetings about medications and how to find a receptive sponsor.

- ***(SCORE-4):*** The program irregularly facilitates the process of matching individuals with COD to self-help recovery groups at discharge. This is not a part of standard discharge planning but occurs with increasing frequency (at least on a 50% basis).

- ***Dual Diagnosis Enhanced = (SCORE-5):*** Yes, routine and systematic, at least 80% of the time with focus on co-occurring disorders peer support community connection (engagement in meetings or functions off-site). The program routinely recognizes the difficulties of individuals with COD in linking or continuing with self-help support groups; and thus, routinely (at least on 80% basis) facilitates this process at discharge. This may be a component of the program's continuity of care policy, and 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 self-help meetings on site indefinitely.

AOS PROGRAMS

Enhancing VD. Facilitation of self-help support groups for COD is documented

Item IV.I describes the benefits of specialized interventions to facilitate the use of mutual support groups for persons with co-occurring disorders during the discharge planning process. 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 support groups. Many patients will have only linked to the degree it satisfies program requirements and once these are lifted 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, it is hypothesized that these 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. Facilitation of self-help support groups for COD is documented

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 insure the introductions of current patients to peer support group members with an eye toward matching, they 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 dual recovery peer support groups are rare, DDE programs insure smooth linkage and integration with more traditional and readily available community peer support groups such as Alcoholics Anonymous and Narcotics Anonymous.

V.E. Sufficient supply and adherence 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 providing sufficient supplies of medications at discharge.

Source: Interview, discharge procedures

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

- ***Dual Diagnosis Capable = (SCORE-3):*** Yes, 30-day or supply to next appointment off-site. When an individual with a co-occurring mental health disorder is discharged, the program has the capacity to provide for medication planning and offers a 30 day supply until the individual can be linked (appointment arranged by the program with some exchange of information to referral site) for follow-up prescriptions at an external site.

- ***Dual Diagnosis Enhanced = (SCORE-5):*** Maintains medication management in program with provider/agency .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, or at least until the individual has successfully transitioned to the new care provider. Collaboration in the transition between providers is evident.

AOS PROGRAMS

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

AOS programs are likely not in position to distribute a supply of medication, but do encourage linkage or collaboration or consultation with the local mental health provider. DDC programs may have continued or initiated psychotropic medication and a sufficient 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 insures 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 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 prescriber

Definition:
Programs that offer treatment to individuals with COD offer pharmacotherapy for both the mental health disorder as well as the substance related disorder 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 adherence, 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: Interview

Item Response Coding:
Coding of this item requires an understanding of the specific competencies of the prescribing professional and the level of involvement of the licensed prescriber 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 off-site provider, or has an on-site medical consultant who can diagnose but does not prescribe.

- ***Dual Diagnosis Capable = (SCORE-3):*** Consultant or contractor onsite. The program has an arrangement with a prescriber who is 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 onsite for clinical matters only. The program has a staff member who is a prescriber who is available on-site to provide specific clinical duties, but does not routinely participate in the organized activities of a clinical team. At this level, this prescriber may be accessed on a limited basis, but this is not routine.

- ***Dual Diagnosis Enhanced = (SCORE-5):*** Staff member, present onsite for clinical, supervision, treatment team, and/or administration. The program has a prescribing staff member who is available on-site to provide prescribing services to individuals. –AND- This prescribing staff member is also an active participant in the full range of the program's clinical activities and 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 prescriber

Many addiction treatment providers consider this item to be pivotal. Having psychiatrist, physician or other prescriber access 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 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 prescriber

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 to 10:30AM. The nurse practitioner agreed to attend the meetings which cut down on the amount of time staff needed to contact her by email 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.

VI.B. On site staff with MH licensure or demonstrated expertise.

Definition:
Substance abuse programs that offer treatment to individuals with COD 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 related disorders.

Source: Interview, review of staff composition.

Item Response Coding:
Coding of this item requires an understanding of the program's 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 at least two years of supervised experience in assessing and treating clients with co-occurring disorders to the point where certification or autonomy has been achieved).

- ***Addiction Only Services = (SCORE-1):*** No formal relationship with program. The program has no staff members with specific expertise or competencies in the provision of services to individuals with mental health disorders.

- ***(SCORE-2):*** One to 24% of clinical staff members. The program has less than 25% of staff with specific expertise or competencies in the provision of services to individuals with mental health disorders.

- ***Dual Diagnosis Capable = (SCORE-3):*** 25-33% of clinical staff members. The addiction program has at least 25% of staff with specific expertise or competencies in the provision of services to individuals with mental health disorders.

- ***(Score)-4:*** 34-49% of clinical staff members.

- ***Dual Diagnosis Enhanced = (SCORE-5):*** 50% or more of clinical staff members. The addiction program has at least 50% of staff with specific expertise or competencies in the provision of services to individuals with mental health disorders.

AOS PROGRAMS

Enhancing VIB. On site staff with mental health licensure or demonstrated expertise

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 can deliver the most basic and generic treatments: CBT, motivational interviewing, family therapy, and assessments. A DDC program may have about 25% 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 addiction treatment education and/or experience should be the top priority.

DDC PROGRAMS

Enhancing VIB. On site staff with mental health licensure or demonstrated expertise

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 psychiatric disorders. Reaching DDE status on this criterion may also involve the inclusion of staff members who are mental health educated (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. DDE residential, inpatient, and detox programs have adequate staff : client ratios and a combination of mental health and substance abuse staff on their second and third shifts as well.

VIC. Access to mental health supervision or consultation

Definition:
Programs that offer treatment to individuals with a co-occurring mental health disorder provide formal mental health supervision for trained providers of mental health services who are unlicensed or who have insufficient competence or experience in the treatment setting.

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. The program does not have the capacity to provide supervision for mental health services.

- ***(SCORE-2):*** Yes, offsite by consultant, undocumented. 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 off-site consultant or only in emergent situations on-site.

- ***Dual Diagnosis Capable = (SCORE-3):*** Yes, onsite supervision provided PRN. 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):*** Yes, onsite supervision. Provided regularly. Irregular documentation. The program offers regular supervision for mental health services through an on-site 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, group observation, etc. BUT this arrangement is NOT formally or consistently documented.

- ***Dual Diagnosis Enhanced = (SCORE-5):*** Yes, onsite, documented regular supervision sessions for clinical matters. The program has the capacity to offer a structured and regular supervision for mental health structure 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, group observation, etc. –AND- Documentation is available that demonstrates this arrangement, which includes regularly scheduled supervision periods.

AOS PROGRAMS

Enhancing VIC. Access to mental health supervision or consultation

AOS programs may not have access to mental health consultation or supervision by a licensed professional (i.e., LCSW, LPC, LMFT, licensed psychologist, psychiatrist, APRN). 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 supervision or consultation

DDE programs have recognized the value of clinical supervision in promoting staff satisfaction, insuring 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. CBT, or 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, and thru the local Addiction Technology Transfer Center 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, 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 CBT.

New research on the supervision process is underway, including motivational interviewing approaches to the process itself.

One suggested resource for clinical supervision is:

Falender CA, Shafranske EP. Clinical supervision: A competency based approach. Washington DC: American Psychological Association, 2004 (http://books.apa.org/books)

VID. Case review, staffing or utilization review procedures emphasize and support COD treatment

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

Source: Interview, agency documents.

Item Response Coding:
Coding of this item requires an understanding of the program's formal process for reviewing psychiatric issues, specifically the cases of individuals with COD.

- ***Addiction Only Services = (SCORE-1):*** **No.** The program has no protocols to review the co-occurring mental health cases through a formal case or utilization review process.

- ***(SCORE-2):*** Variable, by offsite consultant, undocumented. The program has an off-site consultant who occasionally conducts reviews of COD cases. Documentation may not be available and appears to be a largely unstructured and informal process.

- ***Dual Diagnosis Capable = (SCORE-3):*** Yes, onsite, documented as needed (prn) and with co-occurring disorder issues. The program has a regular procedure for reviewing co-occurring mental health cases through case or utilization review process by an on-site supervisor. This process is not routine or systematically on only COD cases but is a regular procedure within the program that allows for the review of COD cases. There is some minimal documentation that supports the consideration of COD services within this process (e.g. weekly staffings).

- ***Dual Diagnosis Enhanced = (SCORE-5):*** Yes. Documented, routine and systematic coverage of co-occurring issues. The program has a routine, formalized protocol that consistently reviews and focuses on co-occurring mental health disorders. This process allows for a systematic and critical review of targeted interventions for COD cases in order to determine appropriateness or effectiveness. Documentation of this formalized process is available.

AOS PROGRAMS

Enhancing VID. Case review, staffing or utilization review procedures emphasize and support COD treatment

In contrast to AOS programs, DDC programs attend to the status and progress with the co-occurring disorder in case review, staffing disposition or rounds team meetings. AOS programs may focus on the achievement of tasks toward recovery or compliance with policy, DDC programs attend to these matters but also review the patient's progress with medications, talking about his/her psychiatric issues in group, the progress on this matter 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 but does so on a consistent basis.

DDC PROGRAMS

Enhancing VID. Case review, staffing or utilization review procedures emphasize and support COD treatment

DDC programs review patient progress on psychiatric problems in a general way. DDE programs do so more 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, psychiatric problems 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 2-week reviews. Another residential program lists psychiatric problems and designates clinically responsible parties. These clinicians then report on patient progress (per treatment plan) at each team meeting (weekly). The DDE program is characterized by routine, systematic and protocol driven case review of psychiatric problems.

One indicator of ABC Clinic's DDE level of service is their staff familiarity with the scores of the screening measures used to describe initial psychiatric problem symptom severity. All staff members know the scales on the MINI and the Beck Depression Inventory and know how to interpret the clinical importance of scores at the mild, moderate or severe level.

VIE. Peer/Alumni supports are available with COD

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 COD peer/alumni supports.

Source: Interview, 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 as peer/ alumni supports, specifically the presence of individuals in recovery from a co-occurring disorder.

- ***Addiction Only Services = (SCORE-1):*** No. The program offers neither on-site staff or volunteers or off-site linkages with COD alumni or COD peer recovery supports.

- ***Dual Diagnosis Capable = (SCORE-3):*** Present, with COD, but as part of community, and routinely available to program patients either through informal relationships or more formal connections, such as through peer support service groups (e.g., AA, H&I committees; NAMI). The program provides off-site linkages with COD peer/ alumni supports on a consistent basis.

- ***Dual Diagnosis Enhanced = (SCORE-5):*** Present, with COD, onsite, either as paid staff, volunteers, or routinely available program "alumni". The program maintains staff or volunteers on-site who can provide COD peer/ alumni support.

AOS PROGRAMS

Enhancing VIE. Peer/Alumni supports are available with COD

This item closely corresponds to item V.D. Facilitation of self-help support groups for COD. 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 comorbidities 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 offsite, in the community.

The Pottsville Hospital was approached by the three members of the district AA hospital and institution committee (HIC). 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 IOP program director felt that adding this component to his Monday thru Thursday treatment services would be an excellent new feature to his program. He agreed to the idea and the meetings have been running for three years. Informally, he has gotten to know some of the "regulars" at the meeting, so he has mentioned to patients, who he knows have psychiatric problems, to look for "Pete" or "Eddie" or "Martha" 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 COD

DDE programs capitalize on a network of community volunteers, alumni, recovering staff and others to serve as onsite COD recovery supports (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 (HIC), 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.

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

<u>VIIA. Basic training in prevalence, common signs and symptoms, screening and assessment for psychiatric symptoms and disorders.</u>

<u>Definition:</u>
Programs that provide treatment to individuals with co-occurring mental health disorders have staff with training in the prevalence of CODs, the screening & assessment of CODs, the signs & symptoms of CODs, and in triage and treatment decision-making.

<u>Source</u>: Interview, Review of strategic training plans

<u>Item Response Coding:</u> Coding of this item requires an understanding of the program's requirements for basic skills and training with regard to CODs.

- ***<u>Addiction Only Services = (SCORE-1):</u>*** Not trained in basic skills. The program's staff have no training and are not required to be trained in basic COD issues.

- ***<u>(SCORE-2):</u>*** Variably training, not documented as part of systematic training plan, but encouraged by management. The program encourages COD training but has not made this a part of their strategic training plan. –OR- A portion of the program's staff are trained in basic COD knowledge and skills.

- ***<u>Dual Diagnosis Capable = (SCORE-3):</u>*** Trained in basic skills per agency strategic training plan. The program's strategic training plan requires basic training in COD issues for all staff -AND- The majority of program staff are trained in these basic COD issues including the prevalence of CODs, screening & assessment of CODs, the signs & symptoms of CODs, and triage and treatment decision-making for CODs.

- ***<u>(SCORE-4):</u>*** Trained in these skills per agency strategic training plan, and also have some advanced training in specialized treatment approaches. The program meets the DDC requirements AND has some staff trained in advanced COD issues and specifically targeted treatments, although this aspect of advanced COD training has NOT been formally incorporated into their strategic training plan.

- ***<u>Dual Diagnosis Enhanced = (SCORE-5):</u>*** Trained in these skills per agency strategic training plan, and also have staff with advanced training in specialized treatment approaches as part of plan. The program's strategic training plan requires basic training in COD issues for all staff and requires advanced training in COD issues for select staff. -AND- All program staff have received this basic COD training (screening & assessment of CODs, the signs & symptoms of CODs, and the prevalence of CODs) and select staff have been trained in advanced COD skills.

AOS PROGRAMS

Enhancing VIIA. Basic training in prevalence, common signs and symptoms, screening and assessment for psychiatric symptoms and 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. Nonetheless, in the field of behavioral health care, training is the principal mechanism to impart new information, and presumably the necessary but not sufficient beginnings of practice change. AOS program staff members have variable exposure to information about co-occurring disorders, and about the prevalence of psychiatric disorders already under their auspices. DDC programs have made commitments to have the majority of their staff trained in basic issues pertaining to co-occurring disorders: attitudes, prevalence, screening, triage, and brief intervention. These trainings might be strategically directed using existing training budget or release time, and 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 in Waterbury Connecticut provides 9 in-service training sessions 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 and brief interventions and therapeutic needs of persons with co-occurring disorders.

DDC PROGRAMS

Enhancing VIIA. Basic training in prevalence, common signs and symptoms, screening and assessment for psychiatric symptoms and disorders

Whereas DDC programs have focused on training the majority of staff on basic issues pertaining to co-occurring disorders, the DDE program has all staff trained in basic issues and is striving to have the majority of staff trained in advanced issues. Advanced issues include: differential diagnostics, evidence-based pharmacological and psychosocial practices, principles of preferred or evidenced based practices, and perhaps in learning specific new treatments for adaptation for persons with co-occurring disorders. 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 has an increasing number of staff trained in treatment approaches for persons with co-occurring disorders.

<u>VIIB. Staff are cross-trained in mental health and substance use disorders, including pharmacotherapies.</u>

Definition:
Programs that offer treatment to individuals with CODs support cross-training of their staff to increase the needed capacity to provide COD treatment within the program. This aspect of training is incorporated into the program's strategic training plan.

<u>Source</u>: Interview, Review of strategic training plan

<u>Item Response Coding:</u>
Coding of this item requires an understanding of the program's training plan, the utilization of cross-training within this plan, and knowledge of the numbers of staff who have completed cross-training. Coding of this item also requires an understanding of how the program has defined cross-training for COD

- ***<u>Addiction Only Services = (SCORE-1):</u>*** Not trained, or not documented. The program has no staff who are cross-trained in COD services and has not incorporated the concept of cross-training into the program's training plan.

- ***<u>(SCORE-2):</u>*** At least 33% trained. The program has at least 33% of staff but not more than 50% who are cross-trained in COD services. Cross-training has not necessarily been incorporated into the overall training plan for the program.

- ***<u>Dual Diagnosis Capable = (SCORE-3):</u>*** At least 50% trained. The program has at least 50% but not more than 75% of staff who are cross-trained in COD services. Cross-training has been incorporated into the overall training plan for the program but not fully implemented.

- ***<u>(SCORE-4):</u>*** At least 75% are trained. The program has at least 75% of staff but not more than 90% who are cross-trained in COD services. Cross-training has been incorporated into the overall training plan for this program but not fully implemented.

- ***<u>Dual Diagnosis Enhanced = (SCORE-5):</u>*** At least 90% are trained. The program has at least 90% of staff who are cross-trained in COD services. Cross-training has been incorporated into the overall training plan for the program and has been largely implemented.

AOS PROGRAMS

Enhancing VIIB. Staff are cross-trained in mental health and substance use disorders, including pharmacotherapies

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 venture in addiction and mental health treatment systems. DDC programs aim to have 50 to 75% of staff cross-trained in addiction and mental health or COD services. This item has not been observed to be cost-intensive but rather forces an organization to be more intentional and strategic in the use of its training dollars and time allocations.

DDC PROGRAMS

Enhancing VIIB. Staff are cross-trained in mental health and substance use disorders, including pharmacotherapies

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. How these relationships work and how alliances and rapport are determined is beyond the present scope. In the DDE program, at least 90% of staff will have training if not expertise in both mental health and addiction treatment.

DDE programs are focused on having the majority if not all staff members develop expertise in treating persons with co-occurring disorders, and see it as routine not specialized practice.

DDCAT Interpretation, Feedback, and Reports

The conduct and scoring of the DDCAT will produce scores on the seven dimensions and categorize the program as AOS, DDC or DDE.

With respect to interpretation, programs are urged not to make too much of the categorization option (since details of this assignment are still being refined). However, many will insist on this label to define in a simple way the co-occurring capacity of their agency's programs.

The dimension scores are the average scores of the items within the dimension. The scores on these dimensions 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 (see Appendix F for an example). 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 those dimensions that are both strengths and areas for potential development. 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.

An Excel Program File for the DDCAT 3.0 is available from the authors to record scores, score and summarize the itemized ratings. This program also generates graphic profiles for display of the program's profile across the seven dimensions.

A qualitative interpretation of the DDCAT profile and items has proven to be the most useful way to engage clinicians and providers in a dialogue and change process. Conversation about dimensions, as well as themes across dimensions is often the most useful way for providers to consider where they are and where they want to go.

Feedback is typically provided in two formats. First, just after the DDCAT site visit, agency directors and leadership may expect some preliminary verbal feedback. This can be offered as the person conducting the visit becomes more experienced. A suggestion is to focus on the strengths of the agency, and where possible join with those issues that have already been identified as quality improvement issues by the agency staff members themselves. This could be seen as a parallel to motivational interviewing techniques. The second format is via written report. This has been accomplished via a summary letter to the agency director. The organization of the feedback letter will vary but essentially consists of a communication of appreciation, a review of what programs and sources of data were assessed, an acknowledgment of relative strengths in existing services, and review of potential areas that can be targeted for enhancement. The reports may vary by how much of an emphasis is placed on specific recommendations (e.g. listing and describing specific screening measures to systematize screening for co-occurring disorders) or to make mention only of thematic areas of potential improvements.

DDCAT assessments for a region, a state or as change indices can be aggregated and analyzed, or simply used to map a territory of the dual diagnosis capacity of addiction treatment providers.

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Substance Abuse and Mental Health Services Administration. Report to Congress on the prevention and treatment of co-occurring substance abuse disorders and mental disorders. Rockville MD: SAMHSA, DHHS, 2002.

Recommended Readings

Co-occurring disorders: General Texts

Baker A, Velleman R. Clinical handbook of co-existing mental health and drug and alcohol problems. New York NY: Routledge, 2007.

Brady KT, Halligan P, Malcolm R. Dual Diagnosis. In M Galanter, HD Kleber (eds). Textbook of substance abuse treatment. Washington DC: American Psychiatric Press, pp. 475-484, 1999.

Centre for Addiction and Mental Health. Best Practices: Concurrent mental health and substance use disorders. Ottawa Canada: Health Canada, 2001.

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Substance use disorders: General Texts

Margules RD, Zweben JE. Treating patients with alcohol and other drug problems. Washington DC: American Psychological Association, 1998.

Miller WR & Rollnick S. Motivational interviewing. 2nd edition. New York: Guilford, 2002.

Co-occurring disorders - Anxiety and substance use disorders

Barlow DH. Anxiety and its disorders. 2nd edition. New York: Guilford, 2002.

CBT for anxiety disorders: www.bu.edu/anxiety/dhb/treatmentmanuals.shtml.

Kushner M, Abrams K, Borchardt C. The relationship between anxiety disorders and alcohol use disorders. Clin Psychol Reve 20: 149-171, 2000.

Randall CL, Thomas S, Thevos AK. Concurrent alcoholism and social anxiety disorder. Alc: Clin Exp Res 25: 210-220, 2001.

Co-occurring disorders - Depression and substance use disorders

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Burns, DD. The feeling good handbook New York: Penguin Books, 1989.

Brown RA, Ramsey SE. Addressing comorbid depressive symptomatology in alcohol treatment. Prof Psychol: Res Prac 31: 418-422, 2000.

Interpersonal Therapy for Depression Therapy Manual: www.interpersonalpsychotherapy.org/index.html

Co-occurring disorders - Posttraumatic stress and substance use disorders

Ouimette P, Brown PJ. Trauma and substance abuse: Causes, consequences and the treatment of comorbid disorders. Washington DC: American Psychological Association, 2002.

Najavits LM. Seeking safety. New York: Guilford, 2001.

Seeking Safety manual: www.seekingsafety.org

Co-occurring disorders - Personality and substance use disorders

Evans K, Sullivan JM. Step study counseling with the dual disordered client. Center City MN: Hazelden, 1990.

Evans K, Sulllivan JM. Dual diagnosis. New York: Guilford, 1990.

Linehan MM et al. Dialectical behavior therapy for patients with borderline personality disorder and drug dependence. Am J on Addictions 8: 279-292, 1999.

Dialectical Behavior Therapy Manual: http://faculty.washington.edu/linehan

Co-occurring disorders – Adolescents

Riggs, P. Treating adolescents for substance abuse and comorbid psychiatric disorders. Science & practice perspectives 2: 18-32, 2003.

Co-Occurring disorders- Web based bibliography

http://www.treatment.org/Topics/dual_documents.html

APPENDIX A

DUAL DIAGNOSIS CAPABILITY IN ADDICTION TREATMENT (DDCAT) INDEX

Version 3.2

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

RATING SCALE COVER SHEET

Program Identification

Date: __________ **Rater(s):** ______________________________ **Time Spent (Hours):** __________________

Agency Name: ____

Program Name: ____

Address: ____ **Zip Code:** ______

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

Telephone: __________________; **FAX:** __________________; **Email:** ______________________________

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

Program Characteristics

Payments received (program):

_____ Self-pay
_____ Private health insurance
_____ Medicaid
_____ Medicare
_____ State financed insurance
_____ Military insurance

Other funding sources:

_____ Other public funds
_____ Other funds

Primary focus of agency:

_____ Addiction treatment services
_____ Mental health services
_____ Mix of addiction & MH services
_____ General health services
_____ Hospital

Size of Program:

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

Agency type:

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

Level of care:

ASAM-PPC-2R (Addiction):

_____ I. Outpatient
_____ II. IOP/Partial Hospital
_____ III. Residential/Inpatient
_____ IV. Medically Managed Intensive Inpatient (Hospital)
_____ OMT: Opioid Maintenance
_____ D: Detoxification

Mental Health:

_____ Outpatient
_____ Partial hospital/Day program
_____ Inpatient

Exclusive program/Admission criteria requirement:

_____ Adolescents
_____ Co-occurring MH & SUDs disorders
_____ HIV/AIDs
_____ Gay & Lesbian
_____ Seniors/Elders
_____ Pregnant/post-partum
_____ Women
_____ Residential setting for pts & children
_____ Men
_____ DUI/DWI
_____ Criminal justice clients
_____ Adult General

DDCAT assessment sources

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

Total # of sources used: _______

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

RATING SCALE

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

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

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

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

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

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

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

	1 **AOS**	2	3 **DDC**	4	5 **DDE**
VII. TRAINING					
VIIA. Direct care staff members have basic training in prevalence, common signs & symptoms, screening and assessment for psychiatric symptoms and disorders.	Not trained in basic skills.	Variably trained, not documented as part of systematic training plan, but encouraged by management.	Trained in basic skills per agency strategic training plan.	Trained in these skills per agency strategic training plan, and also have some advanced training in specialized treatment approaches.	Trained in these skills per agency strategic training plan, and also have staff with advanced training in specialized treatment approaches as part of plan.
VIIB. Direct care staff members are cross-trained in mental health and substance use disorders, including pharmacotherapies, and have advanced specialized training in treatment of persons with co-occurring disorders.	Not trained, or not documented.	At least 33% trained.	At least 50% trained	At least 75% are trained	At least 90% are trained.

ADDITIONAL SITE VISIT NOTES:

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

SCORING SUMMARY

I. Program Structure

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

Sum Total = __________
/4 = **SCORE** __________

II. Program Milieu

A. _____
B. _____

Sum Total = __________
/2 = **SCORE** __________

III. Clinical Process: Assessment

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

Sum Total = __________
/7 = **SCORE** __________

IV. Clinical Process: Treatment

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

Sum Total = __________
/10 = **SCORE** __________

DDCAT INDEX PROGRAM CATEGORY: SCALE METHOD

OVERALL SCORE (Sum of Scale Scores/7): _____
DUAL DIAGNOSIS CAPABILITY:
AOS (1 - 1.99) _____
AOS/DDC (2 - 2.99) _____
DDC (3 - 3.49) _____
DDC/DDE (3.5 - 4.49) _____

DDCAT INDEX PROGRAM CATEGORY: CRITERION METHOD

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

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

V. Continuity of Care

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

Sum Total = __________
/5 = **SCORE** __________

VI. Staffing

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

Sum Total = __________
/5 = **SCORE** __________

VII. Training

A. _____
B. _____

Sum Total = __________
/2 = **SCORE** __________

APPENDIX B

MEMORANDUM OF UNDERSTANDING

MOU OUTLINE

BETWEEN A MENTAL HEALTH AND ADDICTION TREATMENT AGENCY FOR THE PURPOSE OF DELIVERING INTEGRATED TREATMENT TO PEOPLE WITH CO-OCCURRING DISORDERS

Memorandum of Understanding

Between

[mental health program]

and

[addiction treatment program]

The purpose of this Memorandum of Understanding 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.

APPENDIX C

GENERAL SCREENING MEASURES:

Modified MINI Screen (MMS)[1]

Mental Health Screening Form-III (MHSF-III)

CAGE-Adapted to Include Drugs (CAGE-AID)

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

SPECIFIC SCREENING MEASURES

Beck Depression Inventory[1]

Beck Anxiety Inventory[1]

Posttraumatic Stress Disorder Checklist

Social Interaction Anxiety Scale

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[1] These measures are not in the public domain, but may be used for research or program evaluation. For other use, please contact the authors of the tools for purchase and cost information.

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 _____

- -

Section C

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)

MENTAL HEALTH SCREENING FORM III (MHSF-III)

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 to 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 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, insets, 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 <u>ever</u> experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner? YES _____ NO _____

12. Was there <u>ever</u> 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 much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw-up? YES _____ NO _____

13. Have you <u>ever</u> 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 <u>ever</u> had spells or attacks when you suddenly felt anxious, frightened, and uneasy to the extent that you began sweating, your heat 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 <u>ever</u> 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 ridged schedule of daily activities from which you could not deviate. YES _____ NO _____

16. Have you <u>ever</u> 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 <u>ever</u> 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 8 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

Beck Depression Inventory

INSTRUCTIONS: This section consists of 21 groups of statements. Please read each group of statements carefully, and then pick out the one statement in each that best describes the way you have been feeling during the **past two weeks**, including today. **Circle** the number above the statement you have picked. If several statements in the group seem to apply equally well, circle the highest number for that group. **Be sure that you do not choose more than one statement for any group**, including Item 16 (Changes in Sleeping Pattern) or Item 18 (Changes in Appetite).

	0	1	2	3
01. Sadness	I do not feel sad.	I feel sad much of the time.	I am sad all the time.	I am so sad or unhappy that I can't stand it.
	0	1	2	3
02. Pessimism	I am not discouraged about my future.	I feel more discouraged about my future than I used to be.	I do not expect tings to work out for me.	I feel my future is hopeless and will only get worse.
	0	1	2	3
03. Past Failure	I do not feel like a failure.	I have failed more than I should have.	As I look back, I see a lot of failures.	I feel I am a total failure as a person.
	0	1	2	3
04. Loss of Pleasure	I get as much pleasure as I ever did from the things I enjoy.	I don't enjoy things as much as I used to.	I get very little pleasure from the things I used to enjoy.	I can't get any pleasure from the things I used to enjoy.
	0	1	2	3
05. Guilty Feelings	I don't feel particularly guilty.	I feel guilty over many things I have done or should have done.	I feel quite guilty most of the time.	I feel guilty all of the time.
	0	1	2	3
06. Punishment Feelings	I don't feel I am being punished.	I feel I may be punished.	I expect to be punished.	I feel I am being punished.
	0	1	2	3
07. Self-Dislike	I feel the same about myself as ever.	I have lost confidence in myself.	I am disappointed in myself.	I dislike myself.

(continued)

	0	1	2	3
08. Self-Criticalness	I don't criticize or blame myself more than usual.	I am more critical of myself than I used to be.	I criticize myself for all of my faults.	I blame myself for everything bad that happens.
	0	1	2	3
09. Suicidal Thoughts or Wishes	I don't have any thoughts of killing myself.	I have thoughts of killing myself, but I would not carry them out.	I would like to kill myself.	I would kill myself if I had the chance.
	0	1	2	3
10. Crying	I don't cry anymore than I used to.	I cry more than I used to.	I cry over every little thing.	I feel like crying, but I can't.
	0	1	2	3
11. Agitation	I am no more restless or wound up than usual.	I feel more restless or wound up than usual.	I am so restless or agitated that it's hard to stay still.	I am so restless or agitated that I have to keep moving or doing something.
	0	1	2	3
12. Loss of Interest	I have not lost interest in other people or activities.	I am less interested in other people or things than before.	I have lost most of my interest in other people or things.	It's hard to get interested in anything.
	0	1	2	3
13. Indecisiveness	I make decisions about as well as ever.	I find it more difficult to make decisions than usual.	I have much greater difficulty in making decisions than I used to.	I have trouble making any decisions.
	0	1	2	3
14. Worthlessness	I do not feel I am worthless.	I don't consider myself as worthwhile and useful as I used to.	I feel more worthless as compared to other people.	I feel utterly worthless.
	0	1	2	3
15. Loss of Energy	I have as much energy as ever.	I have less energy than I used to have.	I don't have enough energy to do very much.	I don't have enough energy to do anything.

(continued)

	0	1a	1b	2a	2b	3a	3b
16. Changes in sleeping pattern	I have not experienced any change in my sleeping pattern.	I sleep somewhat more than usual.	I sleep somewhat less than usual.	I sleep a lot more than usual.	I sleep a lot less than usual.	I sleep most of the day.	I wake up 1-2 hours early and can't get back to sleep.
	0	1		2		3	
17. Irritability	I am no more irritable than usual.	I am more irritable than usual.		I am much more irritable than usual.		I am irritable all the time.	
	0	1a	1b	2a	2b	3a	3b
18. Changes in Appetite	I have not experienced any change in my appetite.	My appetite is somewhat less than usual.	My appetite is somewhat greater than usual.	My appetite is much less than before.	My appetite is much greater than usual.	I have no appetite at all.	I crave food all the time.
	0	1		2		3	
19. Concentration Difficulty	I can concentrate as well as ever.	I can't concentrate as well as usual.		It's hard to keep my mind on anything for very long.		I find I can't concentrate on anything.	
	0	1		2		3	
20. Tiredness or Fatigue	I am no more tired or fatigued than usual.	I get more tired or fatigued more easily than usual.		I am too tired or fatigued to do a lot of the things I used to do.		I am too tired or fatigued to do most of the things I used to do.	
	0	1		2		3	
21. Loss of Interest in Sex	I have not noticed any recent change in my interest in sex.	I am less interested in sex than I used to be.		I am much less interested in sex now.		I have lost interest in sex completely.	

Scoring	**Total Score:**		**Reverse items:** None
	Interpretation:	0 - 13	Minimal
		14 – 19	Mild
		20 – 28	Moderate
		29 – 63	Severe
	Suicide Risk:	Items 2 and 9	2 or more on either

Beck Anxiety Inventory

INSTRUCTIONS: In this section, indicate how much you have been **bothered** by each symptom **during the past week**, **including today**, circle the number in the column that most closely corresponds to how you've been feeling.

0 = **Not at all**
1 = **Mildly** – It did not bother me much.
2 = **Moderately** – It was very unpleasant but I could stand it.
3 = **Severely** – I could barely stand it.

		Not at all	Mildly	Moderately	Severely
01.	Numbness or tingling	0	1	2	3
02.	Feeling hot	0	1	2	3
03.	Wobbliness in the legs	0	1	2	3
04.	Unable to relax	0	1	2	3
05.	Fear of the worst happening	0	1	2	3
06.	Dizzy or lightheaded	0	1	2	3
07.	Heart pounding or racing	0	1	2	3
08.	Unsteady	0	1	2	3
09.	Terrified	0	1	2	3
10.	Nervous	0	1	2	3
11.	Feelings of choking	0	1	2	3
12.	Hands trembling	0	1	2	3
13.	Shaky	0	1	2	3
14.	Fear of losing control	0	1	2	3
15.	Difficulty breathing	0	1	2	3
16.	Fear of dying	0	1	2	3
17.	Scared	0	1	2	3
18.	Indigestion or discomfort in abdomen	0	1	2	3
19.	Faint	0	1	2	3
20.	Face flushed	0	1	2	3
21.	Sweating (not due to heat)	0	1	2	3

Scoring			
	Total Score:		**Reverse Items:** None
	Interpretation:	0 – 7	Minimal
		8 – 15	Mild
		16 – 25	Moderate
		26 – 63	Severe

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	Leaned about it	Not sure	Doesn't apply
01.	Natural disaster (for example, flood, hurricane, tornado, earthquake)	0	1	2	3	4
02.	Fire or explosion	0	1	2	3	4
03.	Transportation accident (for example, car accident, boat accident, train wreck, plane crash)	0	1	2	3	4
04.	Serious accident at work, home, or during recreational activity	0	1	2	3	4
05.	Exposure to toxic substance (for example, dangerous chemicals, radiation)	0	1	2	3	4
06.	Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)	0	1	2	3	4
07.	Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)	0	1	2	3	4
08.	Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)	0	1	2	3	4
09.	Other unwanted or uncomfortable sexual experience	0	1	2	3	4

(continued)

Event		Happened to me	Witnessed it	Leaned about it	Not sure	Doesn't apply
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

(continued)

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 ________________________ on ______________
(Event) (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
01.	Repeated disturbing **memories**, **thoughts or images** of the stressful experience?	1	2	3	4	5
02.	Repeated, disturbing **dreams** of the **stressful experience**?	1	2	3	4	5
03.	Suddenly **acting or feeling** as if the stressful experience **were happening again**? (**As if you were reliving it?**)	1	2	3	4	5
04.	Feeling **very** upset when something reminded **you** of the stressful experience?	1	2	3	4	5
05.	Having **physical reactions** (e.g., heart pounding, trouble breathing, sweating) when **something reminded you** of the stressful experience?	1	2	3	4	5
06.	Avoiding **thinking about** or **talking about** the stressful experience or avoiding **having feelings** related to it.	1	2	3	4	5
07.	Avoiding **activities or situations** because they **remind you** of the stressful experience?	1	2	3	4	5

(continued)

Bothered by		Not at all	A little bit	Moderately	Quite a bit	Extremely
08.	Trouble remembering **important parts** of the stressful experience?	1	2	3	4	5
09.	**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
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 = **Extremel**y characteristic or true of me

	Characteristic	Not at all	Slightly	Moderately	Very	Extremely
01.	I get nervous if I have to speak with someone in authority (teacher, boss).	0	1	2	3	4
02.	I have difficulty making eye contact with others.	0	1	2	3	4
03.	I become tense if I have to talk about myself or my feelings.	0	1	2	3	4
04.	I find it difficult to mix comfortably with the people I work with.	0	1	2	3	4
05.	I find it easy to make friends my own age.	0	1	2	3	4
06.	I tense up if I meet an acquaintance in the street.	0	1	2	3	4
07.	When mixing socially, I am uncomfortable.	0	1	2	3	4
08.	I feel tense when I am alone with just one person.	0	1	2	3	4
09.	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

(continued)

Characteristic		Not at all	Slightly	Moderately	Very	Extremely
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
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.

APPENDIX D

TIME LINE FOLLOW BACK CALENDAR

30-Day Timeline Follow Back Calendar of Substance Use and Psychiatric Symptoms

For substance abuse entries: note substance and how much used
For mental health entries: note symptoms experienced and intensity on scale of 1-10

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: _______

APPENDIX E

INSTRUMENTS USED TO MEASURE STAGE OF 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.
2. Sometimes I wonder if I am an alcoholic.
3. If I don't change my drinking soon, my problems are going to get worse.
4. I have already started making some changes in my drinking.
5. I was drinking too much at one time, but I've managed to change my drinking.
6. Sometimes I wonder if my drinking is hurting other people.
7. I am a problem drinker.
8. I'm not just thinking about changing my drinking, I'm already doing something about it.
9. I have already changed my drinking, and I am looking for ways to keep from slipping back to my old pattern.
10. I have serious problems with drinking.
11. Sometimes I wonder if I am in control of my drinking.
12. My drinking is causing a lot of harm.
13. I am actively doing things now to cut down or stop drinking.
14. I want help to keep from going back to the drinking problems that I had before.
15. I know that I have a drinking problem.
16. There are times when I wonder if I drink too much.
17. I am an alcoholic.
18. I am working hard to change my drinking.
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.

NH-Dartmouth Psychiatric Research Center – Version date: 1/22/02

Client Name ______________________
Date of Rating _________________

Substance Abuse Treatment Scale

I n s t r u c t i o n s: 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 2-4 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.

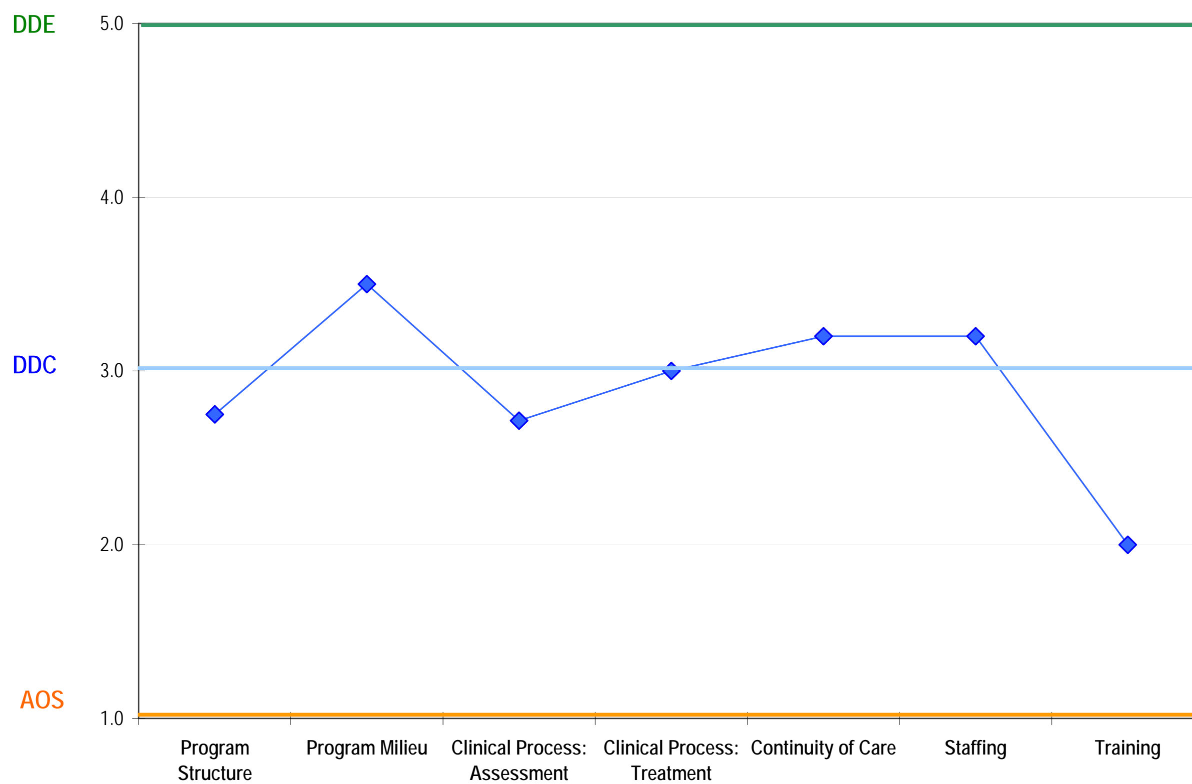
6. **Late Active Treatment** The person is engaged in treatment and has not met criteria for substance abuse or dependence for the past 1-5 months.

7. **Relapse Prevention** The client is engaged in treatment and has not met criteria for substance abuse or dependence for the past 6-12 months.

8. **In Remission or Recovery** The client has not met criteria for substance abuse or dependence for more than the past year.

APPENDIX E

SCORING PROFILE EXAMPLE


DDCAT Summary Profile:
DDE
DDC
AOS
5.0
4.0
3.0
2.0
1.0
Program Structure
Program Milieu
Clinical Process: Assessment
Clinical Process: Treatment
Continuity of Care
Staffing
Training