DDCMHT — Rating Scale Cover Sheet

Program Identification

Date______________________ Rater(s) ______________________ Time Spent (Hours) ________

Agency Name ____

Program Name ____

Address ______________________________________ Zip Code ____________

Contact Person 1) ______________________________ 2) ____________

Telephone ____________ FAX____________ Email ______________________

State____________ Region ____________ Program ID ____________ Time Period ____________

1= Baseline; 2 = 1st-follow-up;
3= 2nd follow-up; 4= 3rd follow-up; etc

Program Characteristics

Payments received (program)

____Self-pay
____Private health insurance
____Medicaid
____Medicare
____State financed insurance
____Military insurance

Other funding sources

____Other public funds
____Other funds

Primary focus of agency

____Addiction treatment services
____Mental health (MH) services
____Mix of addiction & MH services
____General health services
____Hospital

Size of program

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

Agency type

____Private
____Public
____Non-Profit
____Government operated
____Veterans Health Administration

Level of care

ASAM-PPC-2R (Addiction)

____I. Outpatient
____II. IOP/Partial Hospital
____III. Residential/Inpatient
____IV. Medically Managed Intensive Inpatient (Hospital)
____OMT: Opioid Maintenance
____D: Detoxification

Mental Health

____Outpatient
____Partial hospital/Day program
____Inpatient

Exclusive program/ Admission criteria requirement

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

DDCMHT 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:________

DDCMHT — Rating Scale

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

Table Header Key	
1-MHOS	Mental Health Only Services
3-DDC	Dual Diagnosis Capable
5-DDE	Dual Diagnosis Enhanced

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

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IIIC. Mental health and substance use diagnoses made and documented.	Substance use diagnoses are neither made nor recorded in records	Substance use diagnostic impressions or past treatment records are present in records but the program does not have a routine process for making and documenting substance use diagnoses.	The program has a mechanism for providing diagnostic services in a timely manner. Substance use diagnoses are documented in 50-69% of the records.	The program has a mechanism for providing routine, timely diagnostic services. Substance use diagnoses are documented in 70-89% of the records.	Comprehensive diagnostic services are provided in a timely manner. Substance use diagnoses are documented in at least 90% of the records.
IIID. Mental health and substance use history reflected in medical record.	Collection of mental health disorder history only.	Standard form collects mental health disorder history only. Substance use disorder history collected inconsistently.	Routine documentation of both mental health and substance use disorder history in record in narrative section.	Specific section in record dedicated to history and chronology of both disorders.	Specific section in record devoted to history and chronology of both disorders and the interaction between them is examined temporally.
IIIE. Program acceptance based on substance use disorder symptom acuity: low, moderate, high.	Admits persons with no to low acuity.		Admits persons in program with low to moderate acuity, but who are primarily stable.		Admits persons in program with moderate to high acuity, including those unstable in their substance use disorder.
IIIF. Program acceptance based on severity and persistence of substance use disability: low, moderate, high.	Admits persons in program with no to low severity and persistence of substance use disability.		Admits persons in program with low to moderate severity and persistence of substance use disability.		Admits persons in program with moderate to high severity and persistence of substance use disability.
IIIG. Stage-wise assessment.	Not assessed or documented.	Assessed and documented variably by individual clinician.	Clinician assessed and routinely documented, focused on mental health motivation.	Formal measure used and routinely documented but focusing on mental health motivation only.	Formal measure used and routinely documented, focus on both substance use and mental health motivation.

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

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IVE. Policies and procedures for evaluation, management, monitoring and compliance for/ of medications for substance use disorders.	Patients with active substance use routinely not accepted. No capacities to monitor, guide prescribing, or provide medications for substance use disorders during treatment.	Certain types of medication for substance use disorders are not prescribed. Some capacity to monitor medications for substance use disorders.	Some types of medication for substance use disorders are routinely available. Present, coordinated policies regarding medication for substance use disorders. Some access to prescriber for medications and policies to guide prescribing are provided. Monitoring of the medication is largely provided by the prescriber.	Clear standards and routine regarding medication for substance use disorders for medication prescriber who is also a staff member. Routine access to prescriber and guidelines for prescribing in place. The prescriber may periodically consult with other staff regarding medication plan and recruit other staff to assist with medication monitoring.	All types of medication for substance use disorders are available. Clear standards and routine for medication prescriber who is also a staff member. Full access to prescriber and guidelines for prescribing in place. The prescriber is on the treatment team and the entire team can assist with monitoring.
IVF. Specialized interventions with substance use disorders content.	Not addressed in program content.	Based on judgment by individual clinician; variable penetration into routine services.	In program format as generalized intervention with penetration into routine services. Routine clinician adaptation of an evidence-based mental health treatment.	Some specialized interventions by specifically trained clinicians in addition to routine generalized interventions.	Routine substance use disorder management groups; individual therapies focused on specific disorders; systematic adaptation of evidence-based addiction treatment (e.g., motivational interviewing, relapse prevention); or use of integrated evidence-based practices.
IVG. Education about substance use disorders, treatment, and interaction with mental health disorders.	Not offered.	Generic content, offered variably or by clinician judgment.	Generic content, routinely delivered in individual and/or group formats.	Specific content for specific co-morbidities; variably offered in individual and/or group formats.	Specific content for specific co-morbidities; routinely offered in individual and/or group formats.

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IVH. Family education and support.	For mental health disorders only, or no family education at all.	Variably or by clinician judgment.	Substance use disorders routinely but informally incorporated into family education or support sessions. Available as needed.	Generic family group on site on substance use and mental health disorders, variably offered. Structured group with more routine accessibility.	Routine and systematic co-occurring disorder family group integrated into standard program format. Accessed by families of the majority of patients with co-occurring disorders.
IVI. Specialized interventions to facilitate use of peer support groups in planning or during treatment.	No interventions made to facilitate use of either addiction or mental health peer support.	Used variably or infrequently by individual clinicians for individual patients, mostly for facilitation to mental health peer support groups.	Generic format on site, but no specific or intentional facilitation based on substance use disorders. More routine facilitation to mental health peer support groups (e.g., NAMI, Procovery).	Variable facilitation targeting specific co-occurring needs, intended to engage patients in mental health peer support groups or groups specific to both disorders (e.g., DRA, DTR).	Routine facilitation targeting specific co-occurring needs, intended to engage patients in mental health peer support groups or groups specific to both disorders (e.g., DRA, DTR).
IVJ. Availability of peer recovery supports for patients with co-occurring disorders.	Not present, or if present not recommended.	Off site, recommended variably.	Off site and facilitated with contact persons or informal matching with peer supports in the community, some co-occurring focus.	Off site, integrated into plan, and routinely documented with co-occurring focus.	On site, facilitated and integrated into program (e.g., alumni groups); routinely used and documented with co-occurring focus.
V. Continuity of Care					
VA. Co-occurring 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.	Some capacity (less than 80% of the time) to plan for integrated follow-up, i.e., equivalently address both substance use and mental health disorders as a priority.	Both disorders seen as primary, with confirmed plans for on-site follow-up, or documented arrangements for off site follow-up; at least 80% of the time.

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VB. Capacity to maintain treatment continuity.	No mechanism for managing ongoing care of substance use disorder needs when mental health treatment program is completed.	No formal protocol to manage substance use disorder 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 substance use disorder 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 substance use disorder needs indefinitely, but variable documentation that this is routinely practiced, typically within the same program or agency.	Formal protocol to manage substance use disorder needs indefinitely and consistent documentation that this is routinely practiced, typically within the same program or agency.
VC. Focus on ongoing recovery issues for both disorders.	Not observed.	Individual clinician determined.	Routine focus is on recovery from mental health disorders, addiction viewed as potential relapse issue only.		Routine focus on addiction recovery and mental health management and recovery, both seen as primary and ongoing.
VD. Specialized interventions to facilitate use of community-based peer support groups during discharge planning.	No interventions made to facilitate use of either addiction or mental health peer support groups upon discharge.	Used variably or infrequently by individual clinicians for individual patients, mostly for facilitation to mental health peer support groups upon discharge.	Generic, but no specific or intentional facilitation based on substance use disorders. More routine facilitation to mental health peer support groups (e.g., NAMI, Procovery) upon discharge.	Assertive linkages and interventions variably made targeting specific co-occurring needs to facilitate use of mental health peer support groups or groups specific to both disorders (e.g., DRA, DTR) upon discharge.	Assertive linkages and interventions routinely made targeting specific co-occurring needs to facilitate use of mental health peer support groups or groups specific to both disorders (e.g., DRA, DTR) upon discharge.
VE. Sufficient supply and compliance plan for medications for substance use disorders (see IVE) are documented.	No medications in plan.	Variable or undocumented availability of 30-day or supply to next appointment off site.	Routine 30-day or supply to next appointment off site. Prescription and confirmed appointment documented.	Maintains medication management in program/agency until admission to next level of care at different provider (e.g., 45-90 days). Prescription and confirmed admission documented.	Maintains medication management in program with provider.

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VI. Staffing					
VIA. Psychiatrist or other physician or prescriber of medications for substance use disorders.	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 substance abuse licensure, certification, competency, or substantive experience.	Program has no staff who are licensed/certified as substance abuse professionals or have substantial experience sufficient to establish competence in addiction treatment.	1-24% of clinical staff are licensed/ certified substance abuse professionals or have substantial experience sufficient to establish competence in addiction treatment.	25-33% of clinical staff are licensed/ certified substance abuse professionals or have substantial experience sufficient to establish competence in addiction treatment.	34-49% of clinical staff are licensed/ certified substance abuse professionals or have substantial experience sufficient to establish competence in addiction treatment.	50% or more of clinical staff are licensed/ certified substance abuse professionals or have substantial experience sufficient to establish competence in addiction treatment.
VIC. Access to addiction clinical supervision or consultation.	No access.	Consultant or contractor off site, variably provided.	Provided as needed or variably on site by consultant, contractor or staff member.	Routinely provided on site by staff member.	Routinely provided on site by staff member and focuses on in-depth learning.
VID. Case review, staffing or utilization review procedures emphasize and support co-occurring disorder treatment.	Not conducted.	Variable, by off-site consultant, undocumented.	Documented, on site, and as needed coverage of co-occurring issues.	Documented, routine, but not systematic coverage of co-occurring issues.	Documented, routine and systematic coverage of co-occurring issues.
VIE. Peer/Alumni supports are available with co-occurring disorders.	Not available.	Available, with co-occurring disorders, but as part of the community. Variably referred by individual clinicians.	Available, with co-occurring disorders, but as part of the community. Routine referrals made through clinician relationships or more formal connections such as peer support service groups (e.g., AA Hospital and Institutional committees or NAMI).	Available on site, with co-occurring disorders, either as paid staff, volunteers, or program alumni. Variable referrals made.	Available on site, with co-occurring disorders, either as paid staff, volunteers, or program alumni. Routine referrals made.

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	1 – MHOS	2	3 – DDC	4	5 – DDE
VII. Training					
VIIA. All staff members have basic training in attitudes, prevalence, common signs and symptoms, detection and triage for co-occurring disorders.	No staff have basic training (0% trained).	Variably trained, no systematic agency training plan or individual staff member election (1-24% of staff trained).	Certain staff trained, encouraged by management and with systematic training plan (25-50% of staff trained).	Many staff trained and monitored by agency strategic training plan (51-79% of staff trained).	Most staff trained and periodically monitored by agency strategic training plan (80% or more of staff trained).
VIIB. Clinical staff members have advanced specialized training in integrated psychosocial or pharmacological treatment of persons with co-occurring disorders.	No clinical staff have advanced training (0% trained).	Variably trained, no systematic agency training plan or individual staff member election (1-24% of clinical staff trained).	Certain staff trained, encouraged by management and with systematic training plan (25-50% of clinical staff trained).	Many staff trained and monitored by agency strategic training plan (51-79% of clinical staff trained).	Most staff trained and periodically monitored by agency strategic training plan (80% or more of clinical staff trained).

Site Visit Notes

DDCMHT — 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*** ________

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*** ________

DDCMHT Index Program Category: Scale Method

OVERALL SCORE
(Sum of Scale Scores/7)

DUAL DIAGNOSIS CAPABILITY:

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

DDCMHT Index Program Category: Criterion Method

% CRITERIA MET FOR MHOS
(# of “1” or > /35) ____ 100%

% CRITERIA MET FOR DDC
(# of “3” or > scores/35) ________

% CRITERIA MET FOR DDE
(# of “5” scores/35) ________

HIGHEST LEVEL OF DD CAPABILITY
(80% or more) ________