DDCAT Index

Dual Diagnosis Capability in Addiction Treatment

The Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index is a quantitative measure used to assess addiction treatment program capacity for persons with co-occurring mental health and substance use disorders.

The DDCAT consists of 35 benchmark items across seven dimensions. These dimensions are: 1) Program Structure (i.e., organizational aspects such as mission, license or certifications, and financing); 2) Program Milieu (i.e., physical and social environment of an organization); 3) Clinical Process: Assessment (i.e., screening and assessment protocols); 4) Clinical Process: Treatment (i.e., integrated care plan and procedures); 5) Continuity of Care (i.e., treatment coordination, ongoing management and follow-ups); 6) Staffing (i.e., staff expertise and workflow for providing integrated behavioral health services); and 7) Training (i.e., basic and specialized training in behavioral health). Each item is rated on a scale from 1 (Addiction Only Services - AOS) to 3 (Dual Diagnosis Capable - DDC) to 5 (Dual Diagnosis Enhanced – DDE).

Data are collected during site visits to addiction treatment programs. DDCAT ratings are based on interviews with key informants, rapid ethnographic observations, and document review. Scores are then calculated for each item and dimension. An overall DDCAT score (mean of dimension scores) is also derived.

DATE: _____/_____/_____

TIME SPENT (HOURS): _____

RATER(S): _____

AGENCY NAME: _____

PROGRAM NAME: _____

CONTACT PERSON: _____

TITLE: _____

TELEPHONE: _____

FAX: _____

EMAIL: _____

ADDRESS: _____

_____

STATE: _____

ZIP CODE: _____

REGION (RUCA CODE): _____

PROGRAM ID (10 DIGIT CODE): _____

TIME PERIOD (SELECT ONE): T1_____ T2_____ T3_____ T4_____

Please enter Y, N, or NA for all categories below— except for the category 'Size of Program' in which you will put a numerical value.

1. **Payments Received (program)**

   _____ Self-Pay

   _____ Private Health Insurance

   _____ Medicaid

   _____ Medicare

   _____ State Financed Insurance

   _____ Military Insurance

   Other Funding Sources**:**

   _____ Other Public Funds

   _____ Other Funds

2. **Size of Program** (_numeric answers_)

   _____ # of Admissions in the Last Fiscal Year

   _____ Capacity (Highest # Serviceable)

   _____ Average Length of Stay (in Days)

   _____ Planned Length of Stay (in Days)

   _____ # of Unduplicated Clients/Year

3. **Primary Focus of Agency**

   _____ Addiction Treatment Services

   _____ Addiction (MH) Services

   _____ Mix of Addiction & MH Services

   _____ General Health Services

   _____ Hospital

4. **Agency Type**

   _____ Private

   _____ Public

   _____ Non-Profit

   _____ Government Operated

   _____ Veterans' Health Administration

5. **Level of Care**

   ASAM-PCC-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

6. **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

	1. PROGRAM STRUCTURE				
	1 Addiction Only Services (AOS)	2	3 Dual Diagnosis Capable (DDC)	4	5 Dual Diagnosis Enhanced (DDE)
1A. 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.
1B. 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 addiction treatment or treating co-occurring disorders within the context of addiction treatment.		Is certified and/or licensed to provide both.
1C. Coordination and collaboration with mental health services.	No document of formal coordination or collaboration. Meets the SAMHSA definition of minimal Coordination.	Vague, undocumented, or informal relationship with mental health agency, or consulting with a staff member from that agency. Meets the SAMHSA definition of Consultation.	Formalized and documented coordination or collaboration with mental health agency. Meets the SAMHSA definition of Collaboration.	Formalized coordination and collaboration, and the availability of case management staff, or staff exchange programs (variably used). Meets the SAMHSA definition of Collaboration and has some informal components consistent with Integration.	Most services are integrated within the existing program, or routine use of case management staff or staff exchange program. Meets the SAMHSA definition of Integration
1D. Financial incentives.	Can only bill for addiction treatments or bill for persons with addiction disorders.	Could bill for either service type if substance use disorder is primary, but staff report there to be barriers. –OR– Partial reimbursement for mental health services available.	Can bill for either service type, however, a substance use disorder must be primary.		Can bill for addiction or mental health treatments, or their combination and/or integration.

2. PROGRAM MILIEU

	1 Addiction Only Services (AOS)	2	3 Dual Diagnosis Capable (DDC)	4	5 Dual Diagnosis Enhanced (DDE)
2A. Routine expectation of and welcome to treatment for both disorders.	Program expects substance use disorders only, refers or deflects persons with mental health disorders or symptoms.	Documented to expect substance use disorders only (e.g., admission criteria, target population), but has informal procedure to allow some persons with mental health disorders to be admitted.	Focus is on substance use disorders, but accepts mental health disorders by routine and if mild and relatively stable as reflected in program documentation.	Program formally defined like DDC but clinicians and program informally expect and treat co-occurring disorders regardless of severity, not well documented.	Clinicians and program expect and treat co-occurring disorders regardless of severity, well documented.
2B. Display and distribution of literature and patient educational materials.	Addiction or peer support (e.g., AA) only.	Available for both disorders but not routinely offered or formally available.	Routinely available for both mental health and substance use disorders in waiting areas, patient orientation materials and family visits, but distribution is less for mental health disorders.	Routinely available for both mental health and substance use disorders with equivalent distribution.	Routinely and equivalently available for both disorders and for the interaction between mental health and substance use disorders.

3. CLINICAL PROCESS: ASSESSMENT

	1 Addiction Only Services (AOS)	2	3 Dual Diagnosis Capable (DDC)	4	5 Dual Diagnosis Enhanced (DDE)
3A. Routine screening methods for mental health symptoms.	Pre-admission screening based on patient self-report. Decision based on clinician inference from patient presentation or history.	Pre-admission screening for symptom and treatment history, current medications, suicide/homicide history prior to admission.	Routine set of standard interview questions for mental health using generic framework (e.g., ASAM-PPC (Dimension III) or "Biopsychosocial" data collection.	Screen for mental health symptoms using standardized or formal instruments with established psychometric properties.	Screen using standardized or formal instruments for both mental health and substance use disorders with established psychometric properties.
3B. Routine Assessment if screen positive for mental health symptoms.	Assessment for mental health disorders is not recorded in records.	Assessment for mental health disorders occurs for some patients, but is not routine or is variable by clinician.	Assessment for mental health disorders is present, formal, standardized, and documented in 50- 69% of the records.	Assessment for mental health disorders is present, formal, standardized, and documented in 70-89% of the records.	Assessment for mental health disorders is formal, standardized, and integrated with assessment for substance use symptoms, and documented in at least 90% of the records.

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			3. CLINICAL PROCESS: ASSESSMENT, CONT.		
3C. Mental health and substance use diagnoses made and documented.	Mental health diagnoses are neither made nor recorded in records.	Mental health diagnostic impressions or past treatment records are present in records, but the program does not have a routine process for making and documenting mental health diagnoses.	The program has a mechanism for providing diagnostic services in a timely manner. Mental health diagnoses are documented in 50-69% of the records.	The program has a mechanism for providing routine, timely diagnostic services. Mental health diagnoses are documented in 70-89% of the records.	Comprehensive diagnostic services are provided in a timely manner. Mental health diagnoses are documented in at least 90% of the records.
3D. Mental health and substance use history reflected in medical record.	Collection of substance use disorder history only.	Standard form collects substance use disorder history only. Mental health history collected inconsistently.	Routine documentation of both mental health and substance use disorder history in record in narrative section.	Specific section in record dedicated to history and chronology of both disorders.	Specific section in record devoted to history and chronology of both disorders and the interaction between them is examined temporally.
3E. Program acceptance based on mental health symptom acuity: low, moderate, high.	Admits persons with no to low acuity.		Admits persons in program with low to moderate acuity, but who are primarily stable.		Admits persons in program with moderate to high acuity, including those unstable in their mental health disorder.
3F. Program acceptance based on severity and persistence of mental health disability: low, moderate, high.	Admits persons in program with no to low severity and persistence of mental health disability.		Admits persons in program with low to moderate severity and persistence of mental health disability.		Admits persons in program with moderate to high severity and persistence of mental health disability.
3G. Stage-wise assessment.	Not assessed or documented.	Assessed and documented variably by individual clinician.	Clinician assessed and routinely documented, focused on substance use motivation.	Formal measure used and routinely documented but focusing on substance use motivation only.	Formal measure used and routinely documented, focus on both substance use and mental health motivation.

4. CLINICAL PROCESS: TREAMENT					
	1 Addiction Only Services (AOS)	2	3 Dual Diagnosis Capable (DDC)	4	5 Dual Diagnosis Enhanced (DDE)
4A. Treatment plans.	Address addiction only (mental health not listed).	Variable by individual clinician, i.e., plans vaguely or only sometimes address co-occurring mental health disorders.	Plans routinely address both disorders although substance use disorders addressed as primary, mental health as secondary with generic interventions.	Plans routinely address substance use and mental health disorders; equivalent focus on both disorders; some individualized detail is variably observed.	Plans routinely address both disorders equivalently and in specific detail; interventions in addition to medication are used to address mental health disorders.
4B. Assess and monitor interactive courses of both disorders.	No documentation of progress with mental health disorders.	Variable reports of progress on mental health disorder by individual clinicians.	Routine clinical focus in narrative (treatment plan review or progress note) on mental health disorder change; description tends to be generic.	Treatment monitoring and documentation reflecting equivalent in-depth focus on both disorders is available but variably used.	Treatment monitoring and documentation routinely reflects clear, detailed, and systematic focus on change in both substance use and mental health disorders.
4C. Procedures for mental health emergencies and crisis management.	No guidelines conveyed in any manner.	Verbally conveyed in-house guidelines.	Documented guidelines: Referral or collaborations (to local mental health agency or emergency department).	Variable use of documented guidelines, formal risk assessment tools, and advance directives for mental health crisis and substance use relapse.	Routine capability, or a process to ascertain risk with ongoing use of substances and/or severity of mental health symptoms; maintain in program unless commitment is warranted.
4D. 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 substance use stage or motivation only.	Stage of change or motivation routinely incorporated into individualized plan; formally prescribed and delivered stage-wise treatments for both substance use and mental health disorders.

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

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4. CLINICAL PROCESS: TREAMENT, CONT.					
4I. Specialized interventions to facilitate use of peer support groups in planning or during treatment.	No interventions used to facilitate use of either addiction or mental health peer support.	Used variably or infrequently by individual clinicians for individual patients, mostly for facilitation to addiction peer support groups.	Generic format on site, but no specific or intentional facilitation based on mental health disorders. More routine facilitation to addiction peer support groups (e.g., AA, NA).	Variable facilitation targeting specific co-occurring needs, intended to engage patients in addiction peer support groups or groups specific to both disorders (e.g., DRA, DTR).	Routine facilitation targeting specific co-occurring needs, intended to engage patients in addiction peer support groups or groups specific to both disorders (e.g., DRA, DTR).
4J. 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.
5. CONTINUITY OF CARE					
5A. Co-occurring disorders addressed in discharge planning process.	Not addressed.	Variably addressed by individual clinicians.	Co-occurring disorders systematically addressed as secondary in planning process for off-site referral.	Some capacity (less than 80% of the time) to plan for integrated follow-up, i.e., equivalently address both substance use and mental health disorders as a priority.	Both disorders seen as primary, with confirmed plans for on-site follow-up, or documented arrangements for off-site follow-up; at least 80% of the time.
5B. Capacity to maintain treatment continuity.	No mechanism for managing ongoing care of mental health needs when addiction treatment program is completed.	No formal protocol to manage mental health needs once program is completed, but some individual clinicians may provide extended care until appropriate linkage takes place. Variable documentation.	No formal protocol to manage mental health needs once program is completed, but when indicated, most individual clinicians provide extended care until appropriate linkage takes place. Routine documentation.	Formal protocol to manage mental health needs indefinitely, but variable documentation that this is routinely practiced, typically within the same program or agency.	Formal protocol to manage mental health needs indefinitely and consistent documentation that this is routinely practiced, typically within the same program or agency.

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5. CONTINUITY OF CARE, CONT.					
5C. Focus on ongoing recovery issues for both disorders.	Not observed.	Individual clinician determined.	Routine focus is on recovery from addiction disorders, mental health symptoms viewed as potential relapse issue only.		Routine focus on addiction recovery and mental health management and recovery, both seen as primary and ongoing.
5D. Specialized interventions to facilitate use of community-based peer support groups during discharge planning.	No interventions made to facilitate use of either addiction or mental health peer support groups upon discharge.	Used variably or infrequently by individual clinicians for individual patients, mostly for facilitation to addiction peer support groups upon discharge.	Generic, but no specific or intentional facilitation based on mental health disorders. More routine facilitation to addiction peer support groups (e.g., AA, NA) upon discharge.	Assertive linkages and interventions variably made targeting specific co-occurring needs to facilitate use of addiction peer support groups or groups specific to both disorders (e.g., DRA, DTR) upon discharge.	Assertive linkages and interventions routinely made targeting specific co-occurring needs to facilitate use of addiction peer support groups or groups specific to both disorders (e.g., DRA, DTR) upon discharge.
5E. Sufficient supply and compliance plan for medications is documented.	No medications in plan.	Variable or undocumented availability of 30- day or supply to next appointment off-site.	Routine 30-day or supply to next appointment off-site. Prescription and confirmed appointment documented.	Maintains medication management in program/agency until admission to next level of care at different provider (e.g., 45-90 days). Prescription and confirmed admission documented.	Maintains medication management in program with provider.

6. STAFFING					
	1 Addiction Only Services (AOS)	2	3 Dual Diagnosis Capable (DDC)	4	5 Dual Diagnosis Enhanced (DDE)
6A. 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.
6B. On-site clinical staff members with mental health licensure (doctoral or masters level), or competency or substantive experience.	Program has no staff who are licensed as mental health professionals or have had substantial experience sufficient to establish competence in mental health treatment.	1-24% of clinical staff have either a license in a mental health profession or substantial experience sufficient to establish competence in mental health treatment.	25-33% of clinical staff have either a license in a mental health profession or substantial experience sufficient to establish competence in mental health treatment.	34-49% of clinical staff have either a license in a mental health profession or substantial experience sufficient to establish competence in mental health treatment.	50% or more of clinical staff have either a license in a mental health profession or substantial experience sufficient to establish competence in mental health treatment.
6C. Access to mental health clinical supervision or consultation.	No access.	Consultant or contractor off-site, variably provided.	Provided as needed or variably on site by consultant, contractor or staff member.	Routinely provided on site by staff member.	Routinely provided on site by staff member and focuses on in-depth learning.
6D. 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.
6E. 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.

	1 Addiction Only Services (AOS)	2	3 Dual Diagnosis Capable (DDC)	4	5 Dual Diagnosis Enhanced (DDE)
1. TRAINING					
7A. 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).
7B. 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).

SCORING SUMMARY >>

Program: _____

Type: _____

Reviewer(s): _____

Date of Review: _____/_____/_____

1. Program Structure

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

Sum Total= _____
Total/4= _____

2. Program Milieu

A. _____
B. _____

Sum Total= _____
Total/2= _____

3. Clinical Process: Assessment

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

Sum Total= _____
Total/7= _____

4. Clinical Process: Treatment

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

Sum Total= _____
Total/10= _____

5. Continuity of Care

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

Sum Total= _____
Total/5= _____

6. Staffing

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

Sum Total= _____
Total/5= _____

7. Training

A. _____
B. _____

Sum Total= _____
Total/2 = _____

DDCAT INDEX PROGRAM CATEGORY	
% Criteria Met for AOS (# of "1" or >/35):	_____
% Criteria Met for DDC (# of "3" or >/35):	_____
% Criteria Met for DDE (# of "5" or >/35):	_____
Highest Level of DD Capability (80% or more):	_____

DUAL DIAGNOSIS CAPABILITY		
Overall Score:	_____	*Sum of Scale Scores/7*
AOS:	_____	*(1 – 1.99)*
AOS/DDC	_____	*(2 – 2.99)*
DDC	_____	*(3 – 3.49)*
DDC/DDE	_____	*(3.5 – 4.49)*
DDE	_____	*(4.5- 5.0)*

Additional Site Visit Notes:

For more information on the DDCAT Index, please contact:

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