Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) Toolkit

Version 4.0

DDCMHT

Dual Diagnosis Capability in Mental Health Treatment Toolkit

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I. Introduction

Mental health 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 15 years, there has been an increased awareness of the common presentation of persons with co-occurring substance use disorders in routine mental health treatment settings, especially among patients with severe mental illness who are often the primary consumers of state-funded mental health treatment services. Research results suggest that sequential treatment (treating one disorder first, then the other) and purely parallel treatment (treatment for both disorders provided by separate clinicians or teams who do not coordinate services) are not as effective as integrated treatment (Drake, O'Neal, & Wallach, 2008). National and state initiatives related to co-occurring disorders have been significant, stimulating considerable interest in providing better services for people with these challenges. Although clearly interested in so improving existing services, mental health treatment providers have to some extent lacked pragmatic guidance on how to change. Specific evidence-based treatment practices have been developed, including Integrated Dual Disorders Treatment (IDDT; Mueser et al., 2003; SAMHSA, 2003). However, providers continue to identify the need for practical guidance and specific benchmarks with which to plan and develop services.

The Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) index was first developed in 2004. The DDCMHT is a parallel instrument to the Dual Diagnosis Capability in Addiction Treatment (DDCAT) index. Both indices are based on the American Society of Addiction Medicine's (ASAM) taxonomy of program dual diagnosis capability and have been subjected to a series of psychometric studies. The map below reflects the widespread implementation in various stages of the DDCAT, DDCMHT, and another parallel instrument, the Dual Diagnosis Capability in Health Care Settings (DDCHCS). The DDCMHT, described more fully below, guides programs and system authorities in assessing and developing the dual diagnosis capacity of mental health treatment services (McGovern, Matzkin, & Giard, 2007).

States Utilizing the Dual Diagnosis Capability Assessment Measures (April 2011)

Legend:
- States using DDCAT/DDCMHT/DDCHCS in 2011 (32 states, District of Columbia, and Navajo Nation)
- States
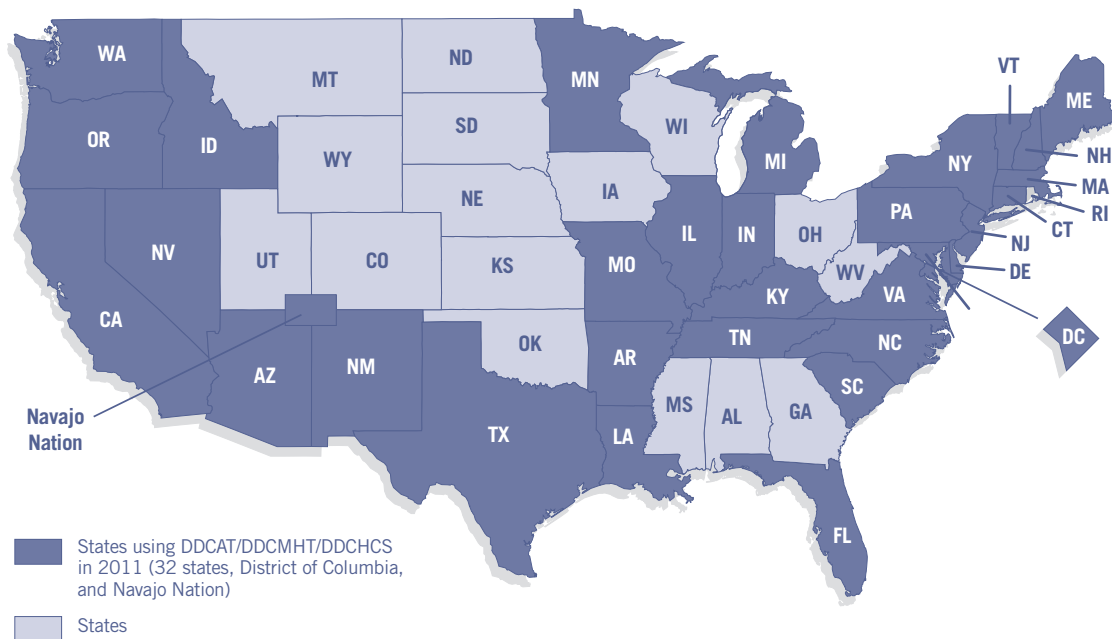
This toolkit emerges from these efforts. It is a response to numerous requests by community treatment providers for more specific guidance on how to enhance services based upon their current status. For programs that the DDCMHT determines to offer services at Mental Health Only Services (MHOS) level, this toolkit provides 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 addresses those requests as well.

The motivation among mental health treatment providers to improve the quality of care offered to their patients is impressive if not inspirational. This toolkit was developed in direct response to mental health treatment programs at the "action" stage of readiness. The toolkit is designed to immediately offer practical tools and useable materials that will rapidly improve services to those programs with co-occurring disorders entrusted to their care.

A. Introduction to Co-occurring Disorders and Integrated Services

1. Literature Support and Report to Congress

Co-occurring mental health and substance use disorders are prevalent and difficult to treat. Although rates vary by disorder combinations and somewhat by study, epidemiological studies have shown that a significant portion of the population experiences co-occurring disorders (Grant et al., 2004; Kessler et al., 1994, 1997; Regier et al., 1990). Moreover, the prevalence of co-occurring disorders is even higher in populations of individuals seeking mental health or substance abuse treatment (Grant et al., 2004; McGovern et al., 2006; Watkins et al., 2004). Furthermore, individuals with co-occurring mental health and substance use disorders have poorer outcomes, including higher rates of relapse, suicide, homelessness, incarceration, hospitalization, and lower quality of life (Compton et al., 2003; Wright, Gournay, Glorney, & Thornicroft, 2000; Xie, McHugo, Helmstetter, & Drake, 2005). Compounding the problem has been that, traditionally, mental health and addiction treatment have been separate systems with separate practitioners and little crossover. Treatment was provided sequentially for the two types of disorders, and individuals were often told that they must deal with one disorder prior to entering treatment for the other. Care was not coordinated.

During the past 15 years, increasing attention has been given to the problem of co-occurring substance use and mental health disorders. In 2002 an important milestone in changing treatment for individuals with co-occurring disorders occurred with the release of the Substance Abuse and Mental Health Services Administration's *Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders*. Not only did the report highlight the significant portion of individuals in the United States with co-occurring disorders and the poor treatment outcomes for these individuals, the report also discussed the lack of effective care available at the time. The report noted an increasing research base suggesting that coordinated and integrated care was effective, and that evidence-based treatment practices were being developed. Treatment research from both the mental health and substance abuse fields has shown that treatments aimed at addressing both disorders simultaneously are generally more effective than dealing with one disorder at a time (Drake et al., 2001; Mangrum, Spence, & Lopez, 2006; SAMHSA, 2002).

The *Report to Congress* was also a call for treatment programs to develop increased capability to serve clients with co-occurring disorders, including increasing access to treatment and initial screening/assessment, stating "any door is the right door" (SAMHSA, 2002). Although not all mental health treatment programs need to have fully integrated services for co-occurring disorders, as suggested by the report, all programs may be expected to have some level of capability to address co-occurring disorders.

To classify the dual diagnosis capability of addiction treatment programs, the American Society of Addiction Medicine (ASAM) developed a taxonomy (ASAM Patient Placement Criteria 2nd Revision [ASAM-PPC-2R]; Mee-Lee et al., 2001). The taxonomy includes three categories of capability: Addiction Only Services (AOS), Dual Diagnosis Capable (DDC), and Dual Diagnosis Enhanced (DDE).

The taxonomy is also applicable to mental health treatment programs. Generally, Mental Health Only Services (MHOS) programs do not accommodate individuals with substance use disorders. DDC programs accommodate individuals with substance use disorders that are relatively stable, and the programs address co-occurring disorders to some extent in policies, procedures, assessment, and programming. DDE programs accommodate individuals with acute and unstable substance use disorders. The ASAM taxonomy provides a useful classification for capability, but it needed a benchmark or fidelity measure to place mental health treatment programs within it.

2. Fidelity and Patient Outcomes

It was assumed that if shown new evidence about treatments that improve patient outcomes, treatment providers would rapidly implement such therapies. In reality, it is less than a straightforward process to use new information to shift routine practice and treatment services. The new field of implementation science focuses on the challenges of implementing evidence-based or expert consensus-based treatments. One component that supports implementation success is the observation by those who implement new treatments that their patients' outcomes are improved. Ironically, most implementation efforts do not include patient outcome tracking, meaning treatment providers do not see that the new treatment or services really do work better.

Another aspect of implementation pertains to fidelity or the adherence to the new practice guidelines or techniques. Simply saying that the new practice is being implemented is not adequate, so systematic observations of the implementation are often used to evaluate whether the practice is being implemented as designed. The research upon which the evidence for any practice has been established typically includes quality monitoring (i.e., integrity of the practice is verified). Therefore, the assumption is that to maximize the outcomes found in the research, real world providers should deliver the new therapy with fidelity.

In medical care, it has been demonstrated that if a new technique is not implemented with fidelity, the expected gain in improved patient outcomes is non-existent (Woolf and Johnson, 2005). This also seems to be the case with behavioral treatments (Durlak and DuPre, 2008).

In reality, some adaptations will likely be needed to assimilate a new service or practice approach into any particular setting, culture, patient population, and provider group. Nonetheless, fidelity to the original model is important. This finding has been established across a variety of interventions, including medical procedures, psychotherapy, addiction treatments, and behavioral therapies (McHugo et al., 1999; Schoenwald, Sheidow, & Letourneau, 2004).

3. Benchmark Measures

Several benchmark instruments have been developed to assess co-occurring capability or fidelity to specific co-occurring disorders treatments in mental health treatment programs. The Integrated Dual Disorders Treatment (IDDT) Fidelity Scale assesses fidelity to a specific evidence-based practice (Mueser et al., 2003; SAMHSA, 2003). This scale is clearly the gold standard for assessing fidelity to IDDT. Several more general agency self-assessment tools have been developed by Minkoff and Cline (2004) and Timko, Dixon, and Moos (2005). Research has shown significant over-reporting of capability with self-assessments (Adams, Soumerai, Lomas, & Ross-Degnan, 1999). For example, McGovern et al. (2006) found that when asked to categorize their addiction treatment programs using the ASAM taxonomy (Mee-Lee et al., 2001), program directors and clinical staff showed less than 50 percent agreement, with program managers rating their programs at a higher level of capability. Similarly, Lee and Cameron (2009) found that programs over-rated their co-occurring disorders capability compared to presumably more objective external raters.

The DDCMHT was developed as an objectively rated instrument for measuring co-occurring disorders capability within mental health treatment programs. It is broad, going beyond specific evidence-based practices such as the IDDT. The DDCMHT is also focused, examining specific co-occurring disorders-related services than scales used by Timko and others.

4. Terminology and Acronyms

Co-occurring disorders is used to denote the status of having a substance use disorder and a psychiatric/mental health disorder.

Dual diagnosis (DD) refers to the same status defined by co-occurring disorders. Dual diagnosis is used in this manual to retain the language initially established by ASAM and the DDCAT Index.

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

Mental health disorders or psychiatric disorders are used to refer to major psychiatric disorders besides the substance use disorders. Generally, this term refers to the mood disorders, anxiety disorders, thought disorders, adjustment disorders, and other disorders that are not related to or induced by substances.

Addiction Only Services (AOS) is an ASAM-PPC-2R category referring to addiction treatment programs that do not accommodate individuals with mental health disorders.

Mental Health Only Services (MHOS) is a category referring to mental health treatment programs that do not accommodate individuals with substance use disorders (parallel to the ASAM-PPC-2R AOS category).

Dual Diagnosis Capable (DDC) is a category referring to mental health treatment programs that accommodate individuals with substance use disorders that are relatively stable. These programs address co-occurring disorders to some extent in policies, procedures, assessment, and programming (parallel to the ASAM-PPC-2R DDC category).

Dual Diagnosis Enhanced (DDE) is a category referring to mental health treatment programs that accommodate individuals with acute and unstable substance use disorders (parallel to the ASAM-PPC-2R DDE category).

B. Description of the Index

The Dual Diagnosis Capability in Mental Health Treatment Index—referred to as the DDCMHT—is a benchmark instrument for assessing mental health treatment program capacity for persons with co-occurring mental health and substance use disorders (see the appendix for a copy of the instrument). The DDCMHT is a parallel instrument to the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index.

The DDCMHT has been in development since 2004, and it is based upon a fidelity assessment methodology. 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 the implementation of Integrated Dual Disorder Treatment (IDDT) by mental health programs. IDDT is an evidence-based practice for persons with co-occurring disorders in mental health settings who suffer from severe and persistent mental illnesses (Mueser et al., 2003). The DDCMHT uses a methodology similar to the IDDT Fidelity Scale, but has been specifically developed to be broader in scope than the specific core components of that scale. Accordingly, the DDCMHT is intended to assess co-occurring capability at any mental health program or service setting, not just a specific

treatment team that may be implementing IDDT. The DDCMHT is also appropriate for mental health settings that do not treat a severely mentally ill population (e.g., mood, anxiety, PTSD, Axis II disorders) and those that are based in settings other than outpatient (e.g., hospital, residential, partial hospital).

The DDCMHT evaluates 35 program elements that are subdivided into seven dimensions.

- The first dimension is **Program Structure**. This dimension focuses on general organizational factors that foster or inhibit the development of co-occurring disorders treatment.

- **Program Milieu** is the second dimension, and it focuses on the culture of the program and whether the staff and physical environment are receptive and welcoming to persons with co-occurring disorders.

- The third and fourth dimensions are referred to as the **Clinical Process** dimensions (**Assessment and Treatment**). These examine whether specific clinical activities achieve specific benchmarks for co-occurring disorders 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 co-occurring disorders.

- The sixth dimension is **Staffing**, which examines staffing patterns and operations that support co-occurring disorders 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 co-occurring disorders.

The DDCMHT 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 mental health treatment services for persons with co-occurring disorders: MHOS, DDC, or DDE.

C. Development and Psychometric Studies

Development of the DDCMHT began in 2004, as part of the Missouri Co-occurring State Incentive Grant (COSIG) project. First, DDCAT items were adapted into mental health terms. For example, a DDCAT item assessing whether a site screened for mental health symptoms was reworded on the DDCMHT to assess screening for substance use disorder symptoms. Next, the items were further refined to fit mental health treatment settings. The DDCMHT was used in the Missouri and Louisiana COSIG projects. DDCMHT items and scoring anchors were further revised in 2008 and in 2011.

Several reliability and validity studies have been conducted on the DDCMHT. Subscale reliability tests based on 67 baseline DDCMHT assessments conducted in six states show moderate to high reliability across the seven DDCMHT dimensions, ranging from Cronbach's $\alpha = .53$ for Training (2 items) to $\alpha = .85$ for Clinical Process: Treatment (10 items) (Gotham, Brown, Comaty, McGovern, & Claus, 2011).

Brown and Comaty (2007) conducted an extensive inter-rater reliability study. Across three raters at 18 mental health treatment programs, they found a high level of agreement, ICC (2, 1) = .829 (95% confidence interval .802-.853), N = 527 expected observations. The DDCMHT's construct validity has been shown in comparison to the IDDT Fidelity Scale (Gotham, Brown, Comaty, McGovern, & Claus, 2011). Across 22 mental health treatment programs the correlation between the DDCMHT total score and the IDDT fidelity scale total score was moderate, r = .70. Correlations between the IDDT total score and the DDCMHT dimension scores ranged from a low of r = .37 (Continuity of Care) to a high of r = .76 (Clinical Process: Treatment).

Other studies have also found effective program improvement efforts, as measured by the DDCMHT, moderately predict baseline program organizational factors as assessed by the Organizational Readiness for Change scales (Gotham, Brown, Comaty, & McGovern, 2008) and leadership styles (Claus, Gotham, Harper-Chang, Selig, & Homer, 2007; Claus, 2008). These findings underscore the importance of:

- gathering information about the implementation or change strategies used when conducting a repeated measures study using the DDCMHT, and

- obtaining information about more generic organizational factors as potential correlates of baseline capacity or moderators of change over time.

D. Toolkit Organization

This toolkit is intrinsic to administering and scoring the DDCMHT. Accordingly, toolkit suggestions are embedded within the context of each item's scoring. Each of the seven dimensions of the DDCMHT is described, and then each item is listed and the scoring procedure articulated.

Each item includes a section titled "Item Response Coding," which provides descriptive anchors to assist scoring the scale item using the DDCMHT rankings of 1-MHOS, 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. Ratings of a 2 or 4 generally reflect observations on a specific benchmark that could not be accurately scored as a 3 or 5 respectively. A section titled "Source" lists sources of the data to be considered in determining the score.

Corresponding to each item, the toolkit offers specific enhancement suggestions for MHOS and DDC programs. Many of the suggestions throughout the toolkit are examples from actual treatment providers. Each of these enhancement suggestions is rated in terms of its estimated potential costs. A complete listing of the no and low cost suggestions is available below, as an appendix. Sample instruments, forms, and other resources that are mentioned in the discussions of each item are also available in the appendix section.

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II. Applications

The widespread use of the DDCAT and DDCMHT measures speaks to their appeal to the behavioral health community. The measures are pragmatic and relatively easy to use. A range of constituencies find the measures useful, and a variety of implementations have occurred by system and regulatory agencies as well as treatment providers.

The sections below summarize examples of how the DDCMHT has been used to assess and guide quality improvement in program co-occurring capacity. In addition, applications for health services research are described. The objective ratings and categorization of programs using the DDCMHT can assist clients and families in making informed choices about treatment.

A. System and Regulatory Agencies

As of 2010, over 30 state regulatory authorities, tribal health entities, several large county governments, private treatment programs, and several nations are in various stages of implementation using the DDCAT and DDCMHT indices. Systems seek to obtain objective information about dual diagnosis capacity among the providers with whom they contract for services. In the absence of objective measures, the regulatory agency has only provider self-report or anecdote upon which to base their appraisal. Research has consistently shown that provider self-assessment of dual diagnosis capability is of dubious validity, and often inflated (McGovern, Xie, et al., 2007; Lee & Cameron, 2009). For this reason, a standardized yardstick, such as the DDCMHT or DDCAT, enables the state or county authority to obtain an accurate and multi-dimensional picture of services within a jurisdiction. System agencies have found multiple uses for this information:

1) Developing a map of types of treatment agencies based upon dual diagnosis capability;

2) Examining variation in funded services by region, level of care, or type of agency;

3) Using the data to plan and implement standards for differential funding;

4) Using the data to plan and offer targeted training and technical assistance;

5) Assessing baseline capacity and then repeating assessments to measure the effectiveness of quality improvement efforts;

6) Featuring the information in grant applications to federal agencies;

7) Using the data to present to legislators; and

8) Linking the DDCMHT and DDCMHT indicators to patient level outcomes.

B. Treatment Providers

The experience of treatment providers who have been assessed with the DDCMHT is near universally positive. Concrete and practical guidance about policy, practice, and workforce development in the arena of co-occurring disorders has been lacking. For at least the past decade, treatment providers have been well aware of federal recommendations, such as SAMHSA's *Report to Congress*, the President's New Freedom Commission, and SAMHSA's *Treatment Improvement Protocol 42*. Community treatment providers have also been highly motivated to address the issue and improve services for persons with co-occurring disorders already under their care. What have been missing are the concrete guidelines and benchmarks with which to do so.

Treatment providers have used the DDCMHT to assess their status on co-occurring capacity relative to established benchmarks on policy, practice, and workforce. Using this guide, many providers have identified specific target scores on benchmarks they wished to achieve, and then made quality improvements in the intended direction. More generally, providers often want to operate at a certain level of overall capacity, such as DDC or DDE. Providers utilize information from the DDCAT and DDCMHT to achieve concrete change to score at these levels. In some instances, having a DDE level program has been associated with increased reimbursement rates, whereas in the private sector, operating an objectively verified DDE program is used to negotiate with private payers and for marketing purposes.

Another application for treatment providers is the use of the measures to articulate specific training needs for programs and clinical staff members. Rather than a more global or vague approach to agency endorsed or funded training, specific clinical goals (e.g., facilitating a co-occurring disorders stage-wise group session) can lead to training exposure that staff members need. In fact, DDCAT and DDCMHT items pertain to the recommended basic co-occurring training for all staff

(item VIIA) and specialized training for clinical staff (VIIB). These benchmarks sharpen the focus and create clarity for professional development plans.

Specifics on Implementing Change

The two sections above discuss how the DDCMHT and DDCAT may be used by system or regulatory agencies and treatment providers. In both instances those applications involve making changes at the system, agency, or program levels. The developing field of implementation science can contribute to the use of the DDCMHT. While a complete review of implementation science findings are beyond the scope of this toolkit, some general recommendations can be made.

Many programs and systems have obtained initial DDCMHT assessments. Using these data as a "baseline" measure of co-occurring capability, the programs go on to develop co-occurring implementation 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. Programs have used the DDCMHT dimensions or domains at baseline to organize the list of goals, and then used the specific items in the DDCMHT to define specific objectives. Interventions and the specific targets of change can be extracted directly from this toolkit. Thus the DDCMHT can provide an addiction treatment program with a practical blueprint and tools to achieve increased capacity for co-occurring disorders. Since the measure can be re-administered, it can also be used to measure the success (or sustainability) of these changes.

In addition to a written implementation plan, other components of a change process that programs often find helpful include:

1. Identify a program "champion" or change agent;
2. Develop a steering committee;
3. Obtain training and technical assistance;

4. Ensure that clinical supervisors in the program are competent in the new skills being expected of clinicians/counselors and lead routine clinical supervision sessions (individual and group) to practice the new skills with staff;

5. Connect with other programs that have or are currently implementing the same kinds of changes, either individually or through a learning collaborative;

6. Track certain data elements that inform whether the service changes are happening and if they are improving patient outcomes; and

7. Conduct ongoing DDCMHT assessments every 3 to 6 months during the first year of implementation, with annual reviews thereafter.

This change process, including a written implementation plan, is meant to be used in an ongoing iterative process; as initial goals and tasks are achieved, other goals and tasks can be added to the plan. For more information on implementation science, please see the reference section.

C. Health Services Researchers

The availability of a program level measure of co-occurring capability has a variety of implications for organizational and clinical research. Descriptive research studies are now possible, such as in assessing variation in co-occurring capability across a specific region, or in comparing capacity in urban and rural areas, mental health and addiction treatment programs, or hospital programs and free-standing clinics. Researchers are often interested in categorizing the characteristics or types of organizations within which multi-site clinical trials take place. This enables the researchers to either understand the potential study confounds due to site differences or to a priori use sites that have similar levels of co-occurring capacity to minimize this influence.

Researchers also are interested in the effectiveness of quality improvement or process improvement strategies. Such strategies may range from training in specific evidence-based practices, increased funding for certain services, Network for Improvement of Addiction Treatment (NIATx) approaches, or Plan-Do-Study-Act cycles. Using the DDCMHT as a pre-post implementation measure identifies changes in co-occurring capability over time.

A burning question remains for health services researchers: What is the relationship between program level measures of capability, such as the DDCMHT, and patient level outcomes, such as mental health symptom reduction, decreased substance use, medication compliance, or improved quality of life? Studies conducted under controlled conditions and of sufficient sample size are needed to address the question.

D. Families and Individuals Seeking Services

Classifying programs as MHOS, DDC, or DDE can help families and individuals seeking care for a co-occurring disorder. Since no current directory sorts programs by co-occurring capability, consumers may be misled by self-appraisals or marketing statements which lack independent validation. A regional, statewide, or national directory would enable consumers to make informed treatment decisions based on preferences. Many patients and families with co-occurring disorders have had negative treatment experiences, in part due to the fact that they did not receive adequate or integrated care. Being able to confidently identify a program providing DDC or DDE services based on objective standards established by the DDCAT and DDCMHT would support persons and families struggling with co-occurring disorders as they make a courageous step towards professional help.

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III. Methodology

A. Observational Approach and Data Sources

The DDCMHT uses observational methods to gather information about a program and rate its co-occurring capability. External raters make a site visit to a mental health treatment agency, collecting data about the program 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, medication prescribers, support personnel, and clients; and

3. Review of documentation, such as medical records, program policy and procedure manuals, brochures, daily patient schedules, telephone intake screening forms, and other materials that may seem relevant.

Information from these sources is used to rate the 35 DDCMHT Index items.

B. The Site Visit

The scheduling of the site visit is done in advance. 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. Since the DDCMHT is used to assess a program, rather than an entire agency, the raters pre-arrange what program or programs within the agency are to be assessed. Experience suggests that it may be possible to fully assess one program in approximately a half day. In a full day it may be possible to assess two to three programs within one agency, depending upon how closely their operations are related. It is important to allocate sufficient time to do the DDCMHT assessment. This process typically becomes more efficient as the assessor gains experience and when multiple assessors can share the site visit tasks.

The DDCMHT process begins with identifying the appropriate contact person, usually the agency director or a designee. In a preliminary conversation, raters can define the scope of the assessment and clarify the time allocation requirements. At this time it is 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—that is, to help the agency learn

about its services to persons with co-occurring disorders, and to suggest practical strategies to enhance services if warranted. This sets an expectation of collaboration rather than evaluation and judgment, which will help the assessor elicit more accurate information.

Scheduling should include both an initial meeting and an "exit" feedback meeting with the agency director, along with time for separate group interviews with the program clinical leaders and supervisors, select clinicians, and patient(s). Conducting separate interviews allows the assessor to identify different perspectives on the program's practices and procedures, and any discrepancies between what one group perceives and another experiences. 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.

This initial contact with the agency director is also a good opportunity to gather descriptive information about the program as listed on the DDCMHT rating scale cover sheet. While this information is not necessary to score the DDCMHT, it can be useful in tabulating or making comparisons of DDCMHT scores, such as across regions or states, or by level of care, size, funding source. The cover sheet offers the assessor an easy format for organizing basic information, as well as providing a program with information about the data sources used and the assessment process.

During the visit a tour of the program's physical site is essential. Agencies have experience doing this for other purposes, and it often serves not only as a way to observe the milieu, but also an opportunity for the assessor to meet additional staff and have conversations along the way. There should also be some time allocated to review documents, such as brochures, policy and procedure manuals, patient activity schedules, and other pertinent materials. When possible, obtaining a copy of any of these materials to review ahead of time will

help save time at the visit. Lastly, enough time should be scheduled to review eight to 10 medical records, all for individuals identified as having co-occurring disorders. Ideally, records should be for recently discharged patients, and representative of different clinicians.

It is important to allow time for the assessor to process and formulate the findings from the DDCMHT assessment at the end of the visit. This may be a period of 15 to 30 minutes. During this time, the assessor considers DDCMHT items that have not yet been addressed. He or she 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. If necessary, a follow-up call can be made after the visit if the assessor finds any data was overlooked.

The preliminary feedback or debriefing at the end of the DDCMHT assessment is typically positive and affirming, and it emphasizes program strengths and themes from the assessment. The assessor is encouraged to consider the program's readiness to change and focus on addressing issues that have already been raised as areas of concern or desired change.

C. Cautions Regarding Self-evaluation

The accuracy and usefulness of a DDCMHT assessment is directly proportional to the objectivity of the assessor and her or his familiarity with the underpinning of each DDCMHT item response coding. Experience has shown that self-assessors generally view their programs as more capable than they actually are (McGovern, Xie, et al., 2007), and that there is a high likelihood self-assessors will score their programs higher in all dimensions (often by a full point or more) than will an objective assessor (Lee and Cameron, 2009). This is not to say that self-assessment should not be attempted and cannot be done effectively.

The self-assessor's foremost task is to look with "fresh eyes" and ask all the questions necessary to base a score on facts, rather than on assumptions based on prior information or impressions. Agencies that choose to self-assess are encouraged to use their quality assurance staff, which due to the nature of their work can typically be more objective, and/or staff from a program other than the one being assessed. A team of two or more self-assessors can be used in order to increase the opportunity to identify, discuss, and mitigate any inherent biases by scoring independently and coming to consensus when initial scores do not agree. Agencies may also want to explore reciprocal arrangements with other agencies to further minimize bias. The Louisiana Office of Behavioral Health conducted DDCMHT assessments using a team that included their expert raters as well as staff from providers to be assessed; this meant that staff raters participated in assessing their own programs. Program staff's inter-rater reliability with the expert raters was demonstrated by the fourth visit (i.e., the quality of assessment increases with practice; Brown & Comaty, 2007).

A thorough understanding of the definition and item response coding for each DDCMHT element is equally as important as objectivity. Louisiana found that the development of manuals enhanced ratings consistency. A recent study of dual diagnosis capability of residential substance abuse programs in Australia found that the self-assessors consistently did not read the DDCAT instructions, resulting in incorrect scores (Matthews, Kelly, & Deane, 2011). Basing scores on the DDCMHT tool's anchors alone often results in inaccurate ratings; the anchors serve only as a prompt for scoring, and they are not intended to be all-encompassing descriptors. This toolkit contains expanded definitions for many of the scores. It describes the essence and nuances of each element. Additionally, the guidance for programs wishing to increase their capability offers examples that can provide further clarity.

D. Training Program Quality Assurance Staff

It is recommended that programs intending to improve their co-occurring capability use both process and outcome measures to monitor and improve program quality over time. DDCMHT baseline and follow-up assessments can be an integral element of such quality assurance efforts. Quality assurance staff not only may be more objective, but also are likely to have interviewing and chart review skills that will help ensure a competent assessment. Quality assurance staff who are trained to conduct DDCMHT assessments can use the results to measure progress over time toward implementation plan goals. The quality assurance staff can also assess and compare different programs within the agency.

E. Training Raters to Conduct the DDCMHT

1. Didactic Training

Individuals who wish to conduct a DDCMHT assessment can attain some proficiency through familiarizing themselves with the information in this toolkit. Some state agencies have offered workshops on the DDCMHT. Other resources are listed in the appendix section.

Prior to a visit, some assessors have found it helpful to note on the scoring sheet the various sources for each item to cue them throughout the visit. They also develop separate lists of questions for each interview group that will elicit information necessary to score each item, in some cases organizing them by topic rather than by assessment dimension and element. Some have found it helpful to develop a brief checklist form to use as a guide when reviewing medical records. Samples of these are included as appendices.

2. Shadowing

One of the best training methods is to shadow an experienced DDCMHT assessor on a visit, preferably more than once. As mentioned above, practice has been shown to improve the quality of the assessment. Observing how the visit is organized, what the assessor looks for on the tour, the assessor's interview questions and techniques, how the assessor manages discrepancies in information, and the preliminary feedback session provides a model for the new assessor to emulate. Reviewing medical records, policies and procedures manuals, and other materials together offers an opportunity to learn how to obtain the desired information in a limited period of time. Individuals who train in this fashion are encouraged to score the assessment independently of the experienced assessor, and then compare and discuss the basis for each score, not just those that were scored differently.

3. The DDCMHT Vignette

A vignette has been developed to help individuals practice evaluating information gathered at a DDCMHT visit and scoring the assessment. The vignette briefly describes a DDCMHT visit to a fictional mental health treatment program and the information gleaned from tour observations, staff and client interviews, policy and procedures review, and medical record reviews. It is a composite of actual DDCMHT visit interactions and observations, intended to give "the feel" of a visit, as well as a demonstration of how a visit might elicit some conflicting information. The vignette and scoring guide are included as appendices.

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IV. Scoring and Profile Interpretation

A. Scoring Each DDCMHT Item

Each program element of the DDCMHT 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 mental health disorders. This level, using ASAM language, is referred to on the DDCMHT as Mental Health Only Services (MHOS).

- A score of 3 indicates a program that is capable of providing services to some individuals with co-occurring substance use and mental health disorders, but has greater capacity to serve individuals with mental health disorders. This level is referred to as being Dual Diagnosis Capable (DDC) by ASAM and the DDCMHT.

- A score of 5 designates a program that is capable of providing services to any individual with co-occurring substance use 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 DDCMHT.

- Scores of 2 and 4 are reflective of intermediary levels between the standards established at the 1-MHOS, 3-DDC, and 5-DDE levels.

When rating a program on the DDCMHT, it is helpful to understand that the objective anchors on the scale for each program element are based on one of the following factors:

1) The *presence or absence* of specific hierarchical or ordinal benchmarks: 1-MHOS sets the most basic mark; a 3-DDC sets the mid-level mark; 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 (MHOS, DDC, or DDE).

    -or-

2) The *relative frequency* of an element in the program, such as in the last Index element regarding clinical staff that have advanced training in co-occurring disorders services. The rating 1-MHOS sets a lower percentage of staff with required training, 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 and be incorporated into a program's routine practices.

-or-

3) A combination of a presence of a 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 DDCMHT item, a program must meet a specific qualifying standard. Also, the program must consistently maintain this standard for the majority of its clients (set at an 80 percent basis). For example, the program element regarding co-occurring disorders assessment sets a qualifying standard for the type of assessment used *and* specifies the frequency with which the standard is routinely applied.

B. Scoring the DDCMHT Index

Scoring the DDCMHT will produce ratings on the seven dimensions and categorize the program as MHOS, DDC, or DDE. This is a simple way to indicate the co-occurring capacity of an agency's program.

The total score for the DDCMHT and rank of the program overall is arrived at by:

1. Tallying the number of 1s, 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, and 5's (scores of 3 or greater) obtained

   c) Percentage of 1's and 2's obtained

3. Applying the following cutoffs to determine the program's DDCMHT category:

   a) Programs are DDE if at least 80 percent of scores (i.e., 28 of the 35) are 5's

   b) Programs are DDC if at least 80 percent of scores are 3's or greater

   c) Programs are MHOS if less than 80 percent of scores are 3's or greater

C. Creating Scoring Profiles

The dimension scores are the average scores of the items within each dimension. Dimension scores 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. 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 both those dimensions that are strengths and areas for potential development. This chart can be very useful to guide feedback and target program enhancement efforts. Lastly, the visual depiction can be enlightening if DDCMHT 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.

D. Feedback to Programs

Feedback to programs based on their assessment is typically provided in two formats: verbal feedback and a written report.

First, at the end of the DDCMHT site visit, agency directors and leadership may receive some preliminary verbal feedback. A suggestion is to focus on the strengths of the program and, where possible, join with those issues that have already been identified as quality improvement issues by the agency/program staff members themselves. This could be seen as a parallel to motivational interviewing techniques.

The second format is via written report, which can be structured in several different ways. The report may be in the form of a summary letter to the agency director or a more formal structured report. Regardless of the format, the feedback letter or report should include:

- a communication of appreciation;
- a review of what programs and sources of data were assessed;
- a summary of their scores, including their categorical rating of MHOS, DDC, or DDE, and a graph from the Excel workbook that shows the seven dimension scores;
- an acknowledgment of relative strengths in existing services; and
- empathic and realistic suggestion of potential areas that can be targeted for enhancement.

Additional components that could be included in the report include:

- a graphical display of the program's overall and dimension scores compared to their region/county/state's overall averages;
- a discussion and graph showing the changes since baseline if the assessment is a follow-up.

Conversation and written summaries about dimensions, as well as themes across dimensions, are often the most useful ways for providers to consider where they are and where they want to go. The report may include specific recommendations (e.g., listing and describing specific screening measures to systematize screening for co-occurring disorders) or make mention only of thematic areas of potential improvements.

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V. DDCMHT Index:
Scoring and Program Enhancement

I. Program Structure

IA. Primary focus of agency as stated in the mission statement. (If program has mission, consider program mission.)

Definition: Programs that offer treatment for individuals with co-occurring disorders should have this philosophy reflected in their mission statements.

Source: Agency or program brochure 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 co-occurring disorders orientation.

- **Mental Health Only Services = (SCORE-1):** *Mental health 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 mental health disorders only.

- **Dual Diagnosis Capable = (SCORE-3):** *Primary focus is mental health, co-occurring disorders are treated.* The program has a mission statement that identifies a primary target population as being individuals with mental health disorders, but the statement also indicates an expectation and willingness to admit individuals with a co-occurring mental health disorder and to address that 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. Note that 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 Mental Health Board is to improve the quality of life for adults with serious and persistent mental illness and children with serious mental illness or severe emotional disturbance. 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 designed to treat individuals with co-occurring disorders. The statement notes that the program has the capacity to treat both mental health and substance use disorders equally.

"The Behavioral Health Unit is a private, non-profit organization dedicated to supporting the recovery of families and individuals who experience co-occurring mental health and substance use disorders."

MHOS PROGRAMS

IA. Primary focus of agency as stated in the mission statement
(If program has mission, consider program mission.)

Programs scoring a 1 for this item likely have a more traditional mission statement, such as: "The Mental Health Board is dedicated to assisting persons with mental health problems regain control over their lives."

Revising a mission statement is emblematic of a "sea change" in leadership philosophy and commitment, even though the new mission statement may not directly or immediately affect the clinical practices at a program. Consider this subtle shift in the last phrase of the mission statement: "The Mental Health Board is dedicated to assisting persons initiate a process of recovery from mental health and its associated problems."

A DDC mission statement is characterized by a clear willingness to treat individuals with co-occurring disorders. Often this is communicated in overarching terminology, such as "behavioral health" or "recovery." Here is an example: "The Recovery Resources Program is committed to offering a full range of behavioral health services to promote well-being and lifelong recovery."

DDC PROGRAMS

IA. Primary focus of agency as stated in the mission statement.
(If program has mission, consider program mission.)

DDC programs have scored a 3 on this item. It is likely that the mission statement reflects a program philosophy that recognizes comorbid substance use disorders as secondary to mental health disorders. A DDE program mission statement is characterized by an equivalent focus on substance use and mental health problems. It will include the term "co-occurring disorders" or clearly encompass both mental health and addiction treatment services.

Some providers take issue with the "behavioral health" terminology, arguing 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 substance use disorders is also fitting.

IB. Organizational certification and licensure.

Definition: Organizations that provide integrated co-occurring disorders treatment are able to provide unrestricted services to individuals with co-occurring disorders. These organizations do so without barriers that have traditionally divided the services for mental health disorders from the services for substance use 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 or program 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.

- **Mental Health Only Services = (SCORE-1):** *Permits only mental health treatment.* The program's certification, licensure agreement, or state permit restricts services to individuals with mental health disorders only.

- **(SCORE-2):** *Has no actual barrier, but staff report there to be certification or licensure barriers.* The program's certification, licensure agreement, or state permit is the same as described at the DDC level in that there are no restrictions in serving individuals with substance use disorders that co-occur with mental health disorders. But the staff and administrators report and perceive barriers in providing substance use services; thus the program operates in a manner consistent with MHOS.

- **Dual Diagnosis Capable = (SCORE-3):** *Has no barrier to providing addiction treatment or treating co-occurring disorders within the context of mental health treatment.* The program's certification, licensure agreement, or state permit identifies the target population to be individuals with mental health disorders, but does not restrict the program from serving individuals with co-occurring substance use disorders. The program provides services in the context of mental health services licensure. It targets substance use problems in a general approach, for example, in the context of mental health symptom management.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Is certified and/or licensed to provide both.* The program's certification, licensure agreement(s), or state permit(s) identifies the program as providing services for both mental health and substance use disorders.

MHOS PROGRAMS

Enhancing IB. Organizational certification and licensure.

Programs at the MHOS level often face legitimate certification or licensure restrictions. This restriction encumbers a program to provide treatment solely to persons who meet criteria for a mental health disorder. Even though many patients will have an active co-occurring substance use disorder, the program must declare the mental health disorder as primary if not singular.

Several practical strategies are possible to elevate a program to the DDC level. Some programs cite long-standing agency traditions to assert their inability to treat persons with co-occurring disorders. Regional, state, and funder policies must be verified so that restrictions, if they do exist, can be clearly determined. Some state authorities have made special allocations for persons with co-occurring disorders (i.e., mental health disorders with complications). Other programs have sought joint addiction licensure or hired licensed staff to bill for unbundled services. Finally, it is common and realistic for a program to provide services that generically target substance use problems within the context and scope of mental health licensure.

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 addiction treatment services.

IC. Coordination and collaboration with addiction services.

Definition: Programs that transform themselves from ones that only provide services for mental health disorders into ones that can provide integrated co-occurring disorders 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 use disorders. The following terms are used to denote the stepwise advances and originate 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 patient. *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.*

Source: Interviews with agency director, program clinical leaders, and clinicians. Some documentation may also exist (e.g., a memorandum of understanding).

Item Response Coding: Coding of this item requires an understanding of the service system and structure of the program, specifically with regard to the provision of substance use as well as mental health services. An understanding of the SAMHSA terms defined above is also necessary. The DDCMHT scoring directly corresponds to those definitions.

- **Mental Health Only Services = (SCORE-1):** *No document of formal coordination or collaboration. Meets the SAMHSA definition of minimal Coordination.*

- **(SCORE-2):** *Vague, undocumented, or informal relationship with addiction agency, or consulting with a staff member from that agency. Meets the SAMHSA definition of Consultation.*

- **Dual Diagnosis Capable = (SCORE-3):** *Formalized and documented coordination or collaboration with addiction agency. Meets the SAMHSA definition of Collaboration.*

- **(SCORE-4):** *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.* These programs have a system of care that meets the definition of collaboration **and** demonstrate an increased frequency of integrated elements. However, these elements are informal and not part of the defined program structure. Typical examples of activities that occur at this level would be informal staff exchange processes or case management on an as-needed basis to coordinate services.

- **Dual Diagnosis Enhanced = (SCORE-5):** *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.*

MHOS PROGRAMS

Enhancing IC. Coordination and collaboration with addiction services.

MHOS level programs either have no existing relationship or an informal one with a local substance abuse treatment provider. Programs intending to achieve DDC status must develop more formalized procedures and protocols to coordinate services for persons with co-occurring disorders.

Staff at The North Shore Alcohol and Drug Treatment Center (NSADTC) often referred patients to the Lakeland Mental Health agency for substance use emergencies (e.g., detox) or for a substance use evaluation. Staff would encounter combative clients under the influence of alcohol or drugs several times per year, and would usually call 911. A counselor at NSADTC who once worked at Lakeland was often asked to contact his former colleagues so that patients might be evaluated within a more expedient time frame.

To become DDC, North Shore initiated a series of meetings with Lakeland, and the agencies composed a memorandum of understanding (MOU) that addressed admission, transfer, and referral procedures (see the appendix section for a sample MOU). Monthly meetings between program coordinators and designated intake clinicians were also initiated to review the protocol and discuss plans for common patients.

A MHOS 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 addiction services.

Programs at the DDC level begin to integrate the delivery of mental health and addiction services in order to reach 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 treatment 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 incentives.

Definition: Programs that are able to merge funding for the treatment of mental health disorders with funding for addiction treatment have a greater capacity to provide integrated services for individuals with co-occurring disorders.

Source: Interview with agency director and 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 use and mental health disorders.

- **Mental Health Only Services = (SCORE-1):** *Can only bill for mental health treatments or for persons with mental health disorders.* Programs can only get reimbursement for services provided to individuals with a primary mental health disorder. There is no mechanism for programs to be reimbursed for services provided to treat substance use disorders.

- **(SCORE-2):** *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.* The program's reimbursement codes allow for reimbursement as described in the DDC category, but the staff and administrators report and perceive barriers in getting reimbursed for substance use services; thus the program operates in a manner consistent with MHOS.

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

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

MHOS PROGRAMS

Enhancing ID. Financial incentives.

Programs scoring at the MHOS level typically cannot bill or receive reimbursement for addiction services. MHOS programs working toward the DDC level may obtain contract or grant funding to provide adjunctive substance use services. As an alternative, programs may locate partners on whose behalf they can bill for unbundled services.

Mental Health Alternatives, an outpatient community mental health provider, obtained a federal grant that allowed them to hire an addiction counselor and incorporate substance use screening and assessment into their intake process.

DDC PROGRAMS

Enhancing ID. Financial incentives.

Programs scoring at the DDE level can bill or receive reimbursement for addiction 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 mental health treatment program, arranged for their onsite consulting psychologist, Dr. Heinrich, to be able to bill Medicaid and Medicare as well as receive payment for services to indigent patients (via state funding) and for diagnostic and couples therapy services.

II. Program Milieu

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

Definition: Persons with co-occurring disorders are welcomed by the program or facility, and this concept is communicated in supporting documents. Persons who present with co-occurring substance use 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, as well as interviews with clinical staff, support staff, and patients.

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

- **Mental Health Only Services = (SCORE-1):** *Program expects mental health disorders only, refers or deflects persons with substance use disorders or symptoms.* The program focuses on individuals with mental health disorders only **and** deflects individuals who present with any type of substance use problem.

- **(SCORE-2):** *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.* The program generally expects to manage only individuals with mental health disorders but does not strictly enforce the refusal or deflection of persons with substance use problems. The acceptance of persons with substance use problems likely varies according to the individual clinician's competency or preferences. There is no formalized documentation indicating acceptance of persons with substance use problems.

- **Dual Diagnosis Capable = (SCORE-3):** *Focus is on mental health disorders, but accepts substance use disorders by routine and if mild and relatively stable as reflected in program documentation.* The program tends to primarily focus on individuals with mental health disorders, but routinely expects and accepts persons with mild or stable forms of co-occurring substance use disorders. This is reflected in the program's documentation and surroundings (e.g., on walls and brochure racks).

- **(SCORE-4):** *Program formally defined like DDC, but clinicians and program informally expect and treat co-occurring disorders regardless of severity, **not** well documented.* The program expects and treats individuals with co-occurring disorders regardless of severity, **but** this program has evolved to this level informally and does **not** have the supporting documentation to reflect this service array.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Clinicians and program expect and treat co-occurring disorders regardless of severity, well documented.* The program routinely accepts individuals with co-occurring disorders regardless of severity and has formally mandated this aspect of its service array through its mission statement, philosophy, welcoming policy, and appropriate protocols.

MHOS PROGRAMS

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

MHOS programs typically foster a more traditional ambiance and environment. This cultural "atmosphere" is focused on mental health issues and recovery only. Often this focus hampers a dialogue or openness about addiction problems or concerns. This milieu may not enable a patient to inquire about the potential for recovery from co-occurring substance use disorders.

MHOS programs seeking to become DDC must document, for example, in their admission criteria, that the program accepts individuals with mild or stable co-occurring substance use disorders.

Programs can decrease the stigma and elevate the awareness of substance use disorders by providing brochures in waiting areas that describe alcohol or drug problems and recovery (e.g., AA and Al-Anon brochures). These subjects can also be routinely raised in orientation sessions, community meetings, or family visits. These practices explicitly convey a welcoming and acceptance of persons with substance use concerns or disorders.

The cultural undercurrent to a DDC program enables persons with co-occurring substance use 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 equivalent focus on addiction and mental health disorders. Programs must demonstrate their acceptance of individuals with co-occurring disorders regardless of severity via mission or philosophy statements, admission criteria, or other documentation. Patients in DDC programs will report that they are in treatment to address a specific mental health concern, but they can also readily talk about

substance use problems and ask questions about addiction consequences. Patients in DDE programs, however, are able to articulate that they have co-occurring disorders and they are getting treatment in both domains. They may contrast this with previous treatment experiences, and remark this is the first program that has addressed both disorders at the same time. Patients also report no stigma or differential status associated with having a co-occurring disorder.

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

Definition: Programs that treat persons with co-occurring disorders create an environment which displays and provides literature and educational materials that address both mental health and substance use disorders.

Source: Observation of milieu and physical settings, review of documentation of patient handouts, videos, brochures, posters, and materials for patients and families that are available and/or used in groups. Patient interviews are also completed.

Item Response Coding: 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 considered.

- **Mental Health Only Services = (SCORE-1):** *Mental health or peer support only.* Materials that address mental health disorders are the only type that is routinely available.

- **(SCORE-2):** *Available for both disorders but not routinely offered or formally available.* Materials are available for both substance use and mental disorders, but they are not routinely accessible or displayed equally. The majority of materials and literature are focused on mental health disorders.

- **Dual Diagnosis Capable = (SCORE-3):** *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.* Materials are routinely available for both substance use and mental disorders, and they are displayed equally. However, materials for substance use disorders are not distributed equivalently by staff or the program.

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

- **Dual Diagnosis Enhanced = (SCORE-5):** *Routinely and equivalently available for both disorders and for the interaction between mental health and substance use disorders.* Materials and literature address both substance use and mental disorders and also attend to concerns specific to co-occurring disorders, such as interactions of co-occurring disorders on psychological function, health, ability to find and keep a job, etc.

MHOS PROGRAMS

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

MHOS programs display materials related to mental health problems. In some instances, MHOS programs may display brochures and have handouts about diseases (e.g., sexually transmitted diseases), mental health stigma, supported employment, or transportation entitlements. To achieve the DDC level, a program must offer materials about co-occurring disorders, or materials specific to substance use problems and recovery. These materials should be visible in waiting areas, in patient orientation packets or binders, and distributed during family visits.

Materials are readily available from SAMHSA (www.samhsa.gov) and the National Institute of Mental Health (www.nimh.nih.gov). Many professional organizations (e.g., the American Psychiatric Association and American Psychological Association)

also provide excellent materials specific to certain co-occurring disorders.

A description of co-occurring disorders and guide to recovery suitable for the general public can be obtained from SAMHSA's National Clearinghouse for Alcohol and Drug Information:

http://store.samhsa.gov/product/Overcoming-Substance-Use-and-Mental-Disorders/PHD1078.

Some states have a clearinghouse of materials. For example, the Connecticut Department of Mental Health and Addiction Services funds the Connecticut Clearinghouse that includes many audiovisual materials, books, curricula, and pamphlets on co-occurring disorders, available for providers to borrow or keep. Visit: www.ctclearinghouse.org.

DDC PROGRAMS

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

DDE level programs display and equally distribute materials related to substance use and mental health problems and their interaction. These programs emphasize the common co-occurrence of the 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 substance use disorders to all patients in their mental health outpatient program. They distribute pamphlets and fact sheets that describe the expected occurrence rates for substance dependence, 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 co-occurring disorders in society in attempting to affiliate with mutual self-help meetings.

DVDs that describe the causes and course of co-occurring disorders are available from a variety of publishers. Hazelden Publishing (www.hazelden.org) offers DVDs on adults with co-occurring disorders and adolescents with co-occurring disorders. These DVDs are brief (about 30 minutes) and targeted to patients and family members.

The DVDs can serve to systematically raise awareness and promote discussion during treatment groups, family education, or visit programs. They can produce educated consumers of addiction treatment services. In addition, Hazelden has a series of DVDs on addiction and specific mental health disorders, and its Co-Occurring Program includes educational handouts on specific mental health disorders and a DVD on co-occurring disorders specifically for families.

III. Clinical Process: Assessment

IIIA. Routine screening methods for substance use.

Definition: Programs that provide services to individuals with co-occurring disorders routinely and systematically screen for both substance use and mental health symptoms. The following text box provides a standard definition of "screening" that 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 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 patient 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 visits or within the first month following admission to treatment.

Source: Interviews with program leadership and staff, observations of medical record (or electronic medical record system) or intake screening form packets.

Item Response Coding: Coding of this item requires the evaluation of screening methods routinely used in the program.

- **Mental Health Only Services = (SCORE-1):** *Pre-admission screening based on patient self-report. Decision based on clinician inference from patient presentation or history.* The program has essentially no screening for substance use problems. On occasion, a program at this level offers a minimal screening for substance use disorders, which is based on the clinician's initial observations and/or impressions.

- **(SCORE-2):** *Pre-admission screening for substance use and treatment history prior to admission.* The program conducts a basic screening for substance use problems prior to admission, **but** it is not a routine or standardized component of the evaluation procedures (occurs less than 80 percent of the time). At this level, the screen might include some symptom review, treatment history, current medications, and/or abstinence/relapse history. Considerable variability across clinicians occurs at this level.

- **Dual Diagnosis Capable = (SCORE-3):** *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.* The program conducts a screening process with interview questions for substance use problems; it is incorporated into a more comprehensive evaluation procedure; and it occurs routinely (at least 80 percent 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 substance use using standardized or formal instruments with established psychometric properties.* The program conducts a systematic screening process that uses standardized, and reliable and valid instrument(s) for screening for substance use. This screening process is routinely used (at least 80 percent of the time).

- **Dual Diagnosis Enhanced = (SCORE-5):** *Screen using 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 valid instrument(s) for screening both substance use and mental disorders. This screening process is used routinely (at least 80 percent of the time), incorporated into the comprehensive evaluation procedures, and considered an essential component in directing the individual's care. If programs routinely use toxicology screening (e.g., such as breath or urine samples) to detect substance use, this would also meet criteria for a standardized measure.

MHOS PROGRAMS

Enhancing IIIA. Routine screening methods for substance use.

MHOS programs typically attempt to capture or detect substance use problems via an initial phone interview. This interview typically asks about current and past alcohol or drug use, prior treatment, and if the caller ever received an addiction diagnosis. The responses may be used to refer a patient to a substance use treatment center and may not routinely trigger a substance use assessment.

In order to become DDC, MHOS programs must extend this procedure to routinely screen for current and past substance use problems using a standard set of interview questions. This may be based upon a generic framework (e.g., the ASAM-PPC) or via a broad biopsychosocial assessment.

For more information on screening, an overview of screening and assessment produced by SAMHSA's Co-Occurring Center for Excellence is available.

Screening, Assessment, and Treatment Planning for Persons with Co-Occurring Disorders is online at www.samhsa.gov/co-occurring/topics/screening-and-assessment/samsha-overview.aspx.

DDC PROGRAMS

Enhancing IIIA. Routine screening methods for substance use.

In order to achieve the DDE level, DDC programs institute standardized screening measures for both mental health and substance use disorders, and the measures are used them routinely (with at least 80 percent of patients). Standard measures may screen for more general mental health and substance use symptoms, while some are sensitive to specific mental health disorders. Examples include the Modified MINI Screen (MMS), Mental Health Screening Form-III, CAGE-AID, Simple Screening Instrument for Alcohol 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 mental health 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). If programs routinely use toxicology screening (e.g., such as breath or urine samples) to detect substance use, this would also meet criteria for a standardized measure. Examples of screening measures are included as appendices.

IIIB. Routine assessment if screened positive for substance use.

Definition: Programs that provide services to persons with co-occurring disorders should routinely and systematically assess for substance use disorders as indicated by a positive screen. The following text box provides a standard definition of "assessment" that originates from SAMHSA's Co-Occurring Measure (2007).

Assessment: An assessment consists of gathering information and engaging in a process with the patient that enables the provider to establish the presence or absence of a co-occurring disorder; determine the patient's readiness for change; identify patient 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 patient 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 use results of the assessment in the 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.)

Use results in the treatment plan: The assessment results must routinely be included in the development of a treatment plan.

Source: Interview with program leadership and staff, policy and procedure manual, and medical record.

Item Response Coding: Coding of this item requires the evaluation of the assessment methodology routinely used in the program or facility.

- **Mental Health Only Services = (SCORE-1):** *Assessment for substance use disorders is not recorded in records.* There is no formal or standardized process that assesses for substance use disorders when such disorders are suspected. At most, a program offers ongoing monitoring for substance use disorders when suspected. In most cases, the ongoing monitoring is to determine appropriateness or exclusion from care.

- **(SCORE-2):** *Assessment for substance use disorders occurs for some patients, but is not routine or is variable by clinician.* This may include a more detailed biopsychosocial assessment or mental status exam, but it is clinician-driven. The program does not offer a standardized process to assess for substance use disorders, but there are variable arrangements for an assessment of substance use disorders that is provided based upon clinician preference and expertise.

- **Dual Diagnosis Capable = (SCORE-3):** *Assessment for substance use disorders is present, formal, standardized, and documented in 50 to 69 percent of the records.* The program has a regular mechanism for providing a formal substance use assessment on site as necessary and based on a positive screen. A formal substance use assessment is defined as a standardized set of elements or interview questions that assesses substance use concerns (current symptoms and chief complaints, past substance use history and typical course and effectiveness of previous treatment, substance use risk, etc.) in a comprehensive fashion. This level of substance use 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 on site or off site with a formal relationship as documented in a memorandum of understanding, for example.

- **(SCORE-4):** *Assessment for substance use disorders is present, formal, standardized, and documented in 70 to 89 percent of the records.* The program has a policy and onsite capacity for formal substance use assessments, as defined above, following all positive substance use screens.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Assessment for substance use disorders is formal, standardized, and integrated with assessment for mental health disorders, and documented in at least 90 percent of the records.* This includes standardized or formal instruments for both mental health and substance use disorders with established psychometric properties. The program routinely provides onsite standardized and formal integrated assessment to all individuals following positive substance use screens per formal policy. An integrated assessment entails comprehensive assessment for both substance use and mental health disorders, which is conducted in a systematic, integrated, and routine manner by a competent provider.

MHOS PROGRAMS

Enhancing IIIB. Routine assessment if screened positive for substance use.

DDC programs offer a substance use assessment to persons who are identified by screening, toxicology, history, or observable behaviors. Such assessments are guided by the belief that there is a potential benefit for addiction treatment. DDC programs offer such assessments on site or off site with a formal relationship as documented in a MOU. At the DDC level, assessments are conducted on a routine, timely, and consistent basis.

The New Hope Clinic provides a substance use assessment to patients who are identified by self-reports of current drug use or heavy drinking. This evaluation is performed by the consultant nurse practitioner who is at the program one day per week.

To achieve the DDE level, DDC programs must institute a systematic substance use assessment for all individuals who screen positive. This is based on the clear expectation that all patients entering the treatment will have a co-occurring substance use 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 found in some electronic medical record systems, 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. Mental health 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 and substance use disorders.

Source: Medical record (or electronic medical record), interviews with staff.

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

- **Mental Health Only Services = (SCORE-1):** *Substance use diagnoses are neither made nor recorded in records.* The program does not provide diagnoses for substance use disorders. In some cases, diagnoses of substance use disorders may be discouraged or not recorded.

- **(SCORE-2):** *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 is capable of providing substance use diagnoses, but its diagnosticians perform this service infrequently or in an inconsistent manner. At most, this service is provided occasionally or on an as needed basis.

- **Dual Diagnosis Capable = (SCORE-3):** *The program has a mechanism for providing diagnostic services in a timely manner. Substance use diagnoses are documented in 50 to 69 percent of the records.* The program has established a formal mechanism to prompt its diagnosticians to provide substance use diagnoses. There is some variability in the program's observable capacity to execute this fully, but evidence supports that substance use diagnoses are offered with some regularity. There is likely some tendency for these programs to diagnose the more severe or acute substance use disorders.

- **(SCORE-4):** *The program has a mechanism for providing routine, timely diagnostic services. Substance use diagnoses are documented in 70 to 89 percent of the records.*

- **Dual Diagnosis Enhanced = (SCORE-5):** *Comprehensive diagnostic services are provided in a timely manner. Substance use diagnoses are documented in at least 90 percent of the records.* The program has a formal mechanism to ensure a comprehensive diagnostic assessment to each individual, which ensures that substance use diagnoses are consistently made and documented. Evidence supports that the full range of substance use diagnoses are provided.

MHOS PROGRAMS

Enhancing IIIC. Mental health and substance use diagnoses made and documented.

MHOS programs register only mental health diagnoses in their medical record or patient chart. There are numerous reasons for this exclusive focus. To become DDC, however, MHOS programs must minimally begin to identify substance use diagnoses, proceeding from screening to assessment to a formal diagnosis. At the DDC level, the program has established a mechanism for routinely providing diagnostic services in a timely manner. A chart review for patients with co-occurring disorders would find substance use diagnoses in 50 to 69 percent of the records. In those cases, a substance use diagnosis must be included in the program's chart or electronic record. Identifying a substance use disorder as a problem (e.g., cocaine problem) or a rule-out diagnosis (e.g., R/O alcohol abuse) is not acceptable at the DDC level.

DDC PROGRAMS

Enhancing IIIC. Mental health and substance use diagnoses made and documented.

DDC programs routinely provide comprehensive diagnostic services in a timely manner, with substance use diagnoses reflected in 90 percent of the patient records. To attain the DDE level, these diagnoses, when present, are more systematically and routinely ascertained. The diagnoses are specific and include all five of the axes on the DSM-IV multi-axial system.

IIID. Mental health and substance use history reflected in medical record.

Definition: Biopsychosocial and other clinical assessment and evaluative processes routinely assess and describe past history and the chronological or sequential relationship between substance use and mental health 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.

- **Mental Health Only Services = (SCORE-1):** *Collection of mental health disorder history only.* The program does not utilize or promote standardized collection of substance use history and only collects mental health history on a routine basis.

- **(SCORE-2):** *Standard form collects mental health disorder history only. Substance use disorder history collected inconsistently.* In addition to the routine collection of mental health history, the program encourages the collection of substance use history but this history is neither structured nor incorporated into the standardized assessment process. The degree and variability in collecting this information varies considerably by clinician preference and competency. If the program provides a means of collecting a substance use history (as set by the standard in DDC),

the program does so only variably (less than 80 percent of the time).

- **Dual Diagnosis Capable = (SCORE-3):** *Routine documentation of both mental health and substance use disorder history in record in narrative section.* In the course of routine collection of mental health history, there is a routine narrative section in the record that discusses substance use history. **And:** This documentation occurs at least 80 percent of the time. This is evident in the records of the majority of individuals assessed, which document and discuss substance use histories. When applicable for an individual's history, narrative sections note even the absence of substance use history.

- **(SCORE-4):** *Specific section in record dedicated to history and chronology of both disorders.*

- **Dual Diagnosis Enhanced = (SCORE-5):** *Specific section in record devoted to history and chronology 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 use histories, and this section also provides historical information regarding the interactions between these two disorders. The substance use 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 percent of the time.

MHOS PROGRAMS

Enhancing IIID. Mental health and substance use history reflected in medical record.

Although mental health and substance use disorders commonly interact, MHOS programs typically document only a history of a patient's mental health disorder. The assessment of substance use disorders in mental health treatment, however, is complicated by the effects of substances, from intoxication to craving to withdrawal to protracted withdrawal. The DSM-IV provides guidelines in making differential diagnoses (e.g., substance-induced vs. independent disorders)

and the Clinical Institute for Withdrawal Assessment (CIWA) assists in identifying the type and severity of withdrawal symptoms.

At the DDC level, programs typically gather information about a patient's substance use and mental health disorders in terms of ages of onset and course. This is often documented in narrative fashion in a quasi-chronological format.

DDC PROGRAMS

Enhancing IIID. Mental health and substance use history reflected in medical record.

DDC programs specifically identify and document the dates of onset, symptoms, and course of mental health and substance use disorders.

DDE programs recognize the complexity and the interaction of disorders by systematically recognizing the temporal relationship between the disorders. DDE programs recognize that the criteria in the DSM-IV necessitate a chronological and sequential symptom review in order to discriminate between substance-induced disorders (e.g., substance-induced mood disorder; substance-induced anxiety disorder, or substance-induced psychotic disorder)

and independent mental health disorders (e.g., dysthymic disorder, panic disorder, or schizophrenia).

DDE programs provide this information in a specific section within the medical record or electronic medical record. Time line follow-back (TLFB) calendars are helpful to assess and document histories of substance use and mental health symptoms (see the appendix section). This temporal display illustrates the interplay between disorders, which may facilitate an appropriate treatment plan and effective relapse prevention strategies.

IIIE. Program acceptance based on substance use disorder symptom acuity: low, moderate, high.

Definition: Programs offering services to individuals with co-occurring disorders use substance use disorder 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 with program leadership and staff, policy and procedure manual, and 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 substance use symptom acuity (e.g., intoxication, withdrawal, dangerousness, risk to self, agitation, self-regulatory capacity). The level of care capacities within the program must be taken into account when rating this item.

- **Mental Health Only Services = (SCORE-1):** *Admits persons with no to low acuity.* The program cannot care for individuals who present with any level of substance use 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 for individuals who present with low to moderate acuity substance use symptoms. Persons are primarily stable at present (i.e., not acutely intoxicated and have some capacity for self-regulation). These programs are able to plan for and temporarily manage some crisis interventions with higher acuity substance use disorders, but tend to rely on linkages and referrals to addiction treatment programs.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Admits persons in program with moderate to high acuity, including those unstable in their substance use disorder.* The program is capable of providing care for individuals who present with all ranges of substance use symptom acuity, including those with high acuity, whose present substance use is severe and ongoing. 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 addiction treatment programs.

MHOS PROGRAMS

Enhancing IIIE. Program acceptance based on substance use disorder symptom acuity: low, moderate, high.

MHOS programs routinely base admission decisions on substance use history (e.g., prior hospitalizations), the present diagnoses an individual carries (e.g., cocaine dependence), or current substance use levels (e.g., daily cocaine use). Even if persons with substance use disorders are presently stable, by virtue of their history the MHOS program will decline or defer admission. Determination of these patients' entry may be based upon perceived clinical appropriateness, rationalized by staffing level, or is milieu-focused ("We don't want other patients to be distracted.").

To reach DDC, MHOS programs must be able, within the capacity of their staff resources and level of care, to accept patients regardless of their history

of substance use disorders. DDC programs admit persons with low to moderate acuity and who are primarily stable. Individuals who are using alcohol or drugs at admission are not automatically diverted by DDC programs. At this level, staff are aware of crisis and emergency procedures and can appropriately manage individuals who are intoxicated, experiencing withdrawal, or pose a risk to themselves or others.

Recovery Resources, an outpatient program, routinely accepted patients in early recovery from substance use disorders. Staff had learned to therapeutically intervene when patients returned to substance use. Using a MOU, the program set up a referral arrangement for individuals who required detox.

DDC PROGRAMS

Enhancing IIIE. Program acceptance based on substance use disorder symptom acuity: low, moderate, high.

Within the constraints of clinical appropriateness by level of care to manage risks (e.g., a residential provider vs. an outpatient provider), DDE programs will accept patients for treatment regardless of present substance abuse acuity. DDC programs seeking to achieve this status should establish appropriate staffing levels, protocols for patient monitoring and observation, and clear crisis and emergency procedures.

Substance use acuity must be assessed in the DDE program using routine protocols and procedures (and qualified staff to do so). The DDE program accepts and can offer effective treatment to patients, including those who are unable to abstain (i.e., patients do not need to be stable for admission). DDE agencies that are unable to offer a complete continuum of care have established and can demonstrate strong collaborative arrangements with addiction providers (e.g., for detoxification services).

IIIF. Program acceptance based on severity and persistence of substance use disability: low, moderate, high.

Definition: Programs offering services to individuals with co-occurring disorders use the severity and persistence of disability related to the substance use disorder as:

- An indicator to assist with the determination of the individual's needs, and

- An indicator whether the program is capable of effectively addressing these needs.

Source: Interviews with program leadership and staff, policy and procedure documentation, and mission statement.

Item Response Coding: Coding of this item requires an understanding of clinical protocol for individuals who present with different levels of severity and persistence of substance use disorder.

- **Mental Health Only Services = (SCORE-1):** *Admits persons in program with no to low severity and persistence of substance use disability.* The program can only provide care for individuals who present with no to low levels of severity and persistence of substance use disability. These individuals are defined as those who have no or a very limited history of functional impairment (e.g., person's capacity to manage relationships, job, finances, and social interactions) as a result of a substance use disorder. Persons with a history of severe and persistent substance use disorders, as well as persons with histories of substance use inpatient/residential treatment or extended treatment episodes, would be deflected from this type of program.

- **Dual Diagnosis Capable = (SCORE-3):** *Admits persons in program with low to moderate severity and persistence of substance use disability.* The program can only match services for individuals who present with low to moderate severity and persistence of substance use disorder disability. These individuals are defined as those who have mild to moderate histories of functional impairment as a result of a substance use disorder. In this case, there may be some substantial history of recurrence in the substance use disorder, and/or there has been evidence of continued impairment in at least one functional area. Individuals with higher severity and persistence of problems and higher relapse potential for substance use problems are directed toward services in an addiction program, or they may be at risk for a premature discharge from this program.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Admits persons in program with moderate to high severity and persistence of substance use disability.* The program can provide care for individuals who present with moderate to high severity and persistence of substance use disorder disability. These individuals are often characterized as having chronic, potentially lifelong functional impairment as a result of a substance use disorder. In this case, there may be significant history of multiple recurrences in the substance use disorder, and/or there has been evidence of continued impairment in several functional areas. DDE programs are able to comprehensively manage the complex treatment needs of these individuals.

MHOS PROGRAMS

Enhancing IIIF. Program acceptance based on severity of persistence and substance use disability: low, moderate, high.

MHOS programs intending to be at the DDC level will need to accept patients for services who have a history or current substance use diagnosis associated with moderate severity and impairment, as indicated by repeated attempts at abstinence or recovery, multiple addiction consequences, or low motivation to change.

Programs clearly operating at the DDC level routinely accept individuals with active substance use disorders, including those unable to consistently maintain appointments due to intoxication and consequences of use.

DDC PROGRAMS

Enhancing IIIF. Program acceptance based on severity of persistence and substance use disability: low, moderate, high.

DDC programs who seek DDE level on this item will extend their program acceptance to patients in both Quadrant III and Quadrant IV (substance dependent level disorders) on a more routine basis. Together with Item IIIE (Program acceptance based on substance use disorder symptom acuity: low, moderate, high), 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 substance use disability and high levels of acuity.

For information on the Quadrant Model of Co-occurring Disorders, see SAMHSA's (2002) Report to Congress, available at www.samhsa.gov/reports/congress2002.

IIIG. Stage-wise assessment.

Definition: For individuals with substance use and mental health disorders, the assessment of readiness for change is essential to the planning of appropriate services. Although the stages of change model has been more traditionally associated with treatment for substance use disorders, assessment of motivational stages across the individual's identified areas of need (including both substance use and mental health) is a more comprehensive approach. Doing so helps to more strategically and efficiently match the individual to appropriate levels of service intensities.

Source: Interview with program staff, medical records (electronic medical record).

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.

- **Mental Health Only Services = (SCORE-1):** *Not assessed or documented.* The program does not have an established protocol within the evaluative procedures that assesses or documents motivation (stage of change or stage of treatment).

- **(SCORE-2):** *Assessed and documented variably by individual clinician.* The program has an informal, non-standardized process to assess motivation (stage of change or stage of treatment), or the program has encouraged the use of a protocol that assesses motivation, but the process is irregularly used (less than 80 percent of the time).

- **Dual Diagnosis Capable = (SCORE-3):** *Clinician assessed and routinely documented, focused on mental health motivation.* The program has a routinely used assessment protocol that incorporates an assessment of motivation (stage of change or stage of treatment) and documents this consistently (at least 80 percent of the time).

- **(SCORE-4):** *Formal measure used and routinely documented but focusing on mental health motivation only.*

- **Dual Diagnosis Enhanced = (SCORE-5):** *Formal measures used and routinely documented, focus on both substance use and mental health motivation.* The program has a routinely used assessment protocol that incorporates standardized instrument(s) to assess and document motivation (stage of change or stage of treatment) for substance use and for mental health.

MHOS PROGRAMS

Enhancing IIIG. Stage-wise assessment.

Assessing stages of patient motivation has added a new level of clinical sophistication to treatment in recent years. As evidence-based practices, Motivational interviewing (MI) and motivational enhancement therapies (MET) depend on a careful assessment of patient motivation. A variety of models have been developed to conceptualize motivation to change a specific problem (e.g., cocaine dependence or panic attacks) or motivation to attend treatment. For MHOS programs to achieve DDC on this item, they must have identified a patient's level of motivation at the initial assessment.

At a DDC program, clinicians routinely focus on and document patient motivation related to mental health disorders. Substance use disorders are not prioritized or may be variably documented. This assessment may focus on readiness to change or treatment motivation, and may use motivational assessment methods or measures that are well established in the scientific literature (see Appendix E for a copy of these instruments). A global rating in a medical record (precontemplation, contemplation, preparation, action, and maintenance) is also possible.

DDC PROGRAMS

Enhancing IIIG. Stage-wise assessment.

DDC programs intending to become DDE will have made a transition from labeling motivation to a more formal, systematic, and complete effort to assess motivation. This can include the routine incorporation of the well-established self-report measures (URICA, SOCRATES) and/or clinician-completed measure (SATS). It may also include training staff to develop ratings on the ASAM-PPC-2R Treatment Acceptance/Resistance Dimension (Dimension IV). Motivation to change both mental health and addiction problems is routinely documented.

In DDE programs, formal measures and ratings are systematically gathered, recorded in medical records, and made explicit in order 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 two-sided "motivational ruler" to patients for their own ratings of motivation and efficacy. The specific wording can vary, but a simple example follows:

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.

The stage of change model has been criticized for its cognitive emphasis, so other approaches include a stronger 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

IVA. Treatment plans.

Definition: In the treatment of individuals with co-occurring disorders, the treatment plans indicate that both the mental health disorder as well as the substance use disorder will be addressed.

Source: Review of treatment plans.

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

- **Mental Health Only Services = (SCORE-1):** *Address mental health only (addiction not listed).* Within the program, the treatment plans focus exclusively on mental health disorders.

- **(SCORE-2):** *Variable by individual clinician, (i.e., plans vaguely or only sometimes address co-occurring substance use disorders).* Within the program, the treatment plans for individuals with co-occurring disorders do not often or specifically address substance use disorders, while the mental health disorders are more comprehensively targeted. The variability is likely due to individual clinician preferences/competencies or resource/time constraints.

- **Dual Diagnosis Capable = (SCORE-3):** *Plans routinely address both disorders although mental health disorders addressed as primary, substance use disorders as secondary with generic interventions.* Within the program, the treatment plans of individuals with co-occurring disorders routinely (at least 80 percent of the time) address both the substance use and mental health disorders. Although mental health treatment planning tends to be more specific and targeted, substance use concerns are regularly addressed, albeit in a non-specific fashion (e.g., "maintain abstinence").

- **(SCORE-4):** *Plans routinely address substance use and mental health disorders; equivalent focus on both disorders; some individualized detail is variably observed.* Within the program, the treatment plans for individuals with co-occurring disorders routinely (at least 80 percent of the time) address both the substance use and mental health disorders. **And:** Treatment plans routinely consider both the substance use and mental health disorders equally. However, individualized objectives and interventions specific to each disorder are not consistently incorporated.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Plans routinely address both disorders equivalently and in specific detail; interventions in addition to abstinence are used to address substance use disorder.* Within the program, the treatment plans of individuals with co-occurring disorders routinely (at least 80 percent of the time) and equally address both substance use and mental health disorders with clear, specific, measurable objectives and individualized interventions that systematically target symptoms of the specific disorders. **And:** The interventions used by the program include both psychosocial and pharmacological treatments.

MHOS 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, as illustrated by research on therapeutic alliance in psychotherapy. MHOS programs, whether by screening, assessment or even diagnosis, may identify addiction problems but routinely do not address these same addiction problems in the treatment plan.

To score at the DDC level, these addiction problems need to be identified, and then targeted by at least generic treatment interventions. The problems are then monitored for treatment response. Interventions may include psychoeducational or therapy groups addressing substance use issues, engagement in appropriate addiction or co-occurring self-help groups, or relapse prevention groups. Although mental health problems may continue to be the major focus of the treatment plan, addiction 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 mental health and substance use disorders. A review of records finds this to be normative, and interventions are generally provided "in house." In the case of both disorders as problems, the objectives are clear, measurable, and specific (rather than overly broad or generic). One defining characteristic of the DDE program is the use of interventions in addition to self-help engagement to address and leverage an addiction problem. These interventions may be identified when connected with treatment plan goals. Interventions are also 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 PTSD. In addition to a series of goals and interventions associated with PTSD, the goal for her continuing prescription narcotic abuse was also specified and included motivational enhancement therapy and maintaining a diary of antecedents, behaviors, and consequences of her use of these medications to manage her PTSD symptoms.

IVB. Assess and monitor interactive courses of both disorders.

Definition: In the treatment of persons with co-occurring disorders, the continued assessment and monitoring of substance use and mental health disorders, as well as the interactive course of the disorders, is necessary.

Source: Medical records.

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

- **Mental Health Only Services = (SCORE-1):** *No documentation of progress with substance use disorders.* Treatment monitoring and documentation reflect a focus on mental health disorders only.

- **(SCORE-2):** *Variable reports of progress on substance use disorder by individual clinicians.* Treatment monitoring of co-occurring substance use problems is conducted variably, largely depending on clinician preference/competence and staff resources.

- **Dual Diagnosis Capable = (SCORE-3):** *Routine clinical focus in narrative (treatment plan review or progress note) on substance use disorder change; description tends to be generic.* Treatment monitoring for individuals with co-occurring disorders routinely (at least 80 percent of the time) reflects a clinical focus on changes in substance use disorder or symptoms **but** this monitoring tends to be a basic or generic description within the record.

- **(SCORE-4):** *Treatment monitoring and documentation reflecting equivalent in-depth focus on both disorders is available but variably used.* Treatment monitoring and documentation reflect a more systematic and equally in-depth focus on changes in the symptoms of both substance use and mental health disorders, although this is done variably (less than 80 percent of the time).

- **Dual Diagnosis Enhanced = (SCORE-5):** *Treatment monitoring and documentation routinely reflects clear, detailed, and systematic focus on change in both substance use and mental health disorders.* Treatment monitoring and documentation routinely (at least 80 percent of the time) reflect a detailed, systematic and in-depth focus on changes in the symptoms of both mental health and substance use disorders.

MHOS 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: Mental health and substance use history reflected in medical record.

In MHOS 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 addiction symptoms in the course of mental health recovery.

DDC programs have attempted to record these chronologies in the assessment, as well as monitor substance use changes in early mental health treatment experiences. They may assist patients in preparing for recovery-related changes (e.g., the return of social phobic symptoms after benzodiazepine and alcohol use are discontinued). DDC programs may also be prepared to rapidly intervene if detoxification is necessary. The DDC record captures the ebbs and flows of both substance use and mental health 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 correlation with abstinence or continued use. DDE programs have a medical record structured 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 the appendix section).

Many programs will admit and treat patients who are experiencing severe mental health symptoms or are in the first weeks of abstinence. Many of these same patients will have never had a period of one month of abstinence. Monitoring craving and substance use during the course of treatment will provide essential diagnostic and treatment planning data. Substance-induced disorders and independent mental health disorders can be differentiated during this assessment period. Programs can anticipate different treatment approaches accordingly.

IVC. Procedures for intoxicated/high patients, relapse, withdrawal, or active users.

Definition: Programs that treat individuals with co-occurring disorders use specific clinical guidelines to manage substance-related emergencies, according to documented protocols.

Source: Interviews with clinicians, policy and procedure manual.

Item Response Coding: Coding of this item requires an understanding of a program's specific clinical protocols used to manage substance use crises or concerns. Consider the program's level of care when coding, meaning that the criteria are met as could be expected from the program's level of care (e.g., programs do not need to be residential/inpatient to score a 5).

- **Mental Health Only Services = (SCORE-1):** *No guidelines conveyed in any manner.* The program has no written clinical guidelines for substance use emergencies, **and** the majority of staff has no general understanding of any unwritten crisis/emergency management procedures for such situations.

- **(SCORE-2):** *Verbally conveyed in-house guidelines.* Program staff is able to communicate a general understanding of emergency procedures for crisis situations associated with substance use concerns, although there are no written guidelines. Automatically turning away (or discharging) patients who present as intoxicated or high, or calling 911 or emergency personnel, are not considered acceptable internal procedures 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 that options for intervention may differ based on the assessment.

- **Dual Diagnosis Capable = (SCORE-3):** *Documented guidelines: referral or collaborations (to local addiction agency, detox unit, or emergency department).* The program has written guidelines for substance use crisis/emergency management that includes a standard risk assessment for substance use emergencies. The written guidelines also define available intervention strategies that are matched to the assessed risk. Most of these strategies include linkage with other providers or entities, such as through formalized arrangement with collaborative entities like an addiction agency or detoxification units to assist in the management of these crisis situations. Staff are thoroughly familiar with guidelines and collaboration agreements.

- **(SCORE-4):** *Variable use of documented guidelines, formal risk assessment tools, and advance directives for mental health crisis and substance use relapse.* The program has detailed written guidelines for in-house crisis/emergency management that are designed to provide consistent risk assessment and interventions to maintain individuals within the program when possible. However, these guidelines are not routinely followed, as evidenced by variable staff competency to use them. This inconsistency is likely due to individual staff preferences/competencies or training resource constraints.

- **Dual Diagnosis Enhanced = (SCORE-5):** *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 (e.g., detox, commitment) is warranted.* The program has explicit and thoroughly written guidelines for comprehensive substance use and mental health crisis/emergency management. Guidelines outline explicit in-house procedures, including the

completion of advance directives pertaining to psychiatric crisis and substance use relapse with every individual, use of a formal risk assessment tool, and expected intervention strategies matched to assessed risk. 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 ongoing risk assessment and management of persons with interacting and exacerbating symptoms. Staff members expect crisis/emergency situations, and all are thoroughly familiar with and adhere to the guidelines.

MHOS PROGRAMS

Enhancing IVC. Procedures for intoxicated/high patients, relapse, withdrawal, or active users.

MHOS programs often have undocumented, informal, outdated or loose arrangements for dealing with substance use emergencies, such as overdose, the need for detoxification, or for an increased level of care. Often, by deferring admission to individuals presenting even moderate risk, these events are kept to a minimum. Calling 911 is often the only plan given such an event.

DDC level programs have more formalized and documented guidelines, and staff can clearly articulate the policy in place. Emergencies may be a more common occurrence. The response to emergencies and crises is typically characterized by a more formalized relationship with a local addiction agency or the emergency services of a nearby hospital. This is a significant upgrade in capability from an internal or informal relationship with the local hospital emergency department staff or paramedics.

DDC PROGRAMS

Enhancing IVC. Procedures for intoxicated/high patients, relapse, withdrawal, or active users.

DDC 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. DDE programs can and do 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.

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.

IVD. Stage-wise treatment.

Definition: Within programs that treat individuals with co-occurring disorders, ongoing assessment of motivation or stage of change/treatment for both substance use and mental health 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 with clinicians, medical records including treatment plans/reviews, and progress notes.

Item Response Coding: Coding of this item requires an understanding of the program's protocol for the continued assessment and monitoring of the individual. Also required is an understanding about whether ongoing assessment motivation or stage or change/treatment for substance use and mental health is part of this continued follow-up. Note: Programs that do not routinely measure motivation or stage of change/treatment in the initial assessment are not likely to consistently address this issue during the course of treatment.

- **Mental Health Only Services = (SCORE-1):** *Not assessed or explicit in treatment plan.* The program does not monitor substance use and mental health motivation in an ongoing fashion throughout treatment.

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

- **Dual Diagnosis Capable = (SCORE-3):** *Stage of change or motivation routinely incorporated into individualized plan, but no specific stage-wise treatments.* The program has endorsed the concept of ongoing assessment of stage of change or motivation for mental health and has inserted this into clinical procedures. The program routinely (at least 80 percent of the time) assesses and documents mental health-related motivation throughout the treatment course, **but** treatments do not reflect these ongoing stage-wise assessments. This mismatch is often due to the generic application of core services or the placement of individuals into service tracts as opposed to an individualized approach.

- **(SCORE-4):** *Stage of change or motivation routinely incorporated into individualized plan; general awareness of adjusting treatments by mental health stage or motivation only.* There is some evidence that the program considers individual stage of change or motivation in delivering treatments for mental health disorders throughout the course of treatment, but this is done variably (less than 80 percent of the time). Stage of readiness related to substance use disorders is typically not assessed and/or not incorporated into treatment planning.

- **Dual Diagnosis Enhanced = (SCORE-5):** *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.* The program routinely assesses and documents stage of change or motivation for both substance use and mental health disorders throughout the course of treatment, **and** specific stage-wise treatments for both disorders are routinely provided (at least 80 percent of the time) to individuals based on these re-assessments.

MHOS PROGRAMS

Enhancing IVD. Stage-wise treatment.

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

MHOS programs may not assess stage of motivation upon admission, and are therefore even less likely to do so during treatment. Individual clinicians may understand the dynamic nature of motivation, in terms of its non-linearity and the difficulty of assessing its verbalized, inferred, and behavioral components.

DDC programs routinely assess and document motivation for mental health issues during treatment 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 sometimes modify treatments accordingly if only informally. For example, instead of developing a medication compliance plan with a patient in the precontemplation stage of change, staff deliver motivational enhancement interventions, engage significant others in treatment planning, or offer appropriate psychoeducational groups. DDC programs do not routinely assess stage of readiness related to substance use issues or deliver stage-wise addiction treatments.

Free resources to assess and build motivational interviewing skills are available. Clinical vignettes used to train clinicians on motivational interviewing principles are available at http://adai.washington.edu/instruments/VASE-R.htm.

Implementing and maintaining this evidence-based practice can be supported by strong clinical supervision. Supervisory tools for enhancing motivational interviewing proficiency are available at www.attcnetwork.org/explore/priorityareas/science/blendinginitiative/miastep/product_materials.asp.

DDC PROGRAMS

Enhancing IVD. Stage-wise treatment.

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 the appendices for examples of stage assessment instruments). Stage is directly correlated to the treatment plan objectives, drives the particular approach used by clinicians in individual and group sessions, and even determines level of care. DDE programs recognize that motivation to address mental health problems often differs from motivation to address substance use and provide tailored interventions.

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?"; 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 of substance use vs. mental health issues, and Bay Park House uses these to assign clients to different groups based on stage. There are motivational enhancement therapy groups for persons who are contemplative (SATS: Persuasion stage), cognitive behavioral therapy groups for those at the action stage (SATS: Active stage), and Twelve-Step Facilitation groups for people at the maintenance phase (SATS: Relapse Prevention stage).

IVE. Policies and procedures for evaluation, management, monitoring and compliance for/of medications for substance use disorders.

Definition: Programs that treat individuals with co-occurring disorders 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 compliance, as documented in a policy and procedure manual. In mental health settings, this specifically means policies and procedures regarding the use of medications for substance use disorders, including: 1) medications to treat intoxication states, decrease/eliminate withdrawal symptoms, decrease reinforcing effects of abused substances, promote abstinence, and prevent relapse; and 2) policies about the use of benzodiazepines or other potentially addictive medications.

Source: Interviews (preferably with the prescriber), policy and procedure manual, and medical records.

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.

- **Mental Health Only Services = (SCORE-1):** *Patients with active substance use routinely not accepted. No capacities to monitor, guide prescribing, or provide medications for substance use disorders during treatment.* The program does not admit individuals with active substance use. The program does not have procedures for managing, monitoring, or prescribing medications for the treatment of substance use disorders.

- **(SCORE-2):** *Certain types of medication for substance use disorders are not prescribed. Some capacity to monitor medications for substance use disorders.* The program does **not** have the capacity or procedures in place to guide the prescribing

of medications for management of substance use disorders. The program has limited capacity to accept and monitor individuals who take such medications, and may work in conjunction with the providers who prescribe these medications, **but** will not prescribe these medications as part of their service array.

- **Dual Diagnosis Capable = (SCORE-3):** *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.* The program provides some medications for the treatment of substance use disorders, but not a comprehensive array. The program maintains written policies and guidelines for prescribing medications for individuals with co-occurring substance use disorders who are admitted for treatment. **And:** The program has a formalized mechanism for accessing the services of a prescriber who is competent in the pharmacotherapy of addiction. In some cases, this prescriber may serve a supervisory or consultative service to other prescribers who are less experienced in the pharmacotherapy of addiction.

- **(SCORE-4):** *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.* The program maintains written standards and guidelines for prescribing and monitoring medications for individuals with co-occurring disorders. **And:** The program retains a staff person(s) who is a prescriber and is competent in the pharmacotherapy of addiction. However, the prescribing staff member(s) is not fully integrated

into the treatment team. The prescribing staff member(s) is frequently perceived as providing an adjunctive service to the program and tends to function in an independent fashion.

- **Dual Diagnosis Enhanced = (SCORE-5):** *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.* The program prescribes a comprehensive array of medications for the treatment of substance use disorders. The program maintains written standards and guidelines for prescribing medications to individuals with co-occurring disorders. **And:** The program retains a staff person(s) who is a prescriber competent in the pharmacotherapy of addiction. The prescriber is also fully integrated into the 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 treatment planning and administrative decisions.

MHOS PROGRAMS

Enhancing IVE. Policies and procedures for evaluation, management, monitoring and compliance for/of medications for substance use disorders.

Data obtained on this item are related to the staffing dimension, in particular item VIA: Psychiatrist or other physician or prescriber of addiction medications. Programs that do not have an onsite prescriber generally will not have formal policies and procedures to guide prescribing within the program.

MHOS programs typically have no patients who are on medication targeting addiction recovery, or the programs have informal or undocumented policies about what medications are appropriate. MHOS 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 evaluation, management, monitoring and compliance for/of medications for substance use disorders.

DDE programs are generally capable of accepting patients on most psychotropic medications, which may also extend to medications for other problems, such as STDs, HIV, chronic pain, hepatitis C, and hypertension.

Available medications may include those to treat intoxication states, decrease/eliminate withdrawal symptoms, decrease the reinforcing effects of abused substances, promote abstinence, and prevent relapse. Examples of these medications include acamprosate, naltrexone and disulfiram for alcohol dependence, and buprenorphine or methadone for opioid use disorders. Additionally, the program has policies that address the use of benzodiazepines or other potentially addictive medications.

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 mental health 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 mental health 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.

IVF. Specialized interventions with substance use disorders content.

Definition: Programs that treat individuals with co-occurring disorders utilize specific therapeutic interventions and practices that target substance use symptoms and disorders. There is a broad array of such interventions and practices that can be effectively integrated into treatment. Some interventions can be generically applied by programs. These interventions might include process groups and individual counseling that focus on barriers to recovery, relapse prevention strategies, and connecting with peer recovery support groups. More advanced clinical interventions for substance use disorders include motivational interviewing techniques, cognitive behavioral interventions specific to substance use problems, and twelve-step facilitation. Another level of specialized and more resource laden practices are integrated interventions for co-occurring disorders (typically for individuals with severe mental illness), which often include assertive outreach strategies,

intensive case management approaches, contingency management, and risk reduction strategies.

DDC programs will typically make co-occurring disorder adaptations to standard mental health treatment practices for group, individual, and psycho-educational formats (e.g., adding curriculum on relapse prevention to a depression treatment protocol). DDE programs will typically adapt psychological/behavioral therapies for substance use disorders for patients in mental health treatment programs. DDE programs also attempt to implement the available evidence-based treatments for persons with co-occurring disorders (e.g., Integrated Dual Disorders Treatment). There are presently few such integrated treatments, although many are in the development and testing stages.

Source: Interviews with staff and patients, review of treatment plans, progress notes, treatment schedule and/or curriculum, and observation of group treatment session if available.

Item Response Coding: Coding of this item requires an understanding of the program's array of services and interventions that focus on substance use concerns, symptoms, and disorders.

- **Mental Health Only Services = (SCORE-1):** *Not addressed in program content.* The program services do NOT include the incorporation of therapeutic interventions intended to specifically address substance use concerns, symptoms, or disorders.

- **(SCORE-2):** *Based on judgment by individual clinician; variable penetration into routine services.* The program inconsistently provides generic interventions for substance use symptoms and disorders. The variability is secondary to the judgment or expertise of the individual clinician.

- **Dual Diagnosis Capable = (SCORE-3):** *In program format as generalized intervention with penetration into routine services. Routine clinician adaptation of an evidence-based mental health treatment.* The program routinely incorporates (at least 80 percent of the time) substance use interventions for individuals with co-occurring disorders. This is translated to mean that individuals with co-occurring disorders who are treated within the program almost always receive treatment interventions that specifically target substance use disorders, **and** the type of substance use interventions at this level tends to be more broadly applicable, generic, and less resource intensive. Some clinicians may adapt evidence-based mental health treatments to include some interventions for substance use disorders. Examples include Assertive Community Treatment [ACT], cognitive behavior therapy, Interpersonal Psychotherapy [IPT], Illness Management and Recovery [IM&R], Psychosocial Rehabilitation [PSR].

- **(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 having some clinicians who offer components of more specialized interventions for substance use disorders.

- **Dual Diagnosis Enhanced = (SCORE-5):** *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.* The program routinely (at least 80 percent of the time) provides targeted, individualized substance use interventions to individuals with co-occurring disorders. This is translated to mean that individuals with co-occurring disorders almost always receive interventions for substance use disorders that are systematically provided (e.g., manual guided) and more resource intensive. Interventions may include: evidence-based addiction treatments (e.g., motivational interviewing, relapse prevention, cognitive-behavioral therapy/skills training, twelve-step facilitation) or integrated evidence-based treatments for persons with co-occurring disorders (e.g., Integrated Dual Disorders Treatment).

MHOS PROGRAMS

Enhancing IVF. Specialized interventions with substance use disorders content.

While the previous item addresses pharmacological interventions for addiction disorders in mental health treatment, this item addresses psychosocial interventions. These interventions do not necessarily require delivery by a licensed or certified addiction professional. However, they do require a trained clinician, who may also have additional certifications, or has attended workshops and received supervision in therapies with a particular co-occurring disorder (e.g., borderline personality disorder and addiction) or has had good training in twelve-step facilitation or cognitive behavioral therapy.

MHOS programs tend to address addiction problems as secondary to a primary mental health disorder. For instance, marijuana abuse may be viewed as a coping strategy used to deal with panic attacks. To reach the DDC level, however, the program must address the addiction problem more intentionally and explicitly. In DDC programs, this may be accomplished through 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 may be driven by clinician initiative rather than program design.

The authors of this guide recommend that DDC providers make thoughtful adaptations to evidence-based practices for mental health problems in order to apply them to substance use disorders. Although the terminology and definition of "evidence-based" is not consistent or regulated (McGovern & Carroll, 2003), resources are offered for manualized approaches that are supported by research. SAMHSA has made strides in creating a National Registry of Evidence-Based Programs and Practices.

Recommendations for evidence-based treatments that may be adapted for persons with co-occurring disorders can be obtained for free from the following websites:

National Institute on Drug Abuse Therapy Manuals
(www.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

National Institute on Alcohol Abuse and Alcoholism Therapy Manuals
(http://pubs.niaaa.nih.gov/publications/match.htm)

1. Twelve Step Facilitation Therapy
2. Motivational Enhancement Therapy
3. Cognitive Behavioral Coping Skills Therapy

SAMHSA Youth Treatment Manuals
(http://kap.samhsa.gov/products/manuals/cyt/index.htm)

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
(http://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 substance use disorders 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, such as Seeking Safety for persons with co-occurring PTSD and substance use; 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. Broad spectrum integrated behavioral therapies for co-occurring disorders that are stage-wise (e.g., Integrating Combined Therapies [ICT] are also an option.

Training is widely available in the approaches noted above, and in some regions certified trainers and supervisors are available. Often DDE programs recognize the need for specifically targeted treatments for the most prevalent substance use disorders 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 mental health 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, this toolkit provides links to resources for programs for persons with co-occurring disorders that either have been tested or documented. A review of evidence-based practices and empirically supported practices for addiction or co-occurring problems is beyond the scope of this toolkit. A general principle seems to be emerging from the research, however. It seems apparent that cognitive behavioral therapies for those conditions are routinely effective, although research is needed to substantiate its effectiveness with some co-occurring diagnoses. Studies with PTSD (Hein et al., 2004; McGovern et al., 2009), depression (Brown et al., 2001), social phobia (Randall et al., 2001), and other diagnostically heterogeneous groups (McEvoy & Nathan, 2007) support integrated cognitive behavioral therapy as a generically effective treatment for co-occurring disorders.

The toolkit references provide citations for specific studies and manuals related to the most common disorders: mood, anxiety (including PTSD and social phobia), Axis II disorders, and bipolar disorder and substance use.

The following is an excellent reference for cognitive behavioral therapy groups for depression, anxiety disorders, and dual disorders, with additional chapters on youth, older adults, and Latino group approaches:

White JR, Freeman AS. Cognitive-behavioral group therapy for specific problems and populations. Washington DC: American Psychological Association, 2002.

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

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

Information on other integrated treatments for adults and youth, including Integrated CBT and Integrating Combined Therapies (ICT) is available at http://www.ct.gov/dmhas/lib/dmhas/cosig/CODCurriculaGuide.pdf .

The Hazelden Co-Occurring Disorders Program for adults with co-occurring disorders in addiction treatment can be obtained at www.hazelden.org. It includes a stage-based curriculum that combines evidence-based motivational enhancement therapy, cognitive behavioral therapy, and Twelve-Step Facilitation, as well as a cognitive behavioral therapy curriculum specifically adapted for individuals with co-occurring disorders. Hazelden Publications also 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 are also available at the Hazelden site.

IVG. Education about substance use disorders, treatment, and interaction with mental health disorders.

Definition: Programs that offer treatment to individuals with co-occurring disorders provide education about mental health and substance use disorders, including treatment information and the characteristics, features, and interactive course of both types of disorders.

Source: Interviews with staff and patients, review of schedules of patient education groups, group curriculum, treatment plans, and progress notes.

Item Response Coding: Coding of this item requires an understanding of the program's educational components that address substance use disorders.

- **Mental Health Only Services = (SCORE-1):** *Not offered.* The program does not offer education about substance use disorders and treatment, or the interaction with mental health disorders.

- **(SCORE-2):** *Generic content, offered variably or by clinician judgment.* The program may occasionally offer education about substance use disorders and addiction treatment, but such programming tends to focus on substance use issues as they relate to mental health disorders and concerns.

- **Dual Diagnosis Capable = (SCORE-3):** *Generic content, routinely delivered in individual and/ or group formats.* The program routinely (at least 80 percent of the time) provides to all patients general education about substance use disorders, addiction treatment, and its interaction with mental health disorders and treatment. Examples include a general orientation to co-occurring disorders, educational lectures about substance use and substance use disorders (e.g., abuse and dependence), educational lectures about the connections between mental health symptoms and substance use, as well as medications for substance use disorders (e.g., medication assisted treatment) and the appropriate use of psychotropic medications, particularly those with abuse potential (e.g., benzodiazepines).

- **(SCORE-4):** *Specific content for specific co-morbidities; variably offered in individual and/ or group formats.* The program variably provides information about a patient's specific substance use disorder(s), including symptoms, treatment, and interaction with mental health disorders and treatment. This is primarily driven by individual clinician preference or competence.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Specific content for specific co-morbidities; routinely offered in individual and/or group formats.* The program regularly offers a combination of general education components to all patients as described at the DDC level. The program also incorporates more individualized instruction (at least 80 percent of the time) that addresses specific issues within substance use disorders. Instruction also addresses substance use treatment and its interaction with mental health disorders and treatment, as they relate to specific needs of the persons in treatment. Examples include topics such as interaction between alcohol and marijuana use and social anxiety. These instructional sets tend to be more in-depth, and they are designed to address specific needs and risks of individuals in treatment.

MHOS PROGRAMS

Enhancing IVG. Education about substance use disorders, treatment, and interaction with mental health disorders.

It is widely believed that educating patients about the nature and treatment of their disorders will improve understanding and compliance. It may also increase the likelihood of positive outcomes. Didactic presentations on aspects of substance use, its effect on the family, and the role of peer recovery support groups in long-term recovery are a longstanding tradition in addiction treatment. MHOS programs may continue with this tradition with regard to mental health disorders or recovery, but they do not routinely offer information related to substance use, its consequences, or recovery.

DDC programs routinely provide information about substance use disorders through general lectures,

group therapy or community meetings, family sessions, and/or individual sessions. They may offer a medication group where the differences between drugs and medications are discussed, and the role of medication in peer recovery traditions is explored. These efforts are a substantial improvement over the attention paid to addiction problems by MHOS programs. These services may include some effort to help people increase their motivation to change, understand their current treatments, express the risks in not following through with treatments in terms of their abstinence from substance use, and have some understanding of the role of the family (including inheritability issues) in both the mental health and substance use disorders.

DDC PROGRAMS

Enhancing IVG. Education about substance use disorders, treatment, and interaction with mental health disorders.

DDE programs, in contrast to DDC programs, deliver didactic and informative material to patients about co-occurring disorders in a systematic, individualized manner. These may be via informational sessions 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 he or she has multiple disorders, that these disorders interact, that there are treatments for each, and that recovery 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 online from the SAMHSA and the National Institutes of Health. For example, the

National Institute of Mental Health (2000) provides a detailed booklet on depression for clients. It describes symptoms, causes, and treatments, with information on getting help and coping www.nimh.nih.gov/health/publications/depression/index.shtml.

Hazelden offers free fact sheets and educational handouts at www.cooccurring.org/public/handouts.page. Hazelden Publications has also produced DVDs for adults with co-occurring disorders and adolescents with co-occurring disorders. Each is 30 minutes in length and can be viewed by groups or individual patients. These can be used for educational purposes and also to initiate a discussion about specific co-occurring disorders.

IVH. Family education and support.

Definition: Programs that offer treatment to individuals with co-occurring disorders provide education and support to family members regarding mental health and substance use disorders. This includes treatment information and the characteristics and features of both types of disorders. This aspect of programming is designed to educate family members about realistic expectations, the interactive course of the disorders, and the positive prospects for recovery. It is also designed to provide a supportive environment for family members to address specific concerns and be involved in the individual's treatment as necessary. Family education and support can occur in individual or group formats. Family is broadly defined to include significant others and members of support systems.

Source: Interviews with clinicians and patients, schedule of group therapies and support groups, and review of treatment plans and progress notes.

Item Response Coding: Coding of this item requires an understanding of the program's educational and supportive components for the family (broadly defined) of individuals with co-occurring disorders.

- **Mental Health Only Services = (SCORE-1):** *For mental health disorders only, or no family education at all.* The program may provide education and support to family members, but the focus tends to be only on mental health disorders.

- **(SCORE-2):** *Variably or by clinician judgment.* The program sometimes provides education or support to families regarding substance use disorders and may at times address substance use issues if raised. These services are informally conducted and usually depend on the competency and preference of the treating clinician.

- **Dual Diagnosis Capable = (SCORE-3):** *Substance use disorders routinely but informally incorporated into family education or support sessions. Available as needed.* The program offers a formalized mechanism that routinely offers general educational groups and support to families of individuals with co-occurring disorders. While this service might be regularly accessed, it would not be considered a standard part of the routine program format.

- **(SCORE-4):** *Generic family group on site on substance use and mental health disorders, variably offered. Structured group with more routine accessibility.* The program meets the criteria for DDC in that it has established an educational group and support to families of individuals with co-occurring disorders. In addition, the program makes some effort to incorporate this service regularly into the interventions, but this occurs less than 80 percent of the time.

- **Dual Diagnosis Enhanced = (SCORE-5):** *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.* The program routinely provides education and support groups to families of individuals with co-occurring disorders, including information on specific disorder comorbidities, **and** the provision of this service is considered a standard part of the treatment intervention. The majority of families of individuals with co-occurring disorders regularly participate in these activities.

MHOS PROGRAMS

Enhancing IVH. Family education and support.

The MHOS program seeking to attain DDC status on this item will need to include many of the same ingredients identified in item IVG (Education about substance use disorders, treatment, and interaction with mental health disorders), but directed towards family members. Mental health treatment programs vary in the inclusion of family members in services. "Family" is often broadened to include significant others, and family members may be a major support or risk factor in ongoing recovery. Many evidence-based practices for substance use disorders use family or couples formats, and it is now widely believed that including family members will augment outcomes. MHOS programs may educate families about mental health and recovery, with a singular focus on symptoms. Typically, MHOS programs do not provide information on Al-Anon to family members.

DDC programs use either individual family sessions or multi-family groups to deliver information and support. These sessions may be required in order to visit the identified patient and often present the co-morbid addiction problem as a complicating factor in recovery. The importance of self-help groups to support recovery may be emphasized. Advanced DDC programs may begin to discuss familial and genetic predispositions, medications vs. drugs, and mutual support organizations such as Al-Anon for family members. These are not protocol-driven and are more often initiated by individual clinicians, particularly staff with a background in family systems or therapies.

DDC PROGRAMS

Enhancing IVH. Family education and support.

DDE programs routinely offer services to family members or significant others of people with addictive, mental health, and co-occurring disorders. Services in DDE programs involve systematic and protocol-driven didactics and materials, as well as an individualized presentation to family members on the interactive risks of co-occurring disorders, in terms of etiology, course, compliance, and recovery. Educational materials are routinely distributed to family members and significant others. They learn about the multiple disorders faced by their identified patient. 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. You can find it online at http://store.samhsa.gov/product/Family-Psychoeducation-Evidence-Based-Practices-EBP-KIT/SMA09-4423.

Hazelden Publications has also produced DVDs for adults with co-occurring disorders and adolescents with co-occurring disorders. Each is 30 minutes in length and can be viewed by families individually or in multi-family groups. These can be used for educational purposes and also to initiate a discussion specific to the co-occurring disorder of their family member. The Hazelden Co-Occurring Disorders Program also includes educational resources and a family curriculum. Hazelden is online at www.hazelden.org.

IV. Specialized interventions to facilitate use of peer support groups in planning or during treatment.

Definition: Mental health programs that offer treatment to individuals with co-occurring disorders provide assistance to individuals in developing a support system through peer recovery support groups. Individuals with co-occurring disorders often face additional barriers in linking with peer support groups. These individuals may require additional assistance, such as being referred, accompanied, or introduced to these groups by clinical staff, designated liaisons, or peer support group volunteers. Additional interventions may be required to help individuals find peer support groups with accepting attitudes toward people with co-occurring disorders and toward the use of psychotropic medication.

Source: Interviews with clinicians and patients, schedule or calendar of available peer recovery support groups, and review of treatment plans and progress notes.

Item Response Coding: Coding of this item requires an understanding of the mechanism through which individuals, specifically those with co-occurring disorders, are linked with peer support groups.

- **Mental Health Only Services = (SCORE-1):** *No interventions made to facilitate use of either 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 substance use disorders to peer support groups.

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

- **Dual Diagnosis Capable = (SCORE-3):** *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).* The program routinely encouraging the use of peer support groups for patients with co-occurring disorders. While the mechanisms to achieve this goal tend to be general and not specific to the individual, they are consistently used. Examples of this include providing individuals with a schedule of peer support groups or making some initial contacts made on their behalf. This is considered to be a standard aspect of the program and occurs at least 80 percent of the time.

- **(SCORE-4):** *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).* Individualized facilitation occurs, including that for peer support groups specifically for patients with co-occurring disorders. However, this is only occasionally documented in charts.

- **Dual Diagnosis Enhanced = (SCORE-5):** *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).* The program systematically advocates for the use of peer support groups with their patients who have co-occurring disorders. Treatment plans and/or progress notes indicate that linkage with peer support groups is regularly discussed with patients. Specialized assistance in making this linkage attempts to proactively plan for potential barriers or difficulties that the patient might experience in the peer support group environment. Examples of individualized approaches to linking a patient with a peer-support group include the following: (1) identifying a liaison, who assists the individual in transitioning

to the group; (2) consultation with the peer support group on behalf of the individual regarding specialized mental health needs of the individual; (3) an onsite "transition group" with specific peer support group members who have some willingness to discuss co-occurring mental health problems

pertaining to use of the peer support group in the community; and (4) assisting individuals to identify specific strategies to help them connect with peer recovery support groups. This specialized support to the individual is a standard part of program activities.

MHOS PROGRAMS

Enhancing IVI. Specialized interventions to facilitate use of peer support groups in planning or during treatment.

Involvement with mutual aid groups, including traditional twelve-step groups such as AA or NA, is associated with long-term recovery and positive life changes. These groups typically embrace a chronic disease model that understands addiction as a lifelong vulnerability, offer a fellowship of non-using peers, provide an explanatory model with suggested steps for change, and have no dues or fees.

There is some evidence to suggest persons with co-occurring disorders have difficulty affiliating and participating in some addiction peer support groups. Integrated treatment approaches to Twelve Step Facilitation Therapy have been developed (e.g. Integrating Combined Therapies). In addition, co-occurring specific recovery groups now exist: Double Trouble in Recovery and Dual Recovery Anonymous. When new co-occurring peer groups are first begun, they have had varying degrees of success, and they are not yet readily available in many communities. In some areas, twelve-step groups for addiction may be optimal, since they have more members with significant periods of sobriety, have clearer guidelines about operations (traditions), and have more available meetings.

MHOS programs typically do not offer special interventions to bridge a person with co-occurring disorders into peer recovery supports. DDC programs, by identifying a mental health problem, will individualize a referral to mutual aid group for mental health problems, such as NAMI or Procovery, or to appropriate peer recovery support groups. The DDC

program presents generic information through individual sessions, group sessions, or onsite meetings to help a person with a co-occurring disorder learn how to join, participate, and benefit from these groups. At the DDC level, these efforts are not systematic but are more often initiated by individual clinicians, many of whom have a personal or working understanding of how certain meetings in the community accept persons with co-occurring disorders.

Two manualized evidence-based treatments focus on facilitating a connection with peer group support in the community. Although neither of these approaches specifically addresses co-occurring barriers, the approaches can be adapted:

National Institute on Drug Abuse (NIDA) Therapy Manuals for Individual Drug Counseling and Group Drug Counseling

(www.nida.nih.gov/DrugPages/Treatment.html)

National Institute on Alcohol Abuse and Alcoholism (NIAAA) Therapy Manual for Twelve-Step Facilitation Therapy

(http://pubs.niaaa.nih.gov/publications/match.htm)

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

DDC PROGRAMS

Enhancing IVI. Specialized interventions to facilitate use of peer support groups in planning or during treatment.

In contrast to DDC programs, DDE programs may have co-occurring recovery groups on site, and will routinely and systematically address the possible difficulties of specific co-occurring disorders. For example, staff may help a person with depression learn about the role of medications in recovery and how to (or not) discuss medicines in groups. Staff may also assist a person with social phobia in 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. Other assistance may include 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 peer support groups.

Dual Recovery Anonymous groups (www.draonline.org) and Double Trouble in Recovery groups (http://nrepp. samhsa.gov/ViewIntervention.aspx?id=13) are the most common peer recovery groups designed specifically for people with co-occurring disorders.

In the absence of local dual recovery groups, DDE programs use intentional and routine facilitation approaches to AA and NA groups for medication, anxiety, avoidance, sponsorship, and speaking challenges common among persons with co-occurring disorders.

IVJ. Availability of peer recovery supports for patients with co-occurring disorders.

Definition: Mental health programs that offer treatment to individuals with a co-occurring substance use disorder encourage and support the use of peer supports and role models that include consumer liaisons, alumni groups, etc. Assistance is provided to individuals in developing a support system that includes the development of relationships with individual peer supports. (Peer support groups are described in the previous item.) For the purpose of this item, peer is defined as a person with a co-occurring disorder.

Source: Interviews with clinicians and patients, review of treatment plans, listing or calendar of available peer recovery supports, understanding of onsite peer recovery supports, consumer liaisons, and alumni staff.

Item Response Coding: Coding of this item requires an understanding of the availability of co-occurring disorders-specific peer supports and role models.

- **Mental Health Only Services = (SCORE-1):** *Not present, or if present not recommended.* The program does not support or guide individuals with co-occurring substance use disorders toward peer supports or role models with co-occurring disorders.

- **(SCORE-2):** *Off site, recommended variably.* The program may occasionally offer referrals to offsite peer supports, primarily individuals with mental health disorders. This is largely dependent on the providers' preferences and knowledge of the available individual supports in the area.

- **Dual Diagnosis Capable = (SCORE-3):** *Off site and facilitated with contact persons or informal matching with peer supports in the community, some co-occurring focus.* The program routinely (at least 80 percent of the time) attempts to refer and link individuals with co-occurring substance use disorders to peer supports and role models located off site, some of whom have co-occurring disorders. This is considered a standard support service that can be offered to individuals, but it is not incorporated into treatment planning.

- **(SCORE-4):** *Off site, integrated into plan, and routinely documented with co-occurring focus.* The program routinely (at least 80 percent of the time) integrates offsite peer recovery supports into the treatment plan for individuals with co-occurring substance use disorders. Utilization of recovery supports is considered a part of standard programming, and treatment plans consistently reflect the utilization of these peer recovery supports.

- **Dual Diagnosis Enhanced = (SCORE-5):** *On site, 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 developing these peer supports on site. Treatment plans consistently document the utilization of these recovery supports.

MHOS PROGRAMS

Enhancing IVJ. Availability of peer recovery supports for patients with co-occurring disorders.

A MHOS score on this item is associated with a program's score on the previous item (IVI. Specialized interventions to facilitate use of peer support groups in planning or during treatment.). MHOS 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 may 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 shared addiction or mental health problems. These efforts are typically clinician-driven and not a routine aspect of a protocol designed to link peers who may identify with each another regarding common co-occurring disorder issues.

DDC programs take these steps intentionally but not in a routine or particularly formalized way.

DDC PROGRAMS

Enhancing IVJ. Availability of peer recovery supports for patients with co-occurring disorders.

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 of addiction or mental health disorders in their background, and the need the individual has to learn how to live with both disorders. This matching is part of the program's protocol (rather than clinician-driven) and may involve partnerships with volunteer boards, program alumni, the twelve-step Hospital and Institution committees, volunteer mentors, or "bridging the gap" groups.

The City Clinic has responded to this crucial issue through the establishment of weekly "bridge" groups, co-led by recovering volunteers and a staff member. A segment of the group is dedicated to co-occurring issues with the goal being the development of individual peer support relationships.

A key feature in the DDE program is creating onsite peer support connections and having a formal protocol to ensure the ongoing availability of these supports.

V. Continuity Of Care

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

Definition: Programs that offer treatment to individuals with a co-occurring substance use disorder develop discharge plans that include an equivalent focus on needed follow-up services for both mental health and substance use disorders.

Source: Discharge plans, memoranda of understanding.

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 substance use disorders.

- **Mental Health Only Services = (SCORE-1):** *Not addressed.* The discharge plans of individuals with co-occurring disorders routinely focus on mental health disorders **only** and do **not** address substance use disorders.

- **(SCORE-2):** *Variably addressed by individual clinicians.* Within the program, the discharge plans of individuals with co-occurring disorders occasionally address both the substance use and mental health disorder, with the mental health disorder taking priority. The variability is typically due to individual clinician judgment or preference.

- **Dual Diagnosis Enhanced = (SCORE-3):** *Co-occurring disorder systematically addressed as secondary in planning process for offsite referral.* Within the program, the discharge plans of individuals with co-occurring disorders routinely (at least 80 percent of the time) address both the substance use and mental health disorders, **but** the mental health disorder takes priority and is likely

to continue to be managed within the program's overall system of care or by the next mental health treatment provider. Follow-up substance use services are managed through an offsite linkage, and are often generically addressed (e.g., "remain abstinent") as part of the discharge plan.

- **(SCORE-4):** *Some capacity (less than 80 percent of the time) to plan for integrated follow-up, i.e., equivalently address both substance use and mental health disorders as a priority.* Discharge plans occasionally include appropriate follow-up services for both disorders equally. The variability is secondary to the judgment or expertise of the individual clinician.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Both disorders seen as primary, with confirmed plans for onsite follow-up, or documented arrangements for offsite follow-up; at least 80 percent of the time.* The discharge plans of individuals with co-occurring disorders routinely (at least 80 percent of the time) address both the substance use and mental health disorder. **And:** Both disorders are considered a priority, with equivalent emphasis placed on ensuring appropriate follow-up services for both disorders. The agency may have the capacity to continue management and support of both disorders in-house or have a formalized agreement with addiction agencies to provide the needed services. In the case of discharge from the agency (not just the mental health program), appropriate services are identified to address both disorders. Referrals are routinely made, confirmed, and documented in the discharge plan. The program has specific protocols that guide the discharge process.

MHOS PROGRAMS

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

Since MHOS programs often do not list the co-existing substance use disorder or problem on the treatment plan, it may not be a subject for intentional discharge planning. In order to achieve DDC status, the MHOS program must make a more deliberate plan post-discharge and consider the potential interaction of the co-occurring disorders. DDC programs will conceptualize mental health disorders as primary, but will also underscore the importance of appropriate psychosocial and pharmacological treatments for substance use disorders and will make discharge plans accordingly. Collaborative relationships with addiction treatment providers are particularly important here, since successful linkage is predicated on a close relationship and clear protocol shared by providers. Programs that admit from and discharge back to wide geographic areas may not have these relationships with every provider, but every effort is made to formally arrange services prior to discharge. The discharge process, in considering both disorders, retains a largely clinician-driven rather than 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 mental health and substance use disorders. Treatment providers and interventions, medications and dose, recovery supports and relapse risks for both disorders are well described and routinely documented for all patients with co-occurring disorders. The DDE program takes a routine approach to this co-occurring informed discharge process, resulting in a systematic rather than clinician-driven discharge plan.

The Miracles detoxification program transfers men from their clinically-managed setting to an affiliated addiction outpatient treatment program that has a collaborative agreement with a local mental health clinic. Miracles staff schedules an initial appointment prior to discharge and arranges for a primary caregiver to accompany the patient on this visit. Upon discharge from detoxification services, a patient has already visited the outpatient program (which offers mental health and addiction treatment) and has met his counselor. This process has improved linkage to both programs and addresses both substance use and mental health problems equally.

VB. Capacity to maintain treatment continuity.

Definition: When programs address the continuum of treatment needs for individuals with co-occurring disorders, there should be a formal mechanism for providing ongoing needed substance use follow-up. Best practice indicates that substance use concerns are followed-up and monitored in a manner that is integrated with traditional mental health 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 with a goal of illness management.

Source: Interview with clinicians, medical records, and policy and procedure manual.

Item Response Coding: Coding of this item requires an understanding of the continuity of care available for the continued treatment and monitoring of substance use disorders in conjunction with mental health disorders. Outpatient programs, or programs in an agency with an outpatient component, will have a greater capacity to provide ongoing follow-up services, even if linkage with another level of care is necessary. Inpatient or residential programs that stand alone or serve a large geographic area may not have this option.

- **Mental Health Only Services = (SCORE-1):**
  No mechanism for managing ongoing care of substance use disorder needs when mental health treatment program is completed. With regard to treatment continuity, the program's system of care may offer follow-up care for mental health disorders **only**, and there is no internal mechanism for providing follow-up care, support, or monitoring of substance use disorders. Follow-up substance use treatment is referred to an offsite provider without any formal consultation or collaboration. Programs at this level may discharge individuals for relapse to substance use with minimal expectation or preparation for returning for services.

- **(SCORE-2):** *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.* With regard to treatment continuity, the program's system of care is similar to that of an MHOS system, but there are individual clinicians who are competent and willing to provide follow-up care and monitoring of co-occurring substance use disorders.

- **Dual Diagnosis Capable = (SCORE-3):** *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.* With regard to treatment continuity, the program's system of care has the capacity to provide **continued monitoring/support** for substance use disorders in addition to any regularly provided follow-up care for mental health disorders. These services are either ongoing or last until the patient is systematically linked to substance use services off site through collaborative efforts. The program does not routinely discharge a patient for exacerbation of mental health symptoms or substance use relapse, but instead reviews on a case-by-case basis with the goal of maintaining the individual in treatment when possible; if referral to another level of care is necessary, the program ensures a rapid return for a new episode of program services when indicated.

- **(SCORE-4):** *Formal protocol to manage substance use disorder needs indefinitely, but variable documentation 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 provide **continued monitoring and treatment** for substance use disorders in addition to any regularly provided follow-up care for mental health disorders, but use of this continuum is inconsistently documented.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Formal protocol to manage substance use disorder needs indefinitely and consistent documentation 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 substance use and mental health disorders over an extended or indefinite period. Onsite clinical recovery check-ups may be an annual or more frequent option in this type of program. The program, within its scope of practice, treats exacerbation of mental health symptoms and substance use relapse on an individualized basis and maintains individuals in treatment whenever possible. If referral to another level of care is necessary, the program ensures a rapid re-admission when indicated.

MHOS PROGRAMS

Enhancing VB. Capacity to maintain treatment continuity.

MHOS programs may discharge persons with co-occurring disorders who present severe mental health symptoms, or who relapse or "slip" in substance use. In order to achieve DDC status, MHOS programs will need to develop increased clinical flexibility to treat the exacerbation of mental health symptoms and to address return to substance use which considers 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 substance use problem, and if the patient is sufficiently stable, he or she will remain in the current program. If a referral is required (preferably within the same agency or to an addiction treatment agency with whom there is a memorandum of understanding), the program 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, is not a barrier to immediately accepting the patient back.

Outpatient DDC programs have the capacity to treat both disorders (substance use and mental health) 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 link to follow-up services through a collaborative relationship with the local addiction treatment provider.

DDC PROGRAMS

Enhancing VB. Capacity to maintain treatment continuity.

DDE programs recognize the chronic nature of addiction and most co-existing mental health disorders. DDE programs, in contrast to DDC, are typically able to provide in-house or within-agency services that promote a patient experience of a seamless continuum of care. Patients understand and can verbalize that this is a program that may be in a position to continue with them for the foreseeable future, if not indefinitely. DDE programs do not see the mental health disorders as primary, but rather maintain continuity for both disorders in an equivalent fashion.

VC. Focus on ongoing recovery issues for both disorders.

Definition: Programs that offer services to individuals with co-occurring disorders support the use of a recovery philosophy (vs. symptom remission only) for both substance use and mental health disorders.

Source: Interviews with clinicians and patients, document review (mission statement, brochure, policy and procedure manual), and review of treatment plans.

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 use and mental health disorders.

- **Mental Health Only Services = (SCORE-1):** *Not observed.* The program embraces the philosophy of the recovery for mental health disorders only. Substance use recovery is not incorporated.

- **(SCORE-2):** *Individual clinician determined.* The program embraces the philosophy of recovery for mental health disorders only, BUT there are individual clinicians who use a recovery philosophy when planning services for substance use disorders as well.

- **Dual Diagnosis Capable = (SCORE-3):** *Routine focus is on recovery from mental health disorders, addiction viewed as potential relapse issue only.* The program systematically embraces the philosophy of recovery for mental health disorders, and substance use issues are only considered as they impact recovery from the mental health disorder. For example, a substance use disorder is perceived as a recovery issue in terms of its probability of leading to recurrence/ exacerbation of the mental health disorder if not appropriately treated. Substance use 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 management and recovery, both seen as primary and ongoing.* The program embraces the philosophy of recovery equivalently for both substance use and mental health disorders, and articulates specific goals for persons to achieve and maintain recovery that include both mental health and substance use objectives.

MHOS PROGRAMS

Enhancing VC. Focus on ongoing recovery issues for both disorders.

MHOS programs will typically focus on recovery from mental health disorders. Emphasis will be placed on those traditional approaches that have been found to be effective, such as medication, case management, and therapy. Although these steps are in fact associated with long-term positive outcomes, another disorder and recovery process will need to be embraced for the person with co-occurring addiction.

DDC programs add to the recovery path outlined above with some emphasis on how substance use problems complicate or are a risk factor to one's recovery from mental health disorders. This may include continuing care for substance use disorders, twelve-step group affiliation, finding a sponsor, working the steps, and remaining abstinent one day at a time.

DDC PROGRAMS

Enhancing VC. Focus on ongoing recovery issues for both disorders.

Whereas the DDC level program recognizes recovery from mental health disorders as primary and substance use 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: http://store.samhsa.gov/product/Illness-Management-and-Recovery-Evidence-Based-Practices-EBP-KIT/SMA09-4463.

The key is that recovery from both disorders is seen as equally important and interactive. The similarity in terms of the distinction between symptom remission and recovery is imparted in the DDE program.

Recovery for both addiction and mental health disorders is presented to patients as a positive lifestyle change and personal transformation. Recovery extends well beyond simple symptom remission or the absence of behavioral health problems. Instead, recovery embraces a new life filled with hope, promise, and opportunity.

VD. Specialized interventions to facilitate use of community-based peer support groups during discharge planning.

Definition: Programs that offer services to individuals with co-occurring disorders anticipate difficulties that the individuals with co-occurring disorders might experience when linking or continuing with peer recovery support groups in the community. Thus these programs provide the needed assistance to support this transition beyond active treatment.

Source: Interviews with clinicians and patients, review of progress notes, and discharge procedures.

Item Response Coding: Coding of this item requires an understanding of peer recovery support groups within the program's continuum of services and the systems for facilitating the connection with groups in the community. Note: Some programs have difficulty with specialized interventions to facilitate the use of peer support groups while the individual is in treatment. These programs will likely have difficulty meeting this goal when the individual is discharged.

- **Mental Health Only Services = (SCORE-1):** *No interventions made to facilitate use of either community addiction or mental health peer support groups upon discharge.* The program does not advocate or assist with linking individuals with co-occurring disorders to peer support groups beyond recommendations, assignments, meetings lists, and suggestions to "find a group" and/or "attend meetings."

- **(SCORE-2):** *Used variably or infrequently by individual clinicians for individual patients, mostly for facilitation to mental health peer support groups upon discharge.* The program does not advocate or generally assist with linking individuals with co-occurring disorders to peer support groups and does not document such attempts. However, there is some indication that it may happen as a result of clinician judgment or preference. A connection specific to co-occurring disorders may be variably developed.

- **Dual Diagnosis Capable = (SCORE-3):** *Generic, but no specific or intentional facilitation based on substance use disorders. More routine facilitation to use mental health peer support groups (e.g., NAMI, Procovery) upon discharge.* The program facilitates the process of linking individuals with co-occurring disorders to primarily mental health peer support groups at discharge. This is not a systematic part of standard discharge planning but occurs with some frequency. Interventions might include providing a list of mental health or addiction peer support meetings that are more tolerant of individuals with substance use disorders, discussing the difference between taking medications vs. mood-altering drugs, and finding an appropriate sponsor.

- **(SCORE-4):** *Assertive linkages and interventions variably made targeting specific co-occurring needs to facilitate use of peer support groups or groups specific to both disorders (e.g., DRA, DTR) upon discharge.* The program sometimes facilitates the process of assertively matching individuals with co-occurring disorders to peer support recovery groups at discharge. This is not a part of standard discharge planning but occurs with increasing frequency (at least 50 percent of the time).

- **Dual Diagnosis Enhanced = (SCORE-5):** *Assertive linkages and interventions routinely made targeting specific co-occurring needs to facilitate use of peer support groups or groups specific to both disorders (e.g., DRA, DTR) upon discharge.* The program routinely recognizes the difficulties of individuals with co-occurring disorders in linking or continuing with peer support groups. It routinely (at least 80 percent of the time) 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 onsite peer support meetings indefinitely.

MHOS PROGRAMS

Enhancing VD. Specialized interventions to facilitate
use of community-based peer support groups during discharge planning.

Item IVI. (Specialized interventions to facilitate use of peer support groups in planning or during treatment) 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 extends this line of clinical reasoning through discharge and supports the future plans of the patient. MHOS 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 attended self-help meetings to the degree it satisfies program requirements, and once these requirements are lifted the patients may no longer attend. Other patients will attend, but not participate. This may be helpful in fostering remission, but

may not lead to lifestyle and psychological changes (transformations) that a person who participates fully could expect.

DDC programs have made efforts to match the patient with community peer recovery support groups, with a plan to foster the connection and deepen the patient's relationships with other non-using people. These can either be traditional twelve-step groups such as AA and NA, or co-occurring specific groups such as Dual Recovery Anonymous or Double Trouble. Further, it is hypothesized that these connections provide mentors or role models who can guide the newcomer on a course of recovery. DDC programs note this in the discharge planning process, and may offer the patient the opportunity to return for alumni events.

DDC PROGRAMS

Enhancing VD. Specialized interventions to facilitate
use of community-based peer support groups during discharge planning.

The DDE program expands on the usual practices of the DDC program on this item by an increase in systematization and use of a protocol-driven process (rather than one that is clinician-initiated). DDE programs ensure the routine introduction of current patients to peer support group members with an eye toward matching. Peer contacts will have accompanied patients to meetings in the community until sufficient linkage and comfort has been verified. DDE programs

may offer in-house Dual Recovery Anonymous or twelve-step meetings that patients can attend indefinitely as alumni.

Since co-occurring recovery peer support groups are less available in some areas, DDE programs ensure smooth linkage and integration with more traditional and readily available community peer support groups, such as AA and NA where appropriate.

VE. Sufficient supply and compliance plan for medications for substance use disorders (see IVE) are documented.

Definition: Programs that serve individuals with co-occurring disorders have the capacity to assist them with medication planning, prescription and medication access and monitoring, and prescribing sufficient supplies of medications for substance use disorders at discharge.

Source: Interview with clinicians and prescriber, discharge procedures, and review of discharge plans.

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

- **Mental Health Only Services = (SCORE-1):** *No medications in plan.* When an individual with a co-occurring substance use disorder is discharged, the program does not offer any accommodations with regard to medication planning for the substance use disorder other than recommending the individual consult with a prescriber or making an appointment on her/his behalf.

- **(SCORE-2):** *Variable or undocumented availability of 30-day or supply to next appointment off site.* When an individual with a co-occurring substance use disorder is discharged, the program may prescribe a 30-day supply of medication for substance use disorders to "bridge" the individual until his/her next appointment. This is not a consistent or documented program practice.

- **Dual Diagnosis Capable = (SCORE-3):** *Routine 30-day or supply to next appointment off site. Prescription and confirmed appointment documented.* When an individual with a co-occurring substance use disorder is discharged, the program has the capacity to provide medication planning and prescribes a 30-day or short-term supply of medications for substance use disorders until the individual can be linked for follow-up prescriptions at an external site. The follow-up appointment is arranged and confirmed by the program with some exchange of information to the referral site, and the appointment and bridge prescription are documented in the chart.

- **(SCORE-4):** *Maintains medication management in program/agency until admission to next level of care at different provider (e.g., 45 to 90 days). Prescription and confirmed admission documented.* The program meets the standards set at DDC and has the capacity to prescribe a longer-term "bridge" supply of medication.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Maintains medication management in program with provider.* When an individual with a co-occurring substance use disorder is discharged, the program or agency has the capacity to provide continued substance use disorder medication management including prescribing within the program/agency for an indefinite period.

MHOS PROGRAMS

Enhancing VE. Sufficient supply and compliance plan for medications for substance use disorders (see IVE) are documented.

MHOS programs are likely not in position to distribute a supply of medication, but they do encourage linkage, collaboration, or consultation with the local prescriber and/or pharmacy. DDC programs may have continued or initiated psychotropic medication and ensure that 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 ensures acknowledgement and successful linkage.

DDC PROGRAMS

Enhancing VE. Sufficient supply and compliance plan for medications for substance use disorders (see IVE) are 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 are DDC providers. Medication is seen to be one key part of an overall strategy of co-occurring recovery and illness management.

VI. Staffing

VIA. Psychiatrist or other physician or prescriber of medications for substance use disorders.

Definition: Programs that offer treatment to individuals with co-occurring disorders offer pharmacotherapy for both the mental health disorder and the substance use 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 compliance, decrease the use of potentially addictive medications such as benzodiazepines, and offer medications such as disulfiram, naltrexone, acamprosate, or buprenorphine that are used in the treatment of substance use disorders.

Source: Interviews with program director and clinical staff (and prescriber if possible).

Item Response Coding: Coding of this item requires an understanding of the specific competencies of the prescribing professional and his or her level of involvement with the clinical treatment team.

- **Mental Health Only Services = (SCORE-1):** *No formal relationship with a prescriber for this program.* The program has no formal relationship with a prescriber who is experienced and competent to prescribe medications for individuals with a co-occurring substance use disorder.

- **(SCORE-2):** *Consultant or contractor off site.* The program has an arrangement with a prescriber, who is experienced and competent to prescribe medications for substance use disorders, to serve as a consultant or as an offsite provider.

- **Dual Diagnosis Capable = (SCORE-3):** *Consultant or contractor on site.* The program has an arrangement with a prescriber, who is experienced and competent to prescribe medications for substance use disorders, to serve as either a consultant or contractor who renders 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 on site for clinical matters only.* The program has a prescriber, who is experienced and competent to prescribe medications for substance use disorders, as an onsite staff member to provide specific clinical duties, but who does **not** routinely participate in the organized activities of a clinical team. This prescriber may be accessed by staff on a limited basis, but this is not routine.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Staff member present on site for clinical, supervision, treatment team, and/or administration.* The program has a prescriber, who is experienced and competent to prescribe medications for substance use disorders (including those with advanced credentials in addiction psychiatry or addiction medicine), as an onsite staff member. **And:** This prescribing staff member is also an active participant in the full range of the program's clinical activities, is an integral member of the clinical team, and may serve in a key clinical decision-making or supervisory role.

MHOS PROGRAMS

Enhancing VIA. Psychiatrist or other physician or prescriber of medications for substance use disorders.

Many addiction treatment providers consider this item to be pivotal and challenging to achieve. Access to a psychiatrist, physician, or other prescriber can provide a foundation that moves a program from MHOS to DDC and is associated with many other aspects of co-occurring capability. However, even programs with physician coverage along with policies for clinical practice and patient admission criteria may be rated at the MHOS level.

MHOS programs typically do not have a formal relationship with a prescriber. They must refer patients in need of addiction 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 physician or prescriber of medications for substance use disorders.

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 can be formally or informally augmented to allow clinical meetings with a team or individual staff. To the extent the prescriber can act in a clinical leadership capacity and in a teaching and supervision role, the program may enhance its co-occurring capability. These relationships are often stronger if formalized and recognized. We have also seen prescribers who act as unofficial leaders for a clinical team.

In order to become DDE, Deerpath Associates decided to ask their nurse practitioner to attend weekly clinical team meetings. These meetings occurred every Wednesday morning from 9:00 to 10:30. The nurse practitioner actively participated in the morning meetings, which not only cut down on the amount of time staff needed to contact her by e-mail 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.

VIB. Onsite clinical staff members with substance abuse licensure, certification, competency or substantive experience.

Definition: Mental health programs that offer treatment to individuals with co-occurring disorders employ persons with expertise in substance use disorders to enhance their capacity to treat the complexities of co-occurring disorders.

Source: Program director interview, review of staff composition.

Item Response Coding: Coding of this item requires an understanding of the program's clinical staff composition, particularly the number of licensed, certified and/or competent addiction staff, defined as licensed or certified addiction/substance abuse/alcohol and drug counselors, or other professionals (e.g., LCSW, LPC, LMFT, licensed psychologist, psychiatrist, APRN or others with education and experience equivalent to a master's degree). In addition, professionals need at least two years of supervised experience in assessing and treating patients with co-occurring disorders, to the point where certification or autonomy has been achieved and competence established. Competence is defined as a demonstrated capability to assess and diagnose substance use disorders, determine treatment needs including appropriate level of care, manage substance-related crises and relapse, and deliver addiction treatments. Clinical staff members are so defined if they carry a caseload, conduct individual or group sessions, or provide clinical supervision or medication management.

- **Mental Health Only Services = (SCORE-1):** *Program has no staff who are licensed/certified as substance abuse professionals or have had substantial experience sufficient to establish competence in addiction treatment.* The program has **no** staff members who have specific expertise or competencies in the provision of services to individuals with substance use disorders.

- **(SCORE-2):** *1 to 24 percent of clinical staff are licensed/certified substance abuse professionals or have had substantial experience sufficient to establish competence in addiction treatment.* The program has **less than 25 percent** of staff who have specific expertise or competencies in the provision of services to individuals with substance use disorders.

- **Dual Diagnosis Capable = (SCORE-3):** *25 to 33 percent of clinical staff are licensed/certified substance abuse professionals or have had substantial experience sufficient to establish competence in addiction treatment.* The program has **at least 25 percent** of staff who have specific expertise or competencies in the provision of services to individuals with substance use disorders.

- **(SCORE-4):** *34 to 49 percent of clinical staff are licensed/certified substance abuse professionals or have had substantial experience sufficient to establish competence in addiction treatment.* The program has **at least 34 percent** of staff who have specific expertise or competencies in the provision of services to individuals with substance use disorders.

- **Dual Diagnosis Enhanced = (SCORE-5):** *50 percent or more of clinical staff are licensed/certified substance abuse professionals or have had substantial experience sufficient to establish competence in addiction treatment.* The program has **at least 50 percent** of staff who have specific expertise or competencies in the provision of services to individuals with substance use disorders.

MHOS PROGRAMS

Enhancing VIB. Onsite clinical staff members with substance abuse licensure, certification, competency, or substantive experience.

The MHOS program intending to become DDC is challenged to provide an increasing array of services in-house. Some mental health clinicians can and will obtain additional training and certification to be able to deliver substance use treatments and assessments to persons with co-occurring disorders. DDC programs have sought to increase the number of certified or licensed substance abuse clinicians who can deliver basic and generic treatments (motivational interviewing or Motivational Enhancement Therapy and cognitive behavioral therapy) and integrated assessments. A DDC program has 25 to 33 percent of its clinical staff who meet this level of competency. A DDC program moving in this direction must be careful not to reduce its capability to effectively treat mental health disorders by enhancing its capacity to treat addiction problems. Thus in hiring clinicians experienced in delivery addiction therapies, those with complementary mental health treatment and/or experience should be the top priority.

DDC PROGRAMS

Enhancing VIB. Onsite clinical staff members with substance abuse licensure, certification, competency, or substantive experience.

DDC programs wishing to achieve DDE status will make a more definitive practice of hiring and staffing the program with personnel who can deliver addiction treatments and who are capable of assessing substance use disorders. Reaching DDE status on this criterion may also involve the inclusion of staff members who have social work, psychology, or counseling degrees and addiction treatment expertise developed in apprenticeship learning models. In DDE programs at least half of the clinical staff has addiction treatment expertise.

VIC. Access to substance abuse clinical supervision or consultation.

Definition: Programs that offer treatment to individuals with co-occurring substance use disorders provide formal addiction supervision by licensed/certified addiction professionals. These include licensed/certified addiction counselors, or other addiction-competent professionals (LCSW, LPC, LMFT, licensed psychologist, psychiatrist, APRN, or others) for both trained providers of addiction services who are unlicensed or who have insufficient competence or experience in the treatment setting, and licensed providers who are developing fidelity to evidence-based practices.

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,"), specifically the credentials/qualifications of those individuals who provide supervision for addiction services.

- **Mental Health Only Services = (SCORE-1):** *No access.* The program does not have the capacity to provide supervision for addiction services.

- **(SCORE-2):** *Consultant or contractor off site, variably provided.* The program provides a very limited form of supervision for addiction services that is informal, occasional, and largely undocumented. This service is typically offered through an offsite consultant or only in emergent situations on site.

- **Dual Diagnosis Capable = (SCORE-3):** *Provided as needed or variably on site by consultant, contractor or staff member.* Informal process. The program has the capacity to offer supervision for addiction services on site on a semi-structured basis. Supervision at this level tends to be focused primarily on case disposition or crisis management issues.

- **(SCORE-4):** *Routinely provided on site by staff member.* The program offers regular supervision for addiction services through an onsite 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, or group observation, **but** this supervision is **not** formally or consistently documented.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Routinely provided on site by staff member and focuses on in-depth learning.* The program has the capacity to offer structured and regular supervision for addiction services 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, or group observation, **and** documentation is available that demonstrates these activities and regularly scheduled supervision sessions occur.

MHOS PROGRAMS

Enhancing VIC. Access to addiction supervision or consultation.

MHOS programs may not have access to substance use disorder consultation or supervision by a licensed professional (e.g., LCSW, LPC, LMFT, licensed psychologist, psychiatrist, APRN). In order to reach DDC on this item, addiction supervision must be provided. This supervision is typically scheduled either on an individual or group basis, and substance use treatments are encouraged and reviewed. Often the focus in this supervision is on diagnosis, appropriate referral to the self-help groups, development of empathy, and the management of countertransference. The supervision, although present in DDC programs, may be provided as needed, for crisis management or for patients with particularly challenging problems.

DDC PROGRAMS

Enhancing VIC. Access to addiction supervision or consultation.

DDE programs have recognized the value of clinical supervision in promoting staff satisfaction, ensuring 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 received training (e.g., cognitive behavioral therapy, Seeking Safety, or Dialectical Behavior Therapy—Substance Abuse). 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. Through the regional Addiction Technology Transfer Center the professional was able to arrange to be supervised by phone over the course of a year. The agency supported his efforts to acquire this skill set since they conceptualized it as an evidence-based practice for which their state agency was beginning to require implementation. The LCSW then found that he could share these skills in individual and group supervision sessions with addiction counseling staff. He used therapy rating forms obtained in the workshop and audiotape recordings of sessions to help the counselors learn how to do cognitive behavioral therapy.

Research on the supervision process is underway, including motivational interviewing approaches to the process itself. A suggested resource for clinical supervision is SAMHA's Technical Assistance Publication 21-A: Competencies for Substance Abuse Treatment Clinical Supervisors, which is online at http://store.samhsa.gov/product/TAP-21A-Competencies-for-Substance-Abuse-Treatment-Clinical-Supervisors/SMA08-4243.

VID. Case review, staffing or utilization review procedures emphasize and support co-occurring disorder treatment.

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

Source: Interview with clinicians, agency documents.

Item Response Coding: Coding of this item requires an understanding of the program's formal process for reviewing substance use issues, specifically the cases of individuals with co-occurring disorders.

- **Mental Health Only Services = (SCORE-1):** *Not conducted.* The program has no protocols to review the cases of individuals with co-occurring substance use disorders through a formal case or utilization review process.

- **(SCORE-2):** *Variable, by offsite consultant, undocumented.* The program has an offsite consultant who occasionally conducts reviews of the cases of individuals with co-occurring substance use disorders. It appears to be a largely unstructured and informal process, and documentation may not be available.

- **Dual Diagnosis Capable = (SCORE-3):** *Documented, on site, and as needed coverage of co-occurring issues.* The program has a regular procedure for reviewing the cases

of individuals with co-occurring substance use disorders through a case or utilization review process by an onsite supervisor. This process is not routine or systematically focused on only cases of individuals with co-occurring disorders, but it is a regular procedure within the program that allows for a general review of progress on substance use disorders. Documentation supports the consideration of co-occurring disorders services within this process (e.g., weekly staffing).

- **(SCORE-4):** *Documented, routine, but not systematic coverage of co-occurring issues.* The program routinely conducts case reviews of individuals with co-occurring substance use disorders. Reviews are documented, and the program may use a standard format that includes general categories related to substance use issues. However, there is no systematic or in-depth evaluation of specific interventions for co-occurring disorders.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Documented, routine, and systematic coverage of co-occurring issues.* The program has a routine, formalized protocol that ensures the cases of all patients are comprehensively reviewed in a process that consistently reviews and focuses on co-occurring substance use disorders. This process takes a patient-centered approach that allows for a systematic and critical review of targeted interventions for co-occurring disorders in order to determine appropriateness or effectiveness, and the process may include the patient. Documentation of this formalized process is available.

MHOS PROGRAMS

**Enhancing VID. Case review, staffing or utilization review procedures
emphasize and support co-occurring disorders treatment.**

While MHOS programs may focus on the achievement of recovery-oriented goals or in compliance with policy, DDC programs attend to these matters but also review the patient's progress with medications and substance abuse issues, changes in family relationships, and peer support group affiliation and ongoing recovery.

In contrast to MHOS programs, DDC programs attend to the status and progress with co-occurring disorders in case review, staffing disposition or team rounds. The DDC program tends to review these issues in a general way and on an as-needed basis.

DDC PROGRAMS

**Enhancing VID. Case review, staffing or utilization review procedures
emphasize and support co-occurring disorders treatment.**

DDC programs review patient progress on substance abuse problems in a general way. DDE programs do so consistently and in a systematic manner. This may be accomplished by using standard case review forms completed during team or utilization review meetings. In addition to mental health recovery progress, addiction 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 intervals. Another residential program lists mental health and substance use disorders and designates clinically responsible parties who report on treatment plan progress at each team meeting. The DDE program is characterized by routine, systematic, and protocol-driven case review of co-occurring problems.

One indicator of Alphabet Clinic's DDE capability level is the familiarity of the clinical staff with the scores of the screening measures used to describe initial addiction and mental health symptom severity. All staff members know the scales on the ASI, the MINI, and the Beck Depression Inventory, and they know how to interpret the clinical importance of scores at the mild, moderate or severe level.

VIE. Peer/Alumni supports are available with co-occurring disorders.

Definition: Programs that offer treatment to individuals with co-occurring substance use disorders maintain staff or a formalized relationship with volunteers who can serve as co-occurring disorders peer/alumni supports.

Source: Interviews with clinicians and patients, staff, and volunteer composition.

Item Response Coding: Coding of this item requires an understanding the program's staff composition and the availability of staff or volunteers as peer/alumni supports, specifically the presence of individuals in recovery from co-occurring disorders.

- **Mental Health Only Services = (SCORE-1):** *Not available.* The program offers neither onsite staff or volunteers nor offsite linkages with either alumni or peer recovery supports with co-occurring disorders.

- **(SCORE-2):** *Available with co-occurring disorders, but as part of the community. Variably referred by individual clinicians.* Referrals are made secondary to clinician knowledge and judgment.

- **Dual Diagnosis Capable = (SCORE-3):** *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).* The program provides offsite linkages with peer/alumni supports on a consistent basis.

- **(SCORE-4):** *Available on site with co-occurring disorders, either as paid staff, volunteers, or program alumni. Variable referrals made.* The program has developed onsite peer recovery supports, although referrals are not routinely made.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Available on site, with co-occurring disorders, either as paid staff, volunteers, or program alumni. Routine referrals made.* The program maintains a network of staff or volunteers on site who can provide peer/alumni support. Referrals are routinely made, and clinicians have developed relationships with the peer supports that facilitate strategic matching of patients and peers. The program has a formal protocol to ensure the ongoing availability of these supports.

MHOS PROGRAMS

Enhancing VIE. Peer/Alumni supports are available with co-occurring disorders.

This item is related to item VD (Facilitation of peer recovery support groups for co-occurring disorders). MHOS programs may not have peer supports available or approach this issue in a less intentional fashion. In order to reach the DDC level, the MHOS program must become more targeted in trying to match persons with specific co-morbidities with peer role models. The use of alumni, volunteers, or even carefully supervised recovering staff members may be one way to accomplish this. The aim is to enable a patient with co-occurring disorders to recognize that he or she is not alone 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 off site in the community. These bridges can either be with traditional twelve-step recovery groups, such as AA or NA, or to those specific to co-occurring disorders (e.g., Dual Recovery Anonymous, Double Trouble).

The Pottsville Hospital was approached by the three members of the District AA Hospital and Institution committee, who wanted to hold meetings for the patients with alcohol problems in the hospital cafeteria on Friday evenings. The Pottsville Hospital evening intensive outpatient program director felt that adding this component to the routine Monday through Thursday treatment services would be an excellent new feature to his program. Informally, the director became familiar with some of the "regulars" at the meeting; he has mentioned to patients with addiction problems to look for specific visitors at the Friday night meetings. He bases these "matches" on his awareness of the patients and AA visitors.

DDC PROGRAMS

Enhancing VIE. Peer/Alumni supports are available with co-occurring disorders.

DDE programs capitalize on a network of community volunteers, alumni, recovering staff, and others to serve as onsite co-occurring disorders recovery supports and to strategically and routinely connect persons with co-occurring disorders with identifiable others who can facilitate an affiliation with mutual self-help groups. DDE programs utilize onsite twelve-step groups, peer-led Illness Management and Recovery groups, staff and volunteer co-led bridge groups, open alumni and/or Dual Recovery Anonymous meetings. Programs have wrestled with HIPAA, confidentiality, patient safety, and integrity of milieu challenges, but all have agreed these challenges led to benefits in facilitating connections with recovering peers.

The key difference in the DDE program is that these supports are available on site. At the DDE level, program clinicians are typically more closely connected with the peer group volunteers, alumni, or members of the community. This connection is often reinforced by monthly meetings which address clinical or administrative issues.

VII. Training

VIIA. All staff members have basic training in attitudes, prevalence, common signs and symptoms, detection and triage for co-occurring disorders.

Definition: Programs that provide treatment to individuals with co-occurring substance use disorders ensure that all agency staff who have contact with patients have basic training in co-occurring disorders. For the purpose of this item, basic training minimally includes understanding one's own attitudes, the prevalence of co-occurring disorders and their screening and assessment, common signs and symptoms of these disorders, and triage/brief interventions and treatment decision-making. Staff includes positions such as outpatient receptionists and intake workers, as well as residential third shift and weekend staff.

Source: Interviews with clinical leadership and clinicians, review of strategic training plan, and staff training records.

Item Response Coding: Coding of this item requires an understanding of the program's requirements for basic skills and training with regard to co-occurring disorders, and knowledge of the number of staff who have completed this training.

- **Mental Health Only Services = (SCORE-1):** *No staff have basic training (0% trained).* The program's staff have no training and are not required to be trained in basic co-occurring disorder issues.

- **(SCORE-2):** *Variably trained, no systematic agency training plan or individual staff member election (1 -24% of staff trained).* The program encourages basic co-occurring disorders training but has not made this a part of their strategic training

plan. A portion of the program's staff are trained as a result of management's encouragement or individual staff interest.

- **Dual Diagnosis Capable = (SCORE-3):** *Certain staff trained, encouraged by management and with systematic training plan (25-50% of staff trained).* The program's strategic training plan requires basic training in co-occurring disorders for certain staff. **And:** At least 25 percent of all program staff are trained in attitudes, prevalence, screening and assessment, common signs and symptoms, and triage/brief interventions, and treatment decision-making for co-occurring disorders

- **(SCORE-4):** *Many staff trained and monitored by agency strategic training plan (51-79% of staff trained).* The program's strategic training plan requires the majority of staff to have basic training in co-occurring disorders. **And:** The majority of staff are trained. The program uses the plan to monitor the number of staff who are trained and to ensure they receive ongoing co-occurring disorders training, typically on an annual basis.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Most staff trained and periodically monitored by agency strategic training plan (80% or more of staff trained).* The program's strategic training plan requires all staff to have basic training in co-occurring disorders. **And:** At least 80 percent of all staff are trained in attitudes, prevalence, screening and assessment, common signs and symptoms, and triage and treatment decision-making for co-occurring disorders. The program periodically monitors the number of staff members who are trained and uses the strategic training plan to ensure that this number is maintained despite staff turnover.

MHOS PROGRAMS

Enhancing VIIA. All staff have basic training in attitudes, prevalence, common signs and symptoms, detection and triage for co-occurring disorders.

Training is the principal mechanism to impart new information and a necessary step toward practice change. 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. MHOS program staff members typically have variable exposure to information about co-occurring disorders and the prevalence of substance use disorders.

DDC programs have made commitments to have certain staff trained in basic issues pertaining to co-occurring disorders: attitudes, prevalence, screening and assessment, common signs and symptoms, triage/brief interventions, and treatment decision making. These trainings might be strategically directed using existing training budgets or release time and are incorporated into a training plan. 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, who may have the most direct contact with patients, are often neglected in training programs. As an example of how

to incorporate training into an existing structure, one program provides nine in-service training sessions a year and has committed 1/3 of these to co-occurring disorders. Clinical supervisors, clinicians, residential aides, and front office administrative support staff all attend.

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, common signs and symptoms, and triage/brief interventions and therapeutic needs of persons with co-occurring disorders.

An excellent introduction to the topic of workforce development can be found in the SAMHSA Co-Occurring Center for Excellence (COCE) Workforce Development and Training: Technical Assistance (TA) Report for the Co-Occurring State Incentive Grants (COSIGS) September 9, 2005, Updated June 2008, available at http://homeless. samhsa.gov/(S(mizsnr455dukej55bgx342z4))/ ResourceFiles/4xcn5gxr.pdf.

DDC PROGRAMS

Enhancing VIIA. All staff members have basic training in attitudes, prevalence, common signs and symptoms, detection and triage for co-occurring disorders.

Whereas DDC programs have focused on training certain staff on basic issues pertaining to co-occurring disorders, the DDE program has all or almost all staff trained in basic issues as a result of a regularly monitored implementation of its strategic training plan. Much like a DDC level program, administrators strategically direct staff training and incorporate the cost of doing so into existing allocations wherever

possible. In support of this goal, the Recovery Resources Program incorporated information on co-occurring disorder basics and related agency policies into its new employee orientation process.

In contrast to the DDC program, the DDE program intentionally plans and ensures that at all times at least 80% of all staff are trained in basic issues related to co-occurring disorders.

VIIB. Clinical staff members have *advanced* specialized training in integrated psychosocial or pharmacological treatment of persons with co-occurring disorders.

Definition: Programs that offer treatment to individuals with co-occurring disorders ensure clinical staff have advanced specialized training to increase the needed capacity to provide co-occurring disorders treatment within the program and create a "no wrong door" experience for patients. This aspect of training is incorporated into the program's strategic training plan. For the purpose of this item, advanced specialized training in integrated treatment minimally includes knowledge of specific therapies and treatment interventions for individuals with co-occurring disorders, assessment and diagnosis, and basic knowledge of pharmacological interventions for co-occurring disorders. Clinical staff is defined as those staff who carry a caseload, conduct individual or group sessions, or provide clinical supervision or medication management.

Source: Interviews with the executive director, clinical leadership and clinicians, and review of strategic training plan and staff training records.

Item Response Coding: Coding of this item requires an understanding of the program's requirements for advanced specialized training in co-occurring disorders, and knowledge of the numbers of staff who have completed this training.

- **Mental Health Only Services = (SCORE-1):** *No clinical staff have advanced training (0% trained).* The program has no staff with advanced specialized training in integrated treatment of co-occurring disorders and does not require this training.

- **(SCORE-2):** *Variably trained, no systematic agency training plan or individual staff member election (1-24% of clinical staff trained).* A portion of the program's clinical staff have advanced

specialized training in integrated treatment of co-occurring disorders. This is either encouraged by management or the result of individual staff interest, but this is not a part of the program's strategic training plan.

- **Dual Diagnosis Capable = (SCORE-3):** *Certain staff trained, encouraged by management and with systematic training plan (25-50% of clinical staff trained).* The program's strategic training plan requires advanced specialized training in integrated treatment of co-occurring disorders for certain staff. **And:** At least 25 percent of clinical staff are trained in specific therapies and treatment interventions, assessment and diagnosis, and pharmacological interventions for co-occurring disorders.

- **(SCORE-4):** *Many staff trained and monitored by agency strategic training plan (51-79% of clinical staff trained).* The program's strategic training plan requires the majority of clinical staff to have advanced specialized training in co-occurring disorders. **And:** The majority of staff are trained. The program uses the plan to monitor the number of staff who are trained.

- **Dual Diagnosis Enhanced = (SCORE-5):** *Most staff trained and periodically monitored by agency strategic training plan (80% or more of clinical staff trained).* The program's strategic training plan requires advanced specialized training in integrated treatment for co-occurring disorders for all clinical staff. **And:** At least 80 percent of all clinical staff are trained in specific therapies and treatment interventions, assessment and diagnosis, and pharmacological interventions for co-occurring disorders. The program periodically monitors the number of staff who are trained and uses the strategic training plan to ensure that this number of trained staff is maintained despite staff turnover.

MHOS PROGRAMS

Enhancing VIIB. Clinical staff members have advanced specialized training in integrated psychosocial or pharmacological treatment of persons with co-occurring disorders.

This item reviews the overall training profile of the staff working within a program. MHOS 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 efforts to organize this critically important and common competency support. DDC programs aim to have 25 to 50 percent of clinical staff co-occurring disorders with advanced specialized training in integrated treatment for individuals with co-occurring disorders as defined above. This item does not have to be cost-intensive but can require an organization to become more intentional and strategic in the use of training dollars and time allocations.

An excellent introduction to the topic of workforce development can be found in the SAMHSA Co-Occurring Center for Excellence (COCE) Workforce Development and Training: Technical Assistance (TA) Report for the Co-Occurring State Incentive Grants (COSIGS) September 9, 2005, Updated June 2008, available at http://homeless.samhsa.gov/(S(mizsnr455dukej55bgx342z4))/ResourceFiles/4xcn5gxr.pdf.

DDC PROGRAMS

Enhancing VIIB. Clinical staff members have advanced specialized training in integrated psychosocial or pharmacological treatment of persons with co-occurring disorders.

DDE programs make a substantial investment in creating a "no wrong door" experience for patients. Advanced specialized training for clinicians supports this aim. Thus any clinician in a DDE program will respond to a patient with a co-occurring disorder with a similarly open framework. In a DDE program, at least 80 percent of clinical staff will have advanced specialized training if not expertise in integrated treatment for co-occurring disorders. An agency strategic training plan allows program administrators to coordinate the delivery of needed training and may undergird the delivery and fidelity of specific integrated services.

To address this item, the Recovery Resources Program used an electronic learning system to assign specific co-occurring disorder topics to clinical staff and to monitor training unit completion. The system supported an annual staff development plan created by the RRP clinical supervisor in conjunction with each clinician.

Dual Diagnosis Capability
in Mental Health Treatment
(DDCMHT) Toolkit
Version 4.0

VI. Epilogue

Both the DDCMHT and DDCAT are designed to be practical measures of program level capacity to address co-occurring substance use and mental health disorders. The developers of the measures intend for each to be used to improve services for persons and families who suffer from these disorders. These individuals and families are beleaguered by the challenges confronting them with the severity of symptoms associated with these disorders. They should not have to confront barriers and confusion in accessing care. The DDCMHT and DDCAT provide objective, standardized, and comparable benchmarks and categorizations of addiction and mental health treatment services and programs. This information can go far to provide consumers with a guide to make informed choices about where to seek treatment.

The DDCMHT and DDCAT are relatively straightforward measures to use. With this toolkit, and the indexes, you can probably proceed with reasonable skill and confidence in assessing services. On the one hand, we support your initiative in doing so. On the other hand, we appreciate the benefits of consultation with others with experience in the administration, scoring, interpretation of findings, and the use of the data for quality improvement efforts. The choice is yours.

Our mission is to improve the chances for recovery among persons with co-occurring substance use and mental health disorders. Their chances are less than average. With the encouragement and pragmatic guidance that the DDCMHT and DDCAT measures provide those who deliver treatment, we hope their chances improve.

Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) Toolkit

Version 4.0

VII. Appendices

A. Dual Diagnosis Capability In Mental Health Treatment (DDCMHT) Index Version 4.0

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

DDCMHT — Rating Scale

	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.

DDCMHT — Rating Scale

	1 – MHOS	2	3 – DDC	4	5 – DDE
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.

DDCMHT — Rating Scale

	1 – MHOS	2	3 – DDC	4	5 – DDE
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.

DDCMHT — Rating Scale

	1−MHOS	2	3−DDC	4	5−DDE
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.

DDCMHT — Rating Scale

	1−MHOS	2	3−DDC	4	5−DDE
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.

DDCMHT — Rating Scale

	1−MHOS	2	3−DDC	4	5−DDE
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.

DDCMHT — Rating Scale

	1 − MHOS	2	3 − DDC	4	5 − DDE
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.

DDCMHT — Rating Scale

	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

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)   _____

B. Frequently Asked Questions (FAQ)

1) Can I use the DDCMHT to rate my whole agency?

The DDCMHT is intended to rate an individual program. Using the DDCMHT to produce a single agency-level rating is **not** recommended. If the entire agency is scored, the rater is forced to consider practices that differ and diverge across multiple programs, usually resulting in scores that are not meaningful or helpful. An examination of separate capability ratings across multiple programs within an agency, however, can assist leadership in understanding variations in agency practice patterns. Such variation may be intentional, but also may signal the need to initiate quality improvement activities to establish consistency across programs within an agency.

2) What do the DDCMHT results tell me?

The DDCMHT results will tell you the level of co-occurring capability in a program. Each of the 35 items in the DDCMHT is scored on a 1 to 5 scale, with 5 reflecting the highest co-occurring capability. An average score is obtained for each of the seven domains in the DDCMHT. An overall score ranks the program at the Mental Health Only Services (MHOS), Dual Diagnosis Capable (DDC), or Dual Diagnosis Enhanced (DDE) level.

3) Is the DDCMHT a psychometrically valid instrument?

Yes. Please see the Psychometric Studies section and the journal articles by McGovern et al. (2007) and Gotham et al. (2010) listed in the appendix.

4) Is there an easy way to do the scoring?

Yes. An Excel workbook (available for download) accepts DDCMHT item scores and calculates the program's average domain scores, an overall average score, and the categorical rank (i.e., MHOS, DDC, or DDE). In addition, the workbook creates several graphic displays.

5) Who can administer the DDCMHT?

Behavioral health professionals can be trained to administer the DDCMHT by others with experience doing these assessments. Training typically involves a didactic component, one or more observations of an assessment, and practice with supervision and feedback.

6) How long does it take to do a DDCMHT assessment?

Typically, a DDCMHT assessment takes from four to eight hours. Requesting documents for review in advance of the visit can reduce the amount of time required at the program location. The number of charts reviewed can also impact the length of the visit.

B. Frequently Asked Questions (FAQ)

7) Can I ask programs to rate themselves on the DDCMHT?

It is not recommended that programs use the DDCMHT to rate themselves. Bias in DDCMHT self-ratings has been documented, with higher self-rated scores observed compared to ratings by an external assessor (e.g., Lee & Cameron, 2009; please see the References section). Research also documents a "learning curve" before raters consistently and accurately use this measure (Brown & Comaty, 2007). The DDCMHT items and anchors can generate valuable discussion among staff and provide the basis for programs to increase their co-occurring capability.

8) What is the incentive for programs to participate in a DDCMHT assessment?

Each program receives concrete feedback on its co-occurring capability as expressed by its policies, assessment and treatment services, staffing, and training, combined with information on how to increase that capability. Increased co-occurring capability may lead to improved services for clients. Given widespread expectations for programs to improve their performance in co-occurring disorders, programs find the DDCMHT assessment and results valuable. Some state or regional funding agencies offer financial incentives for achieving a DDC or DDE rating.

9) How long does it take a program to improve their scores on the DDCMHT?

It depends. As described on the Applications section, a comprehensive implementation plan based on the results of an initial DDCMHT can facilitate change by including targeted strategies for change, identifying persons responsible for leading each task, and setting target dates for completion. Other components of a successful change process often include an overall "champion" or change agent for the program, a steering committee to support the efforts over time, targeted training and technical assistance, connections with peers (i.e., other programs) also working on these kinds of changes for support and lessons learned, and ongoing quality assurance (e.g., semi-annual or annual follow-up DDCMHT assessments).

10) How can I find out more about how others are using the DDCMHT?

Dr. Mark McGovern of Dartmouth Medical School, the primary author of the DDCAT, chairs the national DDCAT/DDCMHT Collaborative, which meets monthly by conference call to discuss ways that states and programs are using the DDCMHT to improve their policies and practices. He can be reached at mark.p.mcgovern@dartmouth.edu if you are interested in joining the Collaborative.

C. No or Low Cost Enhancements to Increase Co-Occurring Capability

Program Structure

IA.   Revise mission statement to include focus on co-occurring disorders.

IC.   Develop formal memorandum of understanding with an addiction program.

Program Milieu

IIA. Revise materials and procedures to welcome individuals with co-occurring disorders.

IIB. Display/distribute free educational materials about substance use/co-occurring disorders.

Assessment

IIIA. Implement free standardized mental health and substance use screening measures.

IIIB. Implement a standard set of substance use bio-psychosocial assessment questions.

IIID. Implement a standard section of the assessment to capture substance use history.

IIIG. Assess patients' stage of change for both their substance use and mental health problems.

Treatment

IVA. Include addiction related interventions in treatment plans.

IVB. Observe and document changes in mental health and substance use symptoms over time.

IVC. Implement guidelines and advance directives for substance abuse emergencies.

IVD. Adjust objectives and interventions to match persons' stages of change.

IVG. Incorporate free addiction/COD curricula into program services.

IVH. Implement family education/support group with co-occurring curricula.

IVI. Assertively link patients to peer support groups welcoming to co-occurring issues.

IVJ. Incorporate program alumni and other peer supports with COD into program.

Continuity of Care

VA.   Implement discharge procedures that plan for mental health and substance use services.

VC.   Focus on ongoing recovery from both disorders.

VD.   Assertively link patients to peer support groups welcoming to COD upon discharge.

Staffing

VID. Implement routine case reviews that support co-occurring disorder treatment.

VIE. Include peers with co-occurring disorders on-site as paid or volunteer staff.

Training

VII. Implement training plan that routinely includes basic training on co-occurring disorders.

D. The Site Visit

DDCMHT — Chart Review Form

	Chart 1	Chart 2	Chart 3
IC. Coordination and collaboration with SA or MH services.			
IIIC. MH & SA diagnoses made and documented.			
IIID. MH & SA history reflected in medical record.			
IIIG. Stage-wise txt assessed/affect treatment planning.			
IVA. Treatment plans address both disorders.			
IVB. Assess and monitor interactive courses of both disorders during treatment.			
VA. COD addressed in discharge planning process.			
VB. Capacity to maintain txt continuity (of opposite disorder during treatment).			
VD. Facilitation of self-help COD support groups doc at d/c.			

Sample Interview Questions for Patients

Environment and Staff (Program Milieu)

1. Did you feel welcomed when you came to this agency for treatment?

2. Have you received any printed materials (brochures, pamphlets) about substance abuse and/or mental health issues? If so, are the materials helpful?

Client Services: Assessment

1. When you started receiving services from this agency, did staff ask you about your mental health and substance use symptoms and history?

2. Was information from this assessment shared with you?

Client Services: Treatment

1. Were you involved in developing your treatment plan?

2. Have you received services for mental health and for substance use issues?

3. If you take medication for mental health or substance use issues, have you been able to get and take your medication(s)?

4. Have you been encouraged to participate in 12-step or other self-help groups?

5. Did your family members/friends receive information and support about your treatment? If so, how?

Client Services: Continuity of Care

1. Do you have a discharge plan? If yes, how involved were you in developing this plan?

2. Is peer/alumni support available from this agency for preparing for discharge and for after you've completed the program?

E. Training Raters to Conduct DDCMHT Assessments

Dual Diagnosis Capability in Mental Health Treatment (DDCMHT)

Scoring Scenario
(for use with DDCMHT v4.0)

Developed by: Ed Riedel, LCSW; Ron Claus, PhD; Steve Winton, PhD; Sharon Thomas-Parks, LPC; Andrew Homer, PhD; and Heather Gotham, PhD. Missouri Institute of Mental Health, St Louis, MO.

Scenario

Behavioral Rehabilitation Services (BRS) started as a community mental health center (CMHC) in a medium sized Midwestern city in 1972. The agency was created to respond to the needs of mentally ill individuals who were being moved from the state hospital system into the community as part of the deinstitutionalization movement. It covers a four-county geographic area. The main office is located in one of the county seats, with a population about 80,000 people. There are two satellite offices, each approximately 40 miles away.

Entering the main office, there is a busy waiting room filled with individuals awaiting appointments with psychiatrists and therapists. In addition to the usual archaic waiting room magazines, the room has shelves with information below a bulletin board on one wall. The shelves contain brochures on the treatment of various types of mental health concerns such as Depression, Anxiety and Post Traumatic Stress Disorder. There is one brochure about co-occurring disorders for consumers. There is also some information for family members but it is not specific to any particular client concern. On the bulletin board is a copy of the program's state certification to provide mental health services including outpatient counseling, pharmacotherapy,

case management and a drop-in center. Another framed paper has the organization's mission statement which reads, "To improve the emotional health and well-being of the people and communities we serve."

During an interview, one of the BRS program directors describes the departments: children and youth services, outpatient services, adult rehabilitation, housing and employment services. Referrals come from many different sources including primary care physicians, crisis response staff, the psychiatric inpatient unit of the county hospital, probation and parole, schools, the forensic system and walk-ins. The director states that since they accept some funding from the state, they are required to accept anyone who lives within their catchment area for services. She reports that the rehabilitation department provides services to individuals with serious and persistent mental illness and many of them have multiple challenges, including physical, developmental and substance use.

The director is very excited to talk about the agency's new co-occurring program named "Polycovery." The program was started because quality improvement data showed that 60% of clients seen for crisis services were using substances. She added that of those clients who were using some of them had histories of long-term dependence, mostly alcohol, some opiates and some cocaine. Referral to treatment at local substance abuse facilities had either been unsuccessful or clients had been denied services due to mental health symptoms.

The program then identified a standardized screening tool, the CAGE-AID, to screen for substance abuse. They had decided to start with individuals currently enrolled in services for more severe mental illnesses. She said the final goal would be to screen all current clients and then

every referral but this has not happened yet. So far, all of the individuals in the adult rehabilitation program and all referrals to this program have been screened. Once a client has screened positive for substance abuse, two assessments are then completed. The first is a narrative biopsychosocial assessment completed by a licensed mental health professional which covers mental health and substance abuse history, current symptoms, a mental status exam, functional obstacles, physical health, resources and recommendations. The director indicates that some of the staff providing assessments have begun to include more detail about substance abuse history and the interaction between substance abuse and mental health in the interpretive summary section at the end. The second assessment the agency is using is the Addiction Severity Index. The director reports that the results of the substance abuse assessment are supposed to be incorporated into the narrative biopsychosocial (if completed) and the treatment plan. A review of records reveals this occurs about half of the time. The licensed mental health professional provides diagnoses if the client hasn't been seen recently by a staff psychiatrist. The narrative assessment also has an attached Readiness for Change section. This appears to have been filled out by the clinician based on his or her own judgment. When asked which disorder this applies to the Director responds, "All of them." She goes on to say the tool was added when the program was started and is used for treatment planning and selecting which groups are best for a client.

When asked about specialized services for individuals with co-occurring disorders, the director reports that they currently are providing three groups. One group is for those individuals who are still using and in the contemplative or precontemplative stage of change, and a second process group is for "everyone else". They also host a consumer-run Double Trouble in Recovery group at the office on Friday. She said they would like to have more groups geared to specific stages, but there have not been enough clients enrolled in co-occurring services and there are not enough staff to facilitate additional groups. In addition they have recently hired a substance abuse counselor who is doing individual sessions, "with the clients who have the most needs" as well as facilitating two of the groups. She further explained that the treatment team decides who has the most needs and would benefit from individual counseling.

In a following interview, the staff's substance abuse counselor reports that she received 15 hours of training in motivational interviewing. She tries to use motivational and cognitive behavioral interventions in her work both in individual counseling and in the Precontemplation Group. The other group mainly offers education about mental health and substance abuse. She says she uses several different sources of information from the internet and from books the agency purchased. She reports they spend quite a bit of time talking about how the two problems interact and how specific symptoms can be triggered by substance use and how substance use can trigger mental health symptoms.

The therapist is then joined by the treatment team, which consists of two case managers with bachelor's degrees; a supervisor who has a master's degree and is a licensed clinical social worker; a registered nurse; and a psychosocial worker who runs groups. They report they have a weekly team meeting which covers all clients' needs; both co-occurring and mental health only, usually attended by the psychiatrist, who is a full time staff member. Each of them has individual supervision weekly with their team leader (Clinical Social Worker) and can access the substance abuse specialist for consultation if needed. Most communication with the psychiatrist outside of team meetings flows through the nurse, but case managers are also able to attend appointments with clients if needed and provided the client agrees. The team is asked about how they handle substance related emergencies and one of them shares a story about a client who came to group intoxicated and then passed out. The team feels that these kinds of emergencies don't happen that often, but they would go by their medical emergency policy. If the client is medically stable and able to participate in group then they could be allowed to stay or they may be taken home

with case manager follow up. The team reports that they have had about 6 hours of Motivational Interviewing training. A few have participated in continuing education on the basics of co-occurring disorders, but it is not required by the agency. They claim their medical record system identifies interventions for clients that are consistent with the client's stage of change. When asked for an example, they talked about how they try to get clients in the action stage connected with either the Double Trouble group, or one of the AA or NA meetings in the community that are open to people with co-occurring disorders. The team was invited to talk more about how they connect clients with self-help groups and they said they always have lists of "where and when": around, that they frequently give clients rides to their first meetings, and sometimes go in with them if they are really nervous about meeting new people. One case manager added that she even role-played with a client about what he might say in a 12-step meeting. The other case manager interjects that, "12-step groups are not for everybody."

The psychiatrist agreed to meet when she had an appointment cancel at the last minute. She states that she has a keen interest in working with individuals with co-occurring disorders and that she helped write the medication policies for the Polycovery program. Her personal philosophy with co-occurring disorders is to work closely with the team in helping clients stay on their medications even when they are using alcohol or drugs. She says that she is very conservative about prescribing substances which have the potential for addiction such Xanax or Valium but does use them in some very controlled situations for limited amounts of time. When an individual comes to her already taking addictive substances, she works to wean them off. She adds that she is using Naltrexone and acamprosate to help clients with cravings and has seen some success with the clients she is treating. "I haven't had the chance to try Suboxone. Most of the time we refer people who need detox though." She appreciates the opportunity to work with clients as long as necessary

and not be required to discharge them. Her pager goes off and she has to excuse herself from the room.

The program director then offers to give you a tour of the facility. During the tour she shows you the waiting area where you came in and the available literature for clients and families. She shows you the offices where individual therapy and team meetings are held. She then takes you to the section of the building that is set up as a drop-in center for clients; the space is bright and inviting, and includes a complete kitchen, laundry facilities, and several classrooms. She said the space is used for the education and activity groups for the adult rehabilitation program as well as the programming for the Polycovery groups, which are integrated into the daily schedule. Programming for co-occurring disorders occurs from 3-5pm Monday through Thursday; on Friday evening there is a DTR group that is open to the community as well as Polycovery clients.

She notes that once a month clients invite their families to come in for a dinner prepared by the staff. Clients and family members who attend are eligible for prizes and sometimes there are educational games which teach people about mental illness and substance abuse in a fun way. Sometimes they show a video about one topic or the other and afterward there is time for discussion, questions and support.

Four clients have volunteered to speak to you. Two of them have been with the agency for over 10 years and two of them have been in the Polycovery program for the past 6 months. Three of them reported they felt very welcome in the Polycovery program and the fourth stated that he only started in the program because his probation officer said it was this or jail. This individual attends the precontemplation group and feels it is helpful to have a place to talk openly about his continued struggle with the law. The rest report that they attend the COD group and one of them also attends DTR on Fridays. All of them see the agency psychiatrist but most of them wish the appointments were longer than the usual 15 minutes once a month. Three of the four take medication; they

feel the nurse helps them with getting their meds and has given them samples at times to "fill the gaps." One of them also reports taking "some medication to help me with cravings." The clients report they have each gotten a Polycovery Program handbook which has information about addiction, 12-step meeting lists and community resources. It has pockets for them to keep copies of their treatment plans, handouts and worksheets. Two of the four reported they were very involved in deciding what needed to be on their plan; the other two said this was mostly decided by the team and the one by their probation officer. All of them felt they had received information that was helpful but none of them felt they had learned much about how their substance abuse influenced their mental health symptoms and vice versa. Two of them reported that their families and significant others had attended family support activities. When asked if they had access to mentors or alumni, they all felt the program had not been around long enough for those leaders to develop. When asked if they participated in discharge planning the clients returned a confused look and said they plan on staying with the program forever. One said, "They're like my family."

Following your discussion with the clients, you are escorted to a room where there are ten small charts and a computer terminal. The director reports that they are halfway through an electronic medical records conversion. She explains that the paper charts contain financial paperwork, screening tools, assessments and records from other providers and that all of the notes

for individual therapy, groups, case management, nursing, doctor and treatment plans are computerized. As stated earlier, half of the charts included a substance use disorder assessment. Assessments used a narrative format to describe both substance abuse and mental health history but only one of ten charts addressed the interaction of the two briefly at the end in the summary. Eight out of ten treatment plans noted both mental health and substance use disorder diagnoses; in the other two charts, both diagnoses were found in the psychiatrist notes and old records. Treatment plan interventions were generated by the computerized system from problem lists and were mostly generic. Mental health interventions were slightly more detailed than substance abuse interventions. Treatment plans rarely, one out of ten, showed revisions or additions by staff over time. Case management notes reported amounts of substance use and even used a rating scale for cravings about 70% of the time. Group notes simply listed whether or not a client attended and a general statement about the group topic. Some individual substance abuse therapy notes focused on relapse prevention, but were mixed with dealing with immediate client concerns. There were only two closed charts in the stack. Both of them contained discharge summaries which used a standardized form that ended with recommendations, but recovery plans for either disorder were not documented. Recommendations in discharge summaries for substance abuse concerns both listed "continue sobriety."

DDCMHT — Case Study Scoring Key

Domain/Item	Comments	
Program Structure		
IA. Primary focus of agency as stated in the mission statement (If program has mission, consider program mission).	**Score 3:** TheThe mission statement of the organization is broad and does not either include or exclude substance use or co-occurring disorders.	
IB. Organizational certification and licensure	**Score 1:** The organization is certified only to provide mental health services. Clarifying Question for Staff: • How are co-occurring services funded by the organization?	
IC. Coordination and collaboration with addiction services	**Score 1:** The agency is attempting to integrate substance abuse services within their current array of services and did not identify any partners.	
ID. Financial incentives	**Score 1:** The organization is currently certified to provide and bill for mental health services. Clarifying point: • If the agency can identify funding for co-occurring or substance abuse services or is able to bill for the COD and substance abuse services they provide as long as the client has a mental health disorder, then score 3.	
Program Milieu		
IIA. Routine expectation of and welcome to treatment for both disorders	**Score 4:** The agency has a formerly defined co-occurring program, "Polycovery", but admission criteria are not mentioned. Clarifying Questions for Staff: • What types of substance use disorders are clients presenting with? • How common are clients with co-occurring disorders? • Are there specific admission criteria for the "Polycovery" program? Clarifying Questions for Clients: • Can you tell me what the staff did to make you feel welcome?	
IIB. Display and distribution of literature and patient educational materials	**Score 2:** The agency has information on several mental health disorders and a limited amount of information on co-occurring disorders. 12-step program information is limited to "Where and When." Clarifying Questions for Staff: • Is there additional information offered to clients? • Can we see a copy of the substance abuse information and co-occurring printed information you give to clients and families?	

DDCMHT — Case Study Scoring Key

Domain/Item	Comments
Assessment	
IIIA. Routine screening methods for substance use	**Score 3**: The agency is using a standardized screening tool. This would normally score a 4, but it was necessary to downgrade one due to irregular penetration into the client population. Clarifying Questions for Staff: • What percentage of clients are screened for substance abuse? • When are clients screened during the intake and/or treatment process?
IIIB. Routine assessment if screened positive for substance use	**Score 3**: The agency is using a standardized substance use disorder assessment, which was found in half of the charts reviewed, but it has little detail regarding the interaction of both disorders. Clarifying Questions for Staff: • Who on the staff completes the SA assessment?
IIIC. Mental health and substance use diagnoses made and documented	**Score 4**: Mental health and substance abuse diagnoses were recorded on 80% of treatment plans. Although substance abuse diagnoses were found in the other two charts, there was inconsistency in documentation and did not warrant a score of 5. The licensed mental health professional provides diagnoses if the client has not seen a staff psychiatrist associated with the agency. Clarifying Questions for Staff: • What is the process for establishing and recording both mental health and substance use diagnoses? • Where are diagnoses supposed to be found in clinical records?
IIID. Mental health and substance use history reflected in medical record	**Score 3**: Assessment did indicate history of both disorders in a narrative format. Although one of the assessments addressed the interaction of both disorders, this did not demonstrate a well thought out chronology. Clarifying Questions for Staff: • Does the agency support an assessment format that addresses the interaction of the two disorders? • Is this done chronologically?
IIIE. Program acceptance based on substance use disorder symptom acuity: low, moderate, high	**Score 5**: The agency reported accepting all individuals including those active and unstable in their substance abuse. This also included those individuals that had extensive histories of dependence. Clarifying Questions for Staff: • What types of substance use or dependence are the staff identifying? • Are individuals with long histories of use, for example those with dependence, multiple previous SA treatment encounters, and limited periods of abstinence, served or referred?
IIIF. Program acceptance based on severity and persistence of substance use disability: low, moderate, high	**Score 5**: The agency indicated that they are able to accept and provide services to all individuals with the exception of those that are in need of detoxification. Clarifying Questions for Staff: • Is there anyone who you do not believe would be appropriate for services due to their substance abuse?
IIIG. Stage-wise assessment	**Score 3**: There is a stage of change section in the assessment process, but it is not specific to diagnosis or individually identified challenges. Clarifying Questions for Staff: • When assessing stage of change how does the clinician come to a decision? • What part of the treatment plan or which interventions does the SOC apply to?

DDCMHT — Case Study Scoring Key

Domain/Item	Comments
Treatment	
IVA. Treatment plans	**Score 3:** The agency uses an electronic medical record which generates interventions based on diagnosis and problems identified. Although this is automatic, it is currently lacking the depth of interventions to fully address both disorders. Clarifying Questions for Staff: • Are staff able to add additional interventions as clinical judgment dictates? • Who is responsible for adding mental health (substance abuse?) interventions to the database?
IVB. Assess and monitor interactive courses of both disorders	**Score 2:** Various notes by selected clinicians reported substance use among clients; however it was not consistent. Clarifying Questions for Staff: • Who is responsible for charting symptom change for both mental health and substance abuse? • Is there a standardized way of collecting this information?
IVC. Procedures for intoxicated/high patients, relapse, withdrawal, or active users	**Score 2:** The agency has a medical emergency policy, but this is not specific to substance abuse emergencies and does not specify which types of actions are to be taken other than assessing for immediate medical attention. The program is able to deal with substance abuse related emergencies, but these procedures are understood through experience. Clarifying Questions for Staff: • Is a copy of the policy available?
IVD. Stage-wise treatment	**Score 3:** The stage of change tool is consistently incorporated into the plan, but the connection between the tool and the interventions generated by the electronic system is not clear. In addition the tool is used for a "general" stage of change and is not specific to disorder or problem. Clarifying Questions for Staff: • How does the assessment of stage of change influence treatment planning? • Is it used to match individuals to stage based groups? • Do case management staff members understand the change tool and how this influences their activities? Clarifying Questions for Clients: • Do staff members talk with you about stage of change? • Have they discussed how this might help them customize what they do to best help you?
IVE. Policies and procedures for evaluation, management, monitoring and compliance for/ of medications for substance use disorders	**Score 3:** The psychiatrist, although having taken an active role with co-occurring clients, uses some substance abuse medications, and has a fair amount of communication and access by team members. The doctor does not indicate how withdrawal is dealt with, and there is some use of benzodiazepines. Clarifying Questions for Staff: • What percentage of team meetings does the psychiatrist attend? • How does the doctor deal with individuals who are in need of detox or experiencing withdrawal symptoms? • Is a copy of the medication policies available?
IVF. Specialized interventions with substance use disorders content	**Score 3:** Stage based groups have become a fairly regular part of services and the organization is utilizing an evidence based practice (CBT). Clarifying Questions for Staff: • Is a group manual or content guide available for review? Clarifying Point • The scenario says that the substance abuse counselor is doing the group

Domain/Item	Comments
IVG. Education about substance use disorders, treatment, and interaction with mental health disorders	**Score 3:** The agency is providing education about substance abuse but is doing this in a mostly generic format in groups and in individual substance abuse-specific sessions. Clarifying Questions for Staff: • What types of education occur regarding addiction? • Does the information presented come from a manual?
IVH. Family education and support	**Score 4:** The agency does have a monthly COD group for family members, which is part social and part educational. It does not follow a specified format. Only a few families participate. Clarifying Questions for Staff: • Does family programming follow a specific format? • What types of education materials are offered? • Are individual client and family education and support services provided?
IVI. Specialized interventions to facilitate use of peer support groups in planning or during treatment	**Score 4:** Several staff members have assisted individuals with getting to DTR and other meetings and role playing interactions at meetings. Some of these interventions were noted in treatment planning, but inconsistently. Clarifying Questions for Staff: • Are clients connected with co-occurring self-help groups? • How does the team determine which group to connect someone with or when to do it? Clarifying Questions for Clients: • Do you attend self-help or 12-step groups? • How did the staff assist you with getting connected with these groups?
IVJ. Availability of peer recovery supports for patients with co-occurring disorders	**Score 1:** Peer support may be available in the community, but the agency has not identified this as a resource that could be helpful for clients. Clarifying Questions for Staff: • Do clients have access to peers, mentors or sponsors from this program to assist them with their recovery? Clarifying Questions for Clients: • Have you had the opportunity to talk to people from the program who have been able to achieve some long term recovery?
Continuity of Care	
VA. Co-occurring disorder addressed in discharge planning process	**Score 1:** The agency provided a limited number of closed files to be reviewed. Of the two, neither addressed co-occurring disorders. Clarifying Questions for Staff: • How is discharge planning approached for clients with co-occurring disorders? • Are certain types of items required in discharge plans? • Can we look at a larger sample of discharged records for individuals with co-occurring disorders? Clarifying Questions for Clients: • Have staff members spoken with you about what will need to be in place when your treatment is completed? • Do you have a written plan for how to maintain your mental health and substance abuse recovery?

DDCMHT — Case Study Scoring Key

Domain/Item	Comments	129
VB. Capacity to maintain treatment continuity	**Score 1:** Based on the two discharge summaries, it does not appear that the agency connects individuals with ongoing substance abuse treatment. It is clear that mental health services, including stage based groups, case management and medication services can be continued as long as needed. Clarifying Questions for Staff: • What types of substance abuse services are individuals connected with when their time in the program is completed? • Do you have formalized relationships with substance abuse providers who can continue care? Clarifying Questions for Clients: • Do you have plans for continuing your sobriety after services are complete? • How do you envision your long term recovery?	
VC. Focus on ongoing recovery issues for both disorders	**Score ?:** There is limited information about how the agency views recovery. Assessors need to attempt to collect more information prior to scoring this item. Clarifying Questions for Staff: • Are there groups that focus on mental health recovery? • Are there groups that focus on substance abuse recovery? Clarifying Questions for Clients: • Do staff members talk with you about mental health and substance abuse recovery? • Could you tell me what "recovery" means to you?	
VD. Specialized interventions to facilitate use of community-based peer support groups during discharge planning	**Score 1:** The two discharge summaries did not include documentation about linkages to community-based peer support. The organization does have an in-house DTR group and clients are able to attend after discharge, yet it's not clear if there is an awareness of this in discharge planning. Clarifying Questions for Staff: • Are there identified contact people in the community you use to get clients connected to outside groups? • What's the process for connecting and facilitating clients to become active in self-help groups for individuals with co-occurring disorders?	
VE. Sufficient supply and compliance plan for medications for substance use disorders (see IVE) are documented	**Score 5:** The agency is able to and continues to provide medication services, including for substance use disorders, to individuals after they have completed intensive outpatient services. This is a required service as part of their state contract.	
Staffing		
VIA. Psychiatrist or other physician or prescriber of medications for substance use disorders	**Score 5:** The agency has an on-staff psychiatrist that attends team meetings and is available for consultation. She has also taken an active role in co-occurring disorders treatment. Clarifying Questions for Prescriber: • Is the prescriber full or part time? • How do you and team members communicate?	
VIB. On site clinical staff members with substance abuse licensure, certification, competency, or substantive experience	**Score 2:** The agency has one certified substance abuse counselor as part of the team. Clarifying Questions for Staff: • Who makes up the team, how many? • Do other staff who are not certified or licensed have substance abuse treatment experience?	

DDCMHT — Case Study Scoring Key

Domain/Item	Comments
VIC. Access to addiction clinical supervision or consultation	**Score 3:** Team members have weekly team meetings with the substance abuse counselor and have access as needed for consultation. Formal, documented supervision with the substance abuse counselor is not occurring. Clarifying Questions for Staff: • How do the non-licensed or certified staff access substance abuse related supervision? • Are there supervision notes or meeting minutes?
VID. Case review, staffing or utilization review procedures emphasize and support co-occurring disorder treatment	**Score 1:** Case review occurs in the weekly team meetings, which covers all clients. It is not specifically focused on co-occurring disorders. Clarifying Questions for Staff: • Are there any types of review procedures for co-occurring clients? • What about quality assurance or utilization review? • Do you use a checklist or form, can we see it?
VIE. Peer/Alumni supports are available with co-occurring disorders	**Score 1:** The clients reported that the program had not been in existence long enough to have an alumni program. The agency has not formalized making connections to community self-help groups. Clarifying Questions for Staff: • Are role models, mentors or alumni a part of the program? Clarifying Questions for Clients: • Are there people other than the staff you go to for support? • Do any of them have mental health and substance abuse problems also?
Training	
VIIA. All staff members have *basic* training in attitudes, prevalence, common signs and symptoms, detection and triage for co-occurring disorders	**Score 2:** A few staff have basic training in co-occurring disorders (25-50%), but it is not encouraged or monitored by the agency. There is no training plan in place. Clarifying Questions for Staff: • Are there particular staff competencies you have identified? • Have substance abuse or co-occurring disorders been integrated into new employee orientation?
VIIB. Clinical staff members have *advanced* specialized training in integrated psychosocial or pharmacological treatment of persons with co-occurring disorders	**Score 1:** One clinical staff member has basic training in Motivational Interviewing; she also reported she used CBT techniques (but did not report training in CBT). The training noted was not specific to co-occurring disorders. Clarifying Questions for Staff: • Does the agency keep a list of training presented and attended?

F. Sample Memorandum of Understanding

Between

[mental health program]

and

[addiction treatment program]

The purpose of this Memorandum of Understanding (MOU) 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.

G. Screening for Mental Health and Substance Use Disorders

Modified MINI Screen (MMS)

Mental Health Screening Form-III (MHSF-III)

CAGE-Adapted to Include Drugs (CAGE-AID)

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

Traumatic Life Events Inventory and Posttraumatic Stress Disorder Checklist

Social Interaction Anxiety Scale

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)**

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 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 had 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, insects, 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 **ever** experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner?   YES _____   NO _____

12. Was there **ever** 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 a lot of exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up?   YES _____   NO _____

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

16. Have you **ever** 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 **ever** 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**

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 eight 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**

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

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
1. Repeated disturbing memories, thoughts or images of the stressful experience?	1	2	3	4	5
2. Repeated, disturbing dreams of the stressful experience?	1	2	3	4	5
3. Suddenly acting or feeling as if the stressful experience were happening again? (As if you were reliving it?)	1	2	3	4	5
4. Feeling very upset when something reminded you of the stressful experience?	1	2	3	4	5
5. Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of the stressful experience?	1	2	3	4	5
6. Avoiding thinking about or talking about the stressful experience or avoiding having feelings related to it.	1	2	3	4	5
7. Avoiding activities or situations because they remind you of the stressful experience?	1	2	3	4	5
8. Trouble remembering important parts of the stressful experience?	1	2	3	4	5
9. 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

Bothered by	Not at all	A little bit	Moderately	Quite a bit	Extremely
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 = **Extremely** characteristic or true of me

Characteristic	Not at all	Slightly	Moderately	Very	Extremely
1. I get nervous if I have to speak with someone in authority (teacher, boss).	0	1	2	3	4
2. I have difficulty making eye contact with others.	0	1	2	3	4
3. I become tense if I have to talk about myself or my feelings.	0	1	2	3	4
4. I find it difficult to mix comfortably with the people I work with.	0	1	2	3	4
5. I find it easy to make friends my own age.	0	1	2	3	4
6. I tense up if I meet an acquaintance in the street.	0	1	2	3	4
7. When mixing socially, I am uncomfortable.	0	1	2	3	4
8. I feel tense when I am alone with just one person.	0	1	2	3	4
9. 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
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

Characteristic	Not at all	Slightly	Moderately	Very	Extremely
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.

H. Measuring Motivation for Change and 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.	1 2 3 4 5
2. Sometimes I wonder if I am an alcoholic.	1 2 3 4 5
3. If I don't change my drinking soon, my problems are going to get worse.	1 2 3 4 5
4. I have already started making some changes in my drinking.	1 2 3 4 5
5. I was drinking too much at one time, but I've managed to change my drinking.	1 2 3 4 5
6. Sometimes I wonder if my drinking is hurting other people.	1 2 3 4 5
7. I am a problem drinker.	1 2 3 4 5
8. I'm not just thinking about changing my drinking, I'm already doing something about it.	1 2 3 4 5
9. I have already changed my drinking, and I am looking for ways to keep from slipping back to my old pattern.	1 2 3 4 5
10. I have serious problems with drinking.	1 2 3 4 5
11. Sometimes I wonder if I am in control of my drinking.	1 2 3 4 5
12. My drinking is causing a lot of harm.	1 2 3 4 5
13. I am actively doing things now to cut down or stop drinking.	1 2 3 4 5
14. I want help to keep from going back to the drinking problems that I had before.	1 2 3 4 5
15. I know that I have a drinking problem.	1 2 3 4 5
16. There are times when I wonder if I drink too much.	1 2 3 4 5
17. I am an alcoholic.	1 2 3 4 5
18. I am working hard to change my drinking.	1 2 3 4 5
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.	1 2 3 4 5

NH-Dartmouth Psychiatric Research Center – Version date: January 22, 2002

Client Name _____

Date of Rating _____

Substance Abuse Treatment Scale

Instructions

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 to 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 to 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 to 12 months.

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

I. Tracking Changes in Substance Use and Mental Health

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

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

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