

DDCAT

**The Dual Diagnosis Capability in Addiction Treatment (DDCAT)
Index Toolkit**

Adapted for use in the

**Improved Services for People with Drug and Alcohol
Problems and Mental Illness Initiative**

for the

Department of Health and Ageing

April 2008

Brief Overview for VAADA Reference Group

August 2008

Use of DDCAT in the Improved Services Initiative

The 2006-07 Department of Health and Ageing Budget provided \$73.9 million over five years for the Improved Services for People with Drug and Alcohol Problems and Mental Illness initiative, which forms part of the Australian Government's contribution to the COAG mental health package. The aim of this initiative is to build the capacity of non-government organisation (NGO) drug and alcohol treatment services to better identify and respond to people with drug and alcohol problems and mental illness (often referred to as co morbidity or dual diagnosis).

As well as the data collected in the progress reports to track each grant, each organisation is required to use a validated tool to assess the services capacity to serve clients with dual diagnosis in drug and alcohol services. It is suggested that the Dual Diagnosis Capability in Addiction Treatment (DDCAT) is used.

Services are expected to use the results of the DDCAT process to plan and prioritise their ongoing capacity building strategies. Services are encouraged to undertake a self assessment as soon as possible to collect a baseline score and then to repeat the self assessment annually.

For services participating in a formal quality improvement/accreditation process, the DDCAT self assessment will provide useful evaluation evidence to support those systems. Services can plan to undertake the self assessment at an appropriate time to integrate with their overall quality improvement plan. Services are required to report when they undertook the self assessment and their overall score obtained through this process as well as their average score for each domain. Those organisations already using the COMPASS tool can continue to do so. There is no requirement to change to DDCAT or to use both tools.

Expectation of Outcome

It should be clearly understood that there is no expectation on behalf of the Department that all services will reach a 5. The way the DDCAT is structured many NGO services will only be operating at the 1- 3 level. 5 would not be a realistic, or even optimal outcome for these services. The expectation is the tool is used to assess and plan capacity building. For some services this may mean only very slight improvements in scores over the life of the Improved Services Initiative.

Introduction

Alcohol and Other Drug treatment providers are continually challenged to improve services. Often, these challenges occur in resource poor and high demand environments. Over the past decade, there has been an increased awareness of the common presentation of persons with co-occurring psychiatric disorders in routine Alcohol and Other Drug settings. National and state initiatives have been significant, and have stimulated considerable interest in providing better services for co-occurring disorders. Although clearly interested in doing so, Alcohol and Other Drug treatment providers have lacked pragmatic guidance on

how to improve existing services. National clinical guidelines are currently being developed by the Department of Health and Ageing, however there has been little guidance around how to build capacity, plan and develop services to better service these clients.

The Dual Diagnosis Capability in Addiction Treatment (DDCAT) index has been subjected to a series of research studies, and has been implemented in a number of different jurisdictions. Its use within Australia has been limited to date. The DDCAT, defined more fully below, has served to guide services in assessing and developing the dual diagnosis capacity of Alcohol and Other Drug treatment services.

The motivation among Alcohol and Other Drug treatment providers to improve the quality of care offered to their clients is impressive if not inspirational. The toolkit has been developed in direct response to Alcohol and Other Drug treatment programs at the “Action” stage of readiness. This is the stage at which most Alcohol and Other Drug treatment providers find themselves and particularly those that have chosen to participate in the Improved Services Initiative. The toolkit is designed to immediately offer practical tools and useable materials that will rapidly improve services to those persons with co-occurring disorders entrusted to their care.

Some parts of the tool may have limited applicability to NGO services that are not providing ‘clinical’ service. This should not detract from the overall use of the tool. Feedback to the Department on parts of the tool that should be modified for increased relevance to NGO services would be welcomed.

What is the DDCAT?

The DDCAT is an acronym for the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index, and is a fidelity instrument for measuring Alcohol and Other Drug treatment program services for persons with co-occurring (i.e., mental health and substance related) disorders (see Appendix A for a copy of the instrument). The DDCAT Index has been in development since 2003.

Fidelity scale methods have been used to ascertain adherence to and competence in the delivery of evidence-based practices. At this point in time, Alcohol and Other Drug treatment services for co-occurring disorders are guided by an amalgam of evidence-based practices and consensus clinical guidelines. The rating scale has been adapted accordingly.

DDCAT Dimensions

The DDCAT evaluates 35 (33 in the Australian context) program elements that are subdivided into 7 dimensions.

Dimension	Description
<i>Program Structure</i>	Focuses on general organizational factors that foster or inhibit the development of COD treatment.
<i>Program Milieu</i>	Focuses on the culture of program and whether the staff and physical environment of the program are receptive and welcoming to persons with COD
<i>Clinical Process dimensions (Assessment and Treatment)</i>	Examines whether specific clinical activities achieve specific benchmarks for COD assessment and treatment
<i>Continuity of Care</i>	Examines the long-term treatment issues and external supportive care issues commonly associated with persons who have COD
<i>Staffing</i>	Examines staffing patterns and operations that support COD assessment and treatment
<i>Training</i>	Measures the appropriateness of training and supports that facilitate the capacity of staff to treat persons with COD

Table 1: 7 dimensions

These seven dimensions are sound components of an overall service structure for any given Alcohol and Other Drug treatment program. These align well with health and community sector accreditation programs.

The DDCAT then separates level of service capacity into three levels:

AODTS (Alcohol and Other Drug Treatment Only Services)	Services that are only aiming at providing services with a focus on clients with Alcohol and Other Drug issues only.
DDC (Dual Diagnosis Capable)	Services capable of providing services to some individuals with co-occurring alcohol and other drug related and mental health disorders but has greater capacity to serve individuals with alcohol and other drug related disorders
DDE (Dual Diagnosis Enhanced)	Services capable of providing services to any individual with co-occurring alcohol and other drug related and mental health disorders, and the program can address both types of disorders fully and equally

Table 2: Service Capacity Levels

The DDCAT utilizes these categories and has developed observational methods (fidelity assessment methodology) and objective metrics to ascertain the dual diagnosis capability of Alcohol and Other Drug treatment services for persons with co-occurring disorders. Each service must determine where their strategic intent is, as mentioned in the introduction not all services will be striving to be DDE and hence scores of 3 will be optimal in these cases. Other services with very defined scope of service may be at an optimal level with scores between 1 and 2.

DUAL DIAGNOSIS CAPABILITY IN ADDICTION TREATMENT PROGRAMS (DDCAT)

Adapted from *VERSION 3.4 for the Improved Services Initiative*

SCORING MANUAL

	1 Alcohol and Other Drug Only Services (AODTS)	2	3 Dual Diagnosis Capable (DDC)	4	5 Dual Diagnosis Enhance (DDE)
I. PROGRAM STRUCTURE					
IA. Primary treatment focus as stated in mission statement.	Alcohol and Other Drug Only		Primary focus is Alcohol and Other Drug, co-occurring disorders are treated		Primary focus on dual-diagnosis clients.
1B. Coordination and collaboration with mental health services.	No document of formal coordination or collaboration. Meets the definition of minimal Coordination.	Vague, undocumented, or informal relationship with MH agencies, or consulting with a staff member from that agency. Meets the definition of Consultation.	Formalised and documented coordination or collaboration with mental health agency. Meets the definition of Collaboration.	Formalised coordination & collaboration, and the availability of case management staff, or staff exchange programs (variably used). Meets the definition of Collaboration and has some informal components consistent with Integration.	Most services are integrated within the existing program, or routine use of case management staff or staff exchange programs. Meets the definition of Integration.
II. PROGRAM MILIEU					
IIA. Routine expectation of and welcome to treatment for both disorders	Expect substance use disorders only, refer or deflect persons with mental health disorders or symptoms.	Documented to expect substance use disorders only (e.g. admission criteria, target population) but have informal procedure to allow some persons with mental health problems to be admitted.	Expect substance use disorders and, with documentation, accepts mental health disorders by routine and if mild and relatively stable.	Program formally defined like DDC but clinicians and program informally expects and treats both disorders, not well documented.	Clinicians and program expect and treat both disorders, well documented.

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IIB. Display and distribution of literature and patient educational materials.	Addiction or peer support (e.g. AA) only.	Available for both disorders but not routinely offered or formally available.	Available for both mental health and substance use disorders, but distribution is less for mental health problems.	Available for both mental health and substance use disorders with equivalent distribution.	Available for the interaction between both mental health and substance use disorders.
III. CLINICAL PROCESS: ASSESSMENT					
IIIA. Routine screening methods for psychiatric symptoms	Pre-admission screening based on patient self-report: Decision based on staff inference from patient presentation or by history.	Pre-admission screening for symptom & treatment history, current medications, suicide/homicide history prior to admission.	Staff have routine set of standard interview questions using generic framework.	Screen for mental health problems using standardised or formal instruments with established psychometric properties.	Standardised or formal instruments for both mental health and substance use disorders with established psychometric properties.
IIIB. Routine assessment if screened positive for psychiatric symptoms	Ongoing monitoring for appropriateness or exclusion from program	More detailed biopsychosocial assessment, mental status exam, each clinician driven	Formal assessment on site by MH professional as necessary	Increased capacity to access follow-up mental health assessments, although not standardised or routine.	Standardised or formal integrated assessment is routine in all cases.
IIIC. Psychiatric and substance use diagnoses made and documented.	Psychiatric diagnoses are not made or recorded	Mental health diagnostic impressions made and recorded variably.	Mental health diagnosis variably recorded in chart.	Mental health diagnosis more frequently recorded but inconsistently.	Standard and routine mental health diagnosis consistently made.
IIID. Psychiatric and substance use history reflected in medical record.	Collection of substance use disorder history only.	Standard form collects substance use disorder history only. Mental health history collected inconsistently.	Routine documentation of both mental health and substance use disorder history in record in narrative section.	Specific section in record dedicated to history and chronology of course of both disorders.	Specific section in record devoted to history and chronology of course of both disorders and the interaction between them is examined temporally.
IIIE. Program acceptance based on psychiatric symptom acuity: low, moderate, high	Admits persons with no to low acuity.		Admits persons in program with low to moderate acuity, but who are primarily stable.		Admits persons in program with moderate to high acuity, including those unstable in their psychiatric condition.
IIIF. Program acceptance based on severity of persistence and disability: low, moderate, high.	Admits persons in program with no to low severity of persistence of disability.		Admits persons in program with low to moderate severity.		Admits persons in program with moderate to high severity.

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IIIG. Stage-wise assessment.	Not assessed or documented.	Assessed & documented variably by individual clinician	Clinician assessed and routinely documented, focused on substance use disorders motivation	Formal measure used and routinely documented but focusing on substance use disorders motivation only.	Formal measure used and routinely documented, focus on both substance use and mental health motivation.
IV. CLINICAL PROCESS: TREATMENT					
IVA. Treatment plans.	Address substance use only (Mental health not listed)	Variable by individual clinician	Substance use disorders addressed as primary, mental health as secondary.	Systematic focus in available but variably used.	Address both as primary, both listed in plan consistently.
IVB. Assess and monitor interactive courses of both disorders.	No attention or documentation of progress with MH problems	Variable reports of progress on mental health problems by individual staff.	Clinical focus in narrative (treatment plan or progress note) on mental health problem change.	Systematic focus in available but variably used.	Clear, detailed, and systematic focus on change in both substance use and mental health disorders.
IVC. Procedures for psychiatric emergencies and crisis management.	No guidelines conveyed in any manner.	Verbally conveyed in-house guidelines	Documented guidelines: referral or collaborations (to local mental health agency or ER)		Routine capability, or a process to ascertain risk with ongoing use of substances: Maintain in program unless commitment is warranted
IVD. Stage-wise treatment.	Not assessed or explicit in treatment plan.	Stage or motivation documented variably by individual staff in treatment plan.	Stage or motivation routinely incorporated into individualised plan, but no specific stage-wise treatments.	Stage or motivation routinely incorporated into individualised plan, and general awareness of adjusting treatments by individual stage of readiness on substance use motivation only.	Stage or motivation routinely incorporated into individualised plan, and formally prescribed and delivered stage-wise treatments for both substance use and mental health issues.

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IVE. Policies and procedures for medication evaluation, management, monitoring and compliance.	Patients on meds routinely not accepted. No capacities to monitor, guide or provide psychotropic medications during treatment.	Certain types of meds are not acceptable. Or must have own supply for entire treatment episode. Some capacity to monitor psychotropic medications.	Present, coordinated medication policies. Some access to prescriber for psychotropic medications and policies to guide the prescribing within the program is provided. Monitoring of the medication is largely provided by the prescriber.	Clear standards and routine for medicating provider who is also a staff member. Regular access to prescriber and guidelines for prescribing in place. The prescriber might more regularly consult with other staff regarding medication plan and recruit other staff to assist with medication monitoring.	Clear standards and routine for medicating provider who is also a staff member and present on treatment teams or administration. Full access to prescriber with appropriate prescribing guidelines in place. As a treatment team member, the prescriber informs the team about the medication plan and the entire team can assist with monitoring.
IVF. Specialised interventions with mental health content.	Not addressed in program content	Based on judgment by individual clinician; irregular penetration into routine services	In program format as generalised intervention, (e.g. stress management.) More regular penetration into routine services. Routine clinician adaptation of an evidence-based addiction treatment (e.g. MI, CBT, TSF)	Some specialised interventions by specifically trained clinicians in addition to routine generalised interventions.	Routine mental health symptom management groups; individual therapies focused on specific disorders; systematic adaptation of an evidence-based addiction treatment (e.g. MI, CBT, TSF)
IVG. Education about psychiatric disorder & its treatment, and interaction with substance use & its treatment.	No	Variably	Present in generic format and content, and delivered in individual and/or group formats.		Present specific content for specific disorder co-morbidities, and delivered in individual and/or group formats.
IVH. Family education and support.	For alcohol or drug problems only	Variably or by individual clinical judgment	Mental health issues regularly but informally incorporated into family education or support sessions. Available as needed	Generic group on site for families on substance use and mental issues, variably offered. Structured group with more routine accessibility.	Routine and systematic co-occurring disorder family group integrated into standard program format. Accessed by the majority of families with co-occurring disorder family member.

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IVI. Specialised interventions to facilitate peer support groups in planning or during treatment..	None used to facilitate either use of addiction or mental health peer support.	Used variably by or infrequently by individual staff, for individual patients, mostly for facilitation of addiction peer support groups..	Present, generic format on site, but no specific or intentional facilitation based on mental health problems. More routine facilitation of traditional addiction peer support groups (e.g. AA, NA)	Present but variable facilitation to peer support groups targeting specific mental health issues, either to traditional peer support groups or those specific to both	Routine and specific to need of co-occurring persons, special programs on site, routinely targeted to specific issues, either to traditional peer support groups or those specific to both.
IVJ. Availability of peer recovery supports for patients with CODs.	Not present, not recommended.	Off site, recommended variably	Present, off site and facilitated with contact persons or informal matching with peer supports in the community, some co-occurring focus.	Present, off site, integrated into plan, and routinely documented with co-occurring focus.	Present, on site, facilitated and integrated into program (e.g. alumni groups); routinely used and documented with co-occurring focus.
V. CONTINUITY OF CARE					
VA. Co-occurring disorder addressed in discharge planning process.	Not addressed	Variably addressed by individual clinicians.	COD systematically addressed as secondary in planning process for off site referral		Both disorders seen as primary, and plans made and insured, on site, or by arrangement - off site, at least 80% of the time.
VB. Capacity to maintain treatment continuity.	No mechanism for managing ongoing care of mental health needs when addiction treatment program is completed.	No formal protocol to manage mental health needs once program is completed, but some individual clinicians may provide extended care until appropriate linkage takes place; variable documentation.	No formal protocol to manage mental health needs once program is completed, but when indicated, most individual clinicians provide extended care until appropriate linkage takes place; routine documentation.	Formal protocol to manage mental health needs indefinitely, but variable documented evidence that this is routinely practiced, typically within the same program or agency.	Formal protocol to manage mental health needs indefinitely consistent documented evidence that this is routinely practiced, typically within the same program or agency.
VC. Focus on ongoing recovery issues for both disorders.	No	Individual staff determined.	Routine focus is on recovery from addiction, mental health issues are viewed as potential relapse issues only.		Routine focus on addiction recovery and mental health illness management and recover, both seen as primary and ongoing.

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VD. Facilitation of peer support groups for co-occurring disorders is documented and a focus in discharge planning, and connections are insured to community peer recovery support groups.	No	Rarely, but addressed by individual clinicians	Yes, variably but not routine or systematic, focus on co-occurring disorders peer support community connection (engagement in meetings or functions off-site)		Yes, routine and systematic, at least 80% of the time with focus on co-occurring disorders peer support community connection (engagement in meetings or functions off-site).
VE. Sufficient supply and compliance plan for medications is documented.	No medications in plan.		Yes, 30-day or supply to next appointment off-site.		Maintains medication management in program with provider.
VI. STAFFING					
VIA. Psychiatrist or other physician.	No formal relationship with a prescriber for this program.	Consultant or contractor off site.	Consultant or contractor for on site.	Staff member, present on site for clinical matters only	Staff member, present on site for clinical, supervision, treatment team, and/or administration.
VIB. On site staff members with mental health qualifications or formal study.	No formal relationship with program.	1-24% of staff members.	25-33% of staff members.	34-49% of staff members.	50% or more of staff members.
VIC. Access to mental health supervision or consultation.	No	Yes, off site by consultant, undocumented.	Yes, on site supervision provided PRN. Informal process	Yes, on site supervision. Provided regularly. Irregular documentation.	Yes, on site, documented regular supervision sessions for clinical matters.
VID. Case review, staffing or utilisation review procedures emphasise and support co-occurring disorder treatment.	No	Variable, by off site consultant, undocumented.	Yes, on site, documented as needed (PRN) and with co-occurring disorder issues.		Yes. Documented, routine and systematic coverage of co-occurring issues.

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VIE. Peer/Alumni supports are available with co-occurring disorders.	No		Present, but as part of community, and routinely available to program patients, either thru informal relationships or more formal connections such as thru peer support service groups (e.g. AA hospital and institutional committees; NAMI).		Present, on site, either as paid staff, volunteers, or routinely available program "alumni".
VII. TRAINING					
VIIA. Direct care staff members have basic training in prevalence, common signs and symptoms, screening and assessment for psychiatric symptoms and disorders.	Not trained in basic skills.	Variably trained, not documented as part of systematic training plan, but encouraged by management.	Trained in basic skills per agency strategic training plan.	Trained in these skills per agency strategic training plan, and also have some advanced training in specialised treatment approaches	Trained in these skills per agency strategic training plan, and also have staff with advanced training in specialised treatment approaches as part of plan.
VIIIB. Direct care staff members are cross-trained in mental health and substance use disorders, including pharmacotherapies, and have advanced specialised training in treatment of persons with co-occurring disorders	Not trained, or not documented.	At least 33% trained.	At least 50% trained	At least 75% are trained	At least 90% are trained.