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Development of a Self-report Measure of Dual Diagnosis Capability for Addiction and Mental Health Programs

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Et al.

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DDCAT Example

	1 AOS	2	3 DDC	4	5 DDE
III. CLINICAL PROCESS: ASSESMENT					
IIIC: Psychiatric and substance use diagnoses made and documented.	Psychiatric diagnoses are not made or recorded.	Off site MH professional may make diagnosis, and then is recorded.	MH professional makes diagnosis, recorded in chart. (Variable).		Standard & routine diagnoses made by MH professional staff member.
IIID: Psychiatric and substance use history reflected in medical record.	Not present.	Variable by individual clinician.	Routine documentation in record in narrative section.		Specific section in record devoted to history and chronology of course of both disorders.
IIIE: Service matching based on psychiatric symptom acuity: low, moderate, high.	Can provide care to persons with no to low acuity.		Can provide care to persons with low to moderate acuity, but who are primarily stable.		Can provide care to persons with moderate to high acuity, including those unstable in their psychiatric condition.

Examples of CODP-BST

Please check each of the following questions Yes, No, or Not Applicable (N/A) or Not Sure (NS):

		Yes	No	N/A or NS
3.	Prior to or at admission, does your program **screen** for addiction problems?	☐	☐	
3a.	**If yes**, does your program use a standardized addiction screening instrument? **If yes,** which one: _____	☐	☐	☐
4.	Prior to or at admission, does your program **screen** for mental health problems?	☐	☐	
4a.	**If yes**, does your program use a standardized mental health screening instrument? **If yes,** which one: _____	☐	☐	☐
5.	After admission, does your program conduct a comprehensive **assessment** for addiction problems?	☐	☐	
5a.	**If yes,** does your program use the Addiction Severity Index, GAIN, or other standardized instrument? **If other,** please specify: _____	☐	☐	☐
6.	After admission, does your program conduct a comprehensive **assessment** for mental health problems?	☐	☐	
6a.	**If yes,** does your program use a standardized instrument? **If yes,** please specify which instrument is used: _____	☐	☐	☐

7. Is your program licensed to provide addiction treatment?
8. Is your program licensed to provide mental health treatment?
9. Is your program licensed or certified to provide treatment for co-occurring addiction and mental health problems?
10. Are you able to bill for addiction problems as a primary diagnosis?
11. Are you able to bill for mental health problems as a primary diagnosis?
12. Does your state have co-occurring disorder codes for billing?
13. Are patients on psychiatric medications allowed into your program?
14. Are patients on methadone allowed into your program?
15. Does your program have collaborative relationships with other agencies who prescribe substance abuse or psychiatric medications for your patients?

32. In the past year, what percent of your staff received professional training in substance abuse treatment? (Check one:)

None	No more than 10%	About 10-25%	About 25-50%	About 50-75%	About 75-100%
☐	☐	☐	☐	☐	☐

33. In the past year, what percent of your staff received professional training in mental illness treatment? (Check one:)

None	No more than 10%	About 10-25%	About 25-50%	About 50-75%	About 75-100%
☐	☐	☐	☐	☐	☐

34. In the past year, what percent of your staff received professional training in treatment for co-occurring disorders? (Check one:)

None	No more than 10%	About 10-25%	About 25-50%	About 50-75%	About 75-100%
☐	☐	☐	☐	☐	☐

35. On a scale of 0-10, how would you rate how well your program addresses co-occurring disorders? (Check one:)

0	1	2	3	4	5	6	7	8	9	10
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Aims:

The purpose of this study is to develop and test the psychometrics of a self-report version of a measure of the capacity of addiction and mental health programs to deliver dual-diagnosis treatment, that is, to provide treatment for both addiction problems and mental health problems. Traditionally these services are provided by very different service providers that did not until recently interact very well, if at all. The increasing recognition that patients who suffer from both kinds of problems – who are dually diagnosed – would benefit from integrated delivery of addiction and mental health services has led to efforts to encourage provision of such integrated services in programs that have tended to focus primarily on the delivery of either addiction or mental health services to the exclusion of the other. In order to assess how well the integration of these services is progressing, various measures have been developed, one of which is the original Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index. The DDCAT, as it now stands, however, is a very time-intensive tool. It requires a rater to visit a site and spend one half to a full day there interviewing administrators, therapists, and patients, reviewing medical records, and attending meetings. The purpose of this study is to test a self-report version of the DDCAT that will be administered to administrators and therapists to see how well it performs compared to the more time-intensive procedures of the original DDCAT.

Methods:

A preliminary version of a self-report measure titled, the Co-occurring Disorders Program Brief Screening Tool (CODP-BST) was developed, consisting of 35-49 items, 25-39 Yes/No questions, and 10 questions with Likert-like responses. This version was sent to several experts in the field who had agreed to provide feedback on the questions regarding the importance and relevance of each one, as well as provide written concerns, comments, and suggestions for each one. Completed responses were received from 11 experts. We are in the process of rewriting some of the questions and adding about 35 more in order to let the CODP-BST parallel the questions rated on the DDCAT as much as possible. We are in the process of training raters to administer the DDCAT to programs in addiction and mental health around the state, where we will also ask administrators and clinicians in the programs to complete the CODP-BST. That way we will be able to examine the reliability, factor structure, and validity of the CODP-BST.

Results:.

The results of the experts' ratings of the importance of each question on the CODP-BST was encouraging. Items could be rated 0 = unimportant/irrelevant; 1 = mostly unimportant/irrelevant; 2 = somewhat important/relevant; 3 = very important/relevant; or 4 = Crucial. No question was rated lower than a 2. The average ratings on the questions ranged from 2.18 to 4.00. The average rating for all of the questions was 3.06 (sd = 0.45), indicating that on average the experts thought the questions were very relevant and important. Only 9 items (18%) averaged lower than 2.75, and of these only 6 (12% of the total scale) averaged 2.18 to 2.40.

Discussion:

We are hopeful that over the next 8-10 months we will be able to complete the revision of the CODP-BST and collect ample evidence of the reliability and validity of our new self-report measure. Such a measure will provide a powerful tool for addiction and mental health programs to assess their own current capacity to provide integrated treatment for co-occurring addiction and mental health disorders and allow them to determine where their strengths lie and where they might mostly effectively concentrate their efforts to improve their co-occurring disorder treatment services.

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