SAMHSA-HRSA
Center for Integrated Health Solutions

Introduction to the Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) Index

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GOALS AND OBJECTIVES

Cite current research about the prevalence of co-occurring disorders in addiction and mental health treatment

Give an overview of the Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) index

Meet the DDCMHT Toolkit

Use the DDCMHT as measure of quality improvement

ACKNOWLEDGEMENTS

Mark P. McGovern, Ph.D.
Professor of Psychiatry and Community &Family Medicine at the Dartmouth Medical School

System collaborators: CA, CT, IL, IN, KY, LA, MO, MN, NH, NJ, NY, SC, TX, VA, VT & WA, Navajo Nation

National Institute on Drug Abuse

The Robert Wood Johnson Foundation

SAMHSA

Programs, staff members, patients

WHY FOCUS ON CO-OCCURRING DISORDERS?

1. Co-occurring disorders are common in the community and even more so in treatment settings
2. Co-occurring disorders lead to worse outcomes and higher costs than single disorders
3. Evidence-based models exist and can be implemented
4. Providers and consumers want a better system and services
5. Few (<10%) people get the treatments they need.

COMORBIDITY OF SUBSTANCE USE AND SPECIFIC AXIS I PSYCHIATRIC DISORDERS

	Any Substance		Alcohol Diagnosis		Other Drug Diagnosis	
Schizophrenia	47%	4.6	33.7%	3.3	27.5%	6.2
ASPD	83.6%	29.6	73.6%	21.0	42%	13.4
Anxiety disorders	23.7%	1.7	17.9%	1.5	11.9%	2.5
Phobia	22.9%	1.6	17.3%	1.4	11.2%	2.2
Panic disorder	35.8%	2.9	28.7%	2.6	16.7%	3.2
OCD	32.8%	2.5	24%	2.1	18.4%	3.7
Bipolar Disorder	60.7%	7.9	46.2%	5.6	40.7%	11.1
Major depression	27.2%	1.9	16.5%*	1.3	18%	3.8

Regier DA et al. JAMA. 1990(Nov 21);264(19):2511-2518

LIFETIME RISK OF ANY MENTAL HEALTH DISORDER BY SUBSTANCE USE DISORDER

▪ Cocaine	76.1% (11.3)
▪ Barbiturates	74.7% (10.8)
▪ Hallucinogens	69.2% (8.0)
▪ Opiates	65.2% (6.7)
▪ Alcohol	36.6% (2.3)

Regier DA et al. JAMA. 1990(Nov 21);264(19):2511-2518

12-MONTH RISK OF MOOD DISORDERS
(Odds Ratios)

Comorbid Disorder	Any SUD	Any Substance Abuse	Any Substance Dependence
Any mood	2.8	1.4	4.5
Major depression	2.5	1.3	4.1
Dysthymia	2.2	1.1	3.4
Mania	3.9	1.5	6.4
Hypomania	3.6	1.9	5.1

Grant BF et al. Arch Gen Psychiatry. 2004(Aug);61(8):807-816

12-MONTH RISK OF ANXIETY DISORDERS
(Odds Ratios)

Comorbid Disorder	Any SUD	Any Substance Abuse	Any Substance Dependence
Any anxiety	1.9	1.1	2.8
Panic disorder	5.2	2.8	7.7
Social phobia	1.9	1.1	2.8
Specific phobia	1.6	1.1	2.2
GAD	2.3	1.1	3.8

Grant BF et al. Arch Gen Psychiatry. 2004(Aug);61(8):807-816

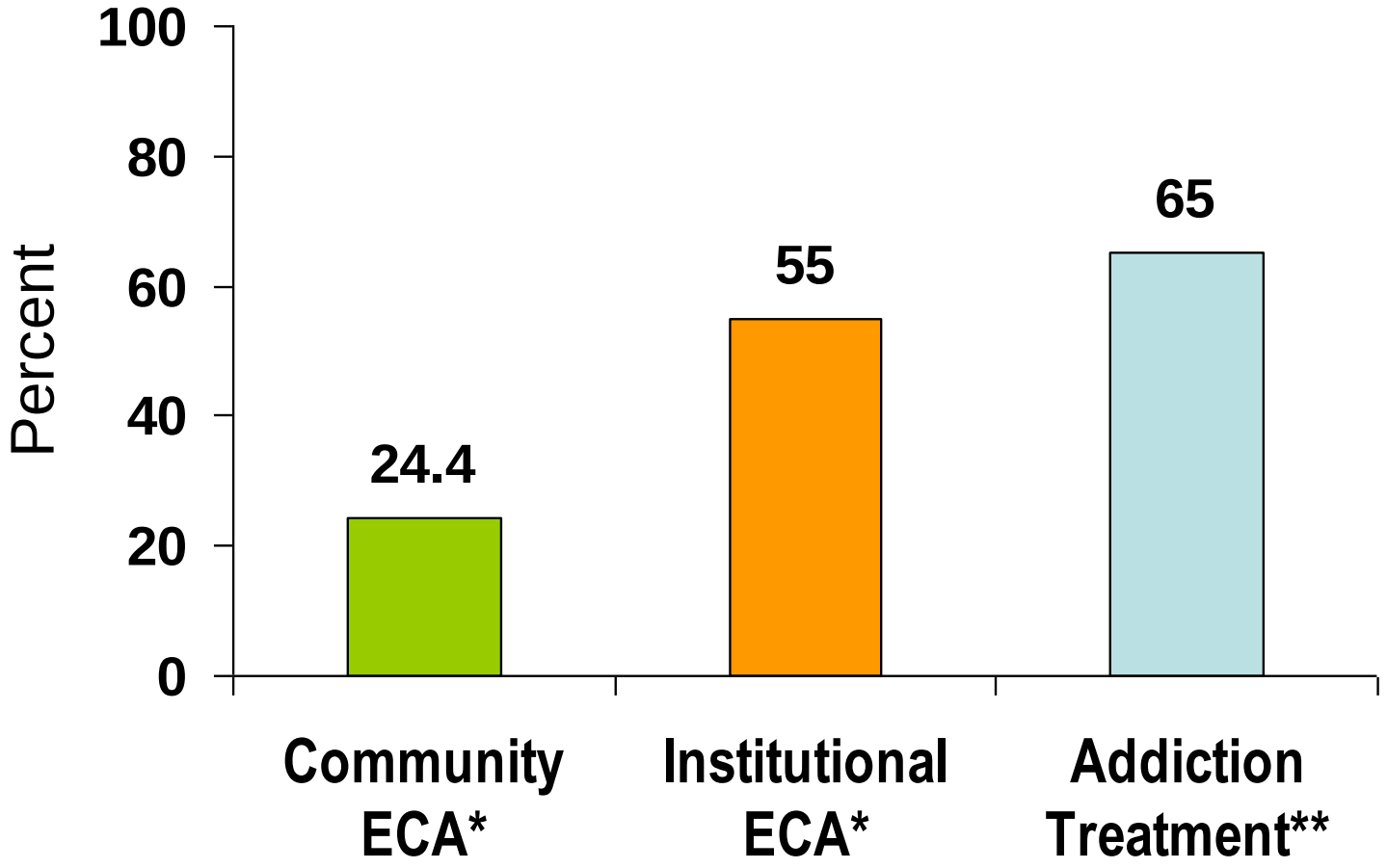
CO-OCCURRING DISORDERS IN TREATMENT SETTINGS

- Community sample prevalence rates are high, but co morbidity rates in treatment-seeking populations are even higher (2-3x)

- The highest rates are found in institutional populations—inpatient and outpatient psychiatric units, addiction treatment programs and jails[1, 2, 3, 4]

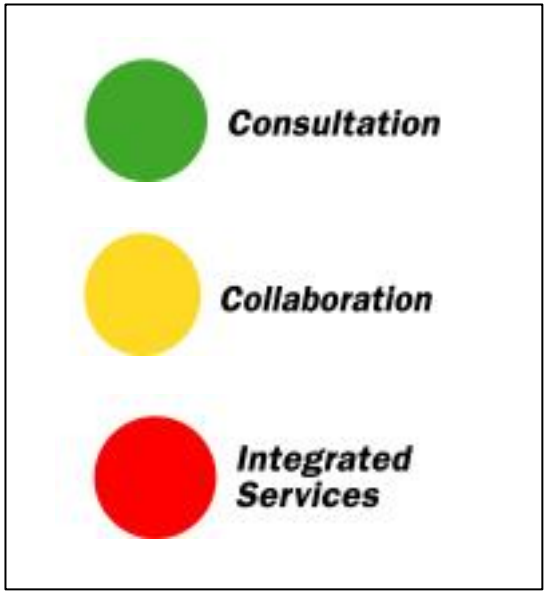
[1]Hien D et al. Psychiatr Serv. 1997(Aug);48(8):1058-1063; [2]Jordan LC et al. J Ment Health Adm. 1996(Summer);23(3):260-271; [3]Kokkevi A et al. Compr Psychiatry. 1995(Sept-Oct);36(5):329-337; [4]Regier DA et al. JAMA. 1990(Nov 21);264(19):2511-2518

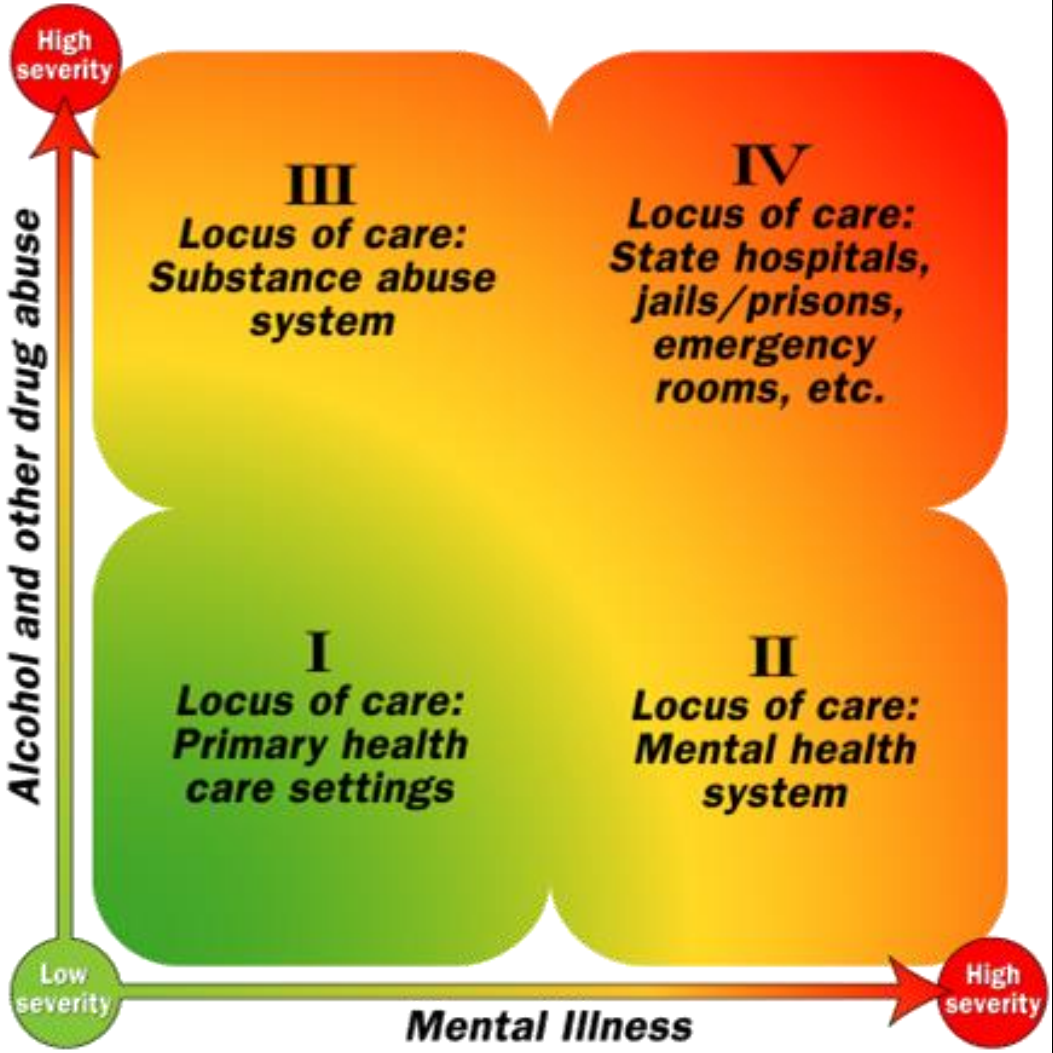
RATES OF CO-OCCURRING DISORDERS BY SETTING

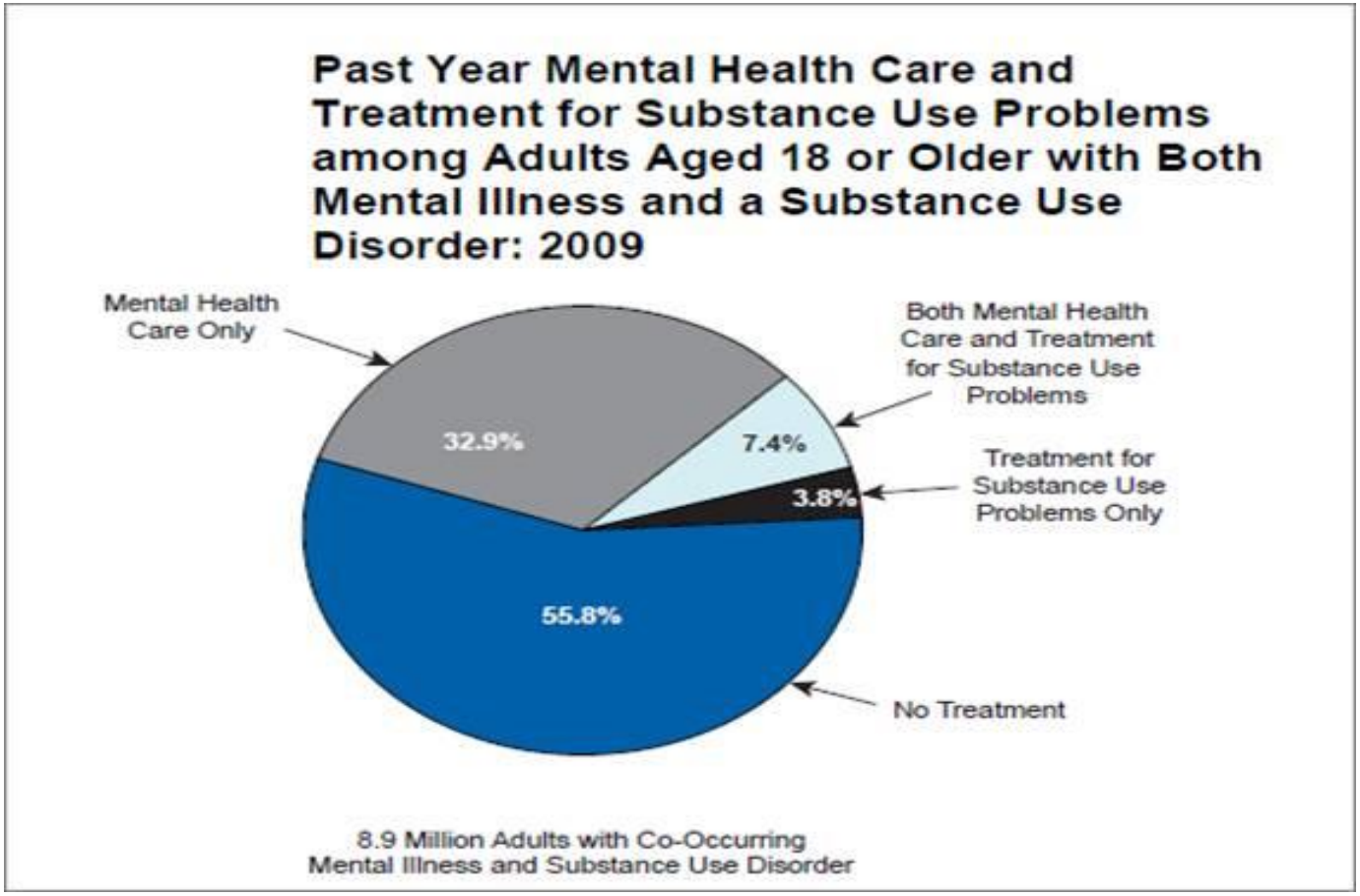


*Regier DA, et al. *JAMA*. 1990;264:2511-2518; **Ross HE, et al. *Arch Gen Psychiatry*. 1988;45:1023-1031.

SERVICE COORDINATION BY SEVERITY







Substance Abuse and Mental Health Services Administration. (2010). *Results from the 2009 National Survey on Drug Use and Health: Mental Health Findings* (Office of Applied Studies, NSDUH Series H-39, HHS Publication No. SMA 10-4609). Rockville, MD.

WHY DO WE NEED TO MEASURE CO-OCCURRING CAPABILITY?

1. Generic terms “integrated” or “enhanced” are “feel good” rhetoric but lack specificity.
2. Systems and providers seek guidance, objective criteria and benchmarks for providing the best possible services.
3. Patients and families should be informed about the range of services, to express preferences and make educated treatment decisions.
4. Change efforts can be focused and outcomes of these initiatives assessed.

TWO EXISTING MEASURES OF DUAL DIAGNOSIS CAPABILITY

1. The Comorbidity Program Audit and Self-Survey for Behavioral Health Services (COMPASS)
   - Adult & Adolescent Program Audit Tool for Dual Diagnosis Capability
   - Ken Minkoff & Christine Cline (2002)
   - Designed for either mental health or addiction programs
   - Leans in the direction of mental health program & SMI clients in utility (Q2)
   - Unit of analysis: System

TWO EXISTING MEASURES OF DUAL DIAGNOSIS CAPABILITY (Cont.)

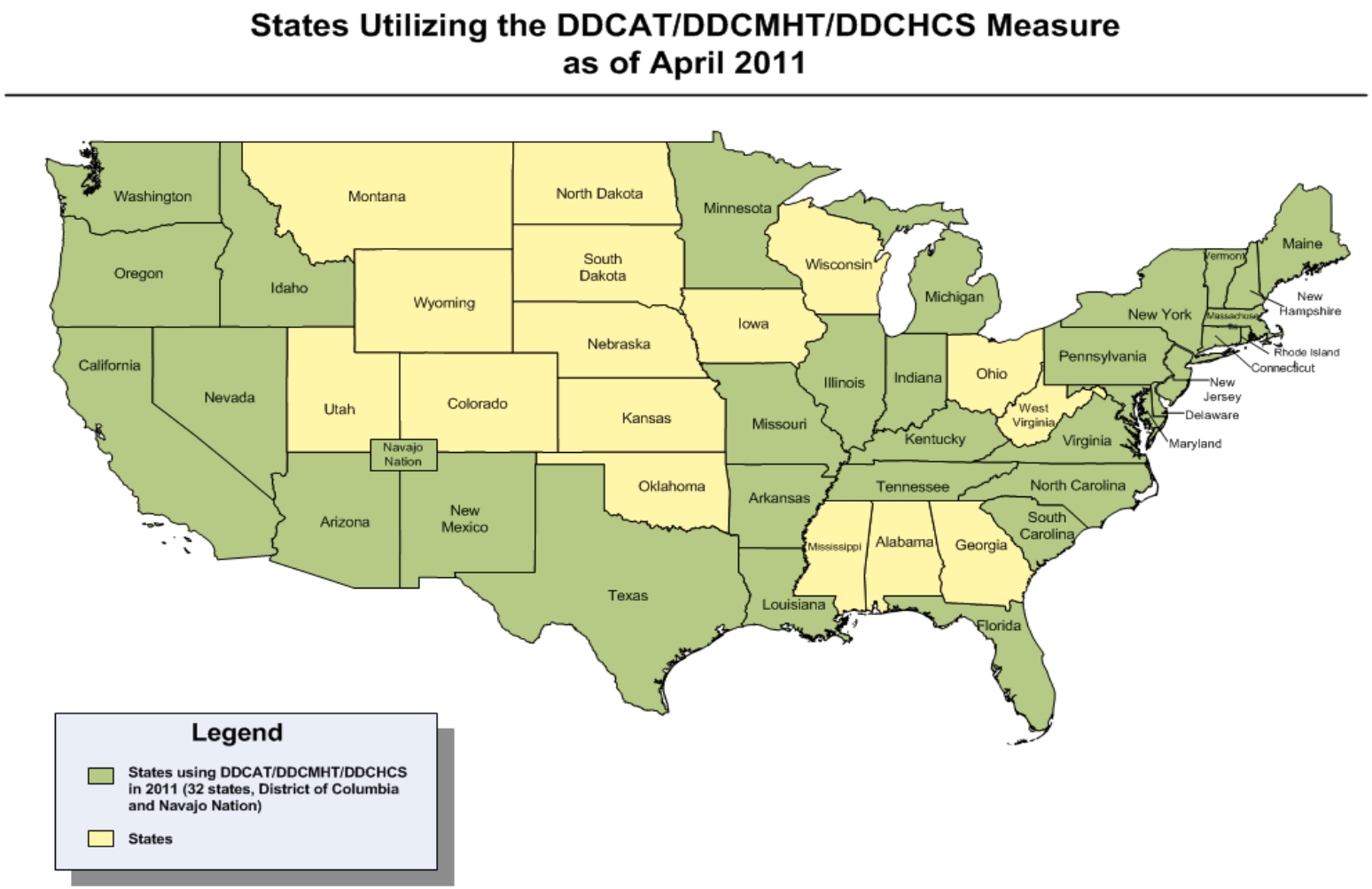
2. Integrated Dual Disorder Treatment Fidelity Scale
   - IDDT developed and standardized in MH settings.
   - IDDT model for persons with SMI (Q2)
   - Does not fit in mental health settings not specifically implementing IDDT
   - Mueser, Drake et al (2003)
   - Unit of analysis: Treatment team(s)

Newer measures of fidelity/capability to treat patients with co-occurring disorders

- Dual Diagnosis Capability in Addiction Treatment (DDCAT) – McGovern et al., 2007
- Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) – Gotham et al., 2013
- Dual Diagnosis Capability in Healthcare Settings (DDCHCS) – McGovern et al., 2012
- Dual Diagnosis in Medically Integrated Care (DDMICe) – Sacks et al.

http://ahsr.dartmouth.edu/html/ddcat.html

A COMMON YARDSTICK



ASAM TAXONOMY OF DUAL DIAGNOSIS SERVICES (ASAM, 2001)

ADDICTION OR MENTAL HEALTH ONLY SERVICES (AOS/MHOS) - serve clients with no or minimal co-occurring disorders

DUAL DIAGNOSIS CAPABLE (DDC) -serve clients with low severity mental health disorder or substance use disorder

DUAL DIAGNOSIS ENHANCED (DDE) - serve clients with more severe, unstable mental health or substance use disorders

ASAM DUAL-DIAGNOSIS TAXONOMY SURVEY IS USEFUL BUT MAY HAVE ACCURACY PROBLEMS

92.9% of sample responded to item (421/453)

No differences in categories by professional role: Agency Directors vs. Clinical Supervisors vs. Clinicians

Modest agreement among staff within programs: 47.3%

Survey method is rapid and economical:

Provides initial data (screening)

Survey method may have bias and error (ambiguity)

***McGovern et al., JSAT, 2006;31:267-275.**

THE NEED FOR A MORE OBJECTIVE ASSESSMENT OF DUAL DIAGNOSIS CAPABILITY

Research has shown significant over-reporting of capability with self-assessments (e.g., Adams, Soumerai, Lomas, & Ross-Degnan, 1999).

Similarly, Lee and Cameron (2009) found that programs over-rated their co-occurring disorders capability compared to presumably more objective external raters

THE NEED FOR A MORE OBJECTIVE ASSESSMENT OF DUAL DIAGNOSIS CAPABILITY

ASAM offers the road map, but no operational definitions for categories or services

Fidelity: Adherence to an evidence-based practice or model

Fidelity scales: Objective ratings of adherence in mental health services research

Can we apply fidelity scale methods to estimate dual diagnosis capability?

DDCAT INDEX: DEVELOPMENT 2002-2007

Practical program level policy, practice and workforce benchmarks: Based on scientific literature and expert consensus

Observational methodology: Interviews; Document review; Social, environmental & cultural ethnography (vs. self-report)

Iterative process of measure refinement: Field testing and psychometric analyses

Materials: Index, manual, toolkit & Excel workbook for scoring and graphic profiles

DUAL DIAGNOSIS CAPABILITY IN MENTAL HEALTH TREATMENT (DDCMHT) INDEX

Designed by Drs. Heather Gotham, Jessica Brown & Joseph Comaty as companion to DDCAT but for use in mental health programs.

More likely presentation of QIII patients in mental health system (rather than addiction treatment system)

Makes comparisons between systems possible

DDCMHT FRAMEWORK – 35 items

Policy

- Program Structure, Program Milieu

Clinical Practices

- Assessment, Treatment, Continuity of Care

Workforce

- Staffing, Training

APPLYING THE FIDELITY SCALE METHODOLOGY FOR A MORE OBJECTIVE ASSESSMENT

Site visit (yields data beyond self-report)

Multiple sources:

1) Documents and materials
2) Ethnographic observation
3) Interviews with staff and patients

Unit of analysis: program

“Triangulation” of data

DDCMHT INDEX RATINGS

1 - Mental Health Only Services (MHOS)

2 -

3 - Dual Diagnosis Capable (DDC)

4 -

5 - Dual Diagnosis Enhanced (DDE)

DDCMHT PSYCHOMETIC PROPERTIES

Reliability

Alpha = Range .53 - .85

Inter-rater reliability (LA): .83

Sensitive to change: MO over 2 years

Validity

Correlation with IDDT Fidelity Scale: Total Score = .70 (.37 to .77)

Relationship with organizational readiness to change

(Gotham et al, 2013)

DDCMHT MATERIALS (Version 4.0, 2011)

DDCMHT Index

DDCMHT Toolkit

DDCMHT Scoring spreadsheet for tabulating and summarizing ratings, and creating graphic profiles

http://www.samhsa.gov/cooccurring/ddcat/introduction/introduction.html

I. PROGRAM STRUCTURE

Primary treatment focus as stated in your mission statement.

Organizational certification and licensure.

Coordination and collaboration with addiction/mental health services.

Ability to merge funding streams to provide COD services.

II. PROGRAM MILIEU

Expectation and welcome of clients with COD.

Display and distribution of substance abuse and mental health related literature and patient educational materials.

III. ASSESSMENT

- Routine screening
- Routine assessment methods for clients who screen positive
- Frequency and documentation of diagnoses
- Documentation of history in the medical record
- Capability to provide services based on clients' acuity of symptoms
- Capability to provide services based on severity and persistence of disability
- Initial assessment of readiness for change

IV. TREATMENT

Documentation in treatment plans

Ongoing capability to assess/monitor disorders

Emergencies and crisis management

Ongoing assessment of readiness for change

Medication evaluation, management, monitoring

Specialized interventions, psychoeducation

Family education and support

Facilitate use of self-help groups

Peer recovery support

V. CONTINUITY OF CARE

- Discharge planning
- Capacity to maintain treatment continuity
- Focus on ongoing recovery
- Documented facilitation to self-help groups
- Documentation of sufficient supply and compliance plan for medication

VI. STAFFING

Access to services from a psychiatrist or other prescriber

On site staff with certification or licensure

Access to supervision or consultation

Supervision, case management, or utilization review procedures for COD

Peer/Alumni supports

VII. TRAINING

All staff have basic training

Clinical staff members have advanced specialized training

TOOLKIT ORGANIZATION

Introduction

- Description of index
- Psychometric studies

Applications

- System and regulatory agencies
- Treatment providers
- Health services researchers
- Families and individuals seeking services

TOOLKIT ORGANIZATION (Cont.)

Methodology

- Site visit specifics
- Cautions regarding self-evaluation
- Training

METHODOLOGY: SITE VISIT SPECIFICS

External raters make a ½ to full day site visit, collecting data about the program from a variety of sources:

Ethnographic observations of milieu and physical settings

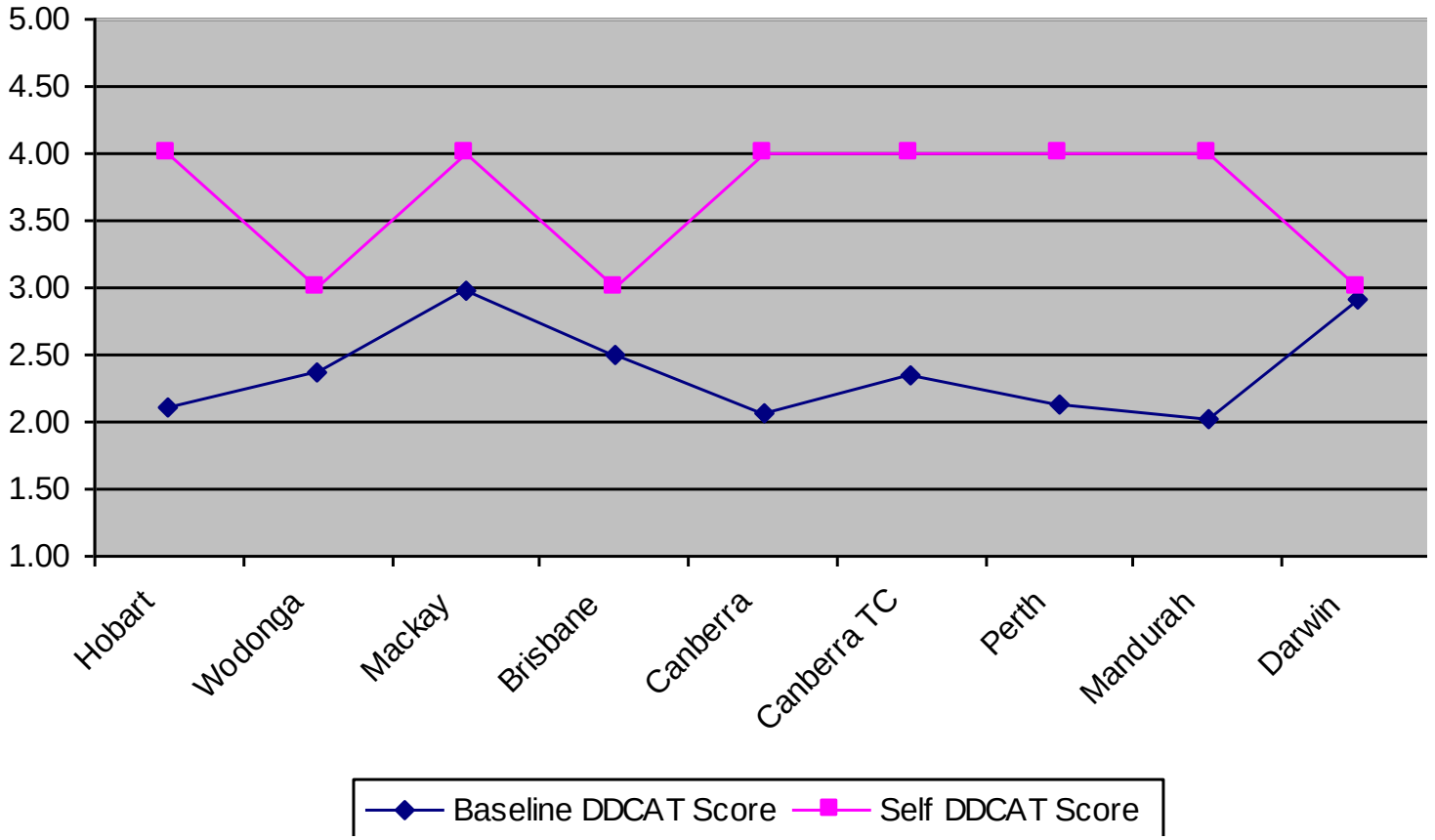
Focused, but open-ended interviews of agency directors, clinical supervisors, clinicians, medication prescribers, support personnel, and clients

Review of documentation such as medical records, program policy and procedure manuals, brochures, daily patient schedules, telephone intake screening forms, etc.

METHODOLOGY: CAUTIONS REGARDING SELF-EVALUATION

- Several efforts to utilize DDCAT index as self-administered measure: Economic, practical, less intensive resource issue
- Balancing accuracy with practicality
- Projects in: MA, NJ, Australia, IN
- Comparison data available for the Australian and CT samples

DDCAT: SELF VS. INDEPENDENT RATINGS
(agencies in Australia)



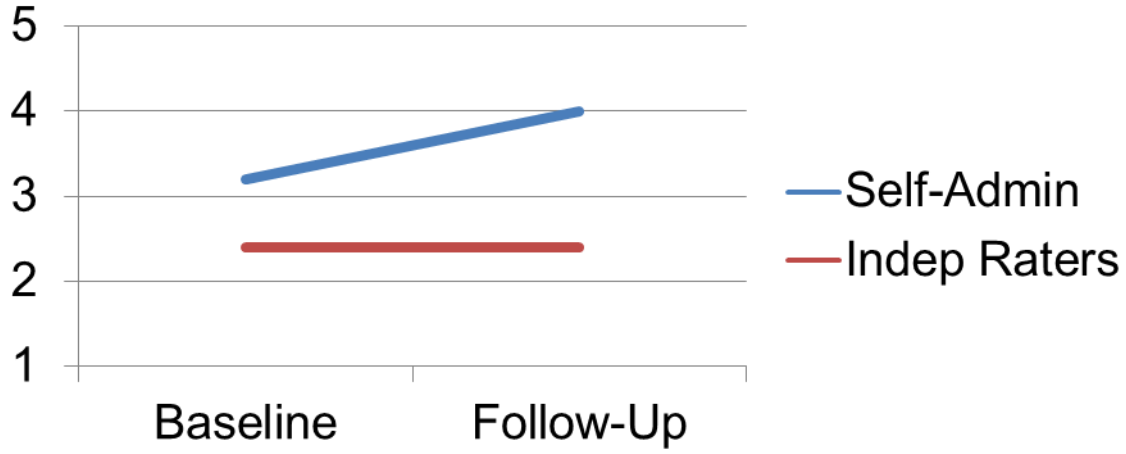
***Lee & Cameron, Drug Alc Review, 2009;28:682-684**

DDCAT: SELF VS. INDEPENDENT RATINGS (agencies in Australia)

Lee and Cameron study

13 alcohol and drug services sites

Baseline and 6-month follow-up



*Lee & Cameron, Drug Alc Review, 2009;28:682-684

METHODOLOGY: CAUTIONS REGARDING SELF-EVALUATION

Accuracy/usefulness of DDCAT/DDCMHT - directly proportional to assessor objectivity & familiarity with each item's response coding

Self-assessor's tasks:

- Look with "fresh eyes"
- Ask all the questions necessary
- Base a score on facts, not assumptions, prior information, impressions

Use Quality Assurance staff

Always a team of two or more assessors

METHODOLOGY: TRAINING

Didactic Training

- Read the Toolkit
- Appendices
  - Chart review form
  - Sample interview questions for clients
  - Website – sample questions for other interviews

Shadowing expert assessor

Practice with vignette

TOOLKIT ORGANIZATION (Cont.)

Scoring and Profile Interpretation

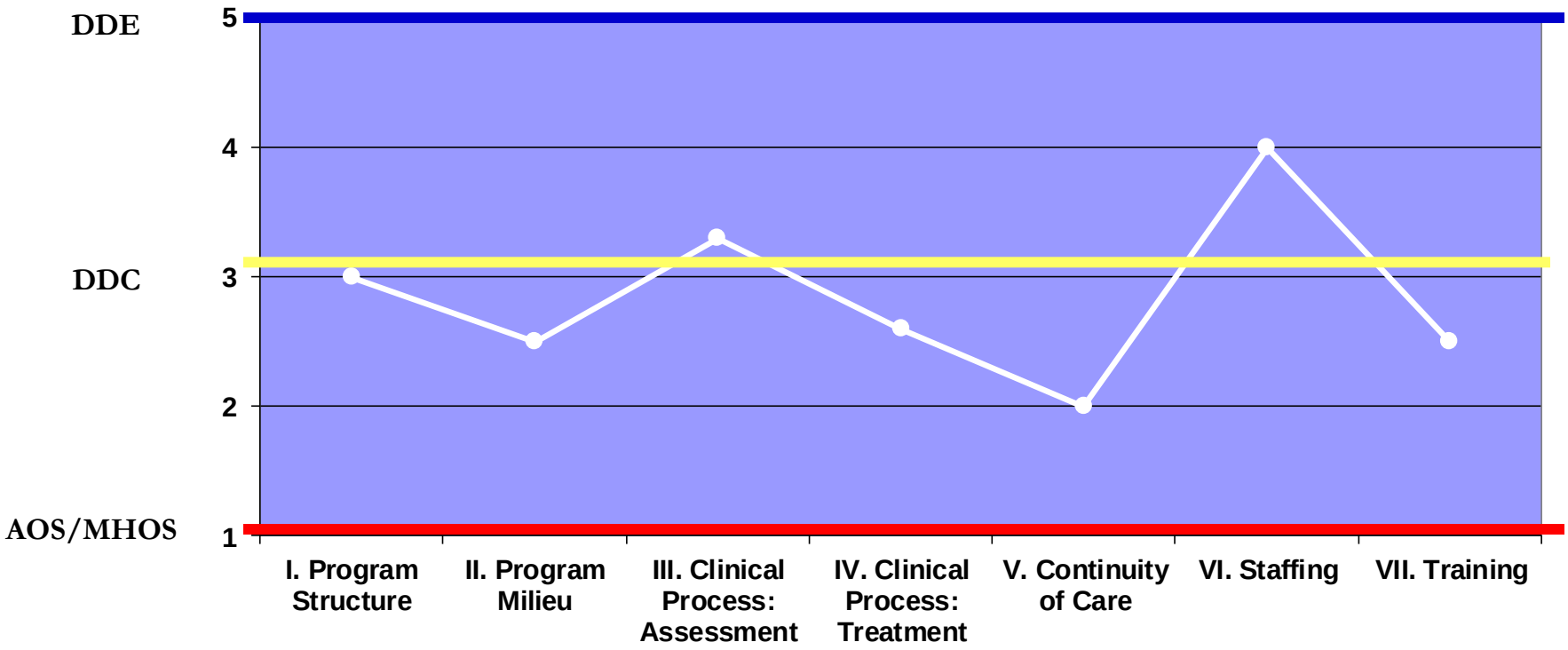
Main Index

- Scoring manual
- Enhancements – moving from AOS/MHOS to DDC, or DDC to DDE

DDCAT/DDCMHT SCORING SPREADSHEET: SUMS & AVERAGES SCORES, CREATES GRAPHIC PROFILE

- Transfer scores from rating scale onto Excel workbook scoring page (no need to calculate dimension averages)
- Review benchmark item scores, dimension averages and program categorization: AOS/MHOS, DDC or DDE
- Review DDCAT/DDCMHT profile line graph

DDCAT/DDCMHT PROFILE



PROGRAM ENHANCEMENT

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 grant funding that allowed them to incorporate substance use screening and assessment into their intake process and to hire an addiction counselor.

PROGRAM ENHANCEMENT

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/Medicare as well as receive payment for services to indigent patients (state funding) for his diagnostic and couples therapy services.

TOOLKIT ORGANIZATION (Cont.)

VI. Appendices

FAQs

No/Low Cost Enhancements

Site Visit

Training

Sample Forms, Screening & Motivation Tools

References

Recommended Reading

USING THE DDCAT/DDCMHT TO GUIDE AND MEASURE CHANGE

- Use of the DDCAT/DDCMHT as assessment method at baseline and as a measure of change over time
- Formal implementation and change plan development
- Co-Occurring State Incentive Grant (COSIG) initiatives
- Private non-profit agencies: CQI process
- Use within NIATx change process

Missouri COSIG: Case Study

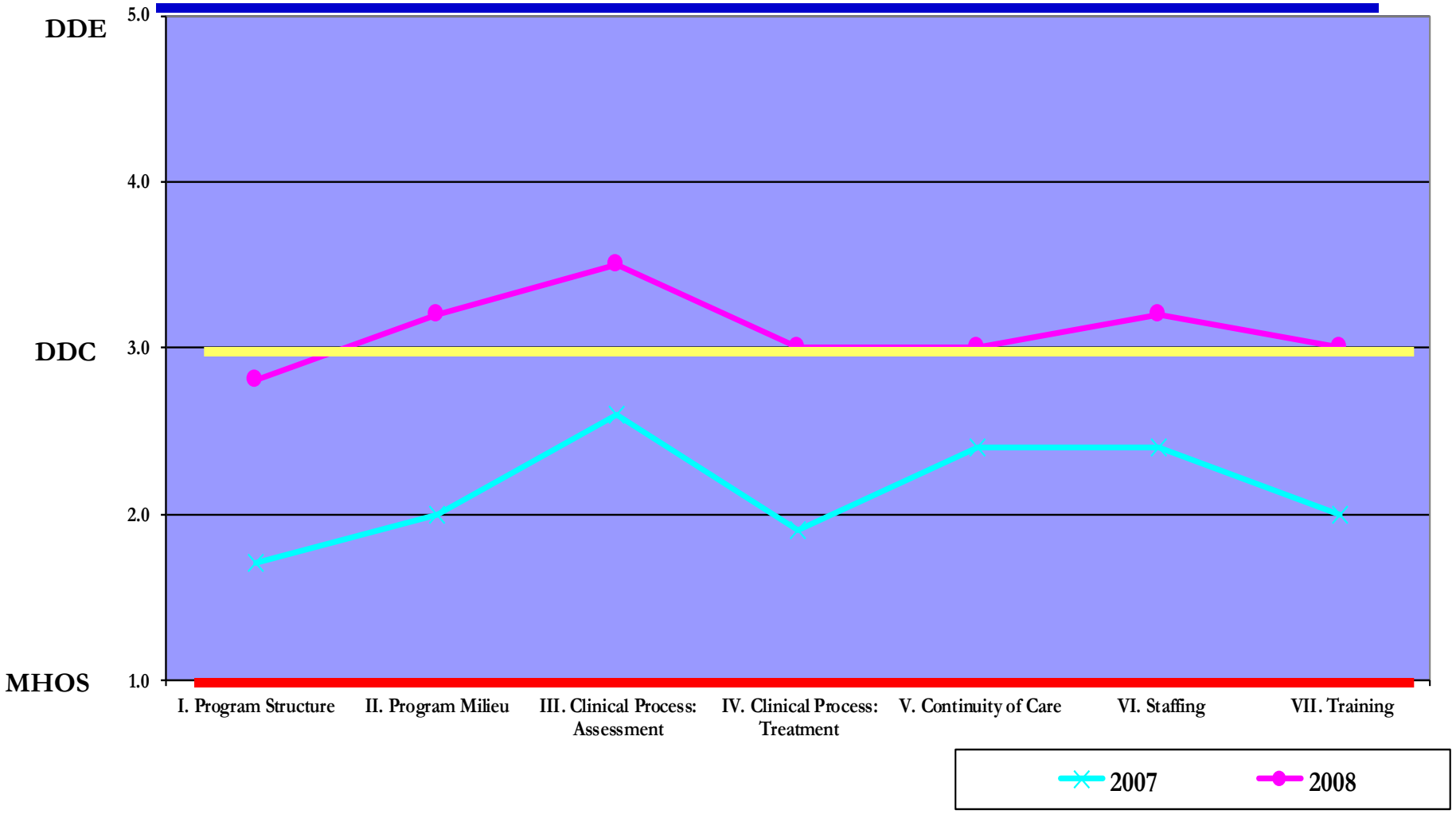
Large Community Mental Health Center

Provides array of psychiatric services, therapy and outpatient programs, crisis services for individuals and families, and substance abuse programs for adults and adolescents

Interested in increasing capability of mental health teams to provide co-occurring services

Year long project with change agent, implementation planning, and coaching by Mid-America ATTC

DDCAT PROFILES OVER TIME: DEPICTING PROGRAM CHANGE



Changes Made to COD Programming

Program Structure: changed mission statement to behavioral health

Program Milieu: literature on COD displayed; staff reflect new acceptance of COD

Assessment: Implemented standardized screener and assessment for substance use; charts reflect both diagnoses

Changes Made to COD Programming

Treatment: Treatment plans routinely and substantively address both disorders; intake and 90-day review now include place to record readiness to change/treatment for both disorders; added COD family education group

Continuity of Care: Discharge plans target both disorders

Staffing: Added staff with substance abuse credential; documented regular clinical supervision pertaining to substance use issues

Training: Basic training in COD required as part of new employee orientation

SUMMARY

DDCMHT is a psychometrically valid measure of co-occurring capability for mental health programs not implementing IDDT

Best when used by outside raters, but possible to conduct fairly accurate self-rating

Leads directly to implementation plan and toolkit provides examples of strategies to increase capability

Any questions?

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