Maine's Co-occurring Capability Self Assessment[1]

August 2009

Version 3.3

Date: **Rater(s)**: **Time Spent:**

Agency Name:

Program Name:

Program Type(s): **Level of Care:**

Address:

Contact Person: **Title:**

Telephone: **Fax:** **E-mail:**

Sources used (check all that apply):

- ☐ **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 Consumers** (#:)
- ☐ **Interview with Other Service Providers** (Specify:)
- ☐ **Physical Site Tour/Observation**

Total # of sources used:

NOTES:

[1] Formerly known as the DDCAT, modified by the COSII Project Team

I. ORGANIZATIONAL STRUCTURE (whole agency): What is permitted in agency policy, agency organizational structure and by licensure? Are there impediments to providing certain types of services? Are these impediments real?					
	1 **No Integration**	**2**	**3** **Integration**	**4**	**5** **High Integration**
IA. Focus of written mission, principles, values or philosophy	Mental Health (MH) or Substance Abuse (SA) only ☐	☐	People with COD are welcomed ☐	☐	Primary focus on people with COD ☐
IB. Organizational certification and licensure	Permits only MH or SA treatment and is not co-occurring capable[2] ☐	☐	Demonstrates co-occurring capability within a single license ☐	☐	Is certified and/or licensed to provide both MH and SA within a single program, including medication management ☐
IC. Organizational Policy					
1. Clinical standards	MH or SA only ☐	☐	All reflect COD capability ☐	☐	All target enhanced COD capability ☐
2. Clinical resources	MH or SA only ☐	Separate MH and SA services can be accessed simultaneously within agency ☐	Policy provides integrated services for MH and SA which are accessed under a single license ☐	☐	Policy provides specialized integrated treatment programs or services that include medication management ☐
3. Human resources	MH or SA only with no defined co-occurring competencies ☐	☐	Policy requires all staff to possess defined co-occurring competencies ☐	☐	Policy requires program teams or individuals to have dually licensed staffing and psychiatrists to have co-occurring competencies ☐
4. Finance / fiscal	Billing for MH or SA only ☐	☐	Co-occurring services can be billed under either MH, SA or COD ☐	☐	Agency has the capacity to bill multiple funding streams for enhanced COD services ☐
5. Management Information System (MIS)	No MIS or for MH or SA only ☐	☐	Collects data on MH and SA separately for prevalence or outcomes of COD ☐	☐	Consistently collects integrated data on prevalence and outcomes of COD ☐

[2] Co-occurring capable definition can be found in the corresponding manual

I. ORGANIZATIONAL STRUCTURE (whole agency): What is permitted in agency policy, agency organizational structure and by licensure? Are there impediments to providing certain types of services? Are these impediments real?					
	1 **No Integration**	**2**	**3** **Integration**	**4**	**5** **High Integration**
6. Quality Improvement (QI)	MH or SA only ☐	☐	Promotes, monitors and uses indicators to improve organizational structure and clinical outcomes (e.g., level of functioning, treatment completion) ☐	☐	Promotes and monitors enhanced COD capability and outcomes ☐
D. Organizational structure	Single-purpose agency with no formal means of collaboration ☐	☐	Formal collaboration across internal and external programs for SA and MH ☐	☐	Aligned to provide co-occurring treatment through continuum of care from intake to crisis, case management, inpatient and outpatient services ☐
E. Consumer / family involvement	No involvement ☐	☐	Built into some organizational structures for planning, implementation and delivery ☐	☐	Throughout all organizational structures for planning, implementation and delivery ☐

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II. PROGRAM STRUCTURE: How are specific programs structured to deliver co-occurring services? Do billing structures limit or promote COD services?					
	1 No Integration	**2**	**3 Integration**	**4**	**5 High Integration**
A. Primary treatment focus as stated in program description	MH or SA only ☐	☐	COD are addressed ☐	☐	COD are the target of treatment ☐
B. Program licensure	Permits only MH or SA treatment ☐	☐	Either single license (MH or SA) permits co-occurring treatment ☐	☐	Programs possess licenses which permit highly integrated co-occurring services, including medication management ☐
C. Treatment delivery	No means provided to obtain co-occurring treatment ☐	Informal case input from clinical staff or other disciplines within or across programs ☐	All programs provide co-occurring capable treatment ☐	Some teams provide integrated treatment through single staff member or treatment team ☐	All programs provide co-occurring enhanced treatment through treatment staff or team ☐
D. Financial incentives	Can bill only for MH or SA treatment ☐	☐	Can bill for only MH or SA and able to provide co-occurring capable treatment under that code; may also use COD billing code ☐	☐	Can bill for both services or can use the COD code ☐

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Chart / Documentation:

III. PROGRAM MILIEU What kind of information is posted on walls, on display in waiting areas, and included in consumer and family handouts and printed materials?					
	1 **No Integration**	**2**	**3** **Integration**	**4**	**5** **High Integration**
A. Routine expectation of and welcome to treatment for both disorders	Expect MH or SA only, refer or ignore other ☐	☐	Expect COD and treat both within scope of license ☐	☐	Actively accepts and addresses all issues within the program scope and level of care ☐
B. Display and distribution of literature and consumer educational materials	MH or SA only ☐	☐	Available for MH, SA and COD ☐	☐	Available for MH, SA and COD; most literature refers specifically to interaction between disorders and to integrated treatment ☐

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Chart / Documentation:

IV. CLINICAL PROCESS: ASSESSMENT

Is stage of change assessed and documented for each disorder? Does it influence what treatment a consumer gets or how s/he is approached?

	1 No Integration	2	3 Integration	4	5 High Integration
A. Routine screening methods for MH and SA	No screening or screens primarily for one disorder ☐	☐	Standardized screening for both MH and SA ☐	☐	Standardized screening for both disorders as well as trauma (e.g., AC-OK) ☐
B. Routine screening for health risks and conditions	Physical health care issues not addressed ☐	☐	Screening for health conditions ☐	☐	Screening for health conditions and risks (e.g., sharing needles, obesity, medication side effects, unprotected sexual activity) ☐
C. Routine integrated assessment if screened positive for MH and SA	Ongoing monitoring for appropriateness or exclusion from program related to treating diagnosis ☐	☐	Formal, integrated assessment for both MH and SA and their interaction when indicated ☐	☐	Formal, integrated assessment for both MH and SA and their interaction in all cases ☐
D. MH and SA diagnoses made and documented	Non-treating diagnoses are not made or recorded ☐	☐	All diagnoses recorded in chart regardless of where diagnoses are made ☐	☐	Standard and routine MH and SA diagnoses made on site and recorded in chart ☐
E. MH and SA history reflected in medical record	History of one or other not present ☐	History of both MH and SA variable by individual clinician ☐	Routine documentation of history of both in record ☐	☐	Specific section in record devoted to integrated history and chronology of both disorders ☐
F. Initial assessment of stage of change	No assessment for stage of change ☐	Assessed and documented variably by individual clinician ☐	Assessed and documented routinely for each identified MH and SA condition ☐	☐	Assessed and documented for all identified conditions (e.g., trauma, medical, wellness) ☐

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V. CLINICAL PROCESS: TREATMENT

Do treatment plans show an equivalent, integrated focus on SA and MH?
Are there defined protocols for consumers who arrive for treatment high/intoxicated and/or those at high risk?
What procedures are in place if you send your consumers to a SA emergency provider such as detox? Do you receive feedback from detox? What if you send person to crisis shelter or psychiatric hospital?
Are medications acceptable? Are certain medications unacceptable? Are medications routine and integrated?

	1 No Integration	2	3 Integration	4	5 High Integration
A. Treatment plans	Address MH or SA only ☐	Variable by individual clinician ☐	One disorder is the focus, with attention to how the other disorder influences it ☐	☐	Addresses COD specifically in plan ☐
B. Assess and monitor interactive courses of both disorders	Separate treatment for MH or SA only ☐	Treatment for MH or SA and evidence of interactive course of other disorder ☐	Treatment for both issues with evidence of interaction between the conditions ☐	☐	Comprehensive treatment for COD with evidence of interaction between all conditions ☐
C. Procedures for suicidal, violent or psychotic consumers	Few documented or explicit in-house guidelines ☐	☐	Routine capability to ascertain risk and make appropriate referral with clear communication back and forth ☐	☐	Routine capability to ascertain risk and treat on site ☐
D. Motivational Interviewing (MI)	Few or no staff are trained in or utilize MI techniques ☐	☐	A majority of staff are trained in MI techniques, but not all utilize them ☐	☐	Most staff are trained in and utilize MI techniques for a majority of their consumers ☐
E. Ongoing treatment strategies reflective of stage of change	Treatment strategies not explicitly based on stage of change ☐	Treatment strategies based on stage of change vary by individual clinician ☐	Treatment strategies reflect stage of change for each MH and SA condition ☐	☐	Treatment strategies reflect stage of change for all identified conditions ☐
F. MH and/or SA counseling	MH or SA counseling is not routinely provided within this agency ☐	MH or SA counseling is provided by referral in parallel or sequential mode ☐	MH or SA counseling is integrated to address the other disorder ☐	MH and SA counseling is provided in specialized integration programs ☐	MH and SA counseling is provided in an integrated fashion throughout all programs ☐
G. Evidence-based Practices (EBP)	No use of EBP ☐	☐	EBP for MH or SA that accommodates COD ☐	☐	EBP for CODs ☐

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Are medications acceptable? Are certain medications unacceptable? Are medications routine and integrated?

	1 No Integration	2	3 Integration	4	5 High Integration
H. MH and SA group counseling	No availability of group treatment ☐	MH or SA groups available ☐	Access to integrated groups ☐	☐	Regularly scheduled COD groups ☐
I. Procedures for consumers who are intoxicated and/or at risk for withdrawal	No capacity or willingness to treat ☐	☐	Routine capability to ascertain risk and make appropriate referral with ongoing communication ☐	☐	Routine capability to treat on site ☐
J. Medication evaluation, management, monitoring and adherence	Consumers on meds routinely not accepted ☐	Certain types of meds are not acceptable or must have own supply for entire treatment episode ☐	Use of prescription meds is acceptable with consultation and collaboration of prescriber ☐	On-site capability to prescribe medication is limited ☐	On-site capability to prescribe mental health and substance abuse medication ☐
VK. Health promotion and treatment	Not addressed ☐	☐	Make referrals for health conditions and routinely address heath promotion ☐	☐	Health promotion and treatment routinely available in house ☐
VL. Education about MH and SA treatment interaction	No education provided ☐	☐	Presented on an individual basis ☐	☐	Psychoeducation groups address COD ☐
VM. Family education and treatment	For MH or SA only, or minimal to no family involvement ☐	☐	Access to family or group counseling for COD ☐	☐	Routine COD family group integrated into standard program format by staff member ☐
VN. Family support	Not present, not recommended ☐	Off site, recommended variably ☐	Present off site with facilitated connections to support ☐	☐	Present on site, through agency or collaboration ☐

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Do treatment plans show an equivalent, integrated focus on SA and MH?
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What procedures are in place if you send your consumers to a SA emergency provider such as detox? Do you receive feedback from detox? What if you send person to crisis shelter or psychiatric hospital?
Are medications acceptable? Are certain medications unacceptable? Are medications routine and integrated?

	1 No Integration	2	3 Integration	4	5 High Integration
O. Specialized interventions to facilitate use of COD and 12-step or other self-help groups	Not present ☐	☐	Education about and referral to 12-step or other self-help groups ☐	☐	Education about group and special COD groups and programs available on site ☐
P. Peer recovery supports for consumers with CODs	Not present, not recommended ☐	Off site, recommended variably ☐	Present off site with facilitated connections to support ☐	☐	Present on site, though agency or collaboration ☐

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VI. CONTINUITY OF CARE

Is recovery from both MH and SA considered when developing a discharge plan? What types of services are people referred to? Are referrals followed up on?

	1 No Integration	2	3 Integration	4	5 High Integration
A. Continuity of care maintained for both disorders	Referral for MH or SA treatments off site with no back and forth communication ☐	☐	MH or SA treatment referral as needed with back and forth communication ☐	☐	Monitoring and ongoing treatment of MH or SA throughout the continuum of care on site ☐
B. COD addressed in discharge planning process	Not addressed ☐	☐	Both disorders systematically addressed and documented in the planning process ☐	☐	Both disorders are systematically addressed and documented in the planning process with follow-up to support implementation ☐
C. Focus on ongoing recovery issues for both disorders	Not present ☐	☐	MH or SA with the other issue as potential relapse concern ☐	☐	Focus on recovery from both disorders, both are primary and ongoing ☐
D. Use of self-help support groups and/or aftercare/peer support groups	Referral to MH or SA only ☐	☐	Referral is routine and systematic with education and support ☐	☐	Referral routine, systematic and available on site ☐
E. Sufficient supply and adherence plan for medications	No plan for continuation of medications and no adherence plan ☐	☐	Provides 30-day prescription or supply to next appointment off site; medication adherence plan addresses all disorders ☐	☐	Maintains medication management in agency with ongoing adherence support ☐
F. Continuity of care maintained for health promotion	No consideration of health issues ☐	☐	Consideration of identified health needs ☐	☐	Standard consideration of health and wellness needs ☐

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VII. STAFFING What is the relationship with a psychiatrist, physician, nurse practitioner (or other licensed prescriber)?					
	1 **No Integration**	**2**	**3** **Integration**	**4**	**5** **High Integration**
A. Psychiatrist, physician, physician's assistant (PA) or nurse practitioner (NP)	No formal relationship with program ☐	☐	Consultant or contractor for clinical services and/or case supervision ☐	☐	COD qualified staff on site for clinical services and/or case supervision ☐
B. On-site, professionally licensed staff	No staff member is dually certified or qualified[3] ☐	☐	At least 25% of staff members are dually certified, licensed or qualified ☐	☐	At least 50% of staff members dually certified, licensed or qualified ☐
C. Access to supervision or consultation	Access to MH or SA only ☐	☐	COD supervision or consultation as needed ☐	☐	On-site, documented, regular supervision by COD-qualified staff ☐
D. Peer/alumni programming is available	No programming present ☐	☐	Alumni programming available within the organization; accommodates COD, volunteer peer involvement ☐	☐	Alumni programming within agency, specific COD focus, peer support person on staff ☐

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Chart / Documentation:

[3] Dually certified or qualified = certified, licensed or qualified to provide both MH and SA services in the State of Maine

VIII. TRAINING Who has basic training in screening and assessment for both disorders?					
	1 **No Integration**	**2**	**3** **Integration**	**4**	**5** **High Integration**
A. Training in COD	Not trained in basic skills for COD ☐	☐	All staff (clinical and non-clinical personnel) have training on COD ☐	☐	All staff have training on COD and clinical staff have specific training on COD EBP or modalities ☐

Notes:

Chart / Documentation:

MAINE'S CO-OCCURRING CAPABILITY SELF ASSESSMENT SUMMARY SCORE SHEET

Program: **Date of Review:**

Level of Care: **Reviewer(s):**

I. Organizational Structure	
A.	
B.	
C.	, , , , ,
D.	
E.	
I. Total= / 10 Domain Score=	
II. Program Structure	
A.	
B.	
C.	
D.	
II. Total= /4 Domain Score=	
III. Program Milieu	
A.	
B.	
III. Total= /2 Domain Score=	
IV. Clinical Process: Assessment	
A.	
B.	
C.	
D.	
E.	
F.	
IV. Total= /6 Domain Score=	

V. Clinical Process: Treatment	
A.	
B.	
C.	
D.	
E.	
F.	
G.	
H.	
I.	
J.	
K.	
L.	
M.	
N.	
O.	
P.	
V. Total= /16 Domain Score=	
VI. Continuity of Care	
A.	
B.	
C.	
D.	
E.	
F.	
VI. Total= /6 Domain Score=	

VII. Staffing	
A.	
B.	
C.	
D.	
VII. Total= /4 Domain Score=	
VIII. Training	
A.	
VIII. Total / Domain=	
OVERALL SCORE=	

DUAL DIAGNOSIS CAPABILITY:
MH/SA only (≤49);
Somewhat Integrated (50-98);
Integrated (99-147);
Quite Integrated (148-196);
Highly Integrated (197-245)

AVERAGE DOMAIN SCORE:
Sum of all Domain Scores / 8

NOTES: