Published in final edited form as:

J Dual Diagn. 2013 ; 9(2): 179–186. doi:10.1080/15504263.2013.778441.

Dual Diagnosis Capability in Mental Health and Substance Use Disorder Treatment Programs

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Abstract

Objective—Improved understanding of the relative strengths and weaknesses of treatment organizations' dual diagnosis capability is critical in order to guide efforts to improve services. This study assesses programs' capacity to meet the needs of clients with dual diagnosis, identifies areas where they are well equipped to serve these clients, and determines where programmatic improvement is needed. The study also undertakes an initial exploration of the potential impact that funding sources have on dual diagnosis capability.

Methods—We administered Dual Diagnosis Capability in Addiction Treatment (DDCAT) and Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) assessments at 30 treatment programs in two California counties. Seven of the programs received funding to provide both mental health and substance use disorder services, 13 received funding to provide mental health services, and 10 received funding to provide substance use disorder services.

Results—The mean DDCAT/DDCMHT score of programs in the sample was 2.83, and just over 43% of the sample met or exceeded DDCAT/DDCMHT criteria for dual diagnosis capability. Programs scored highest and had the highest rates of dual diagnosis capability in domains related to assessment, training, and staffing, whereas scores were weakest and rates of dual diagnosis capability were lowest in the program structure, treatment, and continuity of care domains. Programs that received funding to provide both mental health and substance use disorder services consistently scored higher than the other programs in the sample, and mental health programs scored higher than substance use disorder treatment programs both on the overall assessments and in most domains.

Conclusions—Findings suggest that programs in the sample are functioning at a nearly dual diagnosis capable level. However, structural barriers continue to limit providers' capacity to serve clients with co-occurring mental health and substance use disorders, and many organizations have not yet translated their potential to deliver dual diagnosis capable services into practice. By enhancing their program structure, treatment services, and continuity of care services, these treatment organizations should be able to deliver fully dual diagnosis capable services. Observed

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DISCLOSURES

The authors have no conflicts of interest to disclose, and report no financial relationships with commercial interests.

differences in dual diagnosis capability based on funding source indicate a need for further research to better understand the impact that funding streams have on dual diagnosis capability.

Keywords

DDCAT; DDCMHT; co-occurring disorders; dual diagnosis treatment; mental health services; substance use disorder services; policy

Between 20% and 50% of clients receiving mental health treatment have had a substance use disorder in their lifetime, and over half of those in substance abuse treatment have had a mental health disorder in their lifetime (Center for Substance Abuse Treatment, 2007). The co-occurrence of these conditions (also referred to as “dual diagnosis”) increases symptom severity, complicates treatment, and leads to worse outcomes for both disorders (Horsfall, Cleary, Hunt, & Walter, 2009; Sterling, Chi, & Hinman, 2011). The processes of recovery from mental health and substance use disorders have many things in common (Davidson et al., 2010), and there are many evidence-based practices that can improve outcomes for clients diagnosed with both conditions (Center for Substance Abuse Treatment, 2005; Drake, 2007; Drake, O’Neal, & Wallach 2008). Furthermore, integrated treatment for dual diagnosis leads to better client outcomes than mental health and substance use disorder services that are provided separately (Drake, Mueser, Brunette, & McHugo, 2004). Thus, to appropriately serve clients and improve outcomes, providers should deliver services that are capable of addressing both mental health and substance abuse treatment needs (Minkoff, Zweben, Rosenthal, & Ries, 2003; Center for Substance Abuse Treatment, 2005).

To improve the quality of services clients with dual diagnosis receive, providers and service systems have begun taking steps to change the services they deliver, and initiatives to enhance the dual diagnosis capacity of treatment systems are underway across the country (Clark, Power, Le Fauve, & Lopez, 2008). Yet in spite of these efforts, the delivery of integrated, evidence-based interventions for clients with dual diagnosis is still more the exception than the rule in most service settings (McGovern, Lambert-Harris, McHugo, Giard, & Mangrum, 2010). Financial barriers, administrative obstacles, and provider resistance to change continue to inhibit the provision of dual diagnosis services to clients who need them (Drake & Bond, 2010; Sterling et al., 2011; Torrey, Tepper, & Greenwold, 2011). Thus, only about 4% of individuals with co-occurring mental health and substance use disorders receive integrated interventions designed to address dual diagnosis (Drake & Bond, 2010), and on the rare occasions such services are available, they are usually delivered with low fidelity to evidence-based models (Chandler, 2009).

Improved understanding of the relative strengths and weaknesses of treatment organizations’ dual diagnosis capability is critical in order to guide efforts to improve services for clients with co-occurring disorders. A growing body of research has focused on the question of how to evaluate and improve behavioral health providers’ capacity to deliver quality dual diagnosis treatment (McGovern et al., 2010; Gotham, Claus, Selig, & Homer, 2010; Torrey, et al., 2011; Sacks et al., in press). The current study contributes to this literature by examining the dual diagnosis treatment capacity of publicly funded mental health and substance use disorder treatment providers in Southern California. Our principal aim is to evaluate the capacity of treatment organizations to meet the needs of clients with dual diagnosis, identify areas where they are well equipped to serve these clients, and determine where programmatic improvement is needed. We also undertake an initial exploration of the potential impact that treatment organizations’ funding sources have on their capacity to serve clients with co-occurring mental health and substance use disorders.

METHODS

Sample

The study sample comprised 30 publicly-funded treatment programs that serve clients with dual diagnosis in two Southern California counties located in a major metropolitan area (See Table 1).

In County A, the county department in charge of funding substance use disorder treatment provided the research team with a list of 39 substance use disorder treatment programs that either reported capacity to treat dual diagnosis clients or had dual contracts with the county mental health department. County A and the research team then chose 11 agencies for inclusion in the study. Programs were selected to reflect the county's regional diversity, as well as different treatment populations. Seven of the selected organizations received funding from both the county substance use disorder and mental health departments, and four only provided services for the county substance use disorder treatment department. Six of the programs in County A were residential treatment centers, and five were outpatient counseling centers. The site visits in this county occurred from March-May 2010.

In County B, six substance use programs and 13 mental health programs were selected for evaluation. County B administrative staff identified the programs for evaluation based on size (highest volume programs), geographic dispersion across the county, population treated, and program type. Four of the programs provided residential/inpatient services, and 15 provided outpatient services. The site visits in County B occurred from June 2010-August 2011.

All research was overseen and approved by the UCLA Human Subjects Protection Committee. The project was exempted from informed consent requirements because human subjects were not involved, no patient files were removed from the site, and no data that could identify any specific individual patients was gathered.

Measures

The research team evaluated each program's ability to serve dual diagnosis clients with the *Dual Diagnosis Capability in Addiction Treatment* (DDCAT) Version 3.2 (McGovern, Matzkin, & Giard, 2007; Substance Abuse and Mental Health Services Administration [SAMHSA], 2011a) or the *Dual Diagnosis Capability in Mental Health Treatment* (DDCMHT) Version 3.2 indexes (Gotham, Claus, Selig, & Homer, 2010; SAMHSA 2011b). The indexes mirror each other, with the DDCAT measuring the ability of substance use providers to meet the needs of clients with dual diagnosis, and the DDCMHT doing the same for mental health programs. Though used in different treatment settings, the DDCAT and DDCMHT measure the same domains, and utilize identical scoring schemes, so they can be used to compare the dual diagnosis capabilities of different types of treatment programs with one another (McGovern et al., 2010).

The assessments include 35 items that span seven major domains: program structure, program milieu, assessment, treatment, continuity of care, staffing, and training (see Table 2). Items on the DDCAT and the DDCMHT are scored on scales of 1 to 5, with a score of 3 or higher indicating that a program is dual diagnosis capable in that area. Programs are then given a total rating on each domain and an overall score to indicate their overall dual diagnosis capability: 1–1.99 = a program that is able to provide only addiction services or mental health services (AOS/MHOS), 2–2.99 = a program that is at an intermediate point between AOS/MHOS and being capable of serving dual diagnosis clients (AOS/DDC or MHOS/DDC), 3–3.49 = a program that is capable of adequately serving most clients with dual diagnosis (DDC), 3.50–4.49 = a program that is at an intermediate point between DDC

and providing enhanced services for dual diagnosis clients (DDC/DDE), and 4.50–5.0 = a program that is equipped to provide dual diagnosis enhanced (DDE) services.

Both the DDCAT and DDCMHT are reliable, valid, and sensitive to change (McGovern et al., 2007; Gotham et al., 2010). Policymakers and researchers in over 30 states have used the indexes to guide programs as they work to enhance the services they provide for clients with dual diagnosis (SAMHSA, 2011a; 2011b) and to measure programs' progress as they improve their dual diagnosis capabilities (Gotham et al., 2010; McGovern et al., 2010).

Procedures

Masters and doctoral-level researchers from the UCLA Integrated Substance Abuse Programs received training from staff at the Dartmouth Psychiatric Research Center on how to conduct DDCAT/DDCMHT assessments and participated in ongoing training and technical assistance calls to assure fidelity to DDCAT/DDCMHT evaluation and scoring methods. At the 17 programs that received full or partial funding from county substance use disorder treatment agencies, evaluators conducted DDCAT assessments. At the remaining 13 programs, which only received county funding to provide mental health services, evaluators used the DDCMHT tool.

In both counties, selected programs were mailed a letter from their county substance use disorder and mental health departments and UCLA requesting site visits. Evaluations were conducted in 4-hour blocks at each of the 30 programs. In County A, assessments were conducted by teams of two or three trained evaluators from UCLA, and in County B, evaluations were conducted by UCLA evaluators working with county employees who had also received training on DDCAT/DDCMHT administration and scoring. In both counties, evaluations consisted of site tours, chart and program material reviews, and interviews with clients, substance use counselors, licensed mental health clinicians, program managers, and program directors. At the conclusion of all site visits, evaluation teams met with program administration staff to ask follow-up questions and gather further information.

Following the site visits, evaluators assigned programs scores on the 35 DDCAT/DDCMHT elements, composite scores for each of the seven domains, and an overall score indicating dual diagnosis capability. In cases when evaluators assigned different scores, a rating reconciliation process was used to reach consensus and determine final scores. Reports of evaluation results and recommendations were then developed for each organization, and given to county substance use disorder and mental health administrators to share with each program.

To compare programs by funding source, the authors divided them into three categories. Programs that received county funding to provide both mental health and substance use disorder services were assigned to one category ("dual funded"), programs that only received county funding to provide mental health treatment were assigned to a second category ("mental health funded"), and programs that only receive county funding to provide substance use disorder treatment services were assigned to a third category ("substance use funded"). Seven programs were in the dual funded category (all from County A), 13 programs were in the mental health funded category (all from County B), and 10 programs were in the substance use funded category (four from County A, six from County B).

RESULTS

Overall dual diagnosis capability

The mean DDCAT/DDCMHT score of study sites was 2.83 (See Figure 1), and 13 (43.3%) of those evaluated were rated DDC, DDC/DDE, or DDE (see Figure 2). The majority of the programs that were not DDC or higher did have some capacity to serve dual diagnosis clients, as 13 (43.3%) were rated either AOS/DDC or MHOS/DDC. Only four of the thirty programs (13.3%) received total DDCAT/DDCMHT ratings of AOS or MHOS.

Program Structure

Program structure was the weakest DDCAT/DDCMHT domain for programs in the study. The mean score in the program structure domain was 2.36, and only six of the thirty programs scored DDC or better. Half of programs received a rating of AOS or MHOS, as their agency mission statements, organizational certification and licensure, service coordination, and financial incentives were geared exclusively toward treating mental health or substance use disorders, but not both. Just under one-third of the sample (30.0%) was ranked AOS/DDC or MHOS/DDC in this domain, as staff reported that they were able to deliver some services to treat co-occurring disorders, but that they still faced significant barriers in certification, licensure and finding financing for integrated dual diagnosis services. Billing was particularly challenging for the vast majority of programs, as 24 of the 30 programs reported that they could only bill for mental health or substance use disorder treatment, but not both.

Program Milieu

The mean score in the program milieu domain was 2.95, with half of the programs in the sample receiving rankings of DDC or higher. One-third of the programs in the study were rated DDC/DDE, as clinicians expected and treated individuals with both mental health and substance use disorders, and patient education materials that addressed both disorders were available. Of the 15 programs that were rated less than DDC, the majority (12) were AOS/DDC or MHOS/DDC. At these programs, the procedures to accommodate the needs of clients with dual diagnosis were more informal, and the availability of patient education materials for both mental health and substance use disorders was more variable.

Assessment

Assessment was the strongest domain across the study sample, with an average DDCAT and DDCMHT score of 3.15, and with 56.6% of programs being classified as DDC or better. Eighteen of the thirty programs used a routine set of interview questions to screen for dual diagnosis among their clients, though only six used standardized or formal screening tools. If new clients screened positive for co-occurring mental health and substance use disorders, only five of the thirty programs had procedures to provide comprehensive assessments for dual diagnosis. In spite of inconsistent assessment procedures, 17 programs in the study sample admitted dual diagnosis clients regardless of the severity of their co-occurring disorders.

Treatment

The majority of study sites (18) ranked lower than DDC in the treatment domain, with a mean score of 2.74. Most programs were DDC or higher on items related to dual diagnosis treatment planning, the establishment of procedures for emergencies related to both mental health and substance use disorders, medication evaluation and management for both disorders, the delivery of interventions with specialized content relating to both disorders, and facilitation of peer-support groups. Most programs had low scores on items related to

stage-wise treatment for both mental health and substance use disorders, the delivery of educational services on both types of disorders, and the availability of recovery supports for clients with co-occurring disorders.

Continuity of Care

The mean assessment score in the continuity of care domain was 2.61, with just 10 of the 30 study sites scoring DDC or better. At the majority of programs, co-occurring disorders were variably addressed in the discharge planning process, little was done to facilitate continued utilization of dual diagnosis peer-support groups upon discharge, and providers did not consistently assure that clients had a sufficient supply and compliance plan for both psychiatric and substance abuse medications.

Staffing

Though the mean score for study sites in the staffing domain was less than DDC (2.89), a majority of programs in the sample (56.7%) were rated DDC or better in this area. Eighteen of the thirty programs had psychiatrists or other physicians capable of prescribing medications for both mental health and substance use conditions located onsite, and clinical supervision and consultation for both mental health and substance abuse was available at 23 of the 30 programs in the sample. Most programs also had case review procedures that emphasized co-occurring disorder treatment and made dual diagnosis peer services available to their clients. However, a majority of programs did not have staff members with licensure or competency to provide dual diagnosis services other than medication treatment onsite.

Training

Over half of the programs in the study sample (56.7%) were rated DDC or higher in the training domain, and the mean DDCAT/DDCMHT score was 3.13. At over 80% of study sites, direct care staff received basic training in prevalence, signs, symptoms, and assessment of both mental health and substance use disorders, and at over half the programs (56.7%), staff had at least some advanced training in specialized treatment approaches for dual diagnosis clients.

Variation by Funding Category

Dual funded programs averaged total assessment scores of 3.75, compared to 2.75 for mental health funded programs and 2.31 for substance use funded programs. A majority of the dual funded programs (71.4%) were ranked DDC or higher on the assessments, whereas 46.2% of mental health funded programs and 20.0% of substance use funded programs received overall ratings of DDC or higher. In each of the seven domains, dual funded programs had the highest mean scores, and mental health funded programs had higher mean scores than the substance use funded programs in each of the domains except for program structure (See Figure 1). Over 70% of dual funded programs met or exceeded criteria for dual diagnosis capability in each domain, whereas rates of dual diagnosis capability varied by domain among mental health providers (See Figure 2). Over half of mental health funded programs met or exceeded criteria for dual diagnosis capability in the program milieu, assessment, staffing, and training domains, but few were ranked DDC or higher in the treatment and continuity of care domains, and none achieved dual diagnosis capability in the program structure domain. There was less variability across domains among the substance use funded programs, as 20–30% were dual diagnosis capable or better in each domain except for program structure (10.0%) and training (40.0%). mental health funded programs had higher mean scores than substance use funded programs in every domain except for program structure, and a higher proportion of mental health funded sites met or exceeded

DDC criteria in all domains except for program structure and continuity of care (see Figure 2).

DISCUSSION

Summary

Overall, the mean DDCAT/DDCMHT score for study sites was 2.83, and just over 43% of the sample met or exceeded criteria for dual diagnosis capability. Compared to the baseline scores of programs evaluated in other DDCAT/DDCMHT studies in the United States, the agencies in this study received higher overall assessment scores (Gotham et al., 2010; McGovern et al., 2010; Sacks et al., in press), and a larger proportion of them were rated DDC or higher (McGovern et al., 2010; Sacks et al., in press). However, compared to the DDCAT/DDCMHT ratings of programs that implemented changes to enhance dual diagnosis capability, the mean scores and rates of dual diagnosis capability were lower in the present study (McGovern et al., 2010). The method used to select study sites, which were chosen by county directors who identified them as programs that were particularly adept at serving dual diagnosis clients or had large program capacity, may explain why programs in the study had DDCAT/DDCMHT ratings similar to those of organizations that had already implemented changes to enhance their dual diagnosis capability.

Dual funded sites had higher mean DDCAT/DDCMHT scores (3.75) than mental health funded programs (2.75) and substance use funded programs (2.31), and a higher percentage of dual funded sites (71.4%) were ranked DDC or higher than mental health funded programs (46.2%) and substance use funded programs (20.0%). Thus while the majority of programs in the sample were not functioning at a DDC level, almost all dual funded programs were providing services that met and exceeded the criteria for a DDC ranking.

Differences across DDCAT/DDCMHT Domains

Study sites scored highest in the domains related to assessment, training, and staffing, and over half of the sample received ratings of DDC or higher in these domains. Scores were weakest, and the rates of dual diagnosis capability the lowest, in the program structure, continuity of care, and treatment domains.

Study sites scored the lowest and had the lowest rates of dual diagnosis capability in the program structure domain. This finding confirms the conclusions of Sterling et al. (2011), Burnam & Watkins (2006), and Young & Grella (1998), who found that administrative and financial barriers continue to impede programs' ability to deliver dual diagnosis services. By taking steps to (a) ensure that certification and licensure barriers do not inhibit the delivery of dual diagnosis services, (b) improve the coordination of mental health and substance abuse services, and (c) identify financial resources to support integrated dual diagnosis treatment, program administrators can improve their organizations' ability to serve clients with co-occurring disorders appropriately. Many of these changes are beyond the purview of individual programs, and may require system-level policy and regulatory changes to certification, licensing, and billing procedures. As health systems move toward more integrated models of service delivery and reimbursement under the Affordable Care Act (Croft & Parish 2012), many of the structural barriers that currently limit dual diagnosis capability may be addressed.

Programs in the study sample also had low levels of dual diagnosis capability in the treatment and continuity of care domains. Though the majority of these programs were capable in many other domains that reflect the ability to provide dual diagnosis services (e.g. assessment, staffing, training), study findings indicate that they were still not delivering these services. With further training and technical assistance to help translate resources and

knowledge into practice, many of these programs could enhance the quality of the services that clients with dual diagnosis receive. Furthermore, through the use of appropriate implementation strategies to improve service delivery (Proctor et al., 2009), treatment organizations can make meaningful improvements to their dual diagnosis services in a relatively short amount of time and with few additional resources (McGovern et al., 2010).

Potential Impact of Funding Sources

Though the sample is too small to draw definitive conclusions concerning differences between dual funded, mental health funded, and substance use funded programs, the data reveal trends that may warrant further examination in future research. Compared to mental health funded and substance use funded programs, a higher share of the dual funded programs scored DDC or DDE, both on their overall assessments and on each of the seven domains of the DDCAT and DDCMHT. This finding is not surprising given that what distinguished dual funded programs from mental health funded and substance use funded programs was their capacity – and obligation – to formally provide both mental health and substance use disorder treatment. That the greatest difference in dual diagnosis capability between dual funded programs and other programs was in the domain of program structure underscores the critical role that structural and organizational factors play in enhancing or inhibiting dual diagnosis capability. The data indicate that when providers are able to overcome structural barriers—particularly those involving funding—their ability to provide dual diagnosis capable services may be enhanced; when these barriers remain in place, dual diagnosis capability may be inhibited.

Among the non-dual funded sites, mental health funded programs had higher scores (2.75) than substance use funded sites (2.31), and a higher proportion of mental health funded programs met DDC criteria (46.2%) than substance use funded programs (20.0%). This trend differs from the findings of previous research that compared the dual diagnosis capability of mental health funded and substance use funded programs using different evaluation methods (Timko, Lesar, Noel, & Moos 2003; Gil-Rivas & Grella, 2005; Timko, Dixon, & Moos, 2005). The data, however, are in concordance with some of the findings of the only published study that incorporates DDCAT/DDCMHT data comparing mental health funded and substance use funded programs (McGovern et al., 2010). That study found that after an initiative to improve dual diagnosis capability, mental health funded programs had higher mean DDCAT/DDCMHT scores, but that a greater proportion of substance use funded programs met or exceeded criteria for dual diagnosis capability (McGovern et al. 2010). Though the sample size of 30 programs in this study does not permit a rigorous comparison of mental health funded and substance use funded organizations' dual diagnosis capacity, the data do indicate potential differences that warrant further research in a larger study.

Limitations

The study's main limitations are that sampling of programs was not random, and that the method of site selection made participating programs less representative of the general treatment landscape than a truly random sample would have been. If all treatment providers in these counties were represented in the sample, rates of dual diagnosis capability probably would not have been as high as those reported in this study. Additionally, since the sample included programs from one metropolitan area, it is possible that the dual diagnosis capabilities of providers in other regions may be different.

The sample was not large enough to statistically test differences by provider type, so future studies with larger samples are needed to draw firm conclusions about the effect of funding on dual diagnosis capability. Furthermore, the analysis did not allow for comparison of

providers by county, as the sample did not include any mental health funded programs from County A or dual funded programs from County B. Differences in county service delivery systems may confound findings concerning the influence that funding sources have on dual diagnosis capability. This also warrants examination in future studies.

Conclusion

Study findings show that programs in this sample, which are relatively large and experienced at serving clients with co-occurring disorders, are providing services that are nearly dual diagnosis capable. However, even in these programs, there is significant room for improvement. Structural barriers continue to limit providers' capacity to serve clients with co-occurring disorders, and funding sources may play a significant role in either promoting or impeding dual diagnosis capability. Furthermore, many organizations have not yet translated their potential to deliver dual diagnosis capable services into practice. In spite of considerable progress in the development and dissemination of clinical protocols for integrated dual-disorder treatment, structural barriers need to be removed and treatment and continuity of care services still need to be enhanced even in large programs that have relatively high capacity to serve clients with dual diagnosis. With improvements to their program structure, expanding treatment services, and providing continuity of care services, these treatment organizations should soon reach a point where they can deliver services that adequately meet the needs of clients with dual diagnosis. By making these changes, administrators and providers can enhance the quality and reach of services for clients with co-occurring disorders, and foster the creation of a behavioral healthcare system where a majority—rather than a minority—of providers deliver dual diagnosis capable services.

Acknowledgments

We would like to acknowledge the counties that provided funding for this research, and thank them and participating programs and staff for graciously granting us the access necessary to conduct our assessments. This study was also supported by National Institute on Drug Abuse Grant T32DA07272-20 and National Institutes of Health NCR/NCATS UCLA CTSI Grant UL1TR000124.

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Figure 1.

Mean Program Dual Diagnosis Capability

Note: MHSU = programs funded to provide both mental health and substance use disorder services; MHT = programs funded to provide mental health services; SUT = programs funded to provide substance use disorder services; DDCAT = Dual Diagnosis Capability in Addiction Treatment Index; DDCMHT = Dual Diagnosis Capability in Mental Health Treatment Index.

Figure 2.

Percentage of Programs Rated DDC, DDC/DDE, or DDE

Note: DDC = dual diagnosis capable; DDE = dual diagnosis enhanced; MHSU = programs funded to provide both mental health and substance use disorder services; MHT = programs funded to provide mental health services; SUT = programs funded to provide substance use disorder services.

TABLE 1**PROGRAM FOCUS/ADMISSION CRITERIA (N=30)**

PROGRAM TYPE	n (%)
Inpatient/Residential	10 (33.3%)
Outpatient	20 (66.7%)
PROGRAM FOCUS	
Mental Health Treatment (MHT)	13 (43.3%)
Substance Use Disorder Treatment (SUT)	10 (33.3%)
Mental Health and Substance Use Disorder Treatment (MHSU)	7 (23.3%)
PROGRAM TARGET POPULATION^a	
Adult General	23 (76.7%)
Criminal Justice	16 (53.3%)
Women	12 (40.0%)
Men	11 (36.7%)
Dual Diagnosis	10 (33.3%)
Pregnant	10 (33.3%)
Human Immunodeficiency Virus (HIV)	10 (33.3%)
Gay/Lesbian/Bisexual/Transgender (GLBT)	10 (33.3%)
Adolescents	8 (26.7%)
Drunk/Intoxicated Driving	7 (23.3%)
Seniors	7 (23.3%)
Children (Residential)	3 (10.0%)

^a More than one may be indicated

TABLE 2**DOMAINS OF THE DDCAT/DDCMHT INDEXES**

DOMAIN	DESCRIPTION
Program Structure	Certification, licensure, coordination/collaboration with other providers
Program Milieu	Measures the extent to which programs expect and welcome clients with dual diagnosis
Assessment	Measures screening and assessment procedures for dual diagnosis
Treatment	Measures treatment planning and service delivery for clients with dual diagnosis
Continuity of Care	Assesses program ability to monitor progress of both mental health and substance use disorders, and discharge planning for both disorders
Staffing	Assesses availability of licensed prescribers and staff to provide dual diagnosis services
Training	Measures how much training staff has in dual diagnosis