



NYSHealth
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in Integrated Care

Assessment

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Assessment

OHM & OASAS

Guidance Document

*Domains of Assessment for
Co-occurring Disorders*

31 July 2008
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**OMH AND OASAS GUIDANCE DOCUMENT
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DOMAINS OF ASSESSMENT FOR CO-OCCURRING DISORDERS

available online at—

http://www.omh.state.ny.us/omhweb/resources/providers/co_occurring/adult_services/assessment.html

General Guidance for Assessment

Key concepts for assessment of co-occurring disorders (COD) include:

- 1) “No wrong door” – Individuals should be welcomed into treatment wherever they enter and should receive an assessment that addresses all of their needed services. They should be assisted in accessing those services regardless of whether the client is appropriate for the agency service. Each contact with the client should facilitate engagement in ongoing services.
- 2) Empathy – The counselor expresses empathy for the client and collaborates to achieve the client’s best interests. The clinician recognizes that he or she cannot change the client directly but can work to support the client’s efforts toward change.
- 3) Person-centered assessment – The client’s perceptions, views, and wishes about achieving positive change are actively sought and considered in the assessment process.
- 4) Appreciation of racial and ethnic culture, gender, sexual orientation, and/or other group markers – The clinician recognizes the importance of these group markers on the client’s perception of the problem, treatment, and request for help, as well as presentation in the interview. The clinician needs to consider how his or her own group markers shape his or her world view and be willing to engage in a genuine exploration of how the client’s world view was shaped.
- 5) Trauma sensitivity – There is a high prevalence of trauma in COD populations. Clinicians should recognize the dilemmas that survivors face in seeking help and in forming a therapeutic alliance. Each client should be approached as if he or she has experienced some trauma in the past, and the interviewer should take a non-judgmental, warm, and welcoming stance and sustain emotional safety in the interview.

Each of these concepts is essential to providing an integrated substance use and mental health assessment. Clinicians should take time and use *reflective listening*; they should allow for exploration with the client and avoid rushing through the interview. Engagement of the client in the session is essential in getting an accurate picture of strengths, problem areas, and a diagnostic impression from which to form the plan of treatment.

Domains of Assessment Outline

The goals and principles statements that guided the work of the New York State Task Force on Co-occurring Disorders included anticipated client and family outcomes related to assessment for co-occurring disorders: “Clients and families can (1) access care anywhere in OMH and OASAS-licensed programs; (2) receive one evaluation; and (3) learn if they have a co-occurring disorder.” What follows is an outline of the domains of assessment for co-occurring disorders strongly recommended for inclusion in the assessment protocols of all OMH and OASAS-licensed outpatient clinics.

- Presenting Problem(s)
- Current Symptoms and Functioning
- Background
- Individual History
- Substance Use
- Mental Health
- Medical History
- Mental Status Examination
- Client Perception(s)
- Cultural and Linguistic Considerations
- Supports and Strengths
- Diagnostic Impressions on 5 DSM Axes

Domains of Assessment Guidance

1: Presenting Problem(s), including history and chronology of events, acute and chronic stressors or difficulties, in the client’s words

This is a statement of the problem as the client views it and answers the question, “What brings you here today?” In an integrated mental health and substance abuse assessment, each problem area should be addressed and the relation of each disorder to the other should be explored.

2: Current Symptoms and Functioning

This is an opportunity to identify current symptoms, including current use of substances and mental health symptoms. Is there a relationship between current SA and MH symptoms and functioning? (For example, as intrusive symptoms of PTSD intensify, alcohol and marijuana use increase.)

3: Background, including education, marital status, employment history, socioeconomic status, current housing, legal problems and criminal justice involvement

4: Individual History, including significant developmental, educational, family and social events, trauma history and/or history of domestic violence

5: Substance Use, including age of first use, primary drugs used (including alcohol, tobacco and caffeine), frequency of alcohol and drug use, patterns of alcohol and drug use, treatment episodes (residential and outpatient), and family history of substance abuse problems

A good assessment of substance use includes a thorough history, including age of first use and progression of use over time. Clinicians should also explore periods of time when the client reports no use or much reduced use. The clinician should consider what supports are present during periods of reduced use or abstinence, including symptoms of a co-occurring mental health disorder.

The assessment should include questions about how the substance use has impacted the client to distinguish an abuse diagnosis from a dependence diagnosis and to determine severity that will help to inform a level of care decision.

Areas of exploration include:

- Direct observation of intoxication or withdrawal signs or symptoms
- Collateral contact with significant others
- Questions about tolerance; e.g., “Do you use more now to get the same effect?”
- Pursuit of the “high”
- Time spent in pursuing the high, using the substance or recovering from effects
- Problems associated with use, including employment, family, legal, physical aggression and violence, and physical/medical problems or exacerbation of chronic medical or physical problems
- Use to relieve stress or avoid pain
- Risky behavior, including sexual behavior, driving under the influence, impulsivity
- Cravings, urges to use, use to decrease the effects of withdrawal or substance rebound (hangover or “crash”)
- Guilt about using
- Loss of control, which can include unsuccessful attempts to cut down or stop using, switching the type or method of use to “cut back,” establishing rules around use.

Any use of substances that exacerbates mental health or physical health is a negative consequence of use, and repeated use in a pattern over time that includes predictable negative consequences will meet the criteria for substance abuse based on DSM-IV-TR criteria. In other words, there is no specific amount of use required for a diagnosis. Substance abuse occurs when use causes negative consequences or interferes with normal activities. Substance dependence is when the client experiences a loss of control over use, which is evident in attempts to cut down, symptoms of tolerance or withdrawal, or increases in time spent using and continued use despite significant negative consequences of use.

Intoxication, Withdrawal, and Level of Care

The assessment should determine if there is a need for immediate withdrawal and stabilization in a detoxification program and to identify the most appropriate level of treatment. Common drug intoxication signs and withdrawal symptoms include:

Intoxication

Substance	Cocaine	Alcohol	Heroin	Cannabis
	Stimulant	Sedative	Sedative, euphoriant, analgesic	Euphoriant; at high doses may induce hallucinations
Characteristics of intoxication	↑BP, HR, temp ↑energy ↑paranoia ↑fatigue ↓appetite	Sedation ↓respirations Depresses CNS Can cause coma, death in high doses	Drowsiness, “nodding,” euphoria	↓BP ↑HR ↓pressure in eyes, reddening of eyes, euphoria, giddiness

Withdrawal

Substance	Cocaine	Alcohol	Heroin	Cannabis
Onset	Depends on route of administration; smoking will result in symptoms within hours of last use	24-48 hours after blood alcohol level drops	Within 24 hours of last use	Unclear due to long half-life in fatty tissue – thought to be within a few days of last use
Duration	3-4 days	5-7 days	4-7 days	May last for several weeks
Characteristics	Sleeplessness or excessive restless sleep, appetite increase, depression, paranoia, decreased energy	↑BP ↑HR ↑temp Nausea/vomiting Diarrhea, seizures, delirium, death	Nausea, vomiting, diarrhea, goose bumps, runny nose, teary eyes, yawning	Irritability, appetite disturbance, sleep disturbance, nausea, concentration problems, nystagmus, diarrhea

The assessment should identify any history of withdrawal symptoms on discontinuation of the substance, especially a past history of seizures in alcohol withdrawal. Clients should be referred for detoxification if significant withdrawal symptoms or medical complications are expected.

Level of Care

An assessment of functional domains will help inform a level of care decision. These domains include:

- Acute Intoxication and/or Withdrawal Potential
- Biomedical Conditions and Complications
- Emotional/Behavioral Conditions and Complications
- Motivation
- Relapse Potential
- Recovery Environment

These domains are included in the ***American Society of Addiction Medicine (ASAM) Level of Care Criteria***, which can be accessed through the ASAM website. Decisions about level of care should consider the client view of the problem and motivation for treatment.

Levels of care certified by OASAS include outpatient clinic, intensive outpatient treatment, medically monitored detoxification, non-medically monitored detoxification, inpatient rehabilitation, community residence, supportive living, and methadone maintenance.

6: Mental Health, including current psychiatric symptoms, client history of psychiatric problems, past diagnoses, hospitalizations, and other treatments (inpatient and outpatient), family history of psychiatric problems, current (and when possible, past) medications, and medication adherence

A mental health assessment is a necessary tool in developing and implementing a treatment plan that integrates the best thinking and observations of the clinician. A thorough assessment includes:

- Current Psychiatric Symptoms
 - Psychotic symptoms include:
 - Delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior
 - Depressive symptoms include:
 - Depressed mood, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness, diminished ability to concentrate, suicidal ideation, intent or plan
 - Manic symptoms include:
 - Elevated, expansive, or irritable mood; inflated self-esteem or grandiosity; decreased need for sleep; pressure of speech; flight of ideas; distractibility; psychomotor agitation; excess involvement in pleasurable activities with a high potential for painful consequences
 - Symptoms of anxiety include:
 - Excessive worry, difficulty controlling the worry, restlessness, being easily fatigued, difficulty concentrating, irritability, muscle tension, disturbed sleep

- Symptoms of post-traumatic stress disorder include:
 - Re-experiencing the trauma, cognitive and behavioral avoidance, hyper-arousal, dissociation, emotional numbing

- Risk Assessment

An assessment of risk to self and others involves consideration of risk and protective factors, history of self-harm or violence, use of substances, access to the means of harm, and destabilizing stressors.

- Medications

- Current medications, dosages, duration, and prescriber(s)
- Goals of medication treatments
- Medication adherence, including the client's views about medications
- Problem side effects

- Psychiatric History

Establish a timeline of the course of mental illness and the person's treatment response.

- Current and past diagnoses
- Age of onset
- History of psychiatric hospitalizations or other forms of intensive treatment
- Involuntary treatment, including Assisted Outpatient Treatment (AOT)
- Outpatient treatment
- Client perceptions of care
- Medication adherence
- Family history of mental illness

- Activities of Daily Living (ADL)

This component of the assessment provides the clinician the opportunity to assess the person's current ability to meet basic needs; it includes:

- Adequacy and safety of the person's current living situation
- Effect of symptoms on the person's ability to maintain an independent living situation
- Current financial resources
- Level of assistance, support, and resources the person needs to re-establish and maintain activities of daily living

7: Medical History, current and past, including any medications currently taking

- Identify current medical conditions and treatment, including identifying who is the primary care physician and date of last contact
- Current and past medications
- History of medical hospitalizations

- Health risk factors
- HIV and Hepatitis C
- History of head injury
- Presence of chronic pain

8: Mental Status Examination

The mental status examination (MSE) is a systematic evaluation of the individual's mental functioning conducted partly by asking questions and partly by observing and listening; its findings are directly applicable to both mental health and substance use assessment and the development of treatment plans.

A complete MSE evaluates the following areas of functioning:

- Appearance and Behavior

Record the person's age, sex, race, and ethnic background. Observe and describe the person's overall appearance, including grooming, hygiene, and state of alertness. Also observe and describe the person's: gait; posture and body language; movement (e.g., excessive motor activity, restlessness, disturbance of movement, spasms, startle responses, slowing of physical and emotional reactions, diminished responsiveness, immobility); mannerisms; facial expressions and eye contact; and attitude toward the examiner (e.g., hostile, defensive, guarded, uncomfortable, cooperative, friendly, relaxed).

- Mood and Affect

Mood is the subjective description of a person's sustained emotional state. Ask questions such as "How do you feel most days?" to trigger a response. Helpful answers include those that specifically describe the person's mood, such as "depressed," "anxious," "good," and "tired"; elicited responses that are less helpful in determining mood require additional questioning for clarification. Accurate information about the length of a particular mood, whether or not the mood has been reactive, and if the mood has been stable or unstable is also helpful. Affect is the person's current emotional state as observed by the interviewer; it is usually described as expansive (contagious), euthymic (normal), constricted (limited variation), blunted (minimal variation), or flat (no variation).

- Speech

Document information on all aspects of the person's speech, including: quality (e.g., vocabulary, articulation); quantity (e.g., spontaneity, restricted speech); rate; and volume of speech during the interview. Paying attention to people's responses to determine how to rate their speech is important. Some things to keep in mind during the interview are whether the client raises his or her voice when responding, whether responses to questions are one-word answers or elaborative, and how fast or slow he or she is speaking.

- Thought Process

Thought process refers to the logical connections between thoughts and their relevance to the main thread of the conversation. Listen and record information about the person's thought process. Terms used to describe symptoms of possibly disordered thought processes include: looseness of associations (a pattern of spontaneous speech in which thinking jumps from one idea to another without logical connections); flight of ideas (a thought process that moves so rapidly between ideas that it is difficult to follow, although the links between ideas are understandable); racing (rapid thoughts); tangentiality (replying to a question in an oblique or irrelevant way); circumstantiality (speech that is very indirect and delayed in reaching its goal); word salad (nonsensical responses); derailment (an unexpected change of direction of a 'train of thought' that 'derails' onto a subsidiary idea); neologism (creating new words); clanging (rhyming words); punning (talking in riddles); thought blocking (a thought suddenly ends before it is complete); and poverty of thought (limited content).

- Thought Content

Determine whether or not the person is experiencing hallucinations and delusions. Types of hallucinations include auditory (hearing things), visual (seeing things), gustatory (tasting things), tactile (feeling sensations), and olfactory (smelling things). Types of delusions include grandiose (delusions of grandeur), religious (delusions of special status with God), persecution (belief that someone wants to cause them harm), jealousy (belief that everyone wants what they have), thought insertion (belief that someone is putting ideas or thoughts into their mind), and ideas of reference (belief that everything refers to them). Also check for abnormal preoccupations and obsessions, excessive suspiciousness, compulsive rituals, phobias, and whether or not there is suicidal or homicidal ideation or intent.

- Cognition

Evaluate and record the person's level of consciousness or alertness, orientation (to self, place, and time), concentration and attention (e.g., ask the person to count backwards by threes or sevens), ability to read or write complete sentences, remote memory (e.g., ask "Who was your first grade teacher?") and recent memory (e.g., ask "What did you eat for dinner last night?"). Also evaluate and record abstract thought (e.g., ask how two items, such as an apple and orange, are alike; ask the meaning of culturally appropriate proverbial phrases); and general fund of knowledge (e.g., ask the person to list the last five Presidents or five major American cities). Finally, based on information provided by the person during the interview, estimate and record the client's general intellectual level (below average, average, or above average).

- Insight and Judgment

Insight refers to a person's ability to recognize a problem and understand its nature and severity, so evaluate and document the person's perception of the problem, attribution of responsibility or blame, and perception of stressors in rating insight. Evaluate and document judgment based on history or on a

scenario (such as “What would you do if you smelled smoke in a crowded theater?”) and on an estimation of the person’s impulse control.

9: Client Perception(s) of problems and goals, client readiness for change (as evidenced principally by behaviors)

The clinician should consider the client’s motivation, especially where current behavior or functioning support or conflict with values or major life goals. What has motivated the client to attend the session and how might that motivation influence change over time? A formal assessment of stage of change such as Prochaska and DiClemente’s change model or Osher and Kofoed’s Stages of Treatment, an anchored readiness ruler (Rollnick et al 2007), or other change model may be used to gauge current readiness and to guide the clinician and client in increasing readiness and measuring improvement over time.

The client’s perceptions of problems and goals are central to forming a client-centered treatment plan. The clinician should elicit client goals and include them in the plan even if the clinician would have chosen other goals. In a collaborative process, the goals may be re-framed and expanded upon but should always reflect the client’s point of view.

10: Cultural and Linguistic Considerations

Racial and ethnic culture, gender, sexual orientation, and other group markers play a significant role in determining the client’s view of the problem and also in identifying strengths and a world and self view from which he or she will understand and work toward problem resolution. A clinician needs to have an appreciation of how these factors influence the interview and the assessment.

11: Supports and Strengths (protective factors)

A person-centered assessment should be strength-based. It is important to understand the strengths and supports that the client can build upon and include them in the treatment plan. Often a client is unaware of strengths, and an exploration of personal, family, community, vocational and spiritual strengths can help to guide the treatment plan and to foster self-efficacy for the client. Strengths that should be considered include:

- Talents and interests
- Areas of educational interest and literacy
- Client areas of high motivation with either or both disorders
- Supportive relationships, peer, family, treatment, self-help, spiritual, and others
- Past successes
- Recent successes

12: Diagnostic Impressions on 5 DSM Axes

The use of a multi-axial system is an established standard of care. The five axes in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) are:

Axis I	Psychiatric Disorders
Axis II	Personality Disorders Mental Retardation
Axis III	General Medical Conditions
Axis IV	Psychosocial and Environmental Problems
Axis V	Global Assessment of Functioning (GAF)

Axis I Psychiatric Disorders

Axis I is for reporting all the various disorders or conditions except for Personality Disorders and Mental Retardation. If no Axis I disorder is present, this should be coded as "No Diagnosis" V71.09. The major groups of disorders on Axis I are:

- Disorders Usually First Diagnosed in Infancy, Childhood, or Adolescence (excluding Mental Retardation)
- Delirium, Dementia, and Amnesic and Other Cognitive Disorders
- Mental Disorders Due to a General Medical Condition
- Substance-Related Disorders
- Schizophrenia and Other Psychotic Disorders
- Mood Disorders
- Anxiety Disorders
- Somatoform Disorders
- Factitious Disorders
- Dissociative Disorders
- Sexual and Gender Identity Disorders
- Eating disorders
- Sleep Disorders
- Impulse-Control Disorders Not Elsewhere Classified
- Adjustment Disorders
- Other Conditions That May Be a Focus of Clinical Attention

Axis II Personality Disorders Mental Retardation

Axis II is for reporting Personality Disorders and Mental Retardation. If no Axis II disorder is present, this should be coded as "No Diagnosis" V71.09. The major groups of disorders on Axis II are:

- Paranoid Personality Disorder
- Schizoid Personality Disorder
- Schizotypal Personality Disorder
- Antisocial Personality Disorder
- Borderline Personality Disorder
- Histrionic Personality Disorder
- Narcissistic Personality Disorder

- Avoidant Personality Disorder
- Dependent Personality Disorder
- Obsessive-Compulsive Personality Disorder
- Personality Disorder Not Otherwise specified
- Mental Retardation

Axis III General Medical Conditions

Axis III is for reporting current general medical conditions. General medical conditions can be related to mental disorders in a variety of important ways.

Axis IV Psychosocial and Environmental Problems

Axis IV is for the reporting of psychosocial and environmental problems that may affect the diagnosis, treatment, and prognosis of mental disorders on Axis I and Axis II. A psychosocial or environmental problem may be a negative life event, environment difficulty or deficiency, familial or other interpersonal stress, inadequacy of social support or personal resources, or other problems relating to the context in which a person's difficulties have developed. These are grouped together in the following categories:

- Problems with primary support group
- Problems related to the social environment
- Educational problems
- Occupational problems
- Housing problems
- Economic problems
- Problems with access to health care services
- Problems related to interaction with the legal system/crime
- Other psychosocial and environmental problems

Axis V Global Assessment of Functioning (GAF)

Global Assessment of Functioning is for reporting the clinician's judgment of the individual's overall level of functioning and carrying out activities of daily living. This information is useful in planning treatment and measuring its impact, and in predicting outcome. The Global Assessment of Functioning (GAF) is a numeric scale (0 through 100) used to rate the social, occupational and psychological functioning of adults. The scale is presented and described in the DSM-IV-TR.

Score	Functioning
91-100	Superior functioning in a wide range of activities, life's problems never seem to get out of hand, is sought out by others because of his or her many qualities. No symptoms.
81-90	Absent or minimal symptoms, good functioning in all areas, interested and involved in a wide range of activities, socially effective, generally satisfied with life, no more than everyday problems or concerns.
71-80	If symptoms are present they are transient and expectable reactions to psychosocial stresses; no more than slight impairment in social, occupational, or school functioning

Score	Functioning
61-70	Some mild symptoms OR some difficulty in social, occupational, or school functioning, but generally functioning pretty well, has some meaningful interpersonal relationships.
51-60	Moderate symptoms OR any moderate difficulty in social, occupational, or school functioning.
41-50	Serious symptoms OR any serious impairment in social, occupational, or school functioning.
31-40	Some impairment in reality testing or communication OR major impairment in several areas, such as work or school, family relations, judgment, thinking, or mood.
21-30	Behavior is considerably influenced by delusions or hallucinations OR serious impairment in communications or judgment OR inability to function in all areas.
11-20	Some danger of hurting self or others OR occasionally fails to maintain minimal personal hygiene OR gross impairment in communication.
1-10	Persistent danger of severely hurting self or others OR persistent inability to maintain minimum personal hygiene OR serious suicidal act with clear expectation of death.
0	Not enough information available to provide GAF.