



NYSHealth
Center for Excellence
in Integrated Care

NYS Guidance for Co-occurring Disorders

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Commissioners' Letters

to Directors of OHM- & OASAS-Licensed Clinics

*Improving Services for Adults with
Co-occurring Mental Health &
Substance Use Conditions*

20 June 2008 & 31 July 2008
from OMH Commissioner Michael Hogan &
OASAS Commissioner Karen Carpenter-Palumbo

New York State Office of Mental Health (OMH)
http://www.omh.state.ny.us/omhweb/resources/providers/co_occurring/adult_services/20080731_ltr.pdf

New York State Office of Alcoholism & Substance Abuse Services (OASAS)— Combined documents
<http://www.oasas.state.ny.us/pio/collaborate/documents/co-occurring.pdf>



NEW YORK STATE

OFFICE OF ALCOHOLISM
AND SUBSTANCE ABUSE SERVICES

1450 Western Avenue, Albany, New York 12203-3562
Karen M. Carpenter-Palumbo, Commissioner

OFFICE OF MENTAL HEALTH

44 Holland Avenue, Albany, New York 12229
Michael F. Hogan, Ph.D., Commissioner

June 20, 2008

Dear Colleague,

We are writing this letter to update you on our collaborative interagency work to improve services to people with co-occurring mental and substance use disorders and their families. We launched the planning phase of this initiative in May 2007 and are pleased to announce the beginning of its implementation that, with your assistance, will lead to improved care for those that turn to us for services.

Integrating care for people with co-occurring disorders is essential. We know from New York State Medicaid data that 60% of individuals with a substance use disorder claim also have a psychiatric disorder and that 51% of people with the diagnosis of schizophrenia also have a co-occurring substance use diagnosis. National data indicate that only 8% of persons with co-occurring disorders receive treatment for both disorders. Unless both conditions are detected and effectively treated, a person will have little chance of recovering from either. In the Patient-First philosophy of Governor Paterson's administration, fragmented, "silo-based" care for persons with co-occurring disorders is unacceptable, and as Commissioners of the mental health and addiction service delivery systems, we are committed to changing the status quo.

Since our endorsement of the work of the Co-Occurring Disorder (COD) Task Force in November 2007, we have led an interagency team charged with implementing the Task Force's recommendations in four areas:

- ◆ Clinical: Introduce screening and assessment tools in all OASAS and OMH certified outpatient clinics and implement evidence-based practices (EBPs) to treat both conditions.
- ◆ Regulatory: Identify means by which providers would have greater operating flexibility to better engage and retain persons with co-occurring disorders.
- ◆ Fiscal: Identify means by which integrated care can be financially supported.
- ◆ Systemic Support: Encourage local innovation.

We are very pleased to report on our implementation team's work. They have presented these actions to the Advisory Group of stakeholders, and will continue to seek their guidance, as well as to reach out to the entire community of mental health and substance abuse leaders as we move forward.

1. Clinical: Screening and Assessment:

This summer we will issue a *Guidance Memo* recommending specific *Mental Health screens* for OASAS certified clinics to choose from (the Modified Mini Screen (MMS), the Mental Health Screening Form III (MHSF-III) or the K-6 [Kessler]) and *Substance Use screens* for OMH-certified clinics to choose from (the Modified Simple Screening Instrument for Substance Abuse (MSSI-SA)),

the CAGE-AID and the ASSIST). The Guidance Memo will detail information on these screens to assist providers in choosing the best one for their population. In addition, we will also provide guidance on the clinical *Assessment* that people with COD warrant. We are not recommending any specific form but we will specify areas that would provide the quality assessment needed. We believe that instituting these clinical practices will improve the detection and treatment planning that has heretofore not adequately served our recipients and their families.

We are strongly encouraging all certified outpatient providers to adopt the screening and assessment tools. A Clinical Team of national leaders in the field of co-occurring disorders recommended the selection of these instruments after a thorough review of the evidence base and our Advisory Group endorsed their recommendations. Training and technical assistance will be available through the Co-occurring Disorder Center of Excellence, which we discuss below.

2. Evidence-Based Treatment:

Recognizing the complex challenges posed in treating a person with co-occurring disorders, our agencies are committed to the delivery of Evidence-Based Practices that support integrated treatment. Towards that end we have identified the following EBPs for adoption at OMH and OASAS clinics:

- ◆ For both disorders—approved medications
- ◆ For substance use disorders—evidence-based individual, group, couples, and family treatments, including motivational enhancement, CBT, 12-step facilitation, behavioral couples and family therapy and contingency management
- ◆ For mental illnesses (e.g., depression, anxiety and personality disorders)—CBT and medication
- ◆ For serious mental illnesses—managing illness (e.g., Integrated Dual Diagnosis Treatment, education, medication, and CBT), family psychoeducation, supported employment, social skills training and peer support

Training and technical assistance in EBPs also will be available to counties and providers as part of our implementation plan.

3. Regulatory Reform:

Integrated treatment will be made more possible by enabling OMH and OASAS Clinics to provide care with a single certification. In other words, services associated with substance use and mental disorders will be able to be provided for people with COD in either OASAS or OMH certified clinics, using identified EBPs and credentialed providers, without the need for dual certification.

We believe that if integrated treatment is provided under a single certification, a number of commonly expressed regulatory concerns in treating persons with co-occurring disorders will not be as problematic as they are currently perceived to be. We will be releasing a set of Frequently Asked Questions (FAQs) that will explain this capability in more detail as well as develop a process for technical assistance and managing ongoing request for regulatory relief for providers when and as they need it.

4. Fiscal Reform:

To support the provision of EBPs, OMH and OASAS are in discussion with the Department of Health (DOH) regarding the proper use of existing rate codes and other means by which to compensate providers for these specific services. We anticipate that any fiscal practices established in the

near future will serve as a bridge to the Ambulatory Patient Group codes (which involve severity coding and payment) under development by the DOH, in collaboration with our agencies.

5. Local Innovation:

Finally, in order to encourage systemic support, we are prepared to work with any provider or county that wishes to restructure its services to become more integrated and patient-centered within its existing budget.

We also want to recognize and express our great appreciation to the **New York State Health Foundation** for its generous commitment of \$5 million over the next four years to establish a **COD Integrated Treatment Center of Excellence**. The Foundation anticipates selecting an awardee to establish and open this Center by October of this year. The Center will play a critical role in the dissemination and training needed to make our initiative a reality.

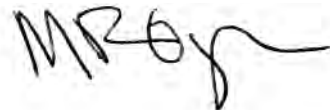
The work of the Task Force and its implementation team has to date focused on adults needing services. We are also pleased to announce the beginning of an **Adolescent Task Force** that will provide recommendations specific for this population. This Task Force is co-chaired by Maria Morris-Groves (OASAS) and Dr. Stewart Gabel (OMH).

An undertaking of this magnitude, that will involve all OASAS and OMH clinics and the patients and the families they serve, will depend not only on the fine work to date but an ongoing commitment, focus and resolve on all our parts to finally be able to deliver treatment that can work for so many people in need.

Thank you,



Commissioner Karen M. Carpenter-Palumbo



Commissioner Michael Hogan



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July 31, 2008

Dear OMH or OASAS Clinic Director:

As a follow-up to our June 20, 2008 letter, we are pleased to share with you the products, to date, of our collaborative interagency efforts intended to improve services to adults with co-occurring mental health and substance use disorders, and their families. We know that unless both conditions are detected and effectively treated, there is little chance of recovery from either. These products will be instrumental to the implementation plan in development.

Enclosed are the following: information on instruments to screen for mental illness and substance use, with related guidance; a document describing recommended assessment domains; frequently asked questions related to the provision of integrated treatment; and a Memorandum of Understanding, which underscores the shared commitment of the Office of Alcoholism and Substance Abuse Services (OASAS) and the Office of Mental Health (OMH) to the provision of integrated treatment, as well as the shared understanding of the operational flexibility needed to support that goal. Each of these documents is described in greater detail below.

SCREENING

We are strongly encouraging all OMH and OASAS clinics to screen all clinic recipients for co-occurring substance use or mental health disorders, depending on the setting. A selection of three screening instruments for each of the two clinic types has been identified by a team of national clinical leaders. For OASAS clinics, these are: Modified Mini Screen (MMS); Mental Health Screening Form III (MHSF-III); and K-6 (Kessler). For OMH clinics, these are: Modified Simple Screening Instrument for Substance Abuse (MSSI-SA); CAGE-AID; and ASSIST. Guidance information related to the rationale for screening, as well as descriptions of each instrument, is enclosed.

ASSESSMENT

All clinics are also strongly encouraged to assess all individuals who screen positive on one of the above instruments. While no specific form is recommended, key components of a quality assessment have been identified. A detailed description of the domains of assessment is enclosed.

REGULATORY REFORM

Although the concept of dual certification (i.e., certification of a single program by both OASAS and OMH) has been discussed, we conclude that integrated treatment is possible within a provider’s existing certification. This is referred to as “single certification,” i.e., services associated with substance use and mental disorders may be provided in an integrated manner for persons with co-occurring disorders in a single setting certified by either OMH or OASAS. In this respect, integrated treatment should be considered a “best practice” for mental health treatment and chemical dependence treatment.

Because of the common misperceptions associated with the State’s standards, a Frequently Asked Questions (FAQ) document has been created and is enclosed.

MEMORANDUM OF AGREEMENT

In support of the operational flexibility that is intended by the single certification approach and clarified by the FAQ document, OASAS and OMH have signed a Memorandum of Agreement (MOA). For your information, a copy of the MOA is included in this package.

Questions related to the enclosed documents may be directed to the appropriate OMH or OASAS Field Office. Training and technical assistance will be available in the future through the Co-Occurring Disorders Center of Excellence. You will be notified as that assistance becomes available.

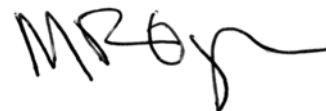
Please note that a separate initiative is underway related to co-occurring disorders among children and adolescents, and that similar products associated with that population will be available in the future. Further, in order to encourage systemic support associated with all age groups, we are prepared to work with any provider or county that wishes to restructure its services to become more integrated and person-centered. To that end, we continue to solicit budget-neutral reform proposals on an ongoing basis.

Thank you for your ongoing partnership, commitment and focused efforts related to the achievement of integrated treatment for persons with co-occurring disorders in New York State.

Sincerely,



Karen M. Carpenter-Palumbo
Commissioner, OASAS



Michael F. Hogan, Ph.D.
Commissioner, OMH

Enc.

cc: County Directors and Field Office Directors



Co-occurring Disorders

OHM & OASAS Guidance Documents

*for Directors of OMH- and OASAS-licensed
outpatient clinics in New York State*

31 July 2008

**from OMH Commissioner Michael Hogan &
OASAS Commissioner Karen Carpenter-Palumbo**

New York State Office of Mental Health (OMH)
http://www.omh.state.ny.us/omhweb/resources/providers/co_occurring/adult_services/20080731_itr.html

New York State Office of Alcoholism & Substance Abuse Services (OASAS)— Combined documents
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Screening

OHM & OASAS

Guidance Document

Screening for Co-occurring Disorders

31 July 2008

from OMH Commissioner Michael Hogan &
OASAS Commissioner Karen Carpenter-Palumbo

New York State Office of Mental Health (OMH)
<http://www.omh.state.ny.us/omhweb/resources/providers/co%5Foccurring/adult%5Fservices/screening.html#mms>

New York State Office of Alcoholism & Substance Abuse Services (OASAS)— Combined documents
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**OMH AND OASAS GUIDANCE DOCUMENT
JULY 31, 2008**

SCREENING FOR CO-OCCURRING DISORDERS

Introduction

The Office of Mental Health (OMH) and the Office of Alcoholism and Substance Abuse Services (OASAS) strongly recommend that all of their licensed outpatient clinics screen all individuals presenting for care for the presence of a co-occurring mental health and substance use disorder. This recommendation derives from the work of the New York State Task Force on Co-occurring Disorders.

A description of specifically recommended screening tools follows and is intended to inform programs in their selection of a tool for their setting. All of the recommended screening instruments are either available or accessible via the internet at no cost.

Rationale and Purpose for Screening

In any given year, 5.6 million adults in the nation have co-occurring mental illness and substance use disorder (NSDUH, 2006). Mueser, et al. (2006) report that, in clinic samples, as many as 40-60 percent of individuals presenting in mental health settings have a co-occurring substance use diagnosis, and 60-80 percent of individuals presenting in a substance abuse facility have a co-occurring mental illness diagnosis. Dr. Robert Drake has also stressed that 50 percent of individuals with co-occurring serious mental illness and substance use disorders receive no care; 45 percent receive poor care; and only five percent receive evidence-based care – a disturbing state of affairs.

The benefits of treating both disorders at the same time are also well documented. Integrated treatment has been found to be more effective than non-integrated care (McHugo et. al, 1999); it has been shown to improve substance use outcomes, with the majority of individuals achieving abstinence or substantially reducing harm from substance abuse. Most individuals experience improvements in independent living, control of symptoms, competitive employment, social contacts with non-substance users, and overall expression of life satisfaction (Drake, 2006).

In 2000, the Center for Substance Abuse Treatment (CSAT) issued a report entitled *Changing the Conversation*, which presented the principle of “No Wrong Door.” This principle has guided policy and decision making regarding co-occurring disorders treatment since that time; it recognizes that most clients do not have a single targeted problem, and that it is the responsibility of treatment and rehabilitation programs to adapt to and meet the specific needs of the individual.

The purpose of screening is to accurately identify individuals who may have a co-occurring disorder. Each of the recommended screening tools has shown good reliability and validity and is proven to have a high degree of accuracy in predicting who may need further assessment and treatment. Screening serves a different purpose than assessment and cannot take the place of a thorough assessment. Screening will identify candidates who should receive a more

comprehensive assessment. Screening positive on a screening instrument does **not** mean that the individual has the disorder for which they have screened positive. Rather, individuals who screen positive should receive a thorough assessment to establish or rule out a related diagnosis.

Implementation of Screening

Once a provider has selected a single screening instrument to be used in an identified setting, all clinicians should become familiar with that instrument and its use and scoring. Clinicians need to be aware that the validity of the screening can be affected by such circumstances as the manner in which instructions are given, what the client believes about how the information will be used, privacy, trust, and the rapport between client and counselor. It is important to be sensitive to the ways in which culture may influence responses to screening questions; many of the recommended screening instruments are available in languages other than English.

Each program needs to establish a protocol for assessing individuals who screen positive. This should include a protocol for responding immediately to urgent needs identified in the screening, including suicidal thoughts or levels of substance use that may require medical attention. Each clinician should know the procedure to follow for when clients screen positive to ensure that they receive a thorough assessment.

MENTAL HEALTH SCREENS RECOMMENDED FOR USE IN CHEMICAL DEPENDENCY SETTINGS

	RATED	DESCRIPTION	PROS	CONS
Modified MINI Screen¹ (MMS)	Most Highly	22 Yes-No items that screen for anxiety and mood disorders, trauma exposure and PTSD, and non-affective psychoses	<ul style="list-style-type: none"> • The MMS can be administered in 5-10 minutes and scored in less than five minutes. • Validation study in public sector settings in New York State, including jails, shelters, outreach programs, and traditional chemical dependency treatment programs, showed good sensitivity, specificity, and reliability. • The screen performs equally well for men and women and for African Americans and Caucasians. • Training is brief, a manual is available, and there is extensive experience in NYC and NYS with implementing the MMS. • The screen is available at no charge and is accessible at: http://www.oasas.state.ny.us/hps/research/pic/index.cfm 	Available in Spanish, but sample is too small to infer equivalent performance as for Caucasians and African Americans.
Mental Health Screening Form III² (MHSF III)	Highly	18 Yes-No items about current and past symptoms covering schizophrenia, depressive disorders, PTSD, phobias, intermittent explosive disorder, delusional disorder, sexual and gender identity disorders, eating disorders, manic episode, panic disorder, obsessive-compulsive disorder, pathological gambling, learning disorders, and mental retardation	<ul style="list-style-type: none"> • The MHSF III was designed specifically to screen for mental health problems among clients entering substance use treatment. • The screen can be administered in approximately 15 minutes. [Positive responses should be followed up by questions regarding the duration, intensity, and co-occurrence of symptoms. A qualified mental health professional should determine whether a follow-up assessment and treatment recommendations are needed.] • Preliminary research using a modest sample in one substance use agency indicates excellent content validity and adequate test-retest reliability and construct validity. A later study indicates that it performs as well as other mental health screens. • The MHSF III is available in English and Spanish. • The screen is available at no charge and is accessible at: http://www.fadaa.org/services/events/2004_FIS/MHSF3ProjectReturn.pdf 	Data on screen performance is limited. None on gender or ethnicity; none on cut points

	RATED	DESCRIPTION	PROS	CONS
K6 Screening Scale ^{3, 4}	Highly	The tool consists of 6 items, each with a with 0-4 point rating scale, that screen for general distress in the last 30 days (Kessler, et al., 2003). Maximum precision is in the clinical range of the scale, that is, for people with anxiety or mood disorders or non-affective psychoses whose level of functioning is seriously impaired.	<ul style="list-style-type: none"> • The K6 can be administered in less than five minutes using paper and pencil, computer assisted, or interview formats • The screen discriminates cases of psychiatric disorder from non-cases well in the moderate to mild range, and extremely well in the severe range. • The screen performs equally well across gender and across many cultures (countries). • The K6 was carefully constructed and has been widely used in epidemiological surveys in the U.S. (NCS-R and NSDUH) and internationally (World Mental Health Survey Initiative; World Mental Health CIDI study). • A score of 13 or higher indicates serious mental illness (citation #4 below). A score of 8-12 indicates an anxiety-mood disorder that does not meet the severity threshold for a diagnosis of serious mental illness (Personal communication, Kessler). • The screen is available in many languages, though not necessarily in local U.S. variants. • The screen is available at no charge and is accessible at: http://www.oaltc.ku.edu/K6%20files/K6%20Form.pdf 	<p>Published data is from general population (except SUD) and GAF < 60. Cut point is a score of 13 or higher; reported sensitivity for this low prevalence event is .36 and is driven by low prevalence but also speaks to the limited utility of existing data for clinical screening decisions.</p> <p>No information on how to identify less severe conditions or in clinical samples.</p> <p>Spanish version is for use in Spain.</p>

References

1. Alexander, MJ, Haugland G, Lin, SP, Bertollo, DN and McCorry FA (2008). Mental Health Screening in Addiction, Corrections and Social Service Settings: Validating the MMS. *International Journal of Mental Health and Addiction*, 6 (1), 105 – 119.
2. Carroll J and McGinley J (2001). A screening form for identifying mental health problems in alcohol/other drug dependent persons. *Alcoholism Treatment Quarterly*, 19 (4), 33-47.
3. Kessler RC, Andrews G, Colpe LJ, Hiripi E, Mroczek DK, Normand SLT, Walters EE and Zaslavsky AM. (2002). Short screening scales to monitor population prevalences and trends in non specific psychological distress. *Psychological Medicine* 32, 959-976.
4. Kessler RC, Barker PR, Colpe LJ, Epstein JF, Gfroerer JC, Hiripi E, Howes MH, Normand S-L T, Manderscheid RW, Walters EE., Zaslavsky AM (2003). Screening for serious mental illness in the general population. *Archives of General Psychiatry*, 60, 184-189.

SUBSTANCE USE SCREENS RECOMMENDED FOR USE IN MENTAL HEALTH SETTINGS

	RATED	DESCRIPTION	PROS	CONS
Modified Simple Screening Instrument for Substance Abuse¹ (MSSI-SA)	Most Highly	16 items, 14 of them scoreable; most items tap symptoms of alcohol and drug dependence, including prescription and over-the-counter medications, during the past six months. Several items tap lifetime and current use problems for respondents and lifetime use problems for family members.	<ul style="list-style-type: none"> • The MSSI-SA is a very slightly modified version of the Simple Screening Instrument for Substance Abuse (SSI-SA) and can be self-administered or administered as an interview in 10 minutes or less. • The screen has good internal psychometrics and very good sensitivity, specificity, and overall accuracy. Convergence with other substance abuse measures for justice-involved individuals is good. • Use of the tool in New York City is being widely expanded as a result of the Quality IMPACT project that demonstrated its utility; it is also widely used in State correctional systems. • The MSSI-SA is available in English, Chinese, Creole, Korean, Russian, and Spanish. • The screen is available at no cost and is accessible at: http://www.nyc.gov/html/doh/html/qi/qi_samhpriority.shtml 	No data is available on equivalent performance across gender, ethnicity, or age.
CAGE Adapted to Include Drugs² (CAGE-AID)	Very Highly	A modified version of the CAGE screen for alcohol problems, the CAGE-AID is a four-item conjoint screen for alcohol and substance abuse.	<ul style="list-style-type: none"> • Very short and easy to administer and score, the screen can be administered in less than five minutes. • The screen has good psychometric properties, based on a primary care sample, and is a useful instrument with which to initiate the conversation about alcohol or substance use. • Because the CAGE-AID is a widely used brief screen, many clinicians are familiar with it, including in primary care. • The original CAGE performs well for men and African American women and is more sensitive for African Americans than Caucasians. • The screen is available in English and Spanish. • The screen is available at not cost and is accessible at: https://www.mhn.com/static/pdfs/CAGE-AID.pdf 	<p>Performance data is mixed for people with severe mental illness.</p> <p>No data is available for Hispanic women.</p>

	RATED	DESCRIPTION	PROS	CONS
Alcohol, Smoking, and Substance Involvement Screening Test³ (ASSIST)	Well	The tool consists of seven items or questions regarding each of ten substances (a total of 70 questions) and one item or question about drug injection. A specific “substance involvement” (risk) score is calculated for each substance, and that score drives a recommendation for no intervention, brief intervention, or more intensive treatment for each substance.	<ul style="list-style-type: none"> • The World Health Organization (WHO), which developed the ASSIST for use in primary and general medical care settings worldwide, reports that screening questions can be answered by most individuals in around ten minutes. • The screen’s reliability and accuracy psychometrics are good. The dimensions it taps are clinically useful and intuitive. • Alcohol and tobacco are among the substances specifically referenced in the screen. • The instrument’s resulting risk scores can be recorded on a custom-designed “feedback report card” to provide feedback to individuals screened about their substance use and associated risks. • The ASSIST is available in English, French, German, Hindi, and Portuguese. • The screen is available at no cost and is accessible at: http://www.who.int/substance_abuse/activities/assist/en/index.html 	<p>Total number of screening questions is high.</p> <p>In a detailed WHO report, there is no mention of its utility for people with mental illness or performance by gender or ethnicity.</p> <p>Not available in Spanish</p>

References

1. Center for Substance Abuse Treatment. Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases. Treatment Improvement Protocol (TIP) Series 11. DHHS Publication No. (SMA) 95-3058. Rockville, MD: Substance Abuse and Mental Health Services Administration, 1994.
 2. Brown RL and Rounds LA. (1995). Conjoint screening questionnaires for alcohol and other drug abuse: criterion validity in a primary care practice. Wisconsin Medical Journal, 94 (3), 135 –140.
 3. Newcombe DAL, Humeniuk RE; Ali R (2005). Validation of the World Health Organization Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): report of results from the Australian site. Drug and Alcohol Review, 24 (3), 217 – 226.
- Poznyak V. (2006).



Assessment

OHM & OASAS

Guidance Document

*Domains of Assessment for
Co-occurring Disorders*

31 July 2008

from OMH Commissioner Michael Hogan &
OASAS Commissioner Karen Carpenter-Palumbo

**OMH AND OASAS GUIDANCE DOCUMENT
JULY 31, 2008**

DOMAINS OF ASSESSMENT FOR CO-OCCURRING DISORDERS

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.



Regulations

OHM & OASAS

Guidance Document

FAQs Regarding Mental Health & Chemical Dependency Regulations

31 July 2008

from OMH Commissioner Michael Hogan &
OASAS Commissioner Karen Carpenter-Palumbo

New York State Office of Mental Health (OMH)
<http://www.omh.state.ny.us/omhweb/resources/providers/co%5Foccurring/adult%5Fservices/screening.html#mms>

New York State Office of Alcoholism & Substance Abuse Services (OASAS)— Combined documents
<http://www.oasas.state.ny.us/pio/collaborate/documents/co-occurring.pdf>

FAQS REGARDING MENTAL HEALTH AND CHEMICAL DEPENDENCY REGULATIONS

ANALYSIS: MUCH OF WHAT ARE PERCEIVED TO BE REGULATORY BARRIERS ARE NOT OR CAN BE MANAGED WITH SUPPORT OR WAIVER ACTIONS

I. GENERAL QUESTIONS RELATED TO AUTHORITY OF OMH AND OASAS:

Q: What is the responsibility of the Office of Mental Health (OMH) with respect to persons with mental illness?

A: OMH is responsible for assuring the development of comprehensive plans, programs, and services for research, prevention, care, treatment, rehabilitation, education, and training of persons with mental illness. OMH is required, by law, to cooperate with the Office of Alcoholism and Substance Abuse Services (OASAS) and the Office of Mental Retardation and Developmental Disabilities (OMRDD) in the development of these plans, programs, and services.

Q: What is the responsibility of the Office of Alcoholism and Substance Abuse Services (OASAS) with respect to persons with chemical dependency?

A: OASAS is responsible for assuring the development of comprehensive plans, programs, and services for research, prevention, care, treatment, rehabilitation, education, and training of persons who abuse or are dependent on alcohol and/or substances and their families. By law, OASAS is required to cooperate with the Office of Mental Health (OMH) and the Office of Mental Retardation and Developmental Disabilities (OMRDD) in the development of these plans, programs, and services.

Q: If a provider is certified by OMH to provide mental health services, is that provider prohibited from admitting an individual who also has a co-occurring substance use disorder?

A: No. There is nothing in NYS law or OMH regulations that would bar a mental health provider from admitting a person who also has a substance use disorder, so long as the person meets the admission criteria of the mental health program and is able to participate in the program.

Q: If a mental health provider admits a person to, for example, an outpatient mental health clinic, and the person also has a substance use diagnosis, isn't the clinic providing substance use services that require an operating certificate from OASAS?

No. Mental Hygiene law Section 32.05 provides that no provider of services shall engage in the provision of outpatient services for persons with chemical dependency without having been issued an operating certificate from OASAS. However, if an outpatient mental health provider admits a person who meets the criteria for admission to the outpatient program, it is providing outpatient mental health services to the person, not chemical dependency services. In this respect, the person's co-occurring substance use disorder is being managed in the course of the provision of mental health services, but the person is not being provided with chemical dependency outpatient services that require OASAS licensure.

Q: If a provider is certified by OASAS to provide chemical dependency services, is that provider prohibited from admitting an individual who also has a co-occurring mental health disorder?

- A: No. There is nothing in NYS law or OASAS regulations that would bar a chemical dependency provider from admitting a person who also has a mental health diagnosis, so long as the person meets the admission criteria of the chemical dependency provider and is able to participate in the program.
- Q: If a chemical dependency provider admits a person to, for example, a Part 822 outpatient clinic, and the person also has a mental health diagnosis, isn't the clinic providing mental health services that require an operating certificate from OMH?
- A: No. Mental Hygiene law Section 31.02 provides that no provider of services shall engage in the provision of outpatient services for persons with mental illness without having been issued an operating certificate from OMH. However, if a Part 822 outpatient clinic admits a person who meets the criteria for admission to the Part 822 clinic, it is providing outpatient chemical dependency services to the person, not mental health services. In this respect, the person's co-occurring mental health disorder is being managed in the course of the provision of chemical dependency services, but the person is not being provided with mental health outpatient services that require OMH licensure.
- Q: What is integrated treatment?
- A: There are several models of integrated treatment. While not necessarily precluding the development of other models, OASAS and OMH are directing initial focus on an integrated treatment model in which traditional chemical dependency and mental health programs seek to manage the multiple symptoms of their presenting patients by incorporating techniques of mental health or addiction screening, assessment, and counseling into their own spectrum of services. However, the primary clinical focus of the program remains on the principal diagnosis that was necessary for admission to the program. In this way, each type of program (chemical dependency or mental health) can work within its current certification structure and is not required to seek licensure from the other governing State agency (OASAS or OMH).

II. STAFFING:

- Q: If an outpatient mental health provider wants to have a CASAC on staff to work with persons with program who have chemical dependency problems in addition to their mental illness, is OASAS approval required? Would OASAS approval be required to bill Medicaid for the services provided by the CASAC?
- A: There is nothing in either OMH or OASAS regulations that would prevent an OMH certified program from directly hiring a CASAC to include on its professional staff team. OASAS approval is not required. If a CASAC is employed by an OMH certified clinic, the services that the CASAC provides are mental health services billable to Medicaid under the provider's OMH operating certificate.

In fact, OMH clinic regulations (14 NYCRR Section 587.4) currently envision inclusion of CASACs as professional staff. Nothing in OASAS regulations prohibits CASACs from working in OMH certified settings, or requires the approval of OASAS before they can do so. Furthermore, in county clinics, there is an additional mechanism by which staff can be shared between OASAS and OMH settings, i.e., CFR reporting of time allotted to each service.

A similar conclusion holds true with respect to the use of mental health professionals in an OASAS program. There is nothing in OASAS regulations that would prohibit OASAS certified programs from hiring mental health professionals. In fact, such professionals are often critical in meeting OASAS “multidisciplinary team” requirements.

Q: Is a physician who works at an OASAS program prohibited from prescribing psychotropic medication? Similarly, is a physician who works at an OMH program prohibited from prescribing a chemical dependency-related medication?

A: Not by either OMH or OASAS regulations, as neither set of regulations dictates what physicians can or cannot prescribe. From the perspective of both agencies, NYS licensed physicians can prescribe any medication they believe is necessary for the appropriate treatment of a disorder. .

Q: Can OMH regulations be changed or waived to require OASAS funded CASACs working in OMH certified programs to go through the criminal background check now required by OMH?

A: No. This is not permitted under the law (MHL Section 31.35 and Executive law Section 845-b. There is no legal authority to request, or to have OMH review, the criminal history background of a person who is not seeking employment with a provider that is under OMH’s jurisdiction. Unless the CASAC is going to be directly employed by an OMH certified clinic, this is not permitted under law, regardless of whether or not OASAS (or OMH) consents to it. The simplest solution is to simply have the OMH certified clinic hire a CASAC.

III. INFORMATION SHARING:

Q: We have both an OMH certified clinic and an OASAS certified clinic co-located at the same site. The need to keep assessments, treatment plans and other chart documents separate is a problem that causes unnecessary hardship for staff and clients alike. Is it possible to waive OASAS or OMH regulations so that patient mental health and chemical dependency charts can be stored in one, combined Medical Chart Room, and ideally also in one integrated medical chart?.

A: If appropriate security mechanisms were in place, OMH and OASAS would likely permit storage of charts in a combined chart room. However, one integrated medical chart is more problematic because in doing so, the OMH clinic information would become subject to the confidentiality strictures of federal regulations governing the confidentiality of information created or maintained by federally funded alcohol/substance abuse providers, found at 42 CFR Part 2. Neither OMH nor OASAS has the ability to waive federal regulations. This presents many concerns with respect to the loss of ability to make some disclosures that are currently permissible, and in some cases required, under MHL Section 33.13 and HIPAA. This is one reason why the strategy of providing appropriate integrated treatment in each setting, without trying to link or merge these areas, is advantageous. In general, co-location of treatment better reflects a parallel system structure rather than true integration, which is what OMH and OASAS wish to encourage.

In addition, a co-located program, unlike integrated treatment, must be able to demonstrate to outside auditors, such as CMS, that certain services have been provided in accordance with governing Medicaid regulations. This drives the

need to have this information separately identifiable. Again, integrated treatment within one program would mitigate this problem.

Q: Can a guideline be developed to permit staff of organizations providing both chemical dependency and mental health certified services to share clinical information when clinically indicated? All agencies that run concurrent or co-located OMH and OASAS services should conform to the most stringent privacy regulations (42CFR Part 2). This regulation and/or our interpretation have frustrated efforts to co-locate in order to better integrate assessment and treatment for individuals experiencing co-occurring disorders. Even though the programs are co-located, mental health and chemical dependency staff hesitate to consult with one another and do not look at each other's records. Help is needed to permit staff of organizations providing both chemical dependence and mental health certified services to share clinical information when clinically indicated.

A: Neither OMH nor OASAS have the ability to waive federal regulations (i.e., 42 CFR Part 2). For patients enrolled in both programs, obtaining consent upon admission to the chemical dependency program to permit disclosures by the mental health program would resolve this issue. Providing appropriate integrated treatment in one program or the other, in accordance with a patient's needs, without trying to link or merge these areas, would be another way to remove this perceived barrier.

Requiring OMH clinic information to be used and disclosed in accordance with the strictures of 42 CFR Part 2 presents many concerns with respect to the loss of ability to make some disclosures that are currently permissible under MHL Section 33.13 and HIPAA, and in some cases required (e.g., reporting crimes against patients, that do not necessarily occur on program premises, in accordance with MHL Section 31.11).

Q: Can assessments/evaluations across both OASAS and OMH certified agencies be standardized to allow for one agency to utilize another's already recently conducted assessment/evaluation?

A: Co-located programs have to be able to demonstrate to outside auditors, such as CMS, that certain services have been provided in accordance with governing Medicaid regulations. It is not clear whether use of an assessment or evaluation service prepared and documented by another agency might prove problematic in this respect. In addition, the clinical and liability implications of relying on another program's work would have to be carefully evaluated before selected as a possible solution.

Q: Can permission be obtained to use the same receptionists for chemical dependency and mental health clients in a co-located treatment setting? In our County clinic, currently, chemical dependency and mental health outpatient clinic patients use one waiting room, but must speak to receptionists through different round holes cut into the glass surrounding the receptionists, based on grounds that the OASAS patients' confidentiality might be violated if more than one receptionist were to be involved.

A: OMH does not have "waiting room regulations," although outpatient regulations do require separately identifiable staff. However, using one receptionist would not be considered a regulatory violation, so long as OMH requirements for fingerprinting had been met. From OMH's perspective, if an employee's job description is to register people who show up for care at both facilities and direct

them to their appointment, then that person is providing an administrative function and has a need to know the information. The employee would need to get HIPAA training, and should treat each person who shows up discreetly so as to avoid making direct disclosures and to limit indirect disclosures. OASAS agrees with the OMH perspective as described here, so long as the employee is also provided confidentiality training on 42 CFR Part 2 and prohibition on re-disclosures.

Q: Can regulations be amended to combine Quality Assurance procedures and place a chemical dependency Outpatient Clinic staff person on OMH Quality Assurance Review Teams? When Critical Incidents occur and must be reviewed to determine how to improve care, it would be helpful to have a combined chemical dependency/mental health discussion, especially in those instances when an investigation involves an individual who has been involved with both programs.

A: This seems miscast as a regulatory burden because it does not appear that either OASAS or OMH regulations would necessarily prohibit this action. The strategy of integrating treatment in both an OASAS and OMH clinic location may mitigate the need to have people enrolled in multiple programs. In any event, the ability to consult with a chemical dependency program in the context of an incident review could likely be done without regulatory revision. This could probably be accomplished on a consult basis through execution of some confidentiality agreements (perhaps a Business Associate/Qualified Service Organization Agreement) to facilitate quality assurance. We would recommend that this be done on a case by case basis, and only when the input and particular expertise of the chemical dependency program is directly relevant to the review.

Q: Can regulations be waived or modified to permit a chemical dependency program to notify a mental health program (or vice versa) of medication management services provided a co-enrolled client?

A: Regulations do not necessarily bar the ability to do this. Depending on the circumstances, patient consent could be obtained to permit disclosures. Neither OMH nor OASAS has the ability to waive federal confidentiality laws (42 CFR Part 2 or HIPAA) or MHL Section 33.13. Voluntarily adhering to the most strict standard may impede other critically important program responsibilities (e.g., Jonathan's Law, Kendra's law). Integrated treatment within one program would mitigate this concern.

IV. MEDICAID/BILLING ISSUES:

Q: Can regulations be revised to permit providers to bill more than one Medicaid service on the same day, if this is clinically and fiscally indicated and consistent with the client's treatment plan as currently updated ?

A: A provider of services can only bill for one Medicaid service per day per visit. A patient could receive a service from an MH provider and an OASAS provider on the same day and each provider could bill Medicaid for the service they provided to the patient. If a provider has both an OMH operating certificate and an OASAS operating certificate, current regulations would not prevent the provider from submitting a bill for both an OASAS service and an OMH service on the same day, provided that all service requisites were met to justify each bill. Again, however, dual enrollment is not a prerequisite for effectively providing necessary services to individuals with co-occurring disorders, and would not be

necessary if the integrated treatment approach that is currently sought were utilized. Nevertheless, this is not a significant barrier since dual enrollment and same day billing are possible, though attending two programs is often difficult for individuals with co-occurring disorders

Q: On our inpatient co-occurring disorder unit we can get some insurance coverage for patients if they come in with severe mental illness and substance use disorder and then they receive detoxification services. But if they come through with a primary need for detoxification third party insurance will not cover it because we are a psychiatric unit not a SUD rehabilitation unit. Can regulations be amended so that insurance will cover either, regardless of licensing?

A: Changes in insurance coverage are outside the bounds of OASAS and OMH regulatory control, and is not a barrier to facilitating integrated treatment – on an inpatient unit as well as in an outpatient setting (which is the focus of the COD initiative). The strategy under consideration would address the issue of integrated treatment, regardless of “which door” the patient entered. From OMH’s perspective, OMH certified psychiatric units are not primary detoxification facilities. The psychiatric units may provide detoxification as a necessary service to someone in need of, and admitted for inpatient mental health care under Article 9 of the Mental Hygiene Law. However, the necessity for admission must meet Article 9 admission criteria. Similarly, someone admitted to a facility subject to Articles 22 and 32 of the Mental Hygiene Law could also receive services to treat a co-occurring mental illness as necessary. However, what insurance companies will contract to pay for is a separate issue not within either agency’s control.

V. PHYSICAL PLANT ISSUES:

Q: OASAS regulations at Part 822 contain a separate space requirement for a dual clinic. Can these regulations be modified? We have been told that offices, bathrooms, and even bulletin boards need to be separate (OMH/OASAS) which really make things a challenge?

A: OASAS and OMH regulations do not prevent the ability of programs to co-locate. There are current examples of OMH and OASAS certified outpatient programs at a single site. However, each set of regulations has its own physical plant, premises, and other requirements which must be met. If there was a specific project under review, an area to explore would be to permit the waiver of certain physical plant or space requirements in co-located situations, provided certain conditions are met. OMH is in the process of developing a waiver regulation; OASAS already has the ability to issue regulatory waivers. Integrated treatment within one program would mitigate this concern.

In addition, 14 NYCRR Section 814.6 (a)(2) would allow space to be shared as long as all treatment staff have schedules for individual rooms so simultaneous use does not occur.

Q: Can regulations be changed so that clients who are enrolled in an OASAS Intensive Residential Treatment program can also attend an OASAS Outpatient 822 chemical dependency program that offers treatment for co-occurring disorders? Alternatively, more fiscal support needs to be provided to the Intensive Residential Treatment programs so that they can incorporate medication and treatment management for persons with co-occurring disorders.

A: OASAS certifies intensive treatment programs to provide holistic chemical dependence treatment. OASAS has reviewed the request to allow for dual enrollment in an intensive residential treatment program and an 822 outpatient clinic and has issued Local Services Bulletin 2007-04 prohibiting dual enrollment. However, OASAS' Part 819 regulations for Intensive Residential Services require the residential provider to have agreements with other providers of services to meet residents' needs. Therefore, the provider may manage the co-occurring disorder (assuming appropriate staffing) or coordinate care with an outpatient mental health provider.



Memo of Agreement

OHM & OASAS Guidance Document

*Memorandum of Agreement between
the Office of Mental Health & the Office of
Alcoholism & Substance Abuse Services
(OMH & OASAS) re Co-occurring Disorders*

31 July 2008

**from OMH Commissioner Michael Hogan &
OASAS Commissioner Karen Carpenter-Palumbo**

New York State Office of Mental Health (OMH)
<http://www.omh.state.ny.us/omhweb/resources/providers/co%5Foccurring/adult%5Fservices/screening.html#mms>

New York State Office of Alcoholism & Substance Abuse Services (OASAS)— Combined documents
<http://www.oasas.state.ny.us/pio/collaborate/documents/co-occurring.pdf>



NEW YORK STATE

**OFFICE OF ALCOHOLISM
AND SUBSTANCE ABUSE SERVICES**
1450 Western Avenue, Albany, New York 12203-3562
Karen M. Carpenter-Palumbo, Commissioner

OFFICE OF MENTAL HEALTH
44 Holland Avenue, Albany, New York 12229
Michael F. Hogan, Ph.D., Commissioner

MEMORANDUM OF AGREEMENT

-BETWEEN-

THE OFFICE OF MENTAL HEALTH

-AND-

THE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES

THIS AGREEMENT is entered into the **31** day of **JULY, 2008**, by and between the New York State Office of Mental Health (OMH) and the New York State Office of Alcoholism and Substance Abuse Services (OASAS).

WHEREAS, in any given year, 5.6 million adults in the nation have a co-occurring mental illness and substance use disorder (National Survey on Drug Use and Health, 2006); and

WHEREAS, New Yorkers with co-occurring mental health and substance use disorders will benefit from more integrated treatment;

WHEREAS, in many instances, a co-occurring disorder can be treated at either an OMH or OASAS certified site, provided that the individual is otherwise able to participate in treatment at such site; and

WHEREAS, OMH and OASAS are autonomous Offices within the Department of Mental Hygiene; and

WHEREAS, in accordance with Mental Hygiene Law Section 7.07, OMH is charged with the responsibility for assuring the development of comprehensive plans, programs, and services in the areas of research, prevention, and care, treatment, rehabilitation, education, and training of persons with mental illness, and shall cooperate with the other Offices of the Department of Mental Hygiene in the development of such plans, programs, and services; and

WHEREAS, in accordance with Mental Hygiene Law Section 19.07, OASAS is charged with the responsibility for assuring the development of comprehensive plans, programs, and services in the areas of research, prevention, care, treatment, rehabilitation, education, and training of persons who abuse or are dependent on alcohol and/or substances and their families, and shall cooperate with the other Offices of the Department of Mental Hygiene in the development of such plans, programs, and services; and

WHEREAS, in accordance with Mental Hygiene law Section 31.02, no provider of services shall engage in the provision of outpatient services for persons with mental illness without having been issued an operating certificate from OMH; and

WHEREAS, in accordance with Mental Hygiene law Section 32.05, no provider of services shall engage in the provision of outpatient services for persons with chemical dependence without having been issued an operating certificate from OASAS; and

NOW, THEREFORE, the parties hereto hereby agree as follows:

I. Interpretation of Statutory Authority:

1. OMH and OASAS agree that the New York State Mental Hygiene Law and implementing regulations at 14 NYCRR Chapter XIII do not prohibit a provider certified by OMH to provide mental health services from admitting an individual who also has a co-occurring substance use disorder, provided, however, that the individual must meet the admission criteria of the mental health program and is able to participate in the program. OMH and OASAS further agree that if a mental health provider admits an individual under these circumstances, the provider is not providing services that require an operating certificate from OASAS. In this respect, OMH and OASAS agree that the person's co-occurring substance use disorder is being managed in the course of the provision of mental health services.
2. OMH and OASAS agree that the New York State Mental Hygiene Law and implementing regulations at 14 NYCRR Chapter XXI do not prohibit an outpatient provider certified by OASAS to provide chemical dependence services from admitting an individual who also has a co-occurring mental illness, provided, however, that the individual must meet the admission criteria of the outpatient chemical dependence program and is able to participate in the program. OMH and OASAS further agree that if an outpatient chemical dependence provider admits an individual under these circumstances, the provider is not providing services that require an operating certificate from OMH. In this respect, OMH and OASAS agree that the person's co-occurring mental illness is being managed in the course of the provision of outpatient chemical dependence services.
3. OMH and OASAS agree to work together and collaborate to facilitate the provision of an integrated treatment model in which traditional chemical dependence and mental health programs seek to manage the multiple symptoms of their presenting patients by incorporating techniques of mental health or addiction screening, assessment, and counseling into their own spectrum of services. However, the primary clinical focus of the program shall remain on the principal diagnosis that was necessary for admission to the program. In this way, each type of program (chemical dependence or mental health) can work within its current certification structure and is not required to seek licensure from the other governing State agency (OASAS or OMH).

II. Identification and Provision of Integrated Treatment Services:

4. OMH and OASAS agree that co-occurring disorders can be revealed in the course of screening and assessment at either an OMH or OASAS certified site.
5. The identification of a diagnosis or functional characteristics of a co-occurring chemical dependence or mental health disorder shall be made utilizing Screening Instruments and Assessment tools that have been approved by both OMH and OASAS.

6. For the purposes of this Agreement, integrated treatment services shall mean OMH and OASAS-defined services for individuals with co-occurring mental health and substance use disorders that are supported by evidence-based practices.
7. OMH and OASAS agree that the diagnosis and treatment of a co-occurring mental health or chemical dependence disorder shall be delivered by staff that are qualified to do so, in accordance with the standards of the Department of Mental Hygiene agency that has jurisdiction of the program. OMH and OASAS further agree that they will consult with each other, as appropriate, to ensure such standards are functionally consistent.

III. Billing for the Provision of Integrated Treatment Services:

8. For purposes of this Agreement, integrated treatment services shall be considered core services included within the mental health program or the outpatient chemical dependence program, as applicable.
9. Nothing in this Agreement shall be deemed to prevent an individual from receiving services from more than one provider of mental health or chemical dependence services, provided, however, that providers of co-occurring disorders services remain responsible for effective treatment planning in accordance with applicable governing regulations.

IV. Roles and Responsibilities:

10. OMH and OASAS agree to collect and share data with respect to the provision of integrated treatment services under this Agreement, in a manner agreed to by both agencies.
11. OMH and OASAS each commit to continuing to work with one another, for the duration of this Agreement, to identify and address limitations and barriers that people with co-occurring mental and chemical dependence disorders, and their families, experience when seeking care in the OMH and OASAS service systems in New York State.

V. Term and Termination:

12. This Agreement shall take effect immediately upon signature by both parties, and shall remain in effect unless terminated by either party.
13. Each party shall have the right to terminate this Agreement upon thirty (30) days written notice to the other party.
14. This Agreement may be modified or amended upon the mutual written consent of both parties.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be signed as of the date first set forth above.



Date: **July 31, 2008**

Michael F. Hogan, Ph.D.
Commissioner
New York State Office of Mental Health



Date: **July 31, 2008**

Karen M. Carpenter-Palumbo
Commissioner
New York State Office of Alcoholism and Substance Abuse Services