NYSHealth
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in Integrated Care

Screening

OMH &OASAS Guidance

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Commissioners' Letters

to Directors of OHM- & OASAS-Licensed Clinics

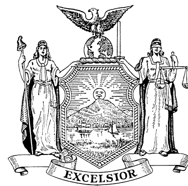
Improving Services for Adults with Co-occurring Mental Health & Substance Use Conditions

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.

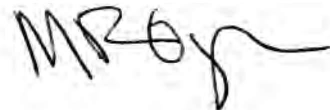
We also want to recognize and express our great appreciation to the **New York State Health Foundation** for its generous commitment of $5 million over the next four years to establish a **COD Integrated Treatment Center of Excellence**. The Foundation anticipates selecting an awardee to establish and 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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Michael F. Hogan, Ph.D., Commissioner

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

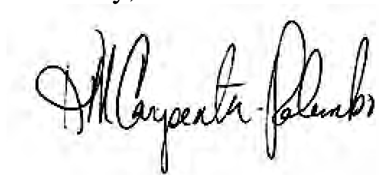
In support of the operational flexibility that is intended by the single certification approach and clarified by the FAQ document, OASAS and OMH have signed a Memorandum of Agreement (MOA). For your information, a copy of the MOA is included in this package.

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

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
http://www.o http://www.oasas.state.ny.us/pio/collaborate/documents/co-occurring.pdf

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 through 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 Screen[1] (MMS)	Most Highly	22 Yes-No items that screen for anxiety and mood disorders, trauma exposure and PTSD, and non-affective psychoses	• 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 III[2] (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	• 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.	• 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	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. No information on how to identify less severe conditions or in clinical samples. Spanish version is for use in Spain.

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 Abuse[1] (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.	• 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 Drugs[2] (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.	• 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	Performance data is mixed for people with severe mental illness. No data is available for Hispanic women.

	RATED	DESCRIPTION	PROS	CONS
Alcohol, Smoking, and Substance Involvement Screening Test[3] (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.	• 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	Total number of screening questions is high. In a detailed WHO report, there is no mention of its utility for people with mental illness or performance by gender or ethnicity. Not available in Spanish

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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).