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Brian J. Wing
Commissioner

INFORMATIONAL LETTER

TRANSMITTAL: 97 INF-16

TO: Commissioners of
Social Services

DIVISION: Temporary
Assistance

DATE: November 13, 1997

SUBJECT: Model Drug and/or Alcohol Assessment Form for Public
Assistance

SUGGESTED

DISTRIBUTION: Income Maintenance Directors
Food Stamp Directors
Medical Assistance Directors
CAP Coordinators
Services Coordinators
Employment Coordinators
Director of Administrative Services Coordinators
Staff Development Coordinators

CONTACT PERSON: Region I (518-473-0332); Region II (518-474-9344);
Region III (518-474-9307); Region IV (518-474-9300);
Region V (518-473-1469); Region VI (212-383-1658)

ATTACHMENTS: "Pre-Treatment Drug and/or Alcohol Assessment Form
for Public Assistance Applicants and Recipients"
(Attachment not available on-line.)

FILING REFERENCES

Previous ADMs/INFs	Releases Cancelled	Dept. Regs.	Soc. Serv. Law & Other Legal Ref.	Manual Ref.	Misc. Ref.
97 ADM-23		351.2(i)			

The purpose of this Informational Letter is to transmit a model "Pre-Treatment Drug and/or Alcohol Assessment Form" which districts may use to conduct the mandated Drug and/or Alcohol assessments of certain public assistance applicants and recipients.

The requirements for drug and/or alcohol abuse screening, assessment and treatment were recently transmitted to you as part of 97 ADM-23 "Public Assistance (Family Assistance/Safety Net Assistance) Changes Resulting from The Welfare Reform Act of 1997". Additionally, Regional Meetings were conducted to provide information for implementation of the new requirements of the Welfare Reform Act, including the requirements for the new drug and/or alcohol provisions.

Basically this information provides that all heads of households and adult household members applying for or in receipt of public assistance must be screened for potential drug and/or alcohol problems using the DSS-4571: "Alcohol/Substance Abuse Screening Instrument". When the screening instrument is completed with two or more "yes" responses, the district otherwise identifies potential drug and/or alcohol problems, or an individual was exempt from screening because they were actively participating in a treatment program, the local district must conduct a drug and alcohol assessment of the individual. The assessment must be conducted by a Drug and Alcohol Counselor credentialed by the Office of Alcohol and Substance Abuse Services (OASAS). The credentialed counselors must be employed by the district or under contract by the district. The purpose of the assessment is to:

1. determine if there is a current drug and/or alcohol problem;
2. determine if the person has a drug and or alcohol problem which results in the person's inability to work; and
3. determine for those unable to work due to drug and/or alcohol problems, the recommended level of treatment.

Neither the Welfare Reform Act, Department regulations, nor 97 ADM-23 mandate that a specific form be used to conduct the assessment. However, in response to district recommendations that a model assessment form be developed to assist the credentialed counselors in completing the assessment, and in recognition of the benefits of a form that would facilitate uniform assessments statewide, we are providing the attached model "Pre-Treatment Assessment Form". This form was developed by OASAS, and we strongly recommend its use. Districts who opt to use the model form must reproduce it locally.



Patricia A. Stevens
Deputy Commissioner
Division of Temporary Assistance

**PRE-TREATMENT ASSESSMENT FORM
FOR PUBLIC ASSISTANCE APPLICANTS AND RECIPIENTS**

INTRODUCTION

INSTRUCTIONS:

Explain to the person who has been sent for this *Assessment* that he/she was referred to you because he/she either: 1.) Answered two or more questions positively on the *Alcohol/Substance Abuse Verbal Screening Instrument*; or 2.) informed District staff that he/she is enrolled in an alcohol/substance abuse treatment program; or 3.) otherwise was identified as having a potential alcohol/substance abuse problem.

The **purpose** of this *Assessment* interview is:

- 1.) To determine if there is a current alcohol/substance abuse problem;
- 2.) To determine if the person has an alcohol and/or substance abuse problem which results in the person's inability to work.
- 3.) To determine for those unable to work due to alcohol and/or substance abuse problems, the recommended level of treatment.

The person must then be informed that:

- 1.) **If** a recommendation is made that the alcohol/substance abuse treatment should occur prior to Work Experience, then his/her participation in such treatment will be a **requirement** for receiving Public Assistance;
- 2.) **If** a recommendation is made that he/she be referred for Work Experience, and the person subsequently fails to comply with the work requirements because of an alcohol/substance problem, he/she will be sent back for another *Assessment*, and may then be required to participate in alcohol/substance abuse treatment.

CASE NAME	CASE NUMBER	OFFICE NUMBER
UNIT NUMBER	WORKER NUMBER	UNIT OR WORKER NUMBER

**PRE-TREATMENT ASSESSMENT FORM
FOR PUBLIC ASSISTANCE APPLICANTS AND RECIPIENTS**

● ***Job-related Functioning***

1. Are you presently employed, or have you been employed in the last 12 months?
Yes _____ No _____

If *Yes*, for each job that you have held:

Describe the type of job _____

How many hours/week? _____ How long did you have the job? _____

Did you have any trouble on this job related to: (CHECK ALL THAT APPLY)

absences lateness co-workers supervisors others

understanding instructions completing tasks on time

meeting quality requirements of the "product" or service

Double check ✓✓ if drinking/drugging caused any of the above "troubles."

Did you lose the job because of your drinking/drugging? Yes _____ No _____

2. Have you been in a job-training program in the last 12 months? Yes _____ No _____

If *Yes*, for each program that you attended:

Describe the type of program: _____

How many hours/week? _____ How long was the program supposed to be? _____

Did you successfully complete the course? Yes _____ No _____

If *No*, how long did you stay? _____

Did you have any trouble in this program related to: (CHECK ALL THAT APPLY)

absences lateness other students teachers/trainers
understanding instructions completing tasks on time passing tests

Double check ✓✓ if drinking/drugging caused any of the above “troubles.”

Did you fail to successfully complete the course because of your drinking/drugging?
Yes _____ No _____

● ***Housing/Living Arrangements***

3. How long have you lived at your present address? _____

If less than 12 months, how many places have you lived in over the last 12 months? _____

For each place you lived, for how long? _____ And, why did you leave? _____

4. For the present address, do you hold the lease? Yes _____ No _____

If *No*, what is your relationship with the person who holds the lease? _____

Are you “doubled-up” in this apartment? Yes _____ No _____

5. Of all the adults who live with you, how many drink or drug? _____

Do you drink or drug with them? Yes _____ No _____

If *Yes*, is this in the apartment or somewhere else? Explain: _____

6. Have you ever been homeless in the past 12 months? (Had to go to a homeless shelter, be placed in a motel by the Welfare Department, stay overnight on the street or in a public place, sleep in a car) Yes _____ No _____

If *Yes*, describe where you stayed and for how long: _____

● **Family/Social Relationships**

7. What people IN your family do you consider close to you? Who cares about you? Who helps you when you are in trouble? _____

If there are such people, how often do you spend time with them; and what do you do together? _____

Do any of the people close to you in your family drink or drug? Yes _____ No _____

If Yes, is this all or most, some, only a few? _____

Have any of the people in your family who are close to you told you to stop drinking or using drugs? Yes _____ No _____

If Yes, do you think any of these people would try to help you stay clean and sober?

8. Who else do you consider close to you? Who cares about you? Who helps you when you are in trouble? _____

If there are such people, how often do you spend time with them, and what do you do together? _____

Do any of your close friends drink or drug? Yes _____ No _____

If Yes, is this all or most, some, only a few? _____

Have any of your friends told you to stop drinking or using drugs? Yes _____ No _____

If Yes, do you think any of these people would try to help you stay clean and sober?

● **Alcohol/Substance Abuse Patterns**

9. In the last 12 months, have you gotten intoxicated or high? Yes _____ No _____

If *Yes*, identify each substance (e.g., alcohol, crack, heroin); how much is typically used; how long is a typical episode; how frequently does this occur? _____

The remaining questions are ONLY for those persons who answered *Yes* to question #9.

10. In the last 12 months, have you ever tried to “cut down” or stop your drinking or drugging? Yes _____ No _____

If *Yes*, were you successful, and for how long were you clean and sober? _____

11. When you have been drinking or drugging, were you ever hospitalized because of something that happened either while you were drinking/drugging, or just before or just after such an episode of getting drunk or high? Yes _____ No _____

If *Yes*, describe what happened you: _____

12. When you have been drinking or drugging, have you ever gotten into fights with other people that resulted in either one or both of you getting seriously hurt?
Yes _____ No _____

If *Yes*, describe what happened to you: _____

13. When you are drinking or drugging, what arrangements do you make for watching your children? (e.g., Do you take them with you? Who stays with them?) _____

14. When you have been drinking or drugging, have you ever experienced severe withdrawal symptoms (e.g., hallucinations, seizures) or acute intoxication (e.g., drug overdose)?

If *Yes*, describe what happened to you: _____

15. In the last 2 years, did you ever go to alcohol/substance abuse treatment?
Yes _____ No _____

If *Yes*, describe what type of program, what happened to you there (including how long you stayed involved, and whether you are still participating in that program): _____

For those persons who are still enrolled in a treatment program, identify the name and address of the program and the telephone number of the staff person to contact through the Patient Informed Consent for Disclosure of Confidential Information process:

● ***Medical/Psychiatric Consequences***

16. In the past 12 months, have you experienced any kind of physical health or psychiatric problem that you think happened right before, during, or just after a drinking or drugging episode (e.g., severe breathing problems just after a crack run, or a suicidal gesture or attempt after a long drinking binge)? Yes _____ No _____

If *Yes*, describe what happened to you: _____

If *Yes* to psychiatric problems, describe any mental health treatment you received (what type of program, what happened to you there --- how long you stayed involved, and whether you are still participating in that program): _____

For those persons who are still involved in a mental health treatment program, identify the name and address of the program and the telephone number of the staff person to contact through the Patient Informed Consent for Disclosure of Confidential Information process: _____

17. Do you have any chronic health problems or current medical conditions that you are aware of (e.g., diabetes, pregnancy)? Yes _____ No _____

If Yes, describe: _____

Do you have any chronic psychiatric problems that you are aware of?
Yes _____ No _____

If Yes, describe: _____

● **Legal Consequences**

18. In the last 12 months, have you had any convictions resulting from your drinking or drugging? Yes _____ No _____

If Yes, describe the type of conviction (felony, misdemeanor) and what happened:

● **Community Consequences**

19. In the last 12 months, have you been actively involved in any community-based organizations or groups, such as a tenants' group, the PTA at your child's school, or a church group? Yes _____ No _____

If Yes, describe the group or organization and the kinds of activities you participate in:

20. Do you consider yourself part of a neighborhood or community --- where you grew up, where you live now --- in which you have ongoing relationships with people who are not involved in drinking or drugging behavior? Yes _____ No _____

● *Is there anything else you think is important for me to know about your situation?*

● *Direct Observation of Client's Appearance and Behavior:*

● *Additional Comments by Person Doing the Assessment :*

RATING FORM

ASSESSMENT DOMAINS: In the last 12 months...

[Check the appropriate box for each Domain]

HIGHLY EFFECTIVE LEVEL OF DAILY FUNCTIONING

● *Job-related Functioning:*

Successfully employed for at least 3 months

● *Housing/Living Arrangements:*

Lives independently with no major problems; holds lease; has been there at least 6 months

● *Family/Social Relationships:*

Most or all of close family and friends are not alcohol/drug-involved, and are actively supportive of client being clean and sober

● *Alcohol/Substance Abuse*

Patterns: No pattern of ongoing abuse; no incidents of use that place the person in danger (i.e., driving care)

● *Medical/Psychiatric*

Consequences: No indications of problems

● *Legal Consequences:*

No history of problems

● *Community Consequences:*

Person is positively involved in community organizations or groups (i.e., PTA, church)

MODERATELY EFFECTIVE LEVEL OF DAILY FUNCTIONING:

Employed but with problems

Lives with another adult who holds lease, and that adult does not drink or drug

Some are positive, but others have negative view of sobriety

Patterns of abuse are episodic; history of successful attempts to "cut down" or abstain for at least three months

Single major episode (i.e., hurt in accident)

One or two non-felony convictions

Some positive sense of community, but not real participation

SEVERELY IMPAIRED LEVEL:

Fired due to problems; not employed at all

Lives with other adults who drink or drug; has had no stable residence ("doubled-up"); has been homeless in last 12 months

Most or all are actively abusing and have negative view of sobriety

Pattern of abuse is most days, most weeks; significant amount of time is spent getting money, buying, using; history of unsuccessful attempts to "cut down;" history of prior treatment failures; history of difficult withdrawal experiences

Multiple episodes (i.e., several suicide attempts before, during, or after use)

One or more felony convictions; three or more non-felony convictions

Person is only involved with others who drink or drug

FINAL RECOMMENDATION

Instructions:

If at least four of the Assessment Domains are rated Highly Effective, and none are rated Severely Impaired, then the applicant/recipient should be referred on to Work Experience activities with no recommendation for alcohol/substance abuse treatment.

If at least four of the Assessment Domains are rated Moderately Effective, and no more than one is rated Severely Impaired --- unless the Domain rated Severely Impaired is the Alcohol/Substance Abuse Patterns domain --- then the applicant/recipient should be referred on to Work Experience with the recommendation for concurrent outpatient alcohol/substance abuse treatment of such a frequency and intensity as to be reasonable for the individual to accommodate both Workfare and treatment into a weekly schedule of activities.

If the Alcohol/Substance Abuse Patterns domain, and at least one other domain, are rated Severely Impaired, then the applicant/recipient should be referred to an OASAS-licensed treatment program for full evaluation, with the recommendation that the individual be mandated into intensive outpatient treatment or residential treatment prior to her/his participation in Workfare. Choose between intensive outpatient or residential treatment according to the following:

If the individual being referred for full evaluation has a previous history of failure in intensive outpatient treatment or residential treatment, that person should be referred to a residential treatment program, unless the person's opiate addiction history and prior treatment history indicates referral to a methadone treatment program.

If the individual being referred for full evaluation has a history of no successful period of sobriety and has no family/social/community positive supports for sobriety, that person should also be referred to residential treatment.

Recommendation:

- | | |
|---|--|
| <input type="checkbox"/> Client failed to cooperate with assessment | <input type="checkbox"/> No alcohol/substance abuse indicated |
| <input type="checkbox"/> Alcohol/substance abuse indicated but <u>able</u> to work | <input type="checkbox"/> Alcohol/substance abuse indicated, unable to work - recommend outpatient |
| <input type="checkbox"/> Alcohol/substance abuse indicated, unable to work - recommend residential | <input type="checkbox"/> Mental illness may be primary reason unable to work - further assessment needed |
| <input type="checkbox"/> Health problem/medical condition may be primary reason unable to work - further assessment needed. | |

Name of CASAC: _____

Signature _____ Date _____

DETOXIFICATION AND INPATIENT REHABILITATION CARE CONSIDERATIONS

INSTRUCTIONS:

During the course of this Assessment interview, it is possible that some clients may demonstrate the need for referral for evaluation for detoxification and/or inpatient rehabilitation services. In those cases, such treatment services would be necessary prior to the client beginning his/her participation in long-term residential or intensive outpatient treatment.

For *Detoxification Services* 1) IF your direct observation of the client's appearance and behavior indicates withdrawal symptoms during the interview; 2) OR the client's self-report of his/her current alcohol/substance usage patterns indicate the potential for the onset of withdrawal symptoms upon abrupt cessation of usage (e.g., hallucinations, seizures); 3) OR the client's self report of chronic health problems or medical conditions which in combination with abrupt cessation of usage would put the client at risk; make the referral for Evaluation for admission to that service.

For *Inpatient Rehabilitation Services*: 1) IF the client's self-report indicates a history of inability to achieve and maintain abstinence for at least three months while living independently in the community and attending outpatient services; AND 2) the client's self-report indicates co-existing health problems or medical conditions or psychiatric problems which would place that person at risk and therefore requires medical/psychiatric management in a twenty-four hour supervised environment; make the referral for Evaluation for admission to that level of care.

RECOMMENDATION:

- Referral for Evaluation for Detoxification
- Referral for Evaluation for Inpatient Rehabilitation

Name of CASAC: _____

Signature: _____ Date: _____