

**OASAS Report on the Utilization of Personnel Subject to the
Provisions of Chapter 132 of the Laws of 2010**

Consistent with the provisions of Chapter 132 of the Laws of 2010, the New York State Office of Alcoholism and Substance Abuse Services (OASAS) has been tasked with the responsibility of analyzing the composition of its workforce and the nature of work it performs to determine the projected impact of the sunset of the exemption from social work, psychology and mental health licensure which has been in place since 2002. Specifically, Chapter 132 directs OASAS to submit a report to the Commissioner of Education on the utilization of personnel which includes: (1) identification of tasks and activities performed by personnel that may be restricted to licensed personnel and those that do not require a license; (2) analysis of costs associated with employing only appropriately licensed personnel; and (3) an action plan which details measures to comply with professional licensure laws by July 1, 2013.

As OASAS proceeds to implement its plan for the future delivery of professional services, it is important to call attention to what it perceives is an unintended consequence of the passage of Chapters 130 and 132 of the Laws of 2010. That is, in removing the exemption that has existed in the multiple systems that are currently regulated and monitored by seven New York State agencies, this Legislation creates the potential for overlapping and redundant oversight of services funded, regulated or licensed by New York State agencies; sets into motion expectations and personnel standards that will dramatically increase the cost of publicly-funded services; and superimpose an “independent practice” model into systems that have been built around the multidisciplinary team approach without assessing the impact or effectiveness on service outcomes. Understanding its obligations under Chapters 130 and 132, OASAS believes it is important to articulate these concerns, particularly given the current movement in New York State to eliminate duplication and provide for operational improvements that serve taxpayers at the lowest possible cost.

The report that follows outlines what OASAS believes are the broad parameters of the challenge that Chapter 132 of the Laws of 2010 presents to its system and identifies a reasonable strategy for proceeding. As more accurate and complete information relative to the composition, qualifications and cost of the direct care workforce becomes available, OASAS requests that it have an opportunity to modify its projections and refine its action plan to ensure that the transition to compliance with professional licensure laws may occur without substantially increased cost to the State of New York and disruption in the services available for persons/families with substance use or compulsive gambling-related disorders.

Introduction and Overview

Under its authorization in Section 19.07 of the New York State Mental Hygiene Law, the NYS Office of Alcoholism and Substance Services (OASAS) plans, develops and regulates the state's system of chemical dependence and gambling treatment agencies. This includes the direct operation of 12 Addiction Treatment Centers, which provide inpatient rehabilitation services to 10,000 persons per year. In addition, the Office certifies, funds, and supervises some 1,550 local, community-based programs which serve about 110,000 persons on any given day in a wide range of comprehensive services. The agency, in collaboration with local governmental units, also routinely inspects and monitors these programs to guarantee quality care and ensure compliance with state and national standards.

OASAS estimates that one in seven state residents (2.5 million) suffer from a substance use disorder (SUD) or problem gambling. The agency estimates that 11 percent, or 1.8 million, state residents age 12 and older (including 160,000 adolescents ages 12-17) experience a SUD (substance dependence or abuse) annually. Problem gambling, which has been included in OASAS efforts since 2005, is estimated to affect five percent of all adults, over 600,000 individuals. Among adolescents, problem gambling affects 160,000, or one out of every ten youths (an additional 160,000 are at risk of developing problem gambling). Approximately 25 percent of the 160,000 adolescents affected by problem gambling also experience a substance use disorder. These figures do not fully depict the widespread impact of addiction in New York because of the millions of other individuals whose lives are also affected: children, spouses, and extended families. The cost to society is compounded by the consequences of addiction, which affect public safety, health, welfare, and education throughout the state.

The workforce that supports and manages the statewide system of addiction services is comprised of approximately 20,000 paid and volunteer addiction professionals who work in a variety of settings, including inpatient, outpatient and residential. In addition to its program monitoring role, the Office also provides education and training for persons dealing with clients; and administers a professional credentialing process for more than 7,500 addiction professionals, including alcoholism and substance abuse counselors, prevention professionals and prevention specialists, and problem gambling counselors.

Multi-Disciplinary Team Approach

The foundation of professional services that are provided in OASAS certified programs is largely based on the concept of the multi-disciplinary team. Unlike the service model that is used by licensed independent practitioners, the multi-disciplinary team involves the collective expertise

of multiple licensed, certified and credentialed professionals who have demonstrated expertise specifically in addiction-related disorders. The multi-disciplinary team typically consists of: licensed social workers; physicians, registered nurses; credentialed counselors (i.e., CASACs); family & marriage therapists; certified rehabilitation counselors; and licensed mental health counselors. A multi-disciplinary team oversees all cases and approves treatment plans for all patients receiving treatment. The broader multi-disciplinary mix of experienced professionals provides an assurance of quality treatment that exceeds the capability of any single Qualified Health Professional and offers a richer blend of expertise and services, assuring that patient needs are met and their overall health and safety is protected.

OASAS Clinical Care Workforce

The workforce that provides clinical care in the OASAS service delivery system consists of a wide array of professionals with licenses, certifications, credentials and/or specialized training in addiction-specific areas that establishes their clinical competency. These professionals provide a range of chemical dependence services within the context of a clinical supervisory structure that includes: screening; intake; orientation; assessment, evaluation and intervention; referral; treatment planning; counseling (i.e., individual, group and family); crisis intervention; patient education; case management; reporting & recordkeeping; and consultation with other professionals.

Within this range of chemical dependence services, functions that will be restricted to licensed professionals are likely to appear. These include: assessment; psychotherapy; diagnosis; treatment planning and treatment (other than psychotherapy). Depending on the program setting and composition of direct care staff, the restricted functions may be performed only by Qualified Health Professionals or by a combination of Qualified Health Professionals and Non-Licensed Direct Care Staff. Qualified Health Professionals include: CASACs, licensed social workers; occupational therapists; physicians; physician's assistants; registered nurses; licensed psychologists; certified rehabilitation counselors; therapeutic recreation specialists; licensed marriage and family therapists and licensed mental health counselors. Non-licensed direct care staff are those clinical staff who have qualifications appropriate to their responsibilities and who have completed specialized training in addiction-related disorders. Non-licensed direct care staff provide clinical services under the supervision of a QHP or otherwise qualified supervisor. OASAS staffing requirements specify that at least 50 percent of all clinical staff in outpatient programs and 25 percent of all clinical staff in residential programs must be QHPs.

By far, the most common professional credential in OASAS' workforce is the CASAC and CASAC Trainee, which together represent more than one-third of the OASAS clinical workforce. The

most common licensed/certified professions in the OASAS workforce (in order of frequency) include: social workers, RNs, Certified Rehabilitation Counselors, psychologists and mental health counselors. However, the contributions of the non-licensed direct care staff continue to be an essential ingredient of the staffing pattern in OASAS programs. These staff support the work of other clinical staff, carry out clinical activities that are less complex in nature and perform their functions under the close supervision of appropriately qualified clinical supervisors. Most importantly, non-licensed direct care staff represent a viable candidate pool and training ground for future licensed or credentialed professionals.

Future Plans for Delivery of Professional Services

OASAS oversees what is recognized to be the nation's largest and most diverse addiction prevention and treatment system. To sustain and strengthen this service delivery system, OASAS has outlined strategic goals that it expects to achieve which have been formally adopted as its agency "Dashboard." Included in the Dashboard are several overarching "metrics" which relate to and support OASAS' plans for the delivery of professional services going forward.

These include:

- Strengthen addiction services through a comprehensive, integrated culturally competent system that focuses on individual needs and accessibility.
- Implement increased program oversight and strengthen accountability to ensure culturally competent, quality services.
- Increase cross-systems training to support integrated, culturally competent behavioral health services.
- Increase full knowledge, expertise and retention of a high-performing, diverse staff throughout the field.

As OASAS implements strategies to support these metrics, it will need to do so in the context of Chapters 130 and 132 of the Laws of 2010. With this in mind, OASAS envisions three substantive changes in the delivery of professional services in its system. These include: (1) promulgation of counselor "scopes of practice" in OASAS regulations which authorize "permitted activities" for counselors, based on education level achieved, professional credential or license status, or qualifying work experience; (2) broader acknowledgement of the multi-disciplinary team model which will allow non-licensed personnel to assist in the delivery of services or to recommend treatment options, which might require direct supervision or sign off by licensed practitioners; and (3) statutory amendment to the Education Law to expand the permanent exemption to OASAS credentialed professionals other than the CASAC and CASAC Trainee.

Snapshot of Staffing

After seeking input from OASAS and six other State agencies (that were exempt from the licensure statute), the State Education Department (SED) developed an on-line survey instrument to gather information on those direct care staff who provide services that fall within 5 broad functional areas, including: Assessment/Evaluation; Diagnosis; Assessment-based Treatment Planning; Psychotherapy; and Treatment (other than psychotherapy). The survey, which was administered in March 2011, produced mixed results – in terms of a less-than-optimal response rate, evidence of incomplete or erroneous data, and a sizable number of non-OASAS programs that submitted workforce data into the OASAS program area.

Despite these concerns, OASAS worked with SED to try and filter out nearly 40 survey responses from Office of Mental Health programs that were inadvertently mixed in with the OASAS data report and deleted information about job titles which were clearly not relevant to OASAS programs. OASAS calculated that the resulting number of what it believed to be legitimate responses (225) represented 30.2% of the total potential pool of unique OASAS program services. OASAS then made the assumption that the data received via 225 responses would be representative and proportional to the total pool of 745 unique OASAS program services.

While the survey validated that all five “restricted” services are performed in OASAS programs, it was not designed in a way that could effectively distinguish if the manner in which the services are provided call for the expertise of a licensed professional. Where it is obvious that only licensed professionals may be authorized to complete a diagnosis or perform psychotherapy, it is not so obvious that an assessment, which takes many forms ranging from financial to housing to vocational to nutritional needs constitutes a “restricted” service. More importantly, when these services are provided in the context of a multi-disciplinary team, non-licensed direct care staff who have qualifications appropriate to their responsibilities, function under the supervision of a QHP or licensed professional. This provides assurances that services are closely monitored and that direct care staff perform tasks that are limited to their skill and competency range. On a broader scale, OASAS supports this oversight with its own comprehensive quality assurance program consisting of four primary focuses: (1) program oversight through routine on-site compliance reviews which include review of treatment plans, operating policies and staff qualifications; (2) on-site fiscal reviews which examine provider fiscal compliance and accountability; (3) on-site physical plant inspections to ensure that services are provided in clean and safe settings, in compliance with building codes; and (4) addiction professional oversight, which involves administration of a statewide credentialing program, coordinating a formal complaint process, and conducting investigations into allegations of improper conduct.

Using the SED survey results as a basis for examining which direct care staff perform which tasks/activities associated with the five major functions, OASAS projected the following:

Function	Licensed Professionals	CASACs/CASAC-Ts	Non-Licensed Titles
Assessment	6,467	4,228	2,897
Psychotherapy	4,119	2,357	1,424
Diagnosis	4,444	2,341	1,228
Tx Planning	4,987	3,506	1,874
Treatment	3,904	3,377	2,129
Any 1 of 5 Functions	5,718	3,350	2,329

Several observations may be made:

- CASACs, CASAC Trainees and other non-licensed titles figure much more prominently in the three functional areas of assessment, treatment and treatment planning, but less so in the areas of psychotherapy and diagnosis. OASAS attributes this to the fact that the non-licensed segment of the workforce engages, to a large degree, in specialized substance abuse assessment, treatment and treatment planning – consistent with their authority under the NYS Mental Hygiene Law.
- The number of individuals who perform “Assessment” exceeds the number that perform “Any 1 of 5 Functions.” This underscores concerns about the accuracy of the survey data and suggests that either the assessment figures are overstated or the estimates for those who perform any of the 5 functions are understated.
- Those that fall into the non-licensed category, and who are not credentialed by OASAS are considered “staff-at-risk” in that they may be performing functions that will be restricted in July 2013.
- The numbers reflect the existing multi-disciplinary team model, which calls for a combination of different disciplines (licensed, credentialed, certified, etc.) and sharing of responsibilities in each functional area.
- The much more limited involvement of non-licensed personnel in the areas of psychotherapy and diagnosis support OASAS’ assertion that their contributions are of a more supporting or assistive nature, as opposed to professional judgment.

The proportional breakdown from the survey for licensed and non-licensed direct care workers for all five functions combined resulted in the table on the following page. Please note that those job titles that are considered to be staff-at risk are highlighted in red.

Licensed Professionals	Non-Licensed Staff
29% -- LMSW 26% -- LCSW 16% -- MD 7% -- Creative Arts Therapists 6% -- Interns 5% -- LMHC 5% -- Nurse Practitioners 3% -- Psychologists 2% -- Physician Assistants	59% -- CASAC/CASAC Trainees 14% -- Counselors 8% -- Certified Rehab Counselors 8% -- Case Managers/Workers 6% -- Social Workers 2% -- Prevention Counselors 2% -- Vocational Counselors (Staff-at-Risk – Highlighted in red)

OASAS conducted its own limited study of four representative service providers to supplement its analysis of the impact of the sunset of the licensure exemption. Included in the sample of four were two upstate providers (outpatient and residential services) and two downstate providers (residential and methadone maintenance services). The study produced some interesting data which OASAS believes will serve as a stronger and more accurate indicator of the impact to the provider system.

Provider	Size/Services	Total Clinical Staff	Clinical Staff-at-Risk	Percentage of Clinical Staff-at -Risk
A (Upstate)	Small/Outpatient & Residential	19	7	36.8%
B (Upstate)	Large/Outpatient, Inpatient, Residential	195	21	10.7%
C (Downstate)	Medium/Methadone Maintenance	95	31	32.6%
D (Downstate)	Large/Outpatient & Residential	152	16	10.5%

While only a sample of four, the study shows that in four representative OASAS agencies, a total of 75 clinical staff members are at risk with the sunset of the exemption in July 2013. Compared this to the total number of clinical staff (in all four agencies), one can reasonably project that the staff-at-risk ratio statewide may be approximated at 16.2%.

Costs

While the number of staff affected varies significantly from function to function, the SED survey data suggests that, at a minimum, an estimated 2,330 unlicensed staff in the OASAS system

who perform one or more of the restricted functions will be displaced when the exemption from licensure sunsets in July 2013. The costs associated with this level of displacement could be significant if proper steps are not taken to mitigate the impact. In analyzing the potential cost of this system-wide shift in staffing patterns, OASAS projects that there would be four primary components: (1) salary differential between non-licensed direct care workers and licensed professionals who would need to be hired to replace them; (2) replacement cost -- the cost of recruitment, selection, and training as well as the cost of decreased productivity during the period of staff turnover; (3) cost to provide support to unlicensed personnel to either obtain licensure (LCSW) or become credentialed as a CASAC or CASAC Trainee; and (4) cost to replace existing unlicensed supervisors (who supervise social workers) with LCSWs .

Salary Differential -- To calculate salary differential, OASAS first projected the total number of direct care staff performing any of the five functions listed in the SED Licensure Survey. This figure was then proportionally broken down into specific licenses, credentials, certifications and job titles, based on the distribution in the survey responses from OASAS providers.

Then, applying the average starting salaries generated from the SED Licensure Survey for each job title, OASAS calculated total salary estimates for the non-licensed job titles that are considered to be "at-risk." (Note: CASACs and CASAC Trainees are not considered staff-at-risk because they are permanently exempt from the licensure statute.) These estimates were then compared to the average starting salary generated from the survey for LCSWs (\$47,690) to determine the overall salary differential between non-licensed and licensed personnel. The results of these calculations/ projections are presented below. It is important to keep in mind that the following projections represent only that segment of the OASAS direct care workforce that was identified as providing one or more of the five functions.

Salary Differential Cost Projections
For Staff-at-Risk

<u>Job Title/Function</u>	<u>Estimated #</u>	<u>Average Salary</u>	<u>Total Salary</u>
Counselors	795	26,626	\$21,167,670
Certified Rehab Counselors	454	38,060	17,279,240
Case Managers/Workers	454	26,410	11,990,140
Social Workers	341	35,976	12,267,816
Prevention Counselors	114	37,349	4,257,786
Vocational Counselors	114	38,237	4,359,018
Other	57	33,776	<u>1,925,232</u>
TOTAL			\$73,246,902

Total Staff-at-Risk = 2,330

Starting Average Salary of LCSW = 47,690

Total Salary Cost of 2,330 LCSWs = \$111,117,700

Total Salary Differential = \$37,870,798

Replacement Cost

The U.S. Department of Labor, Bureau of Labor Statistics projects the cost of replacing an existing, experienced staff member with a new hire at one-third of the new hire's annual salary. Replacement costs include the cost of recruitment, selection, and training as well as costs due to decreased productivity during the time positions are vacant and/or new hires are getting oriented to their jobs. Using these Federal guidelines as the basis for determining replacement cost, OASAS projects that the cost of replacing 2,330 staff-at-risk who perform any of the five restricted functions at: \$36,668,841. While substantial, replacement cost can be offset to the extent that existing staff, who are considered to be "at risk," are able to obtain licensure or acquire a CASAC Trainee by July 1, 2013.

Support for Unlicensed Staff to Become Licensed/Credentialed

Since costs of this nature are entirely dependent on individual direct care worker circumstances (academic degree held, years of supervised experience, training completed, ability to pass licensure or credentialing exams, etc.), it is nearly impossible to accurately project the cost of supporting staff in their efforts become licensed or credentialed. However, if one makes some basic assumptions about the current makeup of the OASAS service delivery workforce and the likelihood of their becoming eligible for licensure or credentialing, reasonable "ball park" projections of costs in this area could be made.

In its pilot study of four service providers, OASAS inquired as to the likelihood of unlicensed staff who performed restricted functions becoming licensed or credentialed as CASACs or CASAC Trainees by July 2013. In total, the four participating providers reported 45 (above and beyond the 75 staff who are considered to be "at-risk." If we assume this to be representative of the provider system statewide, this would suggest that 37.5% of all staff-at-risk might, if the resources were made available, qualify to meet the requirements to provide one or more of the restricted services by July 2013.

Assumptions:

- 1) 37.5% of the unlicensed social workers in the OASAS system may qualify for licensure by July 2013.
- 2) Cost of acquiring an LCSW is \$554 (application fee, exam fee and registration fee).

- 3) Academic tuition expenses are not factored in since it is not likely that any unlicensed direct care worker (currently in the OASAS system) who lacks a Masters Degree in Social Work will acquire one and be licensed by July 2013.
- 4) 37.5% of non-credentialed counselors in the OASAS system are likely to complete 350-hour certificate programs to qualify as CASAC Trainees by July 2013.
- 5) Cost of acquiring a CASAC Trainee is \$4,100 (tuition for 350-hour certificate program and application fee).

Cost of Support for Licensure/Credentialing

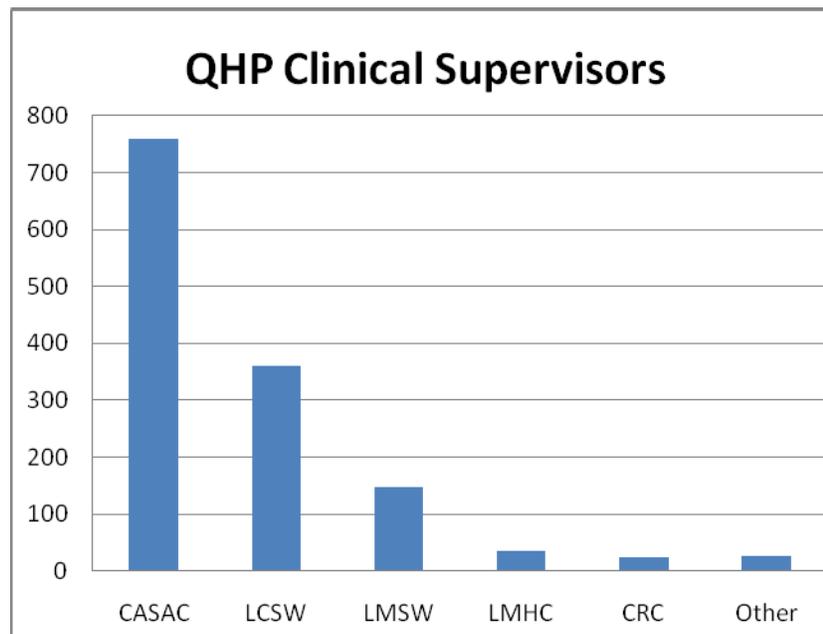
37.5% of Unlicensed Social Workers	128
Cost of Acquiring LCSW Licensure	\$554
Total Cost -- Support for Social Workers	\$70,912
37.5% of Non-Credentialed Counselors	298
Cost of Acquiring CASAC Trainee	\$4,100
Total Cost – Support for Non-Cred Counselors	\$1,221,800
Total Cost – Support for SW & Counselors	\$1,292,712

Displacement of Supervisors

One of the less talked about, but very significant impacts of the sunset of the licensure exemptions in July 2013, will be the displacement of staff who are not LCSWs, but currently have responsibility for supervising clinical work performed by social workers and other licensed professionals. In the OASAS system, there is a substantial number of supervisors who satisfy the OASAS definition of Qualified Health Professional (e.g., LMSWs, CASACs; occupational therapists; physicians; physician’s assistants; registered nurses; licensed psychologists; certified rehabilitation counselors; therapeutic recreation specialists; licensed marriage and family therapists and licensed mental health counselors), but will not qualify as clinical supervisors of social workers once the exemption sunsets.

In 2011, OASAS surveyed the treatment provider community to obtain a clearer understanding of the composition of that segment of the workforce that provides Clinical Supervision. This information was seen as critical, given the substantial system-wide transition that is anticipated with national healthcare reform and the sunset of the Social Work Licensure exemption. The survey produced some useful data for purposes of planning for July 2013.

- The OASAS treatment provider community currently employs a total of 1,164 clinical supervisors, 85 percent (989) of whom are full-time and 15 percent (175) who are part-time.
- Clinical Supervisors in the OASAS system are largely dominated by CASACs, LCSWs and LMSWs.
- Of the total population of clinical supervisors, survey respondents indicated that 90 percent (1,058) were Qualified Health Professionals (QHP) versus 10 percent (106) who were not. The breakdown of clinical supervisor QHP designations, from most common to least, is as follows:



- More than half (54 percent) of the Clinical Supervisors who have a CASAC also have another professional license or designation.
- More than 26 percent of Clinical Supervisors with a CASAC also have a LCSW or LMSW.
- Forty-six (46) percent of Clinical Supervisors are CASACs with no other professional license or designation.
- 128 Clinical Supervisors are LMSWs who are at-risk of losing their positions in July 2013 due to restrictions in their scope of practice relative to clinical supervision.
- 133 are CASACs or CASAC Trainees who are at risk of losing their positions in July 2013 due to limitations in supervising clinical work of licensed professionals.

Projected Costs of Supervisory Displacement:

		CASAC/CASAC Trainee	Total Cost
# Clinical Supervisors Displaced	128	133	
Salary Differential (compared to LCSW) per Supervisor	\$4,700	\$13,557	
Total Salary Differential	\$601,600	\$1,803,081	\$2,404,681
Replacement Cost	\$2,014,427	\$2,093,114	\$4,107,541
Support for Licensure as LCSWs (for 37.5% of affected LMSWs)	\$26,592	N/A	\$26,592
Replacement Cost Offset by Staff Support	(\$755,424)	N/A	(\$755,424)
Total Cost of Supervisory Displacement	\$1,887,195	\$3,896,195	\$5,783,390

Total Projected Statewide Costs Associated with Employing Licensed Personnel:

Cost Component	Projected Cost
Salary Differential – Staff-at Risk	\$37,870,798
Replacement Cost	\$36,668,841
Support for Licensure/Credentialing	\$1,292,712
Replacement Cost Offset by Staff Support	(\$6,704,260)
Displacement of Supervisors	\$5,783,390
Total Cost of Employing Licensed Personnel	\$74,911,481

In total, based on the data derived from the SED Licensure survey, OASAS can reasonably project the cost of employing licensed personnel by July 1, 2013 at an **additional \$75 million**. While this cost projection assumes the data in the survey to be reasonably accurate, it does not take into consideration the toll on the employed personnel who would be displaced by this shift in staffing composition in the OASAS system. As articulated in this narrative, an estimated 2,330 direct care staff and 426 clinical supervisors would likely lose jobs as part of this system-wide change in personnel. The personal costs associated with their termination (unemployment insurance, enrollment in entitlement programs, increases in Medicaid-supported health care, etc.) are not factored into OASAS' projections.

OASAS also believes it important to examine the potential impact at the service provider level. In its pilot study of four service providers, OASAS calculated costs at the agency level using the same factors identified above (staff-at-risk salary differential, replacement cost, cost to support

licensure/credentialing, etc.) to arrive at projections of increased cost and lost personnel. The results of this examination are presented below:

Pilot Sunset Impact Study – Four Providers

	Provider A	Provider B	Provider C	Provider D
Program Type	Small, upstate outpatient & residential	Large, upstate outpatient, inpatient & residential	Medium, downstate, methadone maintenance	Large, downstate, outpatient & residential
Total Clinical Staff/FTEs	19/15.5	195/126	95/95	152/149
Total Staff-at-Risk/FTEs	7/6	21/12.5	31/31	16/15.5
Staff Likely to Obtain CASAC Trainee	2	11	12	20
	\$35,306	\$81,128	\$454,143	\$254,400
	\$94,426	\$243,070	\$582,176	\$265,650
	\$8,000	\$44,000	\$48,000	\$80,000
	\$137,732	\$368,198	\$1,084,319	\$600,050
Total Staff Impact – Lost Jobs	7	12 & 9 per diem	31	16

While the statewide cost figures are substantial, the costs that may be attributed to the agency-level begin to illustrate the organizational impact. Clearly, some organizations are favorably positioned (e.g., Provider B) because they have larger numbers of licensed personnel on staff. Others, such as Provider C, are not and will face significant challenges as they try to prepare for system-wide changes that may threaten their ability to remain fiscally viable. The bottom line

is – costs overall will increase at a time when OASAS and the bulk of its provider system will have limited resources and ability to absorb the increases.

Implementation and Conclusions

As outlined in the preceding pages, the extent of the potential compliance problem for the OASAS service delivery system in July 2013 will be largely determined by the actions that are taken now to clarify those activities that fall within the range of restricted practice and those that may be performed by the collective membership of the multi-disciplinary team. OASAS does not believe it is in the best interest of the State of New York to broadly define restricted practices as that will inevitably lead to long-term disagreement and legal wrangling over what constitutes a restricted practice; not to mention exponentially increasing the costs to the State of New York, and ultimately its taxpayers, to support compliance efforts across multiple human service delivery systems.

Add to this, the widely acknowledged fact that there is not a sufficient supply of licensed personnel in New York State to satisfy the demand, should the exemption be allowed to sunset without more narrowly defining the practices that are considered restricted.

Action Plan

To prepare for the sunset of the exemption in 2013, OASAS believes that a multi-pronged approach is needed to assure that services continue to be provided by appropriately qualified and experienced staff while under the proper supervision of licensed or credentialed professionals. The key elements of this plan are:

- 1) Expanded Exemption to Protect Entry Level Counselors and CASACs -- While CASAC and CASAC Trainees are permanently exempt from the restrictions placed on unlicensed direct care staff, Chapters 130 and 132 of the Laws of 2010 may inadvertently “choke off” the pipeline of entry level counselors who are preparing to become CASACs. To ensure that entry level counselors who pursue a CASAC in New York State will have the ability to earn qualifying work experience as counselors, it will be necessary for OASAS to obtain an expanded exemption. Such an exemption should require sufficient oversight and supervision of services provided by entry level counselors while ensuring that they have “hands on” practical training in the core counseling performance domains.

- 2) Promulgation of Counselor Scopes of Practice -- Building on the model developed by the Federal Substance Abuse and Mental Health Services Administration (SAMHSA) in 2010, OASAS will look to promulgate a Scope of Practice framework for substance abuse counselors who work in its service delivery system. The framework currently under development would authorize “permitted activities” for counselors, based on education level achieved, professional credential or license status, and qualifying work experience. The Scope of Practice framework will be guided by the licensure standards enacted by SED, while incentivizing providers to work with/support unlicensed staff to become credentialed as CASACs or licensed as social workers or mental health practitioners.
- 3) Multi-Disciplinary Team Approach -- OASAS will continue to work with SED to more clearly define the parameters of the multi-disciplinary team model and how it can serve as the solution for the publicly-funded systems to comply with the State’s licensure standards. By allowing unlicensed personnel to work with and assist in the delivery of services and, where appropriate, recommend treatment options, subject to the direct supervision and sign off by licensed practitioners, the multi-disciplinary team offers a proven, cost effective and viable alternative to the traditional private practice model.
- 4) Statutory Amendments to Education Law -- To minimize disruption in the delivery of chemical dependence and compulsive gambling services and provide greater opportunity for the provider agencies in the OASAS system to transition their current staffing to one that is consistent with the provisions of Chapter 132 of the Laws of 2010, OASAS recommends:
 - Expanding the permanent exemption to other OASAS credentialed professionals (e.g., Prevention Professionals, Compulsive Gambling Counselors, etc.)
 - Amending the Education Law to allow other unlicensed OASAS “Qualified Health Professionals” to continue serving as part of the OASAS multi-disciplinary team.
 - Amending the Education Law for temporary grandparenting into existing professions for qualified individuals who meet specified education, experience or credential requirements.

OASAS believes that the combination of these four important steps will provide the necessary assurances of quality care that the State of New York expects to see in its publicly-funded service delivery system, while containing costs and minimizing disruption in essential services. We look forward to working with SED to implement these measures and devising strategies that will serve to complement, rather than duplicate, the oversight systems that are currently in place.