NYSHealth Center for Excellence in Integrated Care

Screening

for Mental Health Disorders in Substance Abuse Treatment Settings

OASAS-licensed outpatient programs

CEIC

NDRI • 71 W 23 Street, 8th Floor • New York, NY 10010
toll free 887.888.6677 • tel 212.845.4400 • fax 212.845.4650
info@nyshealth-ceic.org • http://www.nyshealth-ceic.org

Screening

Table of Contents

Commissioners' Letter July 31, 2008 1

OMH & OASAS Guidance Document 4

Screening Instruments for Substance Abuse Settings 11

Modified Mini Screen (MMS) *12*

MMS Practice Improvement [CAPrI] Series 13

MMS Instrument [English version] 19

[Spanish version] 25

User's Guide 31

Implementation Plan 42

Mental Health Screening Form III (MHSF-III)............... *49*

Guidelines 50

MHSF-III Instrument [English version] 52

Kessler K6 Instrument *56*

K6 Instrument [English version] 57

K6 Performance 59

Screening

Commissioners' Letter to OHM & OASAS Clinics

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

31 July 2008

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

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

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

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).

Screening Instruments

Mental Health Screening Tools

for use in Substance Abuse Outpatient Clinics

Screening Instruments

Mental Health Screening Tools

for use in
Substance Abuse Outpatient Clinics

Modified MINI Screen (MMS)

MMS CAPrI — *The* OASAS *Clinical & Administrative Practice Improvement* [CAPrI] *Series*

MMS *Instrument* — English language version
— Spanish language version

User's Guide

Implementation Plan

Modified MINI Screen (MMS)

MMS CAPrI

The OASAS *Clinical & Administrative Practice Improvement* [CAPrI] *Series*

NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES
1450 WESTERN AVENUE, ALBANY, NY 12203-3526

Volume I, No.1

The OASAS Clinical & Administrative Practice Improvement (CAPrI) Series

(Introductory Note: CAPrI is designed to communicate information to certified providers on effective clinical and administrative practices. At times, a CAPrI bulletin will accompany the release of a Local Services Bulletin (LSB) and provide additional detail and information on the subject of the LSB. On other occasions, OASAS may use CAPrI to distribute information on an evidence-based or best practice, and OASAS projects to promote its adoption.)

The Modified Mini Screen (MMS)
A Validated Mental Health Screening Instrument

I. Description

SAMHSA's Treatment Improvement Protocol (TIP) 42, *Substance Abuse Treatment for Persons with Co-Occurring* Disorders[1], defines screening as "a formal process of testing to determine whether a client warrants further attention at the current time for a particular disorder and, in this context, the possibility of a co-occurring chemical dependence or mental disorder. The screening process for co-occurring disorders seeks to answer a 'yes' or 'no' question: Does the chemical dependence [or mental health] client being screened show signs of a possible mental health [or chemical dependence] problem. Note that the screening process does not necessarily identify what kind of problem the person might have or how serious it might be but determines whether further assessment is warranted. Screening activities may include scores on screening instruments, values from laboratory tests, clinical interviews, and other information offered spontaneously by the client.[2]

The Modified Mini Screen (MMS) is a 22 item scale designed to identify persons in need of an assessment in the domains of Mood Disorders, Anxiety Disorders and Psychotic Disorders. The questions are common to many screening, diagnostic and assessment tools, including the Diagnostic and Statistical Manual IV (DSM-IV)[3], the Structured Clinical Interview for Diagnosis (SCID)[4] and the Mini International Neuropsychiatric Interview (M.I.N.I.)[5].

II. History

In its *Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental* Disorders[6], SAMHSA endorses, "… the growing consensus in the field that all mental health and substance abuse providers must be able to screen, assess and, as needed, provide or refer for treatment to meet the needs of individuals with co-occurring

substance abuse disorders and mental disorders without regard to disease severity, duration or symptomalogy." The National Report substantiates conclusions reached by the OASAS and OMH Joint Taskforce on Co-Occurring Disorders. In its 2001 report, the taskforce recommended that "OMH and OASAS should require screening and follow-up assessments for persons meeting Quadrant IV criteria at all points of entry within the OASAS and OMH systems"[7].

OASAS has recognized a significant practice gap in providers' activities to screen for mental health disorders. In a 2001 survey of mental health screening practices, 73% of the 651 Program Reporting Unit respondents affirmed that their program screened for mental health issues. When asked to identify the screening tool employed, however, 64% could not identify the tool they used. Review of client profiles from the PAS 44 submissions revealed a significant under-identification of persons with co-occurring mental health disorders, when compared with national survey data results. In 1999, only 16.34% of admitted patients to OASAS-certified programs were identified as having a co-existing psychiatric disorder (Question 32c on the PAS 44). Although the number of clients being identified with mental health disorders by OASAS providers has continued to rise since that time (approximately 30% in 2005), the importance of identification as an essential first step in providing care to persons with co-occurring disorders entering the OASAS system of care has not diminished.

III. The Modified Mini Screen Validation Study

To ensure that all clients with co-occurring disorders entering the substance abuse or mental health system would be identified and assessed, the two agencies, as part of the ongoing collaboration between OASAS and OMH, sponsored a validation study of two candidate screening instruments, the Modified Mini Screen (MMS), for use in the OASAS system, and the Dartmouth Assessment of Life Inventory[8] (DALI), for use in the OMH system of care.

The two agencies engaged the Nathan Kline Institute's Center for the Study of Issues in Public Mental Health (NKI) to conduct the study. 17 OASAS sites (2 Addiction Treatment Centers; 2 Methadone Treatment Programs; 3 Therapeutic Communities; 9 Medically Supervised Outpatient Programs; and 1 jail-based medically supervised outpatient program) participated in the validation study. Four sites were located in upstate New York; 4 in Long Island; 3 in Westchester County; and 6 in New York City. Overall, 485 clients were administered the MMS and the validation interview, 338 clients in the 17 OASAS-certified sites and 147 clients in "Quadrant IV" sites (a New York City shelter and a county jail in a New York City suburb). The validation criterion was the presence of a Mood, Anxiety, or Psychotic Disorder based on the Structured Clinical Interview for Diagnosis (SCID), which was administered by experienced SCID interviewers with additional study-specific training.

No screen is completely accurate. The validation study confirmed the value of the MMS as a screening tool for use by OASAS-certified providers. The overall accuracy (i.e., the percentage of "true positives" and "true negatives") of the MMS ranged between .70 and .74, depending on the cut-point employed to define a positive result. The instrument performed equally well among men and women, among African Americans and Hispanics and Whites, and across all modalities, including prison and shelter settings. There is a Spanish version of the MMS as well, though that version was not specifically validated in this study.

The validation study also identified the "trade-offs" involved in selecting particular screen scores or cut points as thresholds for positive screens. As the threshold score or cut point is raised, fewer resources are required to conduct full assessments, however, fewer true cases are

identified. Based on the rate of psychiatric diagnoses found in the NKI study (43%), at cut point 6 (i.e., six positive responses on the 22 item MMS), 58% of those screened would require a further assessment, but the screen would miss 18% of true cases. At a cut point of 9, however, only 37% of those screened would receive further assessment, but 37% of the true cases would have been missed.

The results of the validation study underscore the importance of clinical judgment in making informed decisions about the need for further assessment of particular clients and not relying exclusively on a screen score to determine the decision.

The MMS study validated questions that identify a client's current distress in relation to the following disorders: Major Depressive Episode (2 questions); Dysthymia (1 question); Suicidality (1 question); (Hypo)Manic Episode (2 questions); Panic Disorder (1 question); Agoraphobia (1 question); Social Phobia (1 question); Obsessive-Compulsive Disorder (2 questions); Post-Traumatic Stress Disorder (2 questions); Psychotic Disorder (7 questions); and Generalized Anxiety Disorder (2 questions).

IV. The OASAS Adoption Pilot Study

Before concluding that the MMS is a useful and practical tool for clinicians in OASAS programs, OASAS conducted an implementation pilot study within three programs, two of which had participated in the validation study. An urban MTP, a suburban medically-supervised outpatient program and an upstate rural residential treatment program, which had not participated in the validation study, agreed to implement the MMS among new admissions. Key program staff received on-site training on the MMS. The materials from this training, the User's Guide for the MMS, the Implementation Plan Guidance Document and the MMS instrument are attached to this CAPrI report.

The evaluation of the pilot implementation project in three programs supported the use of the MMS in OASAS-certified programs. All sites viewed the MMS as one component of an assessment process, and recognized that counselors should not use the tool to draw any definitive conclusions about a client's mental health status. The respondents were overwhelmingly positive about the use of the tool, however, and the value of OASAS on-site training and ongoing involvement in the implementation project. Nevertheless, all three programs also placed a high value on the flexibility that allowed them to implement the MMS in a manner consistent with their needs and intake/assessment processes.

OASAS has incorporated the findings from this pilot implementation study into this statewide project to promote the adoption of the MMS.

V. Use of the Modified Mini Screen

It is imperative that a program intending to use the MMS complete a planning process that addresses the multiple clinical and programmatic issues that may arise as a result of regular screening for mental health disorders before introducing the instrument to clinical practice. Most obvious in this list is the determination of a "cut-point" threshold score, which, when achieved, will require that clients receive further assessment. There is a host of other issues, such as when to administer (and readminister) the screen, how to talk with clients about their results, what procedures must be modified or created to ensure that there is appropriate follow-up and how to

record the results and integrate them into the treatment plan. OASAS has intentionally left these determinations to providers, recognizing that each program may have both substantial and subtle differences in their assessment procedures and in the clinical and programmatic resources available to support them. The OASAS "*Provider Implementation Plan*", which is attached, identifies some of the questions that a provider must address **prior to** introducing the screen. OASAS expects that every provider adopting the MMS will complete such a plan, and forward it to their Field Office liaison for review. For New York City providers participating in the Modified Mini Screen Quality Impact Project (QIP), completion of the QIP requirements fulfills this expectation, and thus no Implementation Plan is required of those providers.

As emphasized throughout the MMS Guidance Document (also attached), the screen is not a substitute for the exercise of clinical judgment, and reliance solely on a screening score to indicate that a person might have a mental health disorder, no matter how effective the instrument may have performed in clinical studies, is not an acceptable practice. Programs should guard against such simplistic approaches by integrating the MMS into its clinical supervision and in-service sessions for all staff, and incorporate the screening and assessment processes into its Policy and Procedures Manual.

VI. Contact Information

For more information on the MMS, please contact:

Your OASAS Field Office
Or
Susan Brandau
Performance and Practice Improvement Unit
NYSOASAS
1450 Western Ave.
Albany, NY 12203
(518) 457-6129
susanbrandau@oasas.state.ny.us

References

1. Center for Substance Abuse Treatment. *Substance Abuse Treatment for Persons With Co-Occurring Disorders*. Treatment Improvement Protocol (TIP) Series 42. DHHS Publication No. (SMA) 05-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

2. Center for Substance Abuse Treatment. *Screening Assessment, and Treatment Planning for Persons With Co-Occurring Disorders.* COCE Overview Paper Number 2. Rockville MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services, 2005.

3. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC, American Psychiatric Association, 2000.*

4. Spitzer, R.L., Williams, J.B.W., Gibbon, M. & First, M.B. Structured Clinical Interview for DSM-III-R-Patient Version. New York: New York State Psychiatric Institute, Biometrics Research Department, 1988.

5. Sheehan, D.V., Lecrubier, Y., Sheehan, K.H., Amorim, P., Janavs, J., Weiller, E., Hergueta, T., Baker, R., & Dunbar, G.C. *The mini-international Neuropsychiatric interview (M.I.N.I.): the development and validation of a structured diagnostic psychiatric interview for DSM-1v and ICD-10.* Journal of Clinical Psychiatry, 59 (suppl. 20), 1998.

6. U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration. *Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Health Disorders.* SAMHSA, Rockville, MD., November 2002.

7. New York State Office of Alcoholism & Substance Abuse Services. *Treating Co-Occurring Mental Health and Addictive Disorders in New York State: A Comprehensive View*. NYSOASAS, Albany, NY, 2001.

8. Rosenberg, S.D., Drake, R.E., Wolford, G.L., Mueser, K.T., Oxman, T.E., Vidaver, R.M., Carrieri, K., & Luckoor, R. *The Dartmouth Assessment of Lifestyle Instrument (DALI): A substance use disorder screen for people with severe mental illness*. American Journal of Psychiatry, 155, 232-238, 1998.

Modified MINI Screen (MMS)

MMS *Instrument* — English language version

***

Modified Mini Screen (MMS)

Patient Name ________________________________ OASAS ID ______________

Weeks since admission _____________ Interviewer ________________________

Today's Date _____________ Supervisor Initials (optional) _________________

SECTION A

1. Have you been consistently depressed or down, most of the day, nearly every day, for the past 2 weeks?	YES	NO
2. In the past 2 weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time?	YES	NO
3. Have you felt sad, low or depressed most of the time for the last two years?	YES	NO
4. In the past month, did you think that you would be better off dead or wish you were dead?	YES	NO
5. Have you ever had a period of time when you were feeling up, hyper or so full of energy or full of yourself that you got into trouble or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol.)	YES	NO
6. Have you ever been so irritable, grouchy or annoyed for several days, that you had arguments, verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or overreacted, compared to other people, even when you thought you were right to act this way?	YES	NO
PLEASE TOTAL THE NUMBER OF "YES" RESPONSES TO QUESTIONS 1-6		

SECTION B

7. Note this question is in 2 parts. a. Have you had one or more occasions when you felt intensely anxious, frightened, uncomfortable or uneasy even when most people would not feel that way? YES NO b. If yes, did these intense feelings get to be their worst within 10 minutes? YES NO If the answer to BOTH a and b is YES, code the question YES. If the answer to either or both a and b is NO, code the question NO	YES	NO
8. Do you feel anxious or uneasy in places or situations where you might have the panic-like symptoms we just spoke about? Or do you feel anxious or uneasy in situations where help might not be available or escape might be difficult? Examples include: ❑ Being in a crowd ❑ Standing in a line ❑ Being alone away from home or alone at home ❑ Crossing a bridge ❑ Traveling in a bus, train or car	YES	NO
9. Have you worried excessively or been anxious about several things over the past 6 months? If no to Question 9, answer "no" to Question 10 and proceed to Question 11.	YES	NO
10. Are these worries present most days?	YES	NO
11. In the past month, were you afraid or embarrassed when others were watching you, or when you were the focus of attention? Were you afraid of being humiliated? Examples include: ❑ Speaking in public ❑ Eating in public or with others ❑ Writing while someone watches ❑ Being in social situations	YES	NO
12. In the past month, have you been bothered by thoughts, impulses, or images that you couldn't get rid of that were unwanted, distasteful, inappropriate, intrusive or distressing? Examples include: ❑ Were you afraid that you would act on some impulse that would be really shocking? ❑ Did you worry a lot about being dirty, contaminated or having germs? ❑ Did you worry a lot about contaminating others, or that you would harm someone even though you didn't want to? ❑ Did you have any fears or superstitions that you would be responsible for things going wrong? ❑ Were you obsessed with sexual thoughts, images or impulses? ❑ Did you hoard or collect lots of things? ❑ Did you have religious obsessions?	YES	NO

SECTION B (CONTINUED)

13. In the past month, did you do something repeatedly without being able to resist doing It? Examples include: ❑ Washing or cleaning excessively ❑ Counting or checking things over and over ❑ Repeating, collecting, or arranging things ❑ Other superstitious rituals	YES	NO
14. Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? Examples include: ❑ Serious accidents ❑ Sexual or physical assault ❑ Terrorist attack ❑ Being held hostage ❑ Kidnapping ❑ Fire ❑ Discovering a body ❑ Sudden death of someone close to you ❑ War ❑ Natural disaster	YES	NO
15. Have you re-experienced the awful event in a distressing way in the past month? Examples include: ❑ Dreams ❑ Intense recollections ❑ Flashbacks ❑ Physical reactions	YES	NO
PLEASE TOTAL THE NUMBER OF "YES" RESPONSES TO QUESTIONS 7-15		

SECTION C

16. Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you?	YES	NO
17. Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could actually read someone's mind or hear what another person was thinking?	YES	NO
18. Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self? Or, have you ever felt that you were possessed?	YES	NO
19. Have you ever believed that you were being sent special messages through the TV, radio, or newspaper? Did you believe that someone you did not personally know was particularly interested in you?	YES	NO
20. Have your relatives or friends ever considered any of your beliefs strange or unusual?	YES	NO
21. Have you ever heard things other people couldn't hear, such as voices?	YES	NO
22. Have you ever had visions when you were awake or have you ever seen things other people couldn't see?	YES	NO
PLEASE TOTAL THE NUMBER OF "YES" RESPONSES TO QUESTIONS 16-22	YES	NO

SCORING THE SCREEN

NUMBER OF “YES” RESPONSES FROM SECTION A	
NUMBER OF “YES” RESPONSES FROM SECTION B	
NUMBER OF “YES” RESPONSES FROM SECTION C	
TOTAL NUMBER OF “YES” RESPONSES FROM SECTIONS A, B & C	
YES RESPONSE TO QUESTION #4	
YES RESPONSES TO QUESTIONS #14 AND #15	

Modified MINI Screen (MMS)

MMS *Instrument* — Spanish language version

MODIFIED MINI SCREEN (MMS)

Client Name: ____________________ OASAS ID ______________________________

Weeks since admission _______________ Interviewer _____________________________

Today's Date _______________________ Supervisor Initials (optional) _______________

SECTION A

1. ¿En las últimas dos semanas, se ha sentido deprimido/a o decaído/a la mayor parte del día, casi todos los días?	SI	NO
2. ¿En las últimas dos semanas, ha perdido el interés en la mayoría del las cosas o ha disfrutado menos de las cosas que usualmente le agradaban?	SI	NO
3. ¿En los últimos dos años, se ha sentido triste, desanimado/a o deprimido/a la mayor parte del tiempo?	SI	NO
4. ¿En el ultimo mes ha pensado que estaría mejor muerto/a, o ha deseado estar muerto/a?	SI	NO
5. ¿Alguna vez, ha tenido un período de tiempo en el que se ha sentido exaltado/a, eufórico/a, o tan llena de energía, o seguro de sí mismo/a, que esto le ha ocasionado problemas u otras personas han pensado que usted no estaba en su estado habitual? (No considere períodos en el que estaba intoxicado con drogas o alcohol.)	SI	NO
6. ¿Ha estado usted alguna vez persistentemente irritable por varios días, de tal manera que tenía discusiones, peleaba o gritaba a personas fuera de su familia? ¿Ha usted o los demás, notado que ha estado mas irritable o que reacciona de una manera exagerada, comparada a otras personas, en situaciones que incluso usted creía justificadas?	SI	NO
INTERVIEWER: PLEASE TOTAL THE NUMBER OF "YES" RESPONSES TO QUESTIONS 1-6		

SECTION B

7. Interviewer: Note this question is in 2 parts. a. ¿Alguna vez o más de una vez, se sintió súbitamente ansioso/a, asustado/a, incómodo/a o inquieto/a, incluso cuando la mayoría de la gente no sentiría de esa manera? SÍ NO b. ¿Estos sentimientos intensos llegan a ser su peor dentro de 10 minutos? SÍ NO Interviewer: If the answer to BOTH a and b is YES, code the question YES. If the answer to either or both a and b is NO, code the question NO.	SI	NO
8. ¿Se ha sentido particularmente incómodo/a o ansioso/a en lugares o situaciones donde podria tener un ataque de pánico, o síntomas parecidas a los que acabamos de discutir, o situaciones donde no dispondría de ayuda o escapar pudiera resultar dificil? Como : ❑ el estar en una multitud ❑ el permanecer en fila ❑ el estar sola fuera de casa ❑ el permanecer sola en casa ❑ el cruzar un puente ❑ el viajar en autobús, tren o automóvil	SI	NO
9. ¿Se ha sentido excesivamente preocupado/a o ansioso/a debido a varias cosas en los últimos 6 meses? Interviewer: If NO to question 9, answer NO to question 10 and proceed to question 11.	SI	NO
10. ¿Esas preocupaciones estan presentes la mayoria del los dias?	SI	NO
11. ¿En el mes pasado, tuvo miedo o sintió vergüenza de que la estan observando, de ser el centro de atención o temió una humillación? Incluyendo cosas como: ❑ el hablar en público ❑ comer en público o con otros ❑ el escribir mientras alguien le mira ❑ el estar en situaciones sociales	SI	NO
12. ¿Este último mes, ha estado usted molesta con pensamientos recurrentes, impulsos o imágenes no deseadas, desagradables, inapropiadas, intrusas o angustiosas? Ejemplos: ❑ la idea de estar sucia, contaminada o tener gérmenes o miedo de contaminar a otros ❑ temor de hacerle daño a alguien sin querer ❑ temor que actuaría en funcion de algún impulso ❑ tiene temores o supersticiones de ser la responsable de que las cosas vayan mal ❑ se obsesiona con pensamientos imágenes o impulsos sexuales ❑ acumula o colecciona sin control ❑ tiene obsesiones religiosas	SI	NO

SECTION B (CONTINUED)

13. ¿Durante el mes pasado, volvía hacer algo repetidamente sin poder resistir a hacerlo?	SI	NO
14. ¿Ha vivido o ha sido testigo de un acontecimiento extremadamente traumático, en el cual otras personas han muerto y/o otras personas o usted mismo han estado amenazadas de muerte o en su integridad física? Ejemplos de acontecimientos traumáticos: ❑ Accidentes graves ❑ Atraco ❑ Violación ❑ Atentado terrorista ❑ Ser tomado de rehén ❑ Secuestro ❑ Incendio ❑ Descubrir un cadáver ❑ Muerte súbita de alguien cercano a usted ❑ Guerra ❑ Catástrofe natural.	SI	NO
15. ¿Durante el mes pasado, ha revivido el evento de una manera angustiosa? Ejemplos: ❑ lo ha soñado ❑ ha tenido imágenes vívidas ❑ ha reaccionado físicamente ❑ ha tenido memorias intensas	SI	NO
INTERVIEWER: PLEASE TOTAL THE NUMBER OF "YES" RESPONSES TO QUESTIONS 7-15		

SECTION C

16. ¿Alguna vez, ha tenido la impresión de que alguien le espiaba, o conspiraba contra usted, o que trataban de hacerle daño?	SI	NO
17. ¿Ha tenido usted la impresión de que alguien podia leer o escuchar sus pensamientos, o que usted podía leer o escuchar los pensamientos de otros?	SI	NO
18. ¿Alguna vez ha creido, que alguien o que una fuerza externa haya metido pensamientos ajenos en su mente o le hicieron actuar de una manera no usual en usted? Alguna vez ha tenido la impresión de que está poseido?	SI	NO
19. ¿Alguna vez ha creido que le envian mensajes especiales a través de la radio, el televisor, o el periódico, o que una persona que no conocía personalmente se interesaba particularmente por usted?	SI	NO
20. ¿Consideran sus familiares o amigos que algunas de sus creencias son extrañas o poco usualés?	SI	NO
21. ¿Alguna vez, ha escuchado cosas que otras personas no podian escuchar, como voces?	SI	NO
22. ¿Alguna vez, estando despierto, ha tenido visiones o ha visto cosas que otros no podían ver?	SI	NO
INTERVIEWER: PLEASE TOTAL THE NUMBER OF "YES" RESPONSES TO QUESTIONS 16-22		

SCORING THE SCREEN

NUMBER OF "YES" RESPONSES FROM SECTION A	
NUMBER OF "YES" RESPONSES FROM SECTION B	
NUMBER OF "YES" RESPONSES FROM SECTION C	
TOTAL NUMBER OF "YES" RESPONSES FROM SECTIONS A, B & C	
YES RESPONSE TO QUESTION #4	
YES RESPONSES TO QUESTIONS #14 AND #15	

Modified MINI Screen (MMS)

User's Guide

NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES
1450 WESTERN AVENUE, ALBANY, NY 12203-3526

SCREENING FOR CO-OCCURRING DISORDERS USING THE MODIFIED MINI SCREEN (MMS)

USER'S GUIDE

(Rev. 6/05)

ACKNOWLEDGEMENTS

This user guide was developed by the NYS Practice Improvement Collaborative (PIC) under a grant from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment. It was compiled by PIC Project Director Susan Brandau, in collaboration with the NKI Research team, specifically Mary Jane Alexander and Gary Haugland. We are grateful for suggestions received from pilot trainees that were ultimately incorporated into the document. Some of the content for this manual was adapted from the following sources:

> Summary of the California Board of Corrections Mentally Ill Offender Crime Reduction Grant Project Manager's Meeting presentation conducted by Roger H. Peters, PhD and Richard K. Sherman, MS, October 4, 2001.
>
> The Modified Mini Screen (MMS) is a 22 item scale designed to identify persons in need of an assessment in the domains of Mood Disorders, Anxiety Disorders and Psychotic Disorders. The questions are based on gateway questions and threshold criteria found in the Diagnostic and Statistical Manual IV (DSM-IV)[1], the Structured Clinical Interview for Diagnosis (SCID)[2] and the Mini International Neuropsychiatric Interview (M.I.N.I.)[3].

WHAT ARE CO-OCCURRING DISORDERS?

A person who has alcohol or drug abuse/dependence and emotional/psychiatric problems is said to have co-occurring disorders. To recover fully, treatment is required for both problems.

HOW PREVALENT ARE CO-OCCURRING DISORDERS?

- According to a face-to-face survey of people in randomly sampled households across the U.S., thirty-seven percent of alcohol abusers and fifty-three percent of drug abusers also have at least one mental disorder.
- According to the National Household Survey on Drug Abuse, within the diagnosed mentally ill population, twenty percent currently abuse either alcohol or drugs and sixty percent will have abused either substance during their lifetime.
- Individuals with mental disorders are at increased risk for developing a substance abuse disorder and conversely, people with substance abuse disorders are at increased risk for developing a mental disorder.

WHAT TYPES OF MENTAL OR EMOTIONAL PROBLEMS ARE SEEN WITH PEOPLE WITH CO-OCCURRING DISORDERS?

Psychiatric problems commonly found in persons with co-occurring disorders can be arranged under four main categories:

- *Mood Disorders* are characterized by extreme emotions such as major depression, bipolar disorder (formerly called manic-depression) and dysthymia (a milder but chronic form of depression).
- *Anxiety Disorders* are characterized by powerful fears and avoidance behaviors. They include Post Traumatic Stress Disorder; Obsessive-Compulsive Disorder (obsession are unavoidable thoughts and compulsions are unavoidable behaviors); Social Phobias (e.g., excessive shyness); Agoraphobia (fear of being in crowds or places with no easy exit); Panic Attacks; and generalized, non-specific anxieties.

- *Psychotic Disorders* include severe illnesses such as schizophrenia. These disorders are characterized by unusual thoughts and beliefs, often at odds with evidence apparent to others and the behaviors that result from acting on those ideas. Visual or auditory hallucinations, extreme paranoia and delusional thoughts may be present.
- *Personality Disorders* are characterized by enduring and inflexible patterns of experience and behavior, across a broad range of personal and social situations, that markedly differ from the expectations of a person's culture, and that lead to either significant distress or impaired function in important life domains. (Personality disorder items are not included in the Modified Mini Screen.)

WHAT ARE THE GENERAL CHARACTERISTICS OF PATIENTS WITH CO-OCCURRING DISORDERS?

- Substance abuse and mental disorders have biological, psychological, and social components, so people with co-occurring disorders have disabilities, disadvantages, and psychosocial problems that interact with each other.
- Co-occurring disorders occur across the lifespan in both men and women.
- When one or both disorders are severe, consequences include inability to maintain stable housing or to stay employed, repeated cycles through treatment, probation, jail, or prison.
- Use of even small amounts of alcohol or drugs may trigger recurrence of mental health symptoms.

WHAT ARE THE TREATMENT RELATED CHARACTERISTICS OF A PATIENT WITH CO-OCCURRING DISORDERS?

Patients with one or more severe co-occurring disorders are likely to use services only when in crisis, to be minimally engaged in treatment, and to be involved with the criminal justice system.

Some specific characteristics are:

- More rapid progression from initial use to substance dependence
- Poor adherence to medication
- Decreased likelihood of treatment compliance
- Greater rates of hospitalization
- More frequent suicidal behavior especially for clients with schizophrenia spectrum, major depressive or bipolar disorders. Fifteen to 25% of suicides

are committed by persons who abuse alcohol. Suicide may also be associated with intoxication or withdrawal from addictive substances.

- Difficulties in social functioning
- Shorter time in remission of symptoms

In addition, individuals with severe disorders are:

- More sensitive to substance effects
- Unlikely to develop dependence or medical signs of sustained, heavy use
- More likely to encounter substances and pressure to use
- More likely to experience negative outcomes

WHAT ARE THE BEHAVIORAL CHARACTERISTICS OF PATIENTS WITH CO-OCCURRING DISORDERS?

People with mental disorders will have the characteristics of the disorder they suffer from. Those with severe mental illness may have:

- Difficulty comprehending or remembering important information
- Inability to recognize the consequences of behavior, thereby affecting the ability to plan
- Poor judgment
- Disorganization
- Limited attention span
- Poor response to confrontation

They are likely to use substances to:

- Combat loneliness, social anxiety, boredom, insomnia
- Deal with stress or strong emotions like anger, pain, shame, guilt
- Relieve specific symptoms of mental illness or medication side effects

WHAT BENEFITS ARE ASSOCIATED WITH RECOVERY FOR PATIENTS WITH CO-OCCURRING DISORDERS?

- Regular engagement in enjoyable activity
- Decent, stable housing
- Loving relationships with someone sober who accepts person's mental illness
- Positive, valued relationship with treatment professional
- When actively engaged in treatment, clients with co-occurring disorders are actually more likely to attend outpatient groups

WHAT IS THE PURPOSE OF SCREENING FOR CO-OCCURRING DISORDERS?

The purpose of a screening instrument—such as the Modified Mini Screen—in chemical dependency treatment settings is to identify patients with a high likelihood of having a mental illness that could compromise successful treatment outcomes. A high screen score will prompt a referral for a more thorough psychiatric assessment. Screening should be completed in a timely manner to assist in developing a comprehensive treatment plan, *as required by OASAS Chemical Dependency Regulations*. It should be noted that **screening** is a process for evaluating the possible presence of a problem while **assessment** is a process for defining the nature of that problem and developing specific treatment recommendations to address that problem. While screening can be conducted by any trained clinician, assessments can **only** be conducted by licensed practitioners.

High prevalence, low treatment and low engagement rates, as well as the under identification of co-occurring disorders in treatment settings highlight the need for better detection and assessment procedures. Treatment outcomes have been poor for chemical dependency clients who have mental disorders. The absence of assessment of co-occurring disorders has been identified as a major barrier to effective treatment and prevention. The screening process allows a clinician to assess whether there are signs that a patient with a substance abuse disorder has a mental disorder as well. If a problem is identified, the patient should be referred for a more detailed assessment and an appropriate referral. Adequate assessment of the full picture of a patient's co-occurring disorder occurs over time in an established trusting relationship with a skilled clinician.

Screening for mental disorders is the first step in good clinical practice for patients with co-occurring disorders. Screening demonstrates to the patient that the program is committed to identifying and addressing the full range of their problems. The therapeutic relationship is initiated when these problems are brought out into the open and treatment options and limits are discussed in a context of respect and acceptance.

WHEN SHOULD SCREENING OCCUR?

Alcohol and substance abuse greatly influence symptoms of mental illness, and vice versa. Abuse of addictive substances like alcohol, opiates, and cocaine may precipitate mental disorders like depression and psychotic disorders are

sometimes secondary to use of crack cocaine, hallucinogens, alcohol, and ecstasy. On the other hand, withdrawal from substances may exacerbate symptoms of mental disorders when substance use has been a way for the person to cope with depression, loneliness, boredom, or anxiety. When both disorders are identified, they should be considered as primary and should be treated. In addition, HIV and Hep-C positive patients may exhibit symptoms, such as dementia, due to the disease itself or the medication regimen. Substance related affective symptoms (depression, mania) usually clear within two weeks of abstinence; psychotic symptoms usually clear within days to a week of abstinence while symptoms of anxiety may take up to six months to clear. Administration of the Modified Mini Screen after two weeks of abstinence is recommended. The goal is to screen the patient when their sensorium is not clouded by alcohol or other drugs and/or the withdrawal of substances—at a minimum, the patient should be stabilized prior to screening. Thereafter, a clinician may conduct subsequent screens as appropriate based upon their clinical judgment and as per the program's policies and procedures. **CLINICAL OBSERVATIONS BY STAFF SHOULD NEVER BE REPLACED BY ANY SCREENING TOOL**.

It is the program's responsibility to develop a written implementation plan that identifies the specific screening procedures that the provider will adhere to. A suggested implementation guide has been developed to assist in this process which identifies a range of issues relative to implementation.

HOW ACCURATE IS SCREENING?

Screens are first line identifiers and as such, are imperfect. They may either under identify or over identify the condition they are designed to detect. Standard screens help avoid these problems, and follow up assessments are key to adequately identifying and incorporating co-occurring disorders into a comprehensive treatment plan.

When an effective screen like the Modified Mini Screen is implemented properly, staff is more likely to identify someone who truly has mental illness but will incorrectly identify some others as exhibiting signs or symptoms of mental illness when a mental illness is not present. Screening increases the likelihood of discovering high-risk cases; only a relatively small percentage of mental health assessments are conducted when they are not needed.

WHAT IS THE MODIFIED MINI SCREEN (MMS)?

The Modified Mini Screen is a 22 item questionnaire that may be administered by a clinician in about 15 minutes. The tool uses a set of "gateway" questions that relate to signs of distress that may be attributed to a diagnosable psychiatric disorder; however, **NO SPECIFIC DIAGNOSIS SHOULD BE INFERRED**. The screen is divided into 3 sections to capture the three major categories of mental illness as follows:

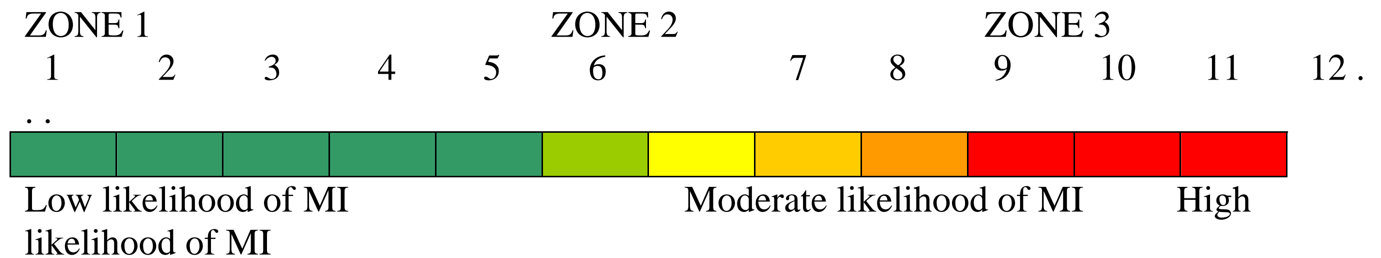
Section A – Mood Disorders
Section B – Anxiety Disorders
Section C – Psychotic Disorders

HOW SHOULD THE MODIFIED MINI SCREEN BE SCORED?

Scoring of the Modified Mini Screen is straightforward and additive—each YES in the screen counts as 1. The clinician adds all the positive responses for a total score which ranges from 1 to 22. Remember, if a patient answers YES to questions, that does not mean they are mentally ill; it simply means that they are reporting distress. It is the responsibility of each program to determine, based upon their patient population, the "score" that will trigger a referral for a complete psychiatric assessment based upon the continuum on the next page. Once a patient has been screened, the results should be utilized to inform the development of the patient's individualized treatment plan. Follow up may be required to ensure that a patient receives an assessment in a timely manner. In addition, a program may need to utilize resources such as primary care physicians if access to standard mental health services is limited.

WHAT SCORE SHOULD TRIGGER A REFERRAL FOR A MENTAL HEALTH ASSESSMENT?

It is useful to view a Modified Mini Screen score as having three distinct zones as follows:



Zone 1 GREEN—no further action is indicated, based only on the screen
Zone 2 YELLOW—the patient should be seriously considered for referral for a detailed diagnostic assessment
Zone 3 RED—the patient should definitely be referred for a diagnostic assessment

In addition, question 4 relates to suicidality. Any patient who answers YES to this should be referred for further evaluation regardless of the total score. Questions 14 and 15 refer to Post-Traumatic Stress Disorder (PTSD). PTSD is not only combat related, but also related to experiences of physical and sexual abuse, as well as other trauma. If BOTH questions 14 and 15 are answered YES, the client should be referred for further evaluation regardless of the patient's total score.

WHAT IF THE PATIENT SCORES WITHIN ZONE 2?

Any patient score within Zone 2 requires some clinical judgment as to whether or not the patient should be referred for a detailed diagnostic assessment. Each agency has its own policies and procedures that should be followed. At the low end of Zone 2, more patients without a disorder will be identified while scores at the high end will result in more patients with mental health disorders being missed.

References

1. American Psychiatric Association, *Diagnostic and Statistical manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC, American Psychiatric Association, 2000.*

2. Spitzer, R.L., Williams, J.B.W., Gibbon, M. & First, M.B. Structured Clinical Interview for DSM-III-R-Patient Version. New York: New York State Psychiatric Institute, Biometrics Research Department, 1988.

3. Sheehan, D.V., Lecrubier, Y., Sheehan, K.H., Amorim, P., Janavs, J., Weiller, E., Hergueta, T., Baker, R., & Dunbar, G.C. *The mini-international neuropsychiatric interview (M.I.N.I.): the development and validation of a structured diagnostic psychiatric interview for DSM-1V and ICD-10*. Journal of Clinical Psychiatry, 59 (suppl. 20), 1998.

Modified MINI Screen (MMS)

Implementation Plan

NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES
1450 WESTERN AVENUE, ALBANY, NY 12203-3526

SCREENING FOR CO-OCCURRING DISORDERS USING THE MODIFIED MINI SCREEN (MMS)

PROVIDER IMPLEMENTATION PLAN

(Rev. 6/05)

Screening for Co-Occurring Disorders using the Modified Mini Screen (MMS)

PROVIDER IMPLEMENTATON PLAN

- Purpose
- Description of the Modified Mini Screen (MMS)
- Issues to be Resolved Prior to Implementation

Purpose

The absence of simple screening tools for mental health problems in chemical dependency treatment settings is a barrier to planning effective treatment services. OASAS seeks to improve the identification of mental health conditions among its chemical dependency patients in order to obtain and/or provide appropriate mental health assessment and treatment services. Such services will improve treatment and recovery outcomes for patients with co-occurring disorders.

Description of Evidence-based Practice (EBP)

The Modified Mini Screen (MMS) is a 22 item scale designed to identify persons in need of an assessment in the domains of Mood Disorders, Anxiety Disorders and Psychotic Disorders. The questions are based on gateway questions and threshold criteria found in the Diagnostic and Statistical Manual IV (DSM-IV)[1], the Structured Clinical Interview for Diagnosis (SCID)[2] and the Mini International Neuropsychiatric Interview (M.I.N.I.)[3].

In 2003, with support from OASAS and OMH, the Nathan Kline Institute for Psychiatric Research validated the utility of the MMS to identify persons in need of further assessment of their mental health. The validation study involved a culturally heterogeneous patient population (N=338) receiving treatment services at 17 OASAS-certified sites across the state. OASAS field tested the screening tool and required each provider to develop a written implementation plan that would address the multitude of issues inherent in the introduction of a new mental health screening practice. The plan was subsequently revised based upon feedback from the participating providers in implementing the MMS.

Issues to be Resolved Prior to Implementation

OASAS has identified three distinct phases of activity in the adoption of any new clinical or administrative practice: readiness; implementation and institutionalization. The following questions are all components of the readiness phase and should help guide the development of an implementation plan. Please respond to each area as best as possible. Once implementation begins, you may find the need to modify your initial plan.

Please use the attached cover sheet to transmit your plan to your OASAS program manager for review ***prior*** to the implementation of the screening tool.

a. Which program units (sites and service types) will implement the Modified Mini Screening tool?

b. Which patients will be screened using the tool? (All persons admitted not known to be currently under psychiatric care?)

c. When in the clinical process will the screening tool be administered? (At intake? Two weeks after admission? Two weeks after abstinence or stabilization?) Will the screening protocol be integrated into the comprehensive evaluation and treatment planning process? Will the tools be re-administered later during the course of treatment?

d. Who will administer the screening tool to the patient? (An intake counselor? A CASAC? The clinician assigned to the patient? A psychologist? Nursing staff?)

e. How will the screening tool be presented to the patient? (As part of a standard practice to assure the best possible care? As part of the treatment planning process?) Is there a sample script? Are persons administering the screening tool expected to adapt the script, not just read it to the patient?

f. How will the screening tool be administered to the patient? Will it be read to the patient in all cases—not self-administered?

g. Will the screening tool be available in languages other than English? Who will administer non-English versions?

h. What score (i.e., "cut point") will be used to indicate a definite need for a mental health diagnostic assessment? For what range of scores, if any, will a diagnostic assessment interview be considered discretionary, but supported, based on patient and/or clinician concerns.

i. How will the patient be advised of the results? Who will interpret the results for the patient?

j. What resources, internal or external, will be used to conduct mental health diagnostic assessments?

k. What procedures, including consent forms, will be used in obtaining mental health assessment services?

l. What supervisory or other procedures will be used to monitor the provision of mental health screening services, including assuring that the protocol is followed? (Will clinical supervisors observe delivery of the procedure?) What provisions are there for training new staff and/or providing "refreshers" for existing staff?

m. What quality improvement procedures will used to assess the adequacy and utility of the evidence-based practice and identify any problems with the procedures during implementation and on an ongoing basis?

n. How will barriers such as time delays in access to assessment services be identified and resolved?

o. How will patients that screen over 5, but under the program's chosen "cut-point" be monitored?

p. What is the target date(s) for implementation of the evidence-based practice (EBP)?

q. Will outside resources be used for consultation and/or training in the EBP? (Training provided by OASAS, Dual Recovery Coordinator, or other?)

r. Who will receive training from outside resources, if any? (Clinical Supervisors?) Where will they be trained? (On-site?) When will this training be provided? Will supervisory staff (e.g., psychiatrist, psychiatric social worker) attend the training to facilitate organizational buy-in? If so, please identify those staff.

s. How will procedures and techniques be communicated to staff responsible for delivering the service? (Group training by supervisors with role playing? Individual training and coaching? Observation by supervisor?) When will training take place?

t. Are there any agency policies that need to be revised or updated in order to implement the evidence-based practice?

u. Are there services agreements, including consent forms, in place for obtaining mental health assessment services?

v. Are there service agreements, including consent forms, in place for obtaining mental health treatment, consultation, or case management services?

w. What is the target date for the development and implementation of WRITTEN policies and procedures specific to patient screening for co-occurring disorders?

x. Who will coordinate the development and submission to OASAS of the implementation plan and serve as a contact person for follow up?

References

1. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC, American Psychiatric Association, 2000.*

2. Spitzer, R.L., Williams, J.B.W., Gibbon, M. & First, M.B. Structured Clinical Interview for DSM-III-R-Patient Version. New York: New York State Psychiatric Institute, Biometrics Research Department, 1988.

3. Sheehan, D.V., Lecrubier, Y., Sheehan, K.H., Amorim, P., Janavs, J., Weiller, E., Hergueta, T., Baker, R., & Dunbar, G.C. *The mini-international neuropsychiatric interview (M.I.N.I.): the development and validation of a structured diagnostic psychiatric interview for DSM-1V and ICD-10.* Journal of Clinical Psychiatry, 59 (suppl. 20), 1998.

MODIFIED MINI SCREEN (MMS) IMPLEMENTATION PLAN

Cover Sheet

Provider Name: _______________________________________

PRU # (Please list *all* PRUs implementing the MMS): _______________________
____

Date of Implementation Plan Submission to OASAS: __________________

Contact Liaison to OASAS

Name: _______________________________________

Title: ______________________________________

Phone: ____________________________

Fax: ______________________________

Email: ____________________________

Screening Instruments

Mental Health Screening Tools

for use in

Substance Abuse Outpatient Clinics

Mental Health Screening Form III (MHSF)

MHSF *Guidelines*

MHSF *Instrument* — English language version

Mental Health Screening Form III (MHSF-III)

MHSF-III Guidelines

Guidelines for the Use of the
Mental Health Screening Form III

Guidelines for Using the
Mental Health Screening Form III

The Mental Health Screening Form-III (MHSF-III) was initially designed as a rough screening device for clients seeking admission to substance abuse treatment programs.

Each MHSF-III question is answered either “yes” or “no.” All questions reflect the respondent’s **entire life history**; therefore all questions begin with the phrase “Have you **ever**...”

The **preferred** mode of administration is for staff members to read each item to the respondent and get their “yes” and “no” responses. Then, **after** completing all 18 questions (question 6 has two parts), the staff member should inquire about any “yes” response by asking “**When** did this problem first develop?”; “**How long** did it last?”; “Did the problem develop **before**, **during**, or **after** you started using substances?”; and, “**What** was happening in your life at that time?” This information can be written below each item in the space provided. There is additional space for staff member comments at the bottom of the form.

The MHSF-III can also be given directly to clients for them to complete, providing they have sufficient reading skills. If there is any doubt about someone’s reading ability, have the client read the MHSF-II instructions and question number one to the staff member monitoring this process. If the client can not read and/or comprehend the questions, the questions must be read and/or explained to him/her.

Whether the MHSF-III is read to a client or s/he reads the questions and responds on his/her own, the completed MHSF-III **should be carefully reviewed** by a staff member to determine how best to use the information. It is strongly recommended that a **qualified mental health specialist** be consulted about any “yes” response to questions 3 through 17. The mental health specialist will determine whether or not a followup, face-to-face interview is needed for a diagnosis and/or treatment recommendation.

The MHSF-III features a “**Total Score**” line to reflect the total number of “yes” responses. The maximum score on the MHSF-III is 18 (question 6 has two parts). This feature will permit programs to do research and program evaluation on the mental health-chemical dependence interface for their clients.

The first four questions on the MHSF-III are not unique to any particular diagnosis; however, **questions 5 through 17 reflect symptoms associated with the following diagnoses/diagnostic categories**: Q5, Schizophrenia; Q6, Depressive Disorders; Q7, Post-Traumatic Stress Disorder; Q8, Phobias; Q9, Intermittent Explosive Disorder; Q10, Delusional Disorder; Q11, Sexual and Gender Identity Disorders; 12Q Eating Disorders (Anorexia, Bulimia); Q13 Manic Episode; Q14 Panic Disorder; Q15 Obsessive-Compulsive Disorder; Q16 Pathological Gambling; Q17 Learning Disorder and Mental Retardation.

The relationship between the diagnoses/diagnostic categories and the above cited questions was investigated by having four mental health specialists independently “select the one MHSF-III question that best matched a list of diagnoses/diagnostic categories.” All of the mental health specialists matched the questions and diagnoses/diagnostic categories in the same manner, that is, as we have noted in the preceding paragraph.

A “yes” response to any of questions 5 through 17 does **not**, by itself, insure that a mental health problems exists at this time. A “yes” response raises only the **possibility** of a **current** problem, which is why a consult with a mental health specialist is strongly recommended.

J.F.X. Carroll, Ph.D. & John J. McGinley, M.S., M.S.W., M.A. © 4/2000 by Project Return Foundation, Inc.
This material may be reproduced or copied, in entirety, without permission. Citation of the source is appreciated.

Mental Health Screening Form III (MHSF-III)

MHSF-III *Instrument* — English Language Version

Mental Health Screening Form – III

In this program, we help people with all of their problems, not just their addictions. This commitment includes helping people with emotional problems. Our staff is ready to help you deal with any emotional problems you may have, but we can do this only if we are aware of the problem. Any information you provide to use on this form will be kept in strict confidence. It will not be released to any outside person or agency without your permission. If you do not know how to answer these questions, ask the staff member giving you this form for guidance. Please note each item refers to your entire life history, not just your current situation. This is why each question begins, "Have you ever.."

1. Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem?

   Yes

   No

2. Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help?

   Yes

   No

3. Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem?

   Yes

   No

4. Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons?

   Yes

   No

5. Have you ever heard voices no one else could hear or seen objects which others could not see?

   Yes

   No

6a. Have you ever been depressed for weeks at a time, lost interest in most activities, had trouble concentrating and making decisions, or thought about killing yourself?

Yes

No

6b. Did you ever attempt to kill yourself?

Yes

No

7. Have you ever had nightmares or flashbacks as a result of being involved in a traumatic/terrible event?

   Yes

   No

8. Have you ever experienced any strong fears? For example, heights, insects, animals, dirt, attending social events, etc?

   Yes

   No

9. Have you ever given in to an aggressive urge or impulse, on more than one occasion, that resulted in serious harm to others or led to the destruction of property?

   Yes

   No

10. Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behaviors?

    Yes

    No

11. Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner?

    Yes

    No

12. Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating?

    Yes

    No

13. Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything?

    Yes

    No

14. Have you ever had spells or attacks when you suddenly felt anxious, frightened, uneasy to the extent that you began sweating, your heart began to beat rapidly,

you were shaking or trembling, your stomach was upset, or you felt dizzy or unsteady?

Yes

No

15. Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations?

    Yes

    No

16. Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling?

    Yes

    No

17. Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem?

    Yes

    No

Print Client's Name: Date:

Program to which the client will be assigned:

Name of Admissions Counselor:

Reviewer's Comments:

Total Score: _________ (each yes = 1pt.)x

Adapted from:
J.F.X. Carroll, Ph.D. & John J. McGinley, M.S., M.S.W., M.A.
Mental Health Screening Form III
Project Return Foundation, Inc., 2000

Screening Instruments

Mental Health Screening Tools

for use in
Substance Abuse Outpatient Clinics

Kessler *K6* (K6)

K6 *Instrument* — English language version

Screening for Serious Mental Illness in Populations with Co-occurring Substance Use Disorders: Performance of the K6 *Scale* (October 2006)

Kessler *K6* (K6)

K6 *Instrument* — English Language Version

Self Administered & Interviewer Administered

**K6 *Instrument* — Translations
in Arabic, Chinese, Dutch, Hebrew,
Italian, Japanese, & Spanish)
are available at**
http://www.hcp.med.harvard.edu/ncs/k6_scales.php

K6 MENTAL HEALTH SCREENING TOOL

About the Scale: The K6 Screening Scale was developed by Dr. Ronald Kessler, Professor of Healthcare Policy at Harvard Medical School, with support from the U.S. Government's National Center for Health Statistics. The scale was distributed for use by aging service providers as part of the University of Kansas School of Social Welfare Office of Aging and Long Term Care's pilot project, "Connecting Older Kansans with Community Mental Health Resources", funded in part by the Kansas Department on Aging and the Kansas Department of Social and Rehabilitation Services.

The K6 is not distributed for use as a diagnostic tool, but as a format to assist aging services providers and their customers in identifying a potential mental health problem from which older adults might benefit from referral to mental health resources. Please reproduce as needed.

Customer Identification: ______________________ Date:___________

The following questions ask a person how he/she has been feeling during the past 4 weeks. For each question, please circle the number that best describes how often she/he had this feeling.

In the last 4 weeks, about how often did you feel...	All of the time	Most of the time	Some of the time	A little of the time	None of the time	Don't know	Refused
a...so sad that nothing could cheer you up?	4	3	2	1	0	0	0
b...nervous	4	3	2	1	0	0	0
c...restless or fidgety	4	3	2	1	0	0	0
d...hopeless	4	3	2	1	0	0	0
e...everything was an effort	4	3	2	1	0	0	0
f...worthless	4	3	2	1	0	0	0

* If necessary, for question e., prompt: How often did you feel everything was hard and difficult to do?

TOTAL SCORE:_________

In the last 4 weeks, how many times have you seen a doctor or other health professional about these feelings? _________

Don't know__________ Refused___________

Comments ____

** *If the customer scores 13 or higher, it is recommended that service provider consider referring the customer to a mental health resource for further support. If the score is below 13, the customer may not need a referral; however, if the service provider or the customer feels that a referral to a resource should be made, proceed with the referral. If a mental health crisis is suspected, follow service provider organization's standard procedures.*

For more information about the K6 and related mental health screening instruments, please visit: http://www.hcp.med.harvard.edu/ncs/k6_scales.php

Binding margin – do not write

Date completed: __ __ / __ __ / __ __ __ __

K6+

Provider: ________________________

Provider ID:

|___|___|___|___|___|___|___|___|___|

Please used gummed label if available

Patient or Client Identifier:

|__|__|__|__|__|__|__|__|__|__|__|__|

Surname:

Other names:

Date of Birth: ___ ___/ ___ ___/ ___ ___ ___ ___

Sex: Male ☐1 Female ☐2

Address:

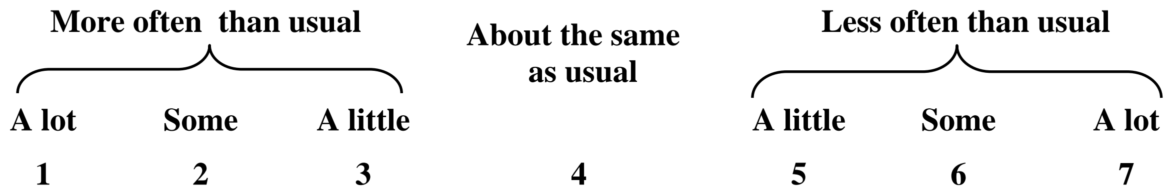
The following questions ask about how you have been feeling during the **past 30 days**. For each question, please circle the number that best describes how often you had this feeling.

Q1. During the past 30 days, about how often did you feel …	**All of the time**	**Most of the time**	**Some of the time**	**A little of the time**	**None of the time**
a. …nervous?	**1**	**2**	**3**	**4**	**5**
b. …hopeless?	**1**	**2**	**3**	**4**	**5**
c. …restless or fidgety?	**1**	**2**	**3**	**4**	**5**
d. …so depressed that nothing could cheer you up?	**1**	**2**	**3**	**4**	**5**
e. …that everything was an effort?	**1**	**2**	**3**	**4**	**5**
f. …worthless?	**1**	**2**	**3**	**4**	**5**

Please turn over the page to continue

MENTAL HEALTH

Q2. The last six questions asked about feelings that might have occurred during the past 30 days. Taking them altogether, did these feelings occur More often in the past 30 days than is usual for you, about the same as usual, or less often than usual? (If you never have any of these feelings, circle response option "4.")



The next few questions are about how these feelings may have affected you in the past 30 days. You need not answer these questions if you answered "None of the time" to **all** of the six questions about your feelings.

Binding margin – do not write

Q3. During the past 30 days, how many days out of 30 were you totally unable to work or carry out your normal activities because of these feelings?

_______ **(Number of days)**

Q4. **Not counting the days you reported in response to Q3**, how many days in the past 30 were you able to do only half or less of what you would normally have been able to do, because of these feelings?

_______ **(Number of days)**

Q5. During the past 30 days, how many times did you see a doctor or other health professional about these feelings?

_______ **(Number of times)**

	All of the time	Most of the time	Some of the time	A little of the time	None of the time
Q6. During the past 30 days, how often have physical health problems been the main cause of these feelings?	1	2	3	4	5

Thank you for completing this questionnaire.

Date completed: __ __ / __ __ / __ __ __ __

Interviewer Administered

K6+

Identifier: |__|__|__|__|__|__|__|__|__|__|__|__|__|__|	
Last Name:	
First Name:	
Date of Birth: ___ ___ / ___ ___ / ___ ___ ___ ___	Sex: Male ☐1 Female ☐2
Address:	

Q1a. The next questions are about how you have been feeling during the **past 30 days**. About how often during the past 30 days did you feel **nervous** — would you say **all** of the time, **most** of the time, **some** of the time, **a little** of the time, or **none** of the time?

1. ALL
2. MOST
3. SOME
4. A LITTLE
5. NONE
8. (IF VOL) DON'T KNOW
9. (IF VOL) REFUSED

Q1b. During the past 30 days, about how often did you feel **hopeless** — **all** of the time, **most** of the time, **some** of the time, **a little** of the time, or **none** of the time?

1. ALL
2. MOST
3. SOME
4. A LITTLE
5. NONE
8. (IF VOL) DON'T KNOW
9. (IF VOL) REFUSED

Q1c. During the past 30 days, about how often did you feel **restless or fidgety**? (IF NEC: **all**, **most**, **some**, **a little**, or **none** of the time?)

1. ALL
2. MOST
3. SOME
4. A LITTLE
5. NONE
8. (IF VOL) DON'T KNOW
9. (IF VOL) REFUSED

Q1d. How often did you feel **so depressed that nothing could cheer you up**? (IF NEC: **all, most**, **some**, **a little**, or **none** of the time?)

1. ALL
2. MOST
3. SOME
4. A LITTLE
5. NONE
8. (IF VOL) DON'T KNOW
9. (IF VOL) REFUSED

Q1e. During the past 30 days, about how often did you feel **that everything was an effort**? (IF NEC: **all, most**, **some**, **a little**, or **none** of the time?)

1. ALL
2. MOST
3. SOME
4. A LITTLE
5. NONE
8. (IF VOL) DON'T KNOW
9. (IF VOL) REFUSED

Q1f. During the past 30 days, about how often did you feel **worthless**? (IF NEC: **all, most**, **some**, **a little**, or **none** of the time?)

1. ALL
2. MOST
3. SOME
4. A LITTLE
5. NONE
8. (IF VOL) DON'T KNOW
9. (IF VOL) REFUSED

Q2. The last set of questions asked about feelings that might have occurred during the past 30 days. Taking them altogether, did these feelings occur **more often** in the past 30 days than is usual for you, **about the same** as usual, or **less often** than usual?

1. MORE OFTEN THAN USUAL .... **GO TO Q2b**
2. ABOUT THE SAME AS USUAL .... **GO TO Q3**
3. LESS OFTEN THAN USUAL
4. (IF VOL) NEVER HAVE THESE FEELINGS .... **GO TO Q3**
8. (IF VOL) DON'T KNOW .... **GO TO Q3**
9. (IF VOL) REFUSED .... **GO TO Q3**

Q2a. A lot less than usual, **somewhat** less, or **only a little** less than usual?

1. A LOT .... **GO TO Q3**
2. SOMEWHAT .... **GO TO Q3**
3. A LITTLE .... **GO TO Q3**
8. (IF VOL) DON'T KNOW .... **GO TO Q3**
9. (IF VOL) REFUSED .... **GO TO Q3**

Q2b. A lot more than usual, **somewhat** more, or **only a little more** than usual?

1. A LOT
2. SOMEWHAT
3. A LITTLE
8. (IF VOL) DON'T KNOW
9. (IF VOL) REFUSED

Q3. INTERVIEWER CHECKPOINT

1. R ANSWERED "A LITLE," "SOME," "MOST," OR "ALL" TO AT LEAST ONE QUESTION IN THE Q1 SERIES
2. ALL OTHERS .... **END SECTION**

Q4. The next questions are about how these feelings may have affected you in the past 30 days. How many days out of the past 30 were you **totally** unable to work or carry out your normal activities because of these feelings?

_________ NUMBER OF DAYS

98. (IF VOL) DON'T KNOW
99. (IF VOL) REFUSED

Q5. INTERVIEWER CHECKPOINT

1. R ANSWERED "30" IN RESPONSE TO Q4 .... **GO TO Q7**
2. ALL OTHERS

Q6. [Not counting (that day/those days)], how many days in the past 30 were you able to do only half or less of what you would normally have been able to do because of these feelings?

_________ NUMBER OF DAYS

98. (IF VOL) DON'T KNOW
99. (IF VOL) REFUSED

Q7. During the past 30 days, how many times did you see a doctor or other health professional about these feelings?

______ NUMBER OF TIMES

98. (IF VOL) DON'T KNOW
99. (IF VOL) REFUSED

Q8. During the past 30 days, how often have physical health problems been the main cause of these feelings – **all** of the time, **most** of the time, **some** of the time, **a little** of the time, or **none** of the time?

1. ALL
2. MOST
3. SOME
4. A LITTLE
5. NONE
8. (IF VOL) DON'T KNOW
9. (IF VOL) REFUSED

INTERVIEWER TRAINING NOTES:

1. The General Interviewer Training (GIT) procedures for nondirective probing outlined in the GIT Training Manual of the Survey Research Center at the University of Michigan are the preferred GIT procedures to be followed in administering the K6. As GIT procedures vary across survey organizations, those used by the organization that carries out the survey should be used if a professional survey organization is administering the questions.

2. All bolded words in questions should be emphasized by voice inflection.

3. All parenthetical phrases in questions are optional.

4. "IF NEC" means "if necessary." The interviewer should prompt R with the response categories, using the truncated wording when specified, until R has learned them well enough to respond without prompting.

5. "IF VOL" means "if volunteered." If the respondent volunteers one of the specified responses, that response should be recorded without additional probing. The interviewer's response to other responses that are not included among the pre-specified responses (e.g., a response of "quite a bit of the time") should be handled following the GIT procedures specified for the survey. In most cases, GIT will call for repeating the response options once and coding the response as a refusal with a marginal note describing the exact response if the respondent continues to give a response other than those that are pre-specified.

Kessler *K6* (K6)

K6 Performance

Screening for Serious Mental Illness in Populations with Co-occurring Substance Use Disorders: Performance of the K6 *Scale* (October 2006)

Screening for Serious Mental Illness in Populations with Co-occurring Substance Use Disorders: Performance of the K6 Scale

Performance of the K6 Scale

October 2006

Serious mental illnesses (SMIs) such as major depression and schizophrenia are common among people who have substance use disorders. SMIs are especially prevalent among those in drug treatment programs. Therefore, it is important to screen people in these programs for SMIs.

Screening for SMIs is a challenge. The symptoms of substance use and withdrawal are similar to SMI and can produce false-positive diagnoses. In addition, no screening tool has yet become the gold standard for assessing the presence of SMI among people who have substance use disorders. The K6 is one scale that has performed effectively as an SMI screening tool in studies using general population samples. This research examines the performance of the K6 as a screening tool for the likely presence of SMIs among people with substance use disorders.

The authors used data from the 2001 and 2002 National Survey on Drug Use and Health (NSDUH). The NSDUH study, conducted yearly, selects noninstitutionalized residents from the general population of the United States. Two scales to screen for SMI were embedded in the adult mental health sections of the NSDUH questionnaires. Participants used a laptop PC to answer the NSDUH questionnaire. The analytic sample for the study included 74,502 adult participants who completed either the 2001 or the 2002 questionnaire.

The findings suggest that the K6 accurately screened for the likely presence of SMI among individuals with substance use disorders. The authors state that the K6 is a conservative screening scale for detecting the most severe psychiatric disorders.

The authors report several limitations common to studies involving substance use (e.g., relying on self-reported information). They state that their findings demonstrate the diagnostic validity of the K6 in idealized circumstances and conclude that their findings should be regarded as preliminary until the K6 can be tested under conditions that are closer to those in drug treatment settings.

Copyright 2009 The Robert Wood Johnson Foundation http://www.rwjf.org
The Robert Wood Johnson Foundation, based in Princeton, N.J., is the nation's largest philanthropy devoted exclusively to health and health care.