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

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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

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