Connecticut Department of
Mental Health and Addiction Services

Statewide Implementation of Standardized Mental Health and Substance Use Screening Measures

Mental Health Screening Form-III (MHSF-III)
Modified Mini
Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD)
CAGE-Adapted to Include Drugs (CAGE-AID)

Frequently Asked Questions (FAQ)
Updated 4/4/12

This manual is separated into three parts. The first part addresses general questions about screening and this implementation. The second part addresses questions about specific items in the four screening measures being implemented. The last part reviews questions related to the statewide data collection component.

Frequently Asked Questions (FAQs)

GENERAL

1. What is screening?

Screening is a formal process of testing to determine whether an individual does or does not warrant further attention at the current time in regard to a particular problem. The screening process does not identify the specific problem the person might have, or how serious it might be, but determines what kind of further assessment is warranted and who should conduct that assessment. Screening is NOT an assessment; it does not replace your biopsychosocial assessment, and does not result in a diagnosis.

2. Why does DMHAS require standardized screening tools for mental health and substance use problems?

Screening, using standardized screening measures, is a recommended best practice, and it is one of many steps to make our system more responsive and effective for people with co-occurring disorders. It helps focus our system to be highly responsive to the multiple and complex needs of people and their families experiencing co-occurring disorders.

3. What is the purpose or benefits of screening for co-occurring disorders?

By implementing statewide screening, DMHAS has established a system of care where there is no "wrong door" for people with co-occurring disorders. The use of these screening measures helps to:

- Facilitate the identification of people at immediate risk;
- Assist in the early and accurate identification of disorders; and
- Create a more welcoming environment for people with co-occurring disorders.

4. What are DMHAS funded and DMHAS operated programs required to do?

Effective July 1, 2007, DMHAS funded and DMHAS operated programs are required to screen all individuals upon all *program* admissions (exceptions are listed in other parts of this document), for both mental health and substance use problems, using standardized screening measures. There are two mental health screening instruments to choose from (i.e., Mental Health Screening Form-III (MHSF-III) or Modified Mini International Neuropsychiatric Interview (Modified Mini)) and two substance use instruments to choose from (i.e., Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD) or CAGE-Adapted to Include Drugs (CAGE-AID)). Each person will need to receive one of these mental health screening instruments and one of these substance use screening instruments. There may be times when it is medically or clinically inappropriate to administer these screens and DMHAS has identified a method to capture that in the reporting (See FAQ #35).

5. When you say the screens should be administered at every "program" admission, are you referring to programs within or across facilities?

Both. But, if there is a treatment team change (or an "admission" to a different team) within the same program, the screens do not need to be administered.

6. How frequently do the screenings need to be administered if people are being admitted to multiple programs around the same time?

The screens should be done at every program admission, except if these admissions are within 60 days of each other.

- For example, if individuals are admitted to the same level of care/program multiple times within 60 days, the screens do not need to be re-administered at the readmissions. The recently completed screens should be referred to.

- Another example includes individuals who are admitted to another program immediately following a detox stay. In this case, the screen completed at the detox should be sent to the next level of care, but it does not need to be redone by the new program. The mental health symptoms endorsed at the detox program should be referred to.

- Sometimes a LMHA may refer individuals to two affiliate agencies, for example, for concurrent services or continuing care. In this example, the private non-profit (PNP) provider that admits the person first should complete the screen and share it with the other PNP(s).

**Only the agency that administers the screen should enter the data into DDaP/Avatar.*
These processes will require coordination and collaboration among programs to share screening results and avoid duplication in the administration and data collection components.

7. The LMHA in our region has a centralized intake process for their affiliate agencies; given this, should they do the screens as part of that intake process for the private non-profit provider (PNP) admissions, instead of the PNP?

In cases where the Local Mental Health Authority (LMHA) does centralized assessments for their affiliate agencies, the LMHA should conduct the screens, enter those data into Avatar, and the private non-profit provider should get a copy of those screens to use in their service planning activities. If there is a 60 day or more delay in the person receiving initial services from the PNP after the LMHA intake process, then the PNP should re-administer the screens for more timely and relevant results, and submit those data to DDaP.

8. How can these screens be administered and which staff can oversee this process? How long does the process take?

All programs should establish a written protocol for screening, including:
1) The use of these standardized measures;
2) How the measures will be administered and by whom (e.g., in-person interview or self-administered);
3) The next steps if a person screens negative or positive on one or both of the measures, or answers "yes" to the questions regarding suicidal thoughts;
4) What other screening information should be collected (e.g., toxicology); and
5) Where the completed forms are stored (e.g., in the chart with other intake materials).
Any staff member trained on these standardized screening measures can administer them to individuals, though administration by non-clinical staff should be supervised by clinical staff. It is important to develop an introduction to the screening process (either verbally or written) that explains why these questions are being asked and that informs individuals of their right to refuse to answer any questions they do not feel comfortable answering. During the pilot, and based on over 3,000 completed sets of these mental health and substance use screens, it took an average of 11 minutes to complete both screening instruments.

9. Can the screens be handed to consumers/individuals in recovery for them to fill out on their own?

Self-administration of the screens is an option. It should be noted that the interview method allows the staff person to clarify ambiguous items, define words as needed, and generally make sure that the person understands what is being asked. Also, some individuals may be embarrassed to disclose that they cannot read or their reading ability is low. If your program is using the self-administration method, please encourage people to ask questions if they don't understand the items.

10. What does a "positive" score mean?

It means that the person should receive a comprehensive assessment for the areas that they were positive on. It does not mean they have a mental health and/or substance use disorder. It only means that they show signs of a possible problem that should be comprehensively assessed by the appropriate staff.

11. What if my agency has both a DMHAS funded program and a program not funded by DMHAS?

Agencies are required to conduct screenings for individuals admitted to DMHAS funded or operated programs. We do, however, encourage agencies to conduct screenings for all individuals to make the entire system of care in Connecticut more responsive to the needs of people with co-occurring disorders.

12. Are there any programs that are exempt from doing the screens?

Only programs coded as "treatment" in DDaP/Avatar are required to do the screens.

The programs coded as "non-treatment" in DDaP/Avatar, which are *not* required to do the screens, are listed here:

- Advocacy/Education
- Consultation
- Day Reporting
- Education Support
- Employment Services
- Fiduciary
- Housing Assistance
- Intensive Case Management, Standard Case Management
- Jail Diversion
- Mobile Crisis Team
- Office of Forensic Evaluation
- Outreach & Engagement
- Peer Based Mentoring
- Pre-Trial Intervention Programs
- Recovery House
- Re-Entry Programs
- Residential Support
- Respite Beds
- Shelter
- Social Rehabilitation
- Specialing
- Supportive Housing (Development, Scattered Site)
- Transportation

13. It's my understanding that DCF social workers are using the GAIN-SS screening measure. For people being referred to my program by DCF, for example from Project SAFE, do we still complete the DMHAS screens?

Yes, you should still complete the DMHAS screens. If you receive a copy of the completed GAIN-SS from DCF, that will also be helpful in your assessment and treatment processes.

14. Should these screens be used over time with individuals? For example, every 90 days as part of the treatment plan review process?

Some of the pilot providers repeated use of the two screens at the 90-day treatment plan review and found this helpful in terms of quickly identifying mental health symptoms and substance use that had been reduced since intake and/or began since intake, in order to revise the recovery plan appropriately. This repeated use of the screens was not a requirement during the pilot nor is it a requirement as part of the statewide implementation, but it can assist with examining the longitudinal and interactive course of both disorders. A caution – these screening tools do not include a severity measure of symptoms, and they should not be the only tool used in the treatment plan review process to determine important events, such as stopping medications or other treatment services. At follow-up intervals more complete assessment information, particularly functional assessment information, is also needed – like it is needed at the initial intake or admission. If you use the screens over time, you may want to change the time frame (e.g., "Have you ever…") to a more pertinent time frame (e.g., "In the past 3 months, have you ever…"). This is not changing the wording of the symptom-related language and therefore is not changing the standardized and validated nature of the instruments.

15. How will providers be trained on these screening measures?

Many training opportunities were available at the time of implementation and for an extensive period after implementation. For current training availability, please contact julienne.giard@ct.gov or 860-418-6946.

16. Where can I get additional copies of the screens?

All four screening measures, in English and Spanish, are available on the DMHAS website for you to download: www.ct.gov/dmhas/cosig/screening
Other related screening materials are available on that site as well.

II. THE SCREENING MEASURES

17. How were these screens chosen for statewide implementation?

The use of standardized screens was one of three goals in the SAMHSA-funded Co-Occurring State Incentive Grant (COSIG) awarded to Connecticut in 2005-2010. The screens were originally chosen by the Screening Workgroup of the Co-Occurring Disorders Initiative for the screening pilot. The group met several times in the Winter/Spring of 2006 and examined many screening tools available in the field, taking into consideration several different variables, such as validity, reliability and ease of use. Based on the positive results from the comprehensive screening pilot, the same screening measures were implemented statewide.

18. Why were the observational checklist and the three open-ended questions on the pilot version of these instruments deleted for the statewide implementation of these measures?

Observations and open-ended questions are an important part of the screening, assessment and treatment planning process. However, during the pilot, the observation checklist did not seem to be used or be particularly helpful. Staff overseeing the screening process in your programs should write down any relevant observations on the screening forms. It was also thought that for statewide implementation of these screens that the three open-ended questions would be duplicative of other paperwork that programs use for other parts of the screening and assessment process and orientation to the program.

19. Where can I read more about the results of the screening pilot?

The final screening pilot report and a DMHAS Information Brief on the pilot are on the Co-Occurring Disorders Initiative page of the DMHAS website: http://www.ct.gov/dmhas/cosig/screening

20. Why are all agencies required to do both a mental health and a substance use screen instead of addiction agencies doing a mental health screen and mental health agencies doing a substance use screen?

Integrated screening (i.e., screening for both disorders) is a recommended best practice by the federal Substance Abuse and Mental Health Services Administration's (SAMHSA) Co-Occurring Center for Excellence (COCE). Integrated screening addresses both mental health and substance use, each in the context of the other disorder. In addition, providers in our screening pilot, including the mental health providers, found the mental health screens particularly helpful and clinically useful.

21. Can we change the wording of the questions in the screens and/or the order of the questions? Can we insert the screening questions into different parts of our assessment document?

No. These screens have been researched and validated in their current form. It is important that the questions be asked the way they are worded and ordered. The questions can be followed up with additional questions and it is a good idea to write notes in the margin or circle parts of the questions that individuals endorse, so other staff reviewing the results of the screen has as much information as possible and can better interpret the "yes" answers. Please see FAQ #14 regarding changing the timeframe of the questions if needed.

22. If I'm supposed to ask the questions exactly as written, what should I do if an individual doesn't understand what I'm asking?

It is true that you need to ask the items as they are written on the form. However, a key "rule" of the screening administration is making sure the individual understands what is being asked. Interviewers can define words, give examples, and clarify the intent of items so individuals know what is being asked. Please make sure that you go back and read the question as it is written on the tool when asking for the individual's final answer.

23. Can we change the screening documents downloaded from the DMHAS website at all?

Yes. You can add an introduction, a place to put the screening date, client identification fields, data entry notes or directions, or other similar kinds of information to help with the administration of the instrument and data collection.

24. How can I make sure the trauma questions (i.e., #7 on the MHSF-III and #14-15 on the Modified Mini) are asked in a trauma-informed manner?

It is important to develop a comprehensive introduction to the screening process (either verbally or written) that explains why these questions are being asked, and that informs individuals of their right to refuse to answer any questions they do not feel comfortable answering. Question 7 on the MHSF-III and questions 14-15 on the Modified Mini are screening questions related to a history of traumatic or distressing events and their reactions to those events. Please note that these are not complete lists of either traumatic events or possible reactions to them, and individuals may not identify with some of the language. For example, someone may have been sexually assaulted, but not identify it as an "assault", but rather "was forced to have sex when they didn't want to". These limitations can be addressed through a separate trauma screening tool or the comprehensive biopsychosocial assessment.

25. On the Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD), what if the person says "No" to the first question about whether they used any alcohol or other drugs during the past 6 months? Do I continue with the remaining questions?

The first question on the SSI-AOD is intended to help the interviewer decide whether to continue with the interview. If the response to this first question is no, continued questioning may be unnecessary. Complete exploration of this first question should be done before it is decided not to continue with the remaining questions on this screen and to report "0" as the score. This should be articulated in your program's written screening policy and procedure.

26. How do I make sure a person's culture is taken into account when using these questions?

It is important to follow-up "yes" responses to some of the mental health questions with additional probes to help interpret if the experience is related to the person's culture, and not indicative of a mental health or substance use problem. For example, a "yes" to question 22 on the Modified Mini ("Have you ever had visions when you were awake or have you ever seen things other people couldn't see?") should be followed by a question to ascertain whether the vision was related to a religious or spiritual experience, if the screener has reason to believe that this may be the case.

27. Why does it say at the top of the two mental health screening measures, "Number of days since last use of alcohol and/or other drugs?"

It is important to screen for signs of a mental health problem knowing the date of their last use of alcohol and/or drugs. This contributes to understanding the interactive nature of the mental health symptoms with substances. Please note this question is asking the date of last "use" and does not mean they misused or abused the substances. A follow-up question at this point could capture the amount. Date of last use is not captured on the substance use screens being implemented.

28. What should I do if a person answers "yes" to the gambling question?

You could follow up with the "20 questions" screen from Gamblers Anonymous available at the following site: www.gamblersanonymous.org/20questions.html
If the person answers "yes" to 7 or more of these questions, you should refer them to one of the Bettor Choice Programs, available through DMHAS' Problem Gambling Services, for gambling specific treatment. Family members of people with gambling problems can also experience significant distress and not know what they are dealing with; a similar set of 20 questions for them is available at www.gam-anon.org.
Information on the Bettor Choice program locations is available on the DMHAS website or by calling 860-344-2244. Family members can also be referred to this program.

29. We are already using the Beck Depression Inventory and Beck Anxiety Inventory screening instruments. How do we incorporate these new screening instruments?

These new screening instruments are considered *general* screens and the Beck measures are considered *specific* screens, which will give you information on severity of the symptoms. It is recommended you could use the general screens first and then administer the Beck instruments if they endorse depression and/or anxiety symptoms on the general screens.

30. We are using the Modified Mini and "6" as a cut-off for a positive score as indicated on that form, but many of our clients are scoring above this and therefore requiring full mental health assessments; are there other cut-offs indicated for this measure that we could explore?

Yes. There is a document on the DMHAS Co-Occurring Disorders Initiative website that was published by New York State where the Modified Mini was created. This document discusses ranges of scores on the Modified Mini and possible higher cut-offs that you may consider given the population your program serves and your setting.

31. I'm told that the screens should only take about 10 minutes to administer, so why is it taking me longer?

It can take longer if a lot of conversation occurs during administration. It is recommended that you go through all of the items first and return to any of particular concern for the interviewer or the client after the interview is complete. This strategy significantly reduces the time it takes to administer the tools.

32. Some of the screening questions are long and I lose people in the middle. How should I ask these questions?

During a list of symptoms in a particular question, it is helpful to pause after every few symptoms to allow the individual time to process what is being asked. It will also be helpful to other staff reviewing the screening results if you circle or make notes in the margin regarding which symptoms within a question are being endorsed. Only the "yes" at the end of such questions will not provide as much information.

III. DATA REPORTING

33. Is data reporting to DMHAS on the completed screening measures required?

Yes. There are variables in DDaP and Avatar to capture the screening data at an individual level.

34. How will these measures be incorporated into required data variables to DMHAS?

For each person being admitted to a program, providers are required to report to DMHAS the following information:
1) Addictions screening form used;
2) Mental health screening form used;
3) If the Modified Mini mental health screen was used, yes/no to question 4 (suicidality) is required
4) If the Modified Mini mental health screen was used, yes/no to questions 14 and 15 (trauma) is required
5) Total score from the addictions screening form; and
6) Total score from the mental health screening form.

35. I understand we don't need to do the screens if it is medically or clinically inappropriate to use them with certain individuals upon admission. How do we report this in the data system?

In cases like this, you can enter "9" in the screening instrument fields. Reports will be run on the screening data to monitor the percentage of screens that are entered as "9". We anticipate that this code will be used for a small percentage of screens.

36. What if a person refuses to answer the screening questions?

In the screening instrument fields, the value "8" captures refusals. We anticipate this will be used very infrequently.

37. We understand that the screens don't have to be re-administered if they were already done within 60 days of the current admission; how do we handle this in terms of the screening data collection?

The program actually administering the screens should enter those data into either DDaP or Avatar, depending on whether they are a PNP or a state-operated facility. In all cases, other programs the person is admitted to after that should receive hard copies of those completed screens. Those additional programs do not need to re-administer the screens or enter/submit the previously completed screens again to DMHAS.

38. If we are not completing the screens because they were done within 60 days of the current admission, do we enter "9" in the data submissions or do we leave the fields blank?

In this scenario, please leave the screening fields blank. We want to reserve the "9" entries for instances when it was specifically decided not to do the screens because it was clinically and/or medically inappropriate to do them.

39. My agency operates an addictions program that is NOT funded by DMHAS, but we are required to submit data to DMHAS for this program. What should we do in this case?

These screenings are only required of DMHAS operated and funded programs. DDaP will not reject your records if these fields are not completed.

40. Where can I ask questions and give feedback on the implementation of these screening measures?

Please contact your DMHAS regional manager or Julienne Giard at julienne.giard@ct.gov or 860-418-6946.