

Results from the Screening Pilot of the Co-Occurring Disorders Initiative

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EXECUTIVE SUMMARY

The Connecticut Department of Mental Health and Addiction Services (DMHAS) received a Co-Occurring State Incentive Grant (COSIG) to enhance and transform the system of care to ensure that best practices for persons with co-occurring disorders are followed. As part of the COSIG, a screening workgroup was convened to initiate a screening pilot program. The workgroup was guided by the principle that effective screening to identify individuals with co-occurring disorders is the first step in recognized best practices. The likelihood of achieving and maintaining recovery is greatly enhanced for people when identified best practices are used for treatment.

A total of 30 agencies and 3,050 consumers participated in the pilot project supported through the COSIG project.

Results of the pilot:

- ❖ Overall, almost half of the 3,050 screened for this pilot have screened positive for signs of co-occurring disorders.
- ❖ Both addictions and mental health programs tended to have the same percentage of positive co-occurring screenings. However, negative screenings in addictions programs occurred at twice the rate as in mental health programs.
- ❖ The Modified Mini Screen and CAGE-AID instruments tended to be used most often by addiction services and mental health programs alike.
- ❖ The highest percentage of positive co-occurring disorder (COD) screens came from providers who used the MHSF-III and SSI-AOD.

Recommendations:

- ❖ System-wide implementation of screening.
- ❖ DMHAS operated and funded programs should have the option of choosing among the four screening instruments used during the pilot.
- ❖ Mostly, screening is the initial contact with individuals seeking care. As such, screening instruments must be administered utilizing welcoming and recovery-oriented engagement techniques. The approach should be person-centered, with respect for individual's strengths, hope, and wellness, and in support of Connecticut's Recovery Practice Guidelines.

I. Introduction

Co-Occurring Mental Health and Substance Use Disorders

The United States Substance Abuse and Mental Health Services Administration (SAMHSA) defines persons with co-occurring disorders as individuals who experience “one or more substance-related disorders as well as one or more mental disorders” (CSAT, 2006a). Both the substance-related and mental health disorders should be identified and treated as primary (DMHAS, 2007).

Although few studies have been done to estimate the prevalence of co-occurring disorders among all Americans, SAMHSA estimates that in any given year between 7 and 10 million adults are affected by co-occurring disorders (DHHS, 1999). This estimate does not include children, youth or older adults.

In looking at individuals in treatment, the U.S. Surgeon General reports that in 1999 “41 to 65% of individuals with a lifetime substance abuse disorder also have a lifetime history of at least one mental disorder, and about 51% of those with one or more lifetime mental disorders also have a lifetime history of at least one substance abuse disorder” (DHHS, 1999). Therefore, for at least 50% of individuals with a behavioral health disorder, substance use and mental health disorders do not occur in isolation.

Individuals experiencing co-occurring disorders have a greater risk of developing major health problems. Dausey and Desai (2003) found that individuals with co-occurring disorders were at especially high risk of engaging in risk behaviors for HIV when compared to individuals diagnosed with a substance use disorder alone. Persons with co-occurring disorders are more likely to experience homelessness and have a greater chance of becoming incarcerated (McNiel et al., 2005). In addition, these individuals are also more likely to be noncompliant with medications, have higher service utilization rates and costs, and are more vulnerable to relapse and re-hospitalization in the absence of integrated care (Drake et al., 1998).

Although limited co-occurring prevalence information is available on older adults, it is known that like their younger counterparts, older adults with mental disorders may be especially prone to the adverse effects of drugs or alcohol. The presence of severe mental illness may create additional biological vulnerability so that even small amounts of psychoactive substances may have adverse consequences for individuals with schizophrenia and other brain disorders (Drake et al., 1998).

Evidence-Based Practices for Co-Occurring Disorders

Researchers and practitioners have identified evidence-based techniques and practices for serving people with co-occurring disorders. Clients with co-occurring disorders are best served through an integrated screening, assessment, and treatment planning process that addresses both substance use and mental disorders, each in the context of the other (CSAT, 2006b).

These practices include early identification of individuals with co-occurring disorders, providing integrated services, and having a clinical workforce that is familiar with the characteristics of both mental health issues and substance use issues. Individuals are more likely to achieve and maintain recovery when these practices are followed.

At the clinical level best practice models for integrated treatment of people with co-occurring disorders bring together both addiction and mental health treatment. This is accomplished by coordinating interventions and coordinating treatment among clinicians. With evidence-based best practices, agencies combine services into one seamless package. Integrated treatment can be

delivered in either an addiction or mental health treatment setting as long as appropriately trained staff is used (Drake et al., 1998; 2001).

Nationally, the fact that little is being done to identify people with co-occurring disorders systematically is recognized by Lehman (1996) as the most significant barrier to people obtaining care. In addition, Kessler et al. (1996) and Regier et al., (1990) also identified the need for additional and enhanced screening strategies based upon the low number of people with co-occurring disorders who receive appropriate services.

The practice of conducting screenings for co-occurring disorders at all points of entry to the system or care – what SAMHSA describes as a “no wrong door” approach -- is essential. Furthermore, in order to be effective, this practice must be done with all providers in a uniform and systematic manner (CSAT 2005).

Department of Mental Health and Addiction Services (DMHAS) Activities

For over 13 years, DMHAS has taken substantial steps to ensure that the system of care provides the best and most effective services needed to achieve and maintain recovery for individuals with co-occurring disorders. These steps include the convening of the first dual diagnosis task force in 1993, laying the ground work for defining dual diagnosis capable programs, and participating in trainings as part of the 2004 National Policy Academy on Co-Occurring Disorders. In 2005, the Department was one of four States awarded a five year, \$3.5 million Co-Occurring State Incentive Grant (COSIG) from SAMHSA. Funds from this resource are being used to build upon the work done since 1993 by enhancing the current system of care so that individuals with co-occurring disorders are identified through use of standardized screening and receive the best possible treatment available.

In addition, DMHAS has worked with treatment providers to enhance services to meet the needs of people with co-occurring disorders, and developed partnerships with nationally known experts in the field of integrated dual disorder treatment. Training and consultation through partnerships with Dartmouth Medical School regarding integrated treatment (e.g., Integrated Dual Disorders Treatment – IDDT -- and Dual Diagnosis Capability in Addiction Treatment -- DDCAT) has been ongoing since 2002.

One of the proposals in the COSIG application was the testing and implementation of standardized screening. In order to achieve this, DMHAS developed and implemented a co-occurring screening pilot. Information from this pilot is being used to further transform the system of care so that standardized screening for co-occurring disorders becomes a standard practice of care for all DMHAS operated and funded, addiction and mental health, service providers in Connecticut.

On January 11, 2007, DMHAS adopted and released the Commissioner’s Policy Statement Number 84, “Serving People with Co-Occurring Mental Health and Substance Use Disorders.” This policy outlines steps to be taken to ensure that the system of care, delivery of care and evaluation of care are responsive to the needs of people with co-occurring mental health and substance use disorders. The full policy is found in Appendix A.

Screening Overview

Screening is a formal process that tests for signs of a mental health and/or substance use disorder before a complete assessment is performed with individuals seeing care. There are three recognized essential elements of screening. First, screening for a co-occurring disorder only determines the *possibility* that a person may have a co-occurring disorder; screening does not produce a diagnosis. Second, screening is a formal process, including standardized measures that are administered and scored according to a protocol. Third, screening is conducted early in the

treatment process (Gamble, 2006; McGovern et al., 2006). In some cases, providers may choose to repeat screening measures at regular intervals during treatment to test for signs after a period of sobriety, after treatment or after other significant changes (CSAT, 2005).

Screening is the first step in evidence-based best practices. In 2005 the National Quality Forum Issued *Evidence-Based Treatment Practices for Substance Abuse Treatment Disorders*. This report, developed by a panel of expert stakeholders, is intended to bridge the gap between evidence-based practices and actual program operations. Screening for alcohol misuse in mental health and primary care settings was identified as a Recommended High-Priority Evidence-Based Treatment Practice. The experts also agreed that screening for drug addiction is likely to be as effective as screening for alcohol.

The benefits of screening are numerous. A standardized screen can assist in early and accurate identification of disorders. Screening results can then be used to direct individuals to the appropriate assessment and care (CSAT, 2005). A reliable screening process helps limit costs by determining who needs and who does not need a more comprehensive assessment (Rush et al., 2005).

Screening methods should not be labor or time intensive. In addition, ideal screening tools and methods must be highly sensitive. Highly sensitive means that someone identified as having a disorder during the screen will have a high chance of actually having the disorder. Screening tools and methods should also have a high negative predictive value, meaning that there is a high probability that those who screen negative actually do not have the condition the screening is examining (Zimmerman, 2001).

Rush et al. (2005) examined different approaches to conducting addiction screenings at two mental health clinics in Ontario. The researchers uncovered some valuable information and feedback from individuals being screened. They found that over half were very comfortable with answering questions about substance use. They also looked at screening methodology and found people were most comfortable with the direct questions as contained in the CAGE-AID screening form (46.8% of all respondents).

Rush et al (2005) asked people to provide their opinion about the best method of asking questions, participants felt that a self-completed questionnaire was the best method (41.4%) followed by being asked direct questions (32.8%). The two methods that clients felt were likely to be least effective were completion of forms with the assistance of a therapist (17.2%) followed by computer assisted questionnaires (8.6%).

To summarize, screening is an identified best practice that assists in early identification of disorders and facilitates appropriate placement of clients. As the first step, screening helps ensure that appropriate and the most effective treatment is provided. Conducting screenings require minimal time and resources and has significant benefits.

II. Methodology and Process

The goals of the Co-Occurring Disorders Initiative and the COSIG project is to improve services to individuals with co-occurring disorders through standardized screening regardless of entry point, service coordination and network building, and developing an infrastructure that allows information sharing to all stakeholders and promotes the use of data in a quality improvement framework.

One specific goal of the COSIG project is the testing and implementation of standardized screening tools for co-occurring disorders. The intent is to screen all people entering care, regardless of what services they are initially seeking. Full implementation of screening will help transform the system of care to ensure that the needs of individuals with co-occurring disorders are met regardless of where they initially seek services. We also believe this will result in early identification of appropriate services, resulting in quality care that is also cost-effective.

A Screening Workgroup was convened in early 2006. COSIG Screening Work Group members were selected to ensure a good representation of the DMHAS system of care.¹ The initial meeting of the workgroup was held on December 19, 2005. Two subsequent meetings were held on January 18, 2006 and February 17, 2006.

Screening Instruments Selected

The COSIG Screening Work Group was charged with reviewing existing screening instruments for substance use, mental health and co-occurring disorders. Work Group members felt strongly that the screen should be in keeping with Connecticut's recovery-oriented system of care.

After reviewing the validity, advantages and disadvantages of several screening instruments, the committee recommended that the CAGE-AID and Simple Screening Instrument for Alcohol and Other Drugs be used as screening tools for substance use problems while the Modified Mini International Neuropsychiatric Interview and Mental Health Screening Form III should be used to screen for mental health problems. The pilot versions of these four selected measures may be found in Appendix B of this document.

CAGE Adapted to Include Drugs (CAGE-AID)

CAGE-AID is the CAGE screening instrument for alcohol modified in 1991 to include questions relating to drug use. Consisting of eight questions, this form was adapted by Brown and Rounds (1995) for use in a primary care setting. With this instrument, individuals are asked if they have ever experienced a reaction or engaged in a certain behavior. Therefore, the questions of the CAGE-AID are not time limited.

Brown and Rounds (1995) found that this instrument had a sensitivity rate of 79% and a specificity of 77%. They noted, however, that limits to this screening tool, including problems with understanding the meaning of some words and a variance in interpretation of the questions, could produce a negative screen for people who were actually at risk for alcohol and/or addiction. In addition, the researchers noted that the lack of time limits to questions might make it difficult to differentiate between active and inactive substance use disorders, and noted that follow-up questions are needed.

Hinkin et al. (2001) found that this modified version of the CAGE was a valid screening instrument for substance use disorders among older adults. The researchers found that this instrument showed high sensitivity in detection. Although specificity was not as high, these researchers found

¹ Please see Appendix C for a list of Work Group Members.

that upon modifying the instrument – removing the question regarding cutting down on drinking and drug use – the specificity greatly improved without significantly reducing sensitivity. Therefore, given its sensitivity and ease of use, this instrument may be ideal in screening for co-occurring disorders since the definition of co-occurring disorders includes all substance use disorders and is not alcohol or drug specific.

Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD)

The Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD) is a screening form that asks individuals questions based upon both their lifetime experiences and experiences within the last six months. Developed by a panel of experts brought together by SAMHSA's Center for Substance Abuse Treatment, it is designed to be either self-administered or administered by agency staff (CSAT, 1994).

Consisting of 14 items, this screening form has been shown to be effective with adolescents (AAP, 2001; Knight et al., 2000). In addition, other studies have shown it to be a reliable instrument with other populations. Peters et al. (2000) found it to be one of several highly reliable instruments when used in a study of male inmates.

Moore and Mears, (2003) in a research study conducted for the Urban Institute, examined several screening instruments used in correctional settings across the United States. They identified the SSI as widely used in correctional settings and as one of the most useful and reliable instruments, especially if the screening goal is to identify the largest number of people in need of services.

Modified Mini Screen (MMS)

The Modified Mini Screen (MMS) (Alexander, et al., in press) is based on the Mini-International Neuropsychiatric Interview. This screening measure consists of 22 items. It was designed to be used in a variety of settings as well as for research studies.

The Modified Mini instrument contains questions that ask individuals to answer based on several different time frames. Although only limited studies have been conducted on the Modified Mini, the original Mini has been shown to be reliable based on retesting. In addition, the Mini has a high percent of inter-rater reliability (Sheehan et al., 1998).

Mental Health Screening Form III (MHSF-III)

The Mental Health Screening Form III was designed for use by addiction treatment agencies in screening individuals for mental health problems and disorders. Developed by Carroll and McGinley (2001) and consisting of 17 questions, this screening instrument is recommended by SAMHSA's Center for Substance Abuse Treatment (CSAT, 2005).

Although the preferred method of administration is by staff in the form of a structural interview, it can be self-administered. Like the CAGE-AID, all questions are based upon lifetime experiences with no time frame references, requiring additional follow-up questions. Tests conducted by the authors indicate that the form is both reliable and valid, though the developers did stress the importance of probing by staff administering the screen (Carroll and McGinley, 2001).

Screening Modifications

Work Group members proposed several additions to the screening process for the pilot. These additions were carefully considered to ensure that they did not alter the validity of each screening form. First, in order to ensure that clients are respected and that the screens are recovery-oriented, three open-ended questions were added. Clients were asked to provide information regarding past diagnoses, asked what they wanted the outcome of treatment to be and what does he/she identify as a problem.

In addition to adding open-ended questions, the Screening Work Group also recommended the addition of an observation check list for the pilot. This observation check list was developed by Nebraska. The intent of this checklist is to enable screeners to look for visible signs that might indicate substance use or mental health issues.

A question from the Mental Health Screening Form concerning gambling was added to the Modified Mini. An additional gambling question, developed in conjunction with the Statewide Problem Gambling Treatment Services program of DMHAS, was added to both forms. Finally, all screening instruments were translated into Spanish by staff from Connecticut Mental Health Center – Hispanic Clinic. At the request of one program, the Modified Mini/CAGE AID screening instrument was translated into Polish for use with their clients.

Screening Pilot Sites

Only the two COSIG pilot sites, Morris Foundation and Connecticut Mental Health Center's (CMHC) Hispanic Clinic were initially slated to participate in the COSIG Screening Pilot. After consideration, the COSIG Screening Work Group concluded that the number of agencies participating in the pilot should be increased. This would ensure a greater sample size and a greater representative sample thus increasing the validity of the conclusions and recommendations made based upon the screening pilot results for implementation in Connecticut.

Following the decision to recruit additional screening pilot sites, a letter from Dr. Thomas Kirk, Jr., Commissioner of DMHAS, was sent to Chief Executive Officers of DMHAS funded and operated agencies inviting them to participate in the screening pilot. Agencies were offered \$2,000 if they chose to participate to cover costs incurred. In addition, agencies were offered free training and data collection support from DMHAS staff. The screening pilot began on May 1, 2006. Thirty mental health and addiction treatment (state operated and private non-profit) agencies participated in the statewide screening pilot over 10 months.

Screening Pilot Trainings and Support

DMHAS staff conducted brief (1 hour) onsite trainings on screenings for each participating agency. The training included an overview of screening, how screening differs from assessments, and the benefits of screening. Staff from pilot sites were also trained on the individual screening forms that they were using and on data entry. Over 35 on-site trainings and two remote trainings have been conducted since the start of the pilot. A list of training dates, sites, and number of staff trained may be found in Appendix D.

In addition to the trainings, providers participated in monthly conference calls to provide feedback on the pilot and to ask questions. Prior to each conference call, each agency received a monthly feedback report from the screens they submitted. A list of conference call dates may be found in Appendix E.

Screening data has been stored in a customized, password-protected Access database, stored on a secure DMHAS server. Some of the sites conducted their own data entry and submitted extracts by secure file transfer, while most sent screening forms to DMHAS for data entry. Data was merged into an Excel spreadsheet and imported into SPSS 12.0 for analysis.

III. Results

Table 1: List of Screening Sites

Agency Name	Type of Program(s) Participating in Pilot	Agency Type
ALSO-Cornerstone	AS	Private Non-Profit
Capitol Region Mental Health Center	MH	State Operated
Catholic Charities of New Haven	MH	Private Non-Profit
Central Naugatuck Valley HELP, Inc.	AS	Private Non-Profit
Chemical Abuse Services Agency (CASA)	AS	Private Non-Profit
Chrysalis Center, Inc.	AS	Private Non-Profit
Community Mental Health Affiliates (CMHA)	AS, MH	Private Non-Profit
Connecticut Mental Health Center	AS, MH	State Operated
Connecticut Renaissance	AS	Private Non-Profit
Crossroads, Inc.	AS	Private Non-Profit
Gilead Community Services, Inc.	MH	Private Non-Profit
Harbor Health Services	AS, MH	Private Non-Profit
Hartford Behavioral Health	MH	Private Non-Profit
Hogar Crea International	AS	Private Non-Profit
Institute for the Hispanic Family (Catholic Charities, Hartford)	AS	Private Non-Profit
Inter-Community Mental Health Group	AS, MH	Private Non-Profit
Liberation Programs, Bridgeport	AS	Private Non-Profit
McCall Foundation	AS	Private Non-Profit
Midwestern Connecticut Council on Alcoholism (MCCA)	AS	Private Non-Profit
Morris Foundation	AS	Private Non-Profit
New Britain General Hospital	AS, MH	Private Non-Profit
Perception House	AS	Private Non-Profit
Regional Network of Programs (Regional Counseling Services only)	AS	Private Non-Profit
Reliance House	MH	Private Non-Profit
River Valley Services	MH	State Operated
Rushford Center	AS	Private Non-Profit
Southeastern Mental Health Authority	AS, MH	State Operated
Southwest Connecticut Mental Health System	MH	State Operated
United Services, Inc.	AS, MH	Private Non-Profit
Western Connecticut Mental Health Network	MH	State Operated

Twenty-four private non-profits and six state-operated providers participated in the pilot. Fifteen agencies piloted the screening instruments in their addiction programs only; 8 piloted the instruments only in their mental health programs; and 7 sites piloted the screenings in both addiction and mental health programs.

Table 2: Overall Frequencies

Positive COD		MH Only		SU Only		Negative for Both		Total	
N	%	N	%	N	%	N	%	N	%
1,345	44	539	18	593	19	573	19	3,050	100

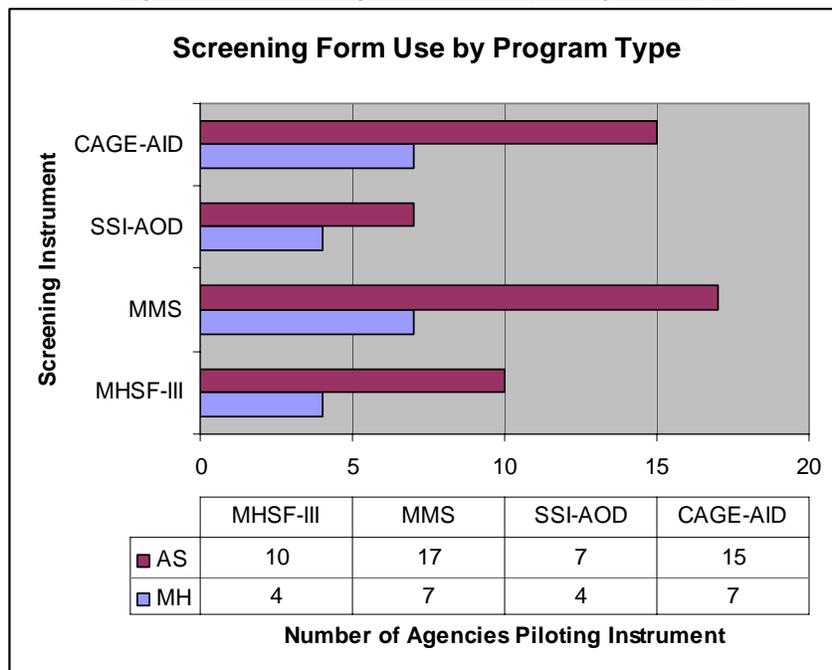
Overall, forty four percent of the 3,050 participants screened positive for signs of co-occurring disorders. Eighteen percent have screened positive for mental health problems only; nineteen percent, for substance use issues only. Nineteen percent have screened negative for both mental health and substance use problems.

Table 3: Frequencies by Type of Program

Program Type	Positive COD		MH Only		SU Only		Negative for Both	
	N	%	N	%	N	%	N	%
AS	1126	44	347	14	563	22	527	21
MH	219	45	192	39	29	6	48	10

Both addictions and mental health programs tended to have the same percentage of positive co-occurring screenings. However, negative screenings in addictions programs occurred at twice the rate as in mental health programs.

Figure 1: Screening Form Use by Program Type



The Modified MINI Screen and CAGE-AID instruments tended to be used most often by addiction services and mental health programs alike.

Table 4: Overall Frequencies by Form

Type of Instrument	Form	Positive COD		MH Only		SU Only		Negative for Both	
		N	%	N	%	N	%	N	%
Mental Health Screening Instrument	Mental Health Screening Form-III (MHSF-III)	552	51	272	25			169	16
	Modified MINI Screen (MMS)	758	40	254	13			398	21
Substance Use Screening Instrument	Simple Screening Instrument for Alcohol and Other Drugs (SSI-AOD)	515	50			82	8	158	16
	CAGE Adapted to Include Drugs (CAGE-AID)	794	48			507	30	209	13

The majority of screenings overall used the MMS and CAGE-AID combination; however, the highest percentage of positive COD screens come from providers who used the MHSF-III and SSI-AOD.

Table 5: Results by Program Type According to Screening Tool

Program Type	Positive COD		MH Only		SU Only	
	N	%	N	%	N	%
MHSF-III						
AS	520	53	204	21		
MH	32	29	68	62		
MMS						
AS	607	38	143	9		
MH	151	47	111	35		
SSI-AOD					N	%
AS	483	53			81	9
MH	32	29			1	1
CAGE-AID					N	%
AS	643	47			481	35
MH	151	48			26	8

Clients screened by addiction service programs tended to screen positive for COD most often when the program piloted the MHSF-III and/or the SSI-AOD (usually these two instruments were paired together.) Client's screened by mental health service programs tended to screen positive for COD most often when the program piloted the MMS and/or the CAGE-AID (usually these two instruments were paired together.) The highest rate of negative screening occurred when an addictions service program piloted the MMS.

Table 6: Results by Agency Type

Agency Type	Positive COD		MH Only		SU Only		Negative for Both	
	N	%	N	%	N	%	N	%
State Operated	76	47	68	43	10	6	6	4
Private Non-Profit	1269	44	471	16	583	20	567	20

As discussed previously in this report, six state operated sites (Local Mental Health Authorities) and 24 private non-profit agencies participated in data collection, so it is difficult to compare the two groups because of uneven group sizes. However, clients screened at state operated clinics have so far tended to screen positive for signs of co-occurring disorders or a mental health problem only, with only 6% reporting signs of a substance use problem only and 4% screening negative for both types of problems

Table 7: Results by Method of Administration

Administration Method	Positive COD		MH Only		SU Only		Negative for Both	
	N	%	N	%	N	%	N	%
Self Administered N=886	406	46	179	20	166	19	135	15
Staff ² Administered N=2155	931	43	359	17	426	20	439	20
	1337		538		592		574	

Data was collected on the method of administration. Staff administered the majority of screenings in this pilot. Self administered screenings have yielded a slightly higher rate of positive scores in general and for co-occurring disorders.

² "Staff" includes clinical as well as other staff such as receptionists.

Table 8: Observation Checklist Results³

Observation Item	N	%
Needle track marks	84	3.9
Skin abscesses, cigarette burns, or nicotine stains	36	1.7
Tremors (shaking and twitching of hands and eyelids)	49	2.3
Unclear speech: slurred, incoherent, or too rapid	52	2.4
Unsteady gait: staggering or off balance	18	0.8
Dilated (enlarged or constricted [pinpoint] pupils)	24	1.1
Scratching	27	1.3
Swollen hands or feet	15	0.7
Smell of alcohol or marijuana on breath	8	0.4
Drug paraphernalia such as pipes, paper, needles, or roach clips	3	0.1
“Nodding out” (dozing or falling asleep)	37	1.7
Agitation	67	3.1
Inability to focus	84	3.9
Burns on the inside of the lips	7	0.3

Few clients screened positive for anything on the Observation Checklist. Providers’ enthusiasm for using this portion of the instrument was low, and many times clinicians would circle the entire column of “no” answers instead of going through each item individually. The most commonly observed items, at 3.9%, were “inability to focus” and “needle track marks”.

Monthly Conference Calls

Conference calls, providing technical assistance as well as updates regarding pilot implementation, were held each month beginning in August, 2006. The second conference call included technical assistance by Dr. JoAnn Sacks of SAMHSA’s Co-Occurring Center for Excellence (COCE) regarding screening and how to integrate screening into regular agency operations. DMHAS conducted eight of these calls with participating providers.

In addition to the conference calls, participants were offered other forms of assistance. A frequently asked questions document was created and distributed to participants. Presentations and supporting documents were also made available on the Co-Occurring Disorders page of the DMHAS website.

Participant Feedback

Focus Groups with Pilot Participants

Three focus groups were conducted with consumers who participated in the pilot process. Individuals were asked to relate how comfortable they were with the screening process, and to evaluate the questions in the screening instruments. They were also asked to identify the best and most comfortable way to administer the screening instruments based on their experience.

³ Screenings conducted by telephone were excluded from this analysis.

Two of the pilot agencies asked individuals who had been asked the screening questions if they would like to participate in a focus group on them. Both of these agencies had used the screening measures in a question-and-answer format conducted by a clinician or other staff member. A total of 24 individuals, 15 males and 9 females, participated in these groups. Two groups were held at the Morris Foundation in Waterbury and one group at Connecticut Mental Health Center's Hispanic Clinic in New Haven. The two groups at Morris Foundation were conducted in English and the group at the Hispanic Clinic was conducted in Spanish. Participants came from a variety of racial and ethnic groups.

Participants felt overwhelmingly comfortable about the co-occurring screening, and expressed mostly positive feelings about the process. The majority of participants understood what the screening process entailed, the purpose of the process, and why specific questions were being asked. Some individuals expressed feeling nervous and uncomfortable at the beginning of the screening, but were put at ease when the process was explained to them. A subset of individuals who expressed initial discomfort also explained that it was difficult for them to talk about their feelings and experiences in general.

During one particular focus group, all participants expressed the importance of being set at ease by the person conducting the screening. Several participants in this focus group indicated that the person performing the screening helped them overcome their reluctance towards answering certain questions and about discussing their feelings and experiences. This topic was addressed in a subsequent focus group; individuals in this group agreed that the role of the person doing the screening is extremely important in building trust and making individuals comfortable, especially since screening is often the first contact people have with a provider.

Participants were asked how they felt about the questions that were used in the screening process. The consensus opinion was that the questions were fairly good. Some individuals felt that the number of questions was too high and that it might be difficult for people, particularly some individuals who are using substances, to comprehend some of the questions. All participants stated that they understood why questions were being asked even if many of the questions used in the instrument seemed repetitive. They stated that the questions were not offensive in any way. As one individual stated, "If it did not apply to me, I did not get offended, as I understood why they were asking it- what they were looking for."

With regard to the best way to administer questions, participants stated a preference for in-person, staff administered screenings. This was followed by client administered (i.e. self) in-person screenings. Perhaps the most noteworthy finding of these focus groups was the degree to which participants stated they would not be comfortable with screenings conducted over the telephone. Throughout all three focus groups, only one person stated that he could "maybe" understand conducting this type of screening over the phone.

Participants articulated fear that someone may overhear the conversation and that information will not be kept confidential and/or shared with others if the screens were done over the phone. Focus group participants also indicated potential reluctance to answer questions truthfully when family/children are present. Several individuals shared past negative experiences with information shared over the telephone that was subsequently disclosed to others. Additionally, one individual stated that screening over the phone might give the impression that a person is being qualified for services rather than being screened in order to place him or her into the most effective services.

With regard to changes to the current screening process, participants did not feel that any changes were necessary. Several individuals stated that any process should be monitored to ensure cultural

competency and effectiveness. All focus group participants emphasized their belief that this process was important to help people obtain the best services possible.

In conclusion, the focus group participants expressed positive feelings about the screening pilot. All participants understood the importance of the process and felt that it was useful in helping people to access services they need to achieve and maintain recovery. Some participants expressed discomfort with the questions, but their discomfort was not long lasting once they understood why the questions were being asked. People also emphasized the important role of the person administering the screening instrument in making people feel comfortable. Participants overwhelmingly felt that screening should not be conducted over the telephone, due to concerns with confidentiality, personal comfort and safety.

Provider Survey

Providers were asked to relate their experience with the pilot process via an online survey. A total of 19 providers submitted feedback via this method. Participants were asked to comment on their experiences with clients completing the instruments on their own. Several respondents indicated that clients had some problems while others indicated few problems. Specific comments included:

- Sometimes clients didn't understand the questions therefore couldn't complete it accurately.
- Most were willing, but did not find it helpful.
- I found it quicker and easier to read questions to clients and fill in appropriate responses.
- Most of us read the questions to the client.
- We had no problems, and no complaints. Clients sometimes needed assistance.
- Clinicians found screening tools very helpful.
- We encountered few problems.
- No problems reported.
- Vast majority of clients had no problem completing on their own.

Three providers responded to the question that asked about their experience with administering the screenings over the phone. Two reported no problems or issues. One of these felt it was useful in establishing a rapport with clients before they came into the office. One of the three respondents indicated that he/she felt the face to face interview was clinically more viable. This individual reported that since they were administering the instrument to people just prior to release from incarceration, they had no choice but to use the telephone as the method of administration.

Fifteen providers responded to questions that asked about ease of administration. All fifteen stated that the instruments were easy to administer. In addition, thirteen providers answered the question regarding ease of scoring by stating that the instruments were easy to score.

Eleven providers responded to the question regarding client comprehension of the questions and process. All individuals responding to this question stated that for the most part clients understood the questions and process well. In addition, all respondents who answered indicated that client response was positive.

Specific comments concerning comprehension included the following:

- Most of the time they didn't understand the question when it got too long.
- Very few difficulties.
- Clients would get confused at times because there were too many questions in one.

- Most had no trouble. In situations when the client did not understand, the staff had no trouble explaining the question.
- Very few hesitations in answering.
- Information was misunderstood or confused with questions starting out using 'ever', 'past two weeks' or 'Do you feel'. When asked to elaborate on what situation, they reported 'oh that was before not now.'
- Some clients required clarification of questions in the mental health section.
- Clients rarely had questions or needed explanations.
- Often the client would ask for clarification, but would understand with a little additional explanation.
- Sometimes questions had to be repeated in a slow manner and sometimes people didn't understand the meaning of the words in some of the questions.

Participants reported that they feel the screening tools and process are very useful. All eleven individuals who responded stated that they felt this way. In terms of ease of use on the staff and length of time to use, participants commented:

- Pretty straight-forward assessment tool.
- Questions could be shorter.
- It was a much quicker process and they understand it much easier.
- It was ok.
- Useful in making a better assessment to the client's needs related to mental health services.
- No problems, easy to use.
- Very useful tool; helps to determine a lot.
- Some clients were difficult to reach by phone so this sometimes took more time for the worker to complete the tool. Average time for our agency was around 10 minutes. It would be hard to shorten it and have it still be meaningful.
- Just difficult because it does not necessarily tie in with the assessment (adds to the overall paperwork necessary to get a client into services).
- At times it was too long for the clients and they would start answering anything just to finish quickly.
- It is a brief test but anything added to an assessment consumes valuable time. However it is only about 9 minutes in our case and worth it.

When asked about the clinical utility of the screening process, respondents made the following comments:

- Prompted our realizing how many of our clients needed further evaluation/monitoring of emotional issues.
- We already ask most of the same questions, but they are all important to get a clear picture of our client's mental health and substance abuse treatment needs.
- Useful, however, our clinical intake captures the same information on MH, SA and Dual Disorders, trauma etc.
- I believe this instrument is useful in having some information about the client, however, the final diagnosis is usually determined by figuring out if the client meets certain criteria of DSMIV disorders.
- Good tool.
- Useful for screening - which was the intended purpose. Not useful for assessment/diagnosis - which is not its intended purpose anyway.
- Helped pinpoint needs.

- Useful in identifying recommendation for psychiatric services when clients reported no diagnosis for mental health.
- It was useful in gaining knowledge about the individual person, but not the population that we serve.
- Gave staff an enormous help in being aware of psych issues of clients.

The only barriers to implementing the combined mental health and substance abuse screening tool centered on clients language ability and time issues. Specific comments included the following:

- I had no barriers.
- We already deal with various barriers i.e. language, writing skills, phone limitations, time if there are many to interview. We deal with these and have found ways to meet the needs of the clients.
- Clients showing up late for appointments
- None.
- Clients who are illiterate or speak another language. Since using this form we have very few incidents where this has occurred.
- Our intake interviews are typically 1 1/2 hours long, an extra 10 to 15 minutes was not always welcomed.

Participants were asked to indicate how the screening pilot influenced or changed their agency's assessment process. All responses indicated a positive influence. Specifically, respondents reported that:

- It give a clear view on what areas the client's need more assistance on and case managers can work on those areas needed.
- We have picked up mental health issues much earlier, have been able to make a more thorough assessment of potential clients, and identified clients in crisis that may not have shared that with us.
- Increased clinician awareness of mental health issues.
- We're able to make referral prior to behavior problems while in a treatment setting.
- We have made screening tools standard part of intake process.
- We are now using this form for all clients and plan to continue to use it because of the information provided and that it is not time consuming and is easy to administer.
- It provides us with a clearer view of the person's needs and supports.

When asked if their agency would continue to use the screening instruments, seven participants responded yes. One individual stated that he/she was unsure. Specific comments included:

- It might give us more accuracy when attending a clients needs.
- We will continue to use the tool. Thank you!
- We will continue to use as part of basic assessment package.
- It provides additional tools with information on mental health status to determine eligibility for placement.
- Will be part of a to-be-developed centralized intake process.
- It is now part of the admission process.

In conclusion, provider participants had a positive response to the screening pilot. Despite the various ways of instrument administration and different options of screening forms, providers who participated in the screening process had a positive experience and found implementation of

screening for co-occurring disorders to be useful. They indicated few negative experiences and felt that using the screening instruments would help them to better serve their clients.

IV. Discussion and Recommendations

Preliminary results suggest that one screening instrument does not fit all and that certain types of agencies tend to gravitate towards certain tools. The MHSF-III, at first glance, seems to be more attractive and potentially useful to addiction service providers, while the MMS seems more desirable and useful to mental health service providers. We suggest that providers be allowed to evaluate a menu of screening instruments and choose the form that they feel fits their population best.

The relatively large number of overall negative screenings (19%) was explored further. In December of 2006, COSIG staff decided to survey providers whose clients screened negative for any behavioral health problem. Lists of client names and the dates of negative screenings were securely faxed to 15 programs in the COSIG screening pilot; DMHAS received 10 responses in return, concerning a total of 57 clients.

Of these 57 clients, 25 (44%) people reportedly denied or minimized issues. Twenty-two (39%) people had been mandated by court to receive an evaluation. Seven (12%) people were currently in treatment or remission from their symptoms. Three clients actually did have a positive score, and their screening data was updated in the COSIG database.

Many of the addiction service providers, which provided the bulk of the pilot's data, receive mandated referrals from the criminal justice system and the Department of Children and Families (DCF). Many of these referrals screen negative for a variety of reasons, including fear of consequences as reported by staff.

Based on feedback from pilot sites, it appears that all methods used in administering the screening instrument are effective. Sites which conducted screens over the phone reported no problems and in fact reported that those being screened over the phone were more likely to come to their initial in-person appointment than those not being screened. It also appears that there is little difference in client (self) administered and staff administered screenings. Although this question will continue to be examined, based upon these findings, client and provider feedback, and research regarding methods of administration (Rush et al. 2005), providers should be allowed to choose a method of administration.

The observation checklist, included as an addition to the standardized screening tools, has not proven useful as less than 4% of the client screenings have shown outward symptoms of behavioral issues. Clinicians may not have been engaged in the observation process or chose not to answer the questions. Since 81% of screenings performed have yielded positive results of some kind in this pilot, it is probably unnecessary to add this additional component to augment self-report screening results.

Although it sometimes took a few months to take hold, screening has been adopted as a routine practice by many of the participants in the COSIG pilot. Several agencies have reported liking the instruments and finding them clinically useful in addition to making adaptations to their intake protocols to accommodate the use of the co-occurring screening. Additionally, some of the addiction service agencies told project staff that this initiative has caused them to begin implementing more formal referral and collaboration procedures for clients screening positive for mental health problems if they do not have capacity to provide the needed services.

System-wide implementation of screening is the major recommendation of this pilot. DMHAS operated and funded programs should have the option of choosing among the four screening instruments used during the pilot. In many instances, screening is the initial contact with individuals. As such, screening instruments must be administered utilizing welcoming and recovery-oriented engagement techniques. The approach is to be person-centered, with respect for individual's strengths, hope, and wellness, and in support of Connecticut's Recovery Practice Guidelines.

In summary, our recommendations include:

- **July 1, 2007 statewide implementation of screening: screening requirement be included in policies of all DMHAS operated facilities and in the contracts of DMHAS funded programs. Screening instruments must be administered utilizing welcoming and recovery-oriented engagement techniques. The approach is to be person-centered, with respect for individual's strengths, hope, and wellness, and in support of Connecticut's Recovery Practice Guidelines.**
- **DMHAS operated and funded programs have the option of choosing among the four screening instruments used during the pilot.**
- **Multiple methods of administration: In person or phone, self or clinician administered.**
- **Addition of four fields to the DMHAS Provider Access System (DPAS) and Behavioral Healthcare Information System (BHIS) for Private Non-profits and DMHAS operated facilities: 1) which mental health screening instrument used, 2) which substance use screening instrument used, 3) mental health screening score, and 4) substance use score.**
- **Continue and expand formalized training offered in a variety of ways such as web-based, training of trainers, in-person workshops and other assistance. Training should continue to include a focus on providing a screening overview, relating the importance of screening to clinical practice, and an opportunity to practice using screening instruments.**

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APPENDIX A

Commissioner's Policy Statement No. 84

Effective Date: January 11, 2007

Policy on Serving People with Co-Occurring Mental Health and Substance Use Disorders

Purpose

The single overarching goal of the Department of Mental Health and Addiction Services (DMHAS), as a healthcare service agency, is promoting and achieving a quality-focused, culturally responsive, and recovery-oriented system of care. The full attainment of this goal is not possible if the service system design, delivery, and evaluation are not fully responsive to people with co-occurring mental health and substance use disorders. Given the high prevalence of co-occurring disorders, the high number of critical incidents involving individuals with co-occurring disorders, and the often poor outcomes associated with co-occurring disorders in the absence of integrated care, it is extremely important that we collectively improve our system in this area. There have been advances in research and practice related to co-occurring disorders and it is important that the system close the science to service gap. Through these and other related improvements, the citizens of the state can expect better processes of care and better outcomes for people with co-occurring disorders.

Policy Statement

The publicly funded healthcare system in Connecticut will be highly responsive to the multiple and complex needs of persons and families experiencing co-occurring mental health and substance use disorders, in all levels of care, across all agencies, and throughout all phases of the recovery process (e.g., engagement, screening, assessment, treatment, rehabilitation, discharge planning, and continuing care).

Definitions

- Co-occurring disorders are defined as the coexistence of two or more disorders, at least one of which relates to the use of alcohol and/or other drugs and at least one of which is a mental health disorder.
- Integrated treatment is a means of coordinating both substance use and mental health interventions; it is preferable if this can be done by one clinician, but it can be accomplished by two or more clinicians working together within one program or a network of services. Integrated services must appear seamless to the individual participating in services.

Guiding Principles

- People with co-occurring disorders are the expectation in our healthcare system, and not the exception.
- There is "no wrong door" for people with co-occurring disorders entering into the healthcare system.
- Mental health and substance use disorders are both "primary".
- The system of care is committed to integrated treatment with one plan for one person.
- The system will offer evidence-based techniques and protocols, and evaluate how these relate to outcomes.
- The system will strive to identify, develop, evaluate, and document new emerging or promising practices.
- Improvements will be made to program structures and milieu, staffing, and workforce development relative to co-occurring disorders.
- Recovery support (including self-help, mutual support, peer-delivered and peer-run services) and family education and support are important components of a co-occurring enhanced system of care.
- Integrated care must be accomplished by preserving and capitalizing on the values, philosophies, and core technologies of both the mental health and addiction treatment fields.

Background

Connecticut has taken significant and important steps over the last several years to increase the system's capacity to provide accessible, effective, comprehensive, integrated, and evidence-based services for adults with co-occurring disorders. In this respect, Connecticut is fortunate to have combined separate agencies into a single state authority that has responsibility for both mental health and addiction services. Subsequent to this merger, DMHAS has undertaken both an Integrated Dual Disorders Treatment (IDDT) initiative and a Dual

Diagnosis Capability in Addiction Treatment (DDCAT) initiative. DMHAS has also established strong academic partnerships related to co-occurring disorders with Dartmouth Medical School, the University of Connecticut, and Yale University. Finally, Connecticut was one of several states to participate in the National Policy Academy on Co-occurring Disorders and to receive a SAMHSA award for a Co-Occurring State Incentive Grant (COSIG) in 2005. This policy is yet an additional important step forward in achieving a fully integrated and co-occurring disorders enhanced system of care for all of the state's citizens receiving publicly funded behavioral health services.

There has been significant national attention in recent years to the issues associated with co-occurring disorders. The Surgeon General's *Report on Mental Health* in 1999, the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2002 *Report to Congress* on co-occurring disorders, the President's New Freedom Commission Report on *Achieving the Promise* in 2003, and SAMHSA's Treatment Improvement Protocol (TIP) #42 on co-occurring disorders issued in 2005 all note the high prevalence of co-occurring disorders, the lack of integrated care available in our healthcare system, and the poor outcomes experienced in the absence of integrated care. In addition, the National Association of State Alcohol and Drug Abuse Directors (NASADAD) and the National Association of State Mental Health Program Directors (NASMHPD) jointly developed a "four quadrant" model describing different groups of people with co-occurring disorders; the American Society of Addiction Medicine (ASAM) developed the vocabulary of "addiction only," "dual diagnosis capable," and "dual diagnosis enhanced" for program assessments; and SAMHSA began awarding Co-Occurring State Incentive Grants (COSIG) in 2002. As is evident throughout these developments and initiatives, there is a clear consensus in the field that the integration of mental health and addiction services is a pre-requisite for meeting the needs of an increasing number of individuals with co-occurring disorders.

Tools for Implementing the Policy

Resources available to help implement integrated mental health and addiction treatment:

The DMHAS Co-Occurring Disorders Initiative website - <http://www.dmhas.state.ct.us/cosig.htm> - includes the following resources:

- Definitions and standards for co-occurring enhanced services
- Integrated Dual Disorders Treatment (IDDT) Toolkit
- Dual Diagnosis Capability in Addiction Treatment (DDCAT) Toolkit
- SAMHSA's Treatment Improvement Protocol (TIP) #42: Substance Abuse Treatment for Persons with Co-Occurring Disorders
- DMHAS Co-Occurring Training Academy
- Access to consultants to assist with organizational and practice changes
- Specialty credentials for serving people with co-occurring disorders
- Standardized mental health and substance use screening measures in English and Spanish
- Outcome reports specific to people with co-occurring disorders
- Audiovisuals, books, curricula, pamphlets, and posters on co-occurring disorders
- The national Co-Occurring Center for Excellence: coce.samhsa.gov/
- Commissioner's Policy Statement #76: Policy on Cultural Competence: <http://www.dmhas.state.ct.us/policies/policy76.htm>
- Commissioner's Policy Statement #83: Promoting a Recovery-Oriented Service System: <http://www.dmhas.state.ct.us/policies/policy83.htm>
- Practice Guidelines for Recovery-Oriented Behavioral Health Care: www.dmhas.state.ct.us/documents/practiceguidelines.pdf
- Key Principles and Practices of Person-Centered Care: www.dmhas.state.ct.us/recovery/pcc.pdf

Thomas A. Kirk, Jr., Ph.D.
Commissioner

APPENDIX B

Modified MINI and CAGE-AID Screening Measure - Client Section

Date: _____

Time started: _____

Client Name: _____

Date of Birth: _____

Introduction: In this program, we help people with all their problems - their addictions and emotional problems. Our staff is ready to help you to deal with any problems you may have, but we can do this only if we are aware of the problems. I'm going to ask you some questions, and some of them might bring up some strong feelings. I want you to know that you don't have to answer any questions if you don't want to or if you feel uncomfortable, and that we can stop at any time - just let me know.

Section 1 – Modified MINI

Section A

1. Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks?
YES _____ NO _____
2. In the past two 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 _____

Section B

7. 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? Did these intense feelings get to be their worst within 10 minutes? (If "yes" to both questions, answer "yes", otherwise check "no")
YES _____ NO _____
8. Do you feel anxious, frightened, uncomfortable 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 you answered "no" to this question, please skip 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 _____

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 _____

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 _____

Section D

23. Have you ever borrowed money to gamble, gambled more than you intended to, or lied about how much you gambled?

YES _____ NO _____

24. Have you or someone else ever thought that gambling might be causing problems in your life?

YES _____ NO _____

Section 2 – CAGE-AID

1. Have you ever felt you should Cut down on your drinking or drug use?

Drinking: YES _____ NO _____
Drug Use: YES _____ NO _____

2. Have people Annoyed you by criticizing your drinking or drug use?

Drinking: YES _____ NO _____
Drug Use: YES _____ NO _____

3. Have you ever felt bad or Guilty about your drinking or drug use?

Drinking: YES _____ NO _____
Drug Use: YES _____ NO _____

4. Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (Eye opener)?

Drinking: YES _____ NO _____
Drug Use: YES _____ NO _____

Section 3

1. What, if any, diagnosis have you received in the past? _____

2. What do you identify as your problem at this time? _____

3. What would you like to happen as a result of being here today? _____

Time ended: _____

Modified Mini International Neuropsychiatric Interview (Modified M.I.N.I.)/ CAGE-AID Clinician's Section

Agency: _____ Program: _____

Clinician Name: _____

The client section of these screenings was administered by the: Client _____ Clinician _____

Observation Checklist for Interviewer:

Did you observe any of the following while screening this individual?

a. Needle track marks	Yes	No
b. Skin abscesses, cigarette burns, or nicotine stains	Yes	No
c. Tremors (shaking and twitching of hands and eyelids)	Yes	No
d. Unclear speech: slurred, incoherent, or too rapid	Yes	No
e. Unsteady gait: staggering or off balance	Yes	No
f. Dilated (enlarged or constricted [pinpoint] pupils)	Yes	No
g. Scratching	Yes	No
h. Swollen hands or feet	Yes	No
i. Smell of alcohol or marijuana on breath	Yes	No
j. Drug paraphernalia such as pipes, paper, needles, or roach clips	Yes	No
k. "Nodding out" (dozing or falling asleep)	Yes	No
l. Agitation	Yes	No
m. Inability to focus	Yes	No
n. Burns on the inside of the lips	Yes	No

Summary

___ Screened positive for a mental health problem

- Total score of 6 or higher on the MINI – OR –
- Question 4 = yes (suicidality) – OR –
- Question 14 AND 15 = yes (trauma)

___ Screened positive for a substance abuse problem

- Total score of 1 or greater on the CAGE-AID-- OR –
- Score of less than 1 does not rule out a substance abuse/dependence problem; use observations to assist with screening decision.

Interviewer Comments:

MHSF-III and SSI-AOD Screening Measure – Client Section

Date: _____ Time started: _____

Client Name: _____ Date of Birth: _____

Introduction: In this program, we help people with all their problems - their addictions and emotional issues. Our staff is ready to help you to deal with any problems you may have, but we can do this only if we are aware of them. I'm going to ask you some questions, and some of them might bring up some strong feelings. I want you to know that you don't have to answer any questions if you don't want to or if you feel uncomfortable, and that we can stop at any time - just let me know.

Section 1 – MHSF-III

I am going to ask you some questions and please note that 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 for your emotional problems? 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 or things which others could not see? YES _____ NO _____
6. a) Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself? YES _____ NO _____
b) Did you ever attempt to kill yourself? YES _____ NO _____
7. Have you ever had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed? YES _____ NO _____
8. Have you ever experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help? 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 behavior? 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? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw-up?
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, and uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint?
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? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate.
YES _____ NO _____
16. Have you ever borrowed money to gamble, gambled more than you intended to, or lied about how much you gambled?
YES _____ NO _____
17. Have you or someone else ever thought that gambling might be causing problems in your life?
YES _____ NO _____
18. Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem?
YES _____ NO _____

Section 2 – SSI-AOD

I'm going to ask you a few questions about your use of alcohol and other drugs during the past 6 months. During the past 6 months...

1. Have you used alcohol or other drugs? (such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants). YES _____ NO _____
2. Have you felt that you use too much alcohol or other drugs? YES _____ NO _____
3. Have you tried to cut down or quit drinking or using drugs? YES _____ NO _____
4. Have you gone to anyone for help because of your drinking or drug use? YES _____ NO _____
5. Have you had any health problems? For example, have you:
 - ___ had blackouts or other periods of memory loss?
 - ___ injured your head after drinking or using drugs?
 - ___ had convulsions, delirium tremens (DTs)?
 - ___ had hepatitis or other liver problems?
 - ___ felt sick, shaky, or depressed when you stopped?

___ felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs?

___ been injured after drinking or using?

___ used needles to shoot drugs?

Give a "YES" answer if at least one of the 8 presented items is marked ✓

YES _____ NO _____

6. Has drinking or other drug use caused problems between you and family or friends?

YES _____ NO _____

7. Has your drinking or other drug use caused problems at school or work?

YES _____ NO _____

8. Have you been arrested or had other legal problems? (such as bouncing bad checks, driving while intoxicated, theft, or drug possession)?

YES _____ NO _____

9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs?

YES _____ NO _____

10. Are you needing to drink or use drugs more and more to get the effect you want?

YES _____ NO _____

11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs?

YES _____ NO _____

12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone?

YES _____ NO _____

13. Do you feel bad or guilty about your drinking or drug use?

YES _____ NO _____

The next questions are about your lifetime experiences.

14. Have you ever had a drinking or other drug problem?

YES _____ NO _____

15. Have any of your family members ever had a drinking or drug problem?

YES _____ NO _____

16. Do you feel that you have a drinking or drug problem now?

YES _____ NO _____

Section 3

1. What, if any, diagnosis have you received in the past? _____

2. What do you identify as your problem at this time? _____

3. What would you like to happen as a result of being here today? _____

Time ended: _____

Mental Health Screening Form-III (MHSF-III)/ Simple Screening Instrument (SSI-AOD)

Clinician's Section

Agency: _____ Program: _____

Clinician Name: _____

The client section of these screenings was administered by the:
Client _____ Clinician _____

Observation Checklist for Interviewer:

Did you observe any of the following while screening this individual?

o. Needle track marks	Yes	No
p. Skin abscesses, cigarette burns, or nicotine stains	Yes	No
q. Tremors (shaking and twitching of hands and eyelids)	Yes	No
r. Unclear speech: slurred, incoherent, or too rapid	Yes	No
s. Unsteady gait: staggering or off balance	Yes	No
t. Dilated (enlarged or constricted [pinpoint] pupils)	Yes	No
u. Scratching	Yes	No
v. Swollen hands or feet	Yes	No
w. Smell of alcohol or marijuana on breath	Yes	No
x. Drug paraphernalia such as pipes, paper, needles, or roach clips	Yes	No
y. "Nodding out" (dozing or falling asleep)	Yes	No
z. Agitation	Yes	No
aa. Inability to focus	Yes	No
bb. Burns on the inside of the lips	Yes	No

Summary

- ___ Screened positive for a mental health problem
 - At least one "yes" response to questions 3 – 18 on the MHSF-III

- ___ Screened positive for a substance abuse problem
 - (Questions 1 and 15 are not scored).
 - Score of 5 or higher on the SSI-AOD measure
 - Score of less than 5 does not rule out a substance abuse/dependence problem; use observations to assist with screening decision

Interviewer Comments:

APPENDIX C

COSIG SCREENING PILOT WORK GROUP

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APPENDIX D

Agency	Training Date	# Trained
ALSO-Cornerstone	June 30, 2006	1
Capitol Region Mental Health Center	December 28, 2006 and October 16, 2006	1 10
Catholic Charities of New Haven	August 14, 2006	6
Central Naugatuck Valley HELP, Inc.	June 12, 2006	10
Chemical Abuse Services Agency (CASA)	June 20, 2006	7
Chrysalis Center, Inc.	June 14, 2006	2
Community Mental Health Affiliates (CMHA)	June 15, 2006	12
Connecticut Mental Health Center	January 16, 2007	10
Connecticut Renaissance	June 13, 2006	1
Crossroads, Inc.	May 19, 2006	2
F.S. Dubois Center	December 12, 2006 January 18, 2007	10 10
Gilead Community Services, Inc. (by telephone)	August 16, 2006	1
Greater Bridgeport Mental Health Center	November 30, 2006 January 4, 2007	10 2
Harbor Health Services	June 30, 2006	7
Hartford Behavioral Health	July 5, 2006	2
Hispanic Clinic - CMHC	April 18, 2006	2
Hogar Crea International	July 18, 2006	1
Institute for the Hispanic Family (Catholic Charities, Hartford)	August 25, 2006 and January 23, 2007	3
Inter-Community Mental Health Group	August 22, 2006	6
Liberation Programs, Bridgeport	August 15, 2009	19
Liberation Programs, Stamford (by telephone)	August 8, 2006	6
McCall Foundation	June 7, 2006	4
Midwestern Connecticut Council on Alcoholism (MCCA)	June 20, 2006	19
Morris Foundation	April 19, 2006	12
New Britain General Hospital	June 13, 2006	11
Perception House	July 20, 2006	5
Regional Network of Programs (Regional Counseling Services only)	August 14, 2006	9
Reliance House	October 10, 2006	20
Rushford Center	July 11 and 13, 2006	16
Southeastern Mental Health Authority	August 12, 2006	6
United Services, Inc.	June 1 and 2, 2006	11
Total trainings	37	242 staff

APPENDIX E

List of Conference Calls.

Note: Individual conference calls with providers were conducted as needed.

Providers/Topics	Date
Participants using Modified MINI	08/29/06
Participants using MHSF III	08/30/06
Participants using Modified MINI	09/26/06
Participants using MHSF III	09/27/06
Participants using MHSF III	10/30/06
Participants using Modified MINI	10/31/06
All participants	11/28/06
All participants	01/11/07