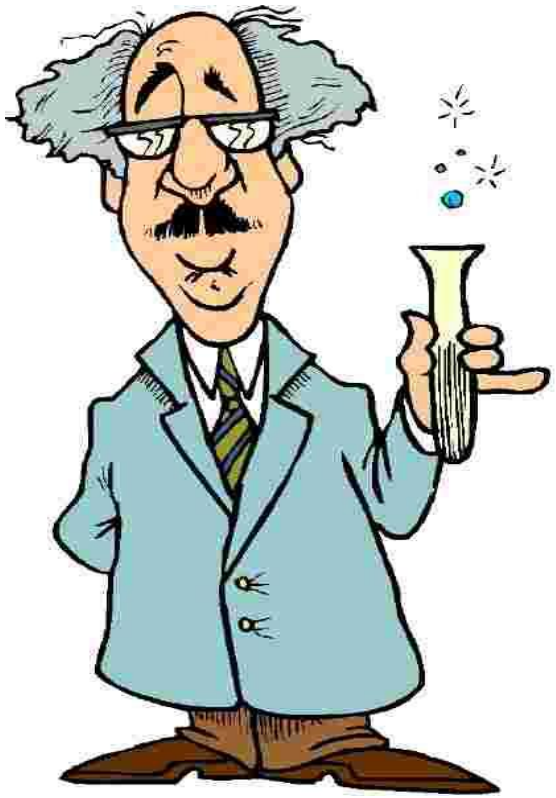
“The Science of PASRR”
Validated BH Instruments – Let’s Envision The Possibilities



Level I Screening: Where Are We?

- CFR provides limited guidance beyond identifying those who “may have a MI/ID/RC”
- Variability in state tools
  - National Report feedback on 14 data elements
- Variability in screeners
  - MH/ID/DD KSA’s
  - Location/role

Level I Screening: What Do We Know?

- Recent Findings from Analyses of Level I Screens and the Minimum Data Set (MDS) - PTAC Webinar Tuesday, October 13, 2015
  - Low sensitivity and accuracy for mental illness
  - Better sensitivity and accuracy for ID, but room for improvement

- "Self-report as well as claims and medical records based data analyses generally capture those individuals who have been treated for a particular disorder, whereas symptom-based studies identify individuals who meet criteria for a mental disorder regardless of whether they have been treated. *Given the fact that less than one-third of individuals meeting criteria for a mental disorder receive treatment, this distinction is particularly important for this group of conditions."* – ***Robert Wood Johnson Foundation,*** *2011 Research Synthesis Report entitled Mental Disorders and Medical Comorbidity*

Level I Screening: Where Do We Go?

- Continually measure the effectiveness of our current tools
  - Are they sensitive?
  - Are they accurate?
  - Are they understood and easily used?
- Can validated instruments help us improve sensitivity and accuracy?

Screens to Detect Serious Behavioral Health Conditions

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November 10, 2015

Objectives

- Enhance understanding of prevalence of several disabling BH disorders (expanded view of MI)
- Gain insight about the relationship between BH disorders and co-morbid medical conditions
- Understand the value of using targeted BH screenings and how to access the screenings
- Learn about appropriate times and settings when BH screenings can be used to augment existing evaluations, e.g., PASRR Level I evaluations

Prevalence of BH Disorders

- 50% of the 10 most disabling disorders worldwide are psychiatric in nature; major depression, alcohol abuse, bipolar affective disorder, schizophrenia, and obsessive compulsive disorder
- When screened, > 25% of primary care patients screen positive for a probable mental health or substance abuse problem (without screens the rate of detection is < 10%)

Prevalence (con't)

- Why do we overlook these conditions?
- > 50% of the patients screening positive for BH conditions also have 1> chronic medical conditions known to obscure recognition of psychiatric issues
- Culture's limited recognition of impact co-morbid BH conditions have on overall health
- Time limitations to fully evaluate patients
- Lack of person-centered approach to healthcare; promotes fragmentation and lack of collaboration
- Decision not to use a BH screening tool

Why consider use of BH Screenings

- Validated BH screening instruments used for > 55 years;
  (supports evidence-based approach to Level I evaluations)
- Since 1990s, BH screenings are more sophisticated in design; now aligned with the Diagnostic and Statistical Manual of Mental Disorders (DSM)
- Many screens can be self-administered or conducted by a para-professional; provide a snapshot of current functioning based on admission of symptoms
- Screenings are increasingly easy to access, score, yield a quantitative score (often with a severity index) and are highly predictive of the existence of a BH condition

Limitations of BH Screenings

- Results should be considered within the context of the setting (many screenings are based entirely on a self-report and do not take into consideration observations by an evaluator)
- A screening score should not be seen as conclusive or interpreted as a diagnosis; rather it is an indicator that further assessment of a “suspected” BH condition should be completed

Appropriate Times To Administer BH Screens

- When there is a “suspected” BH condition
- Annual wellness visits; Screens for depression, alcohol abuse and mild cognitive impairment (MCI) are mandated by CMS for Medicare pts
- When authorities learn about biopsychosocial stressors often associated with BH symptoms
- Prior, during and/or subsequent to transitional care to or from a variety of settings

Criteria for Review of BH Screenings

- Validated BH instruments proven to assist in detection of specific disorders associated with MI
- Available in the public domain
- Designed to be self-administered or administered and scored by a paraprofessional
- Easily accessed from the internet
- Written on 6-9th grade level
- Available in multiple languages

Structure for Review of BH Screenings

- Identification of each BH Disorder reviewed
- Provide data that demonstrates potential severity of condition and frequently associated co-morbidities
- Provide table of screening tools used for detection of each BH condition and note important characteristics
- Select 1 frequently used and easily accessible screening tool for each BH disorder
- Provide a single link through National Substance Abuse and Mental Health Administration (SAMHSA) to access the BH screening for review and use

Depression Screenings

- Depression is considered among the top chronic diseases in the US, often co-occurring with other chronic diseases including diabetes, congestive heart failure, coronary artery disease, asthma and COPD
- Many adults experience 1st episode of major depression in later life; older adults have 6 times the risk of suicide than any other age group
- Surveys indicate that >30% of PC physicians normalize mental health related symptoms in aging population and believe that depression is natural part aging

Table 1: Screening Tools for Depression

Characteristics	Beck Depression Inventory (BDI)	Geriatric Depression Scale (GDS)	Patient Health Questionnaire (PHQ-2)	Patient Health Questionnaire (PHQ-9)	Zung Self-Assessment Depression Scale (Zung SDS)	Suicide Behaviors Questionnaire – Revised (SBQ-R)
Year Released	1996	1986	2000	1999	1965/1997	1999
Target population	Adult screen to identify depressive symptoms over the previous 2 weeks	Geriatric screen to identify symptoms of depression (no time-frame noted)	Adult screen to identify symptoms of depression during the past 2 weeks	Adult screen for depression, specific to symptoms experienced during the last 2 weeks	Adult screen for depressive symptoms over the past several days	Adult screen specific to detection suicidality (present and during last 12 months) and identifies likelihood of future suicidal behavior
How administered	Self-administered (assist as needed)	Initially designed to be administered in the context of a patient interview; also self-administered	Self-administered (assist as needed)	Self-administered (assist as needed)	Self-administered (assist if needed)	Self-administered (assist if needed)
# questions	21	15	2	9	4	4
Response choices	4 options	Y/N format	4 options	4 options	5 & 6 options	5 & 6 options
Avg time to complete	<5 min	< 5 min	30 secs	< 3 min	< 5 min	< 5 min
Scoring time & complexity	3 min, simple	3 min, simple	30 secs, simple	< 2 min, simple	< 10 min, simple	< 10 min, simple
In public domain	N	Y	Y	Y	Y	Y
Notes	Includes question on self-harm		Positive screen should always generate a PHQ-9 screening; no severity rating		Screener should be directly supervised by a health care provider (on site); if screen is positive, patient should be immediately evaluated by a healthcare professional	If screen is positive, patient should be immediately evaluated by a healthcare professional.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last 2 *weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

PHQ-9 Patient Depression Questionnaire

For initial diagnosis:

1. Patient completes PHQ-9 Quick Depression Assessment.
2. If there are at least 4 ✓s in the shaded section (including Questions #1 and #2), consider a depressive disorder. Add score to determine severity.

Consider Major Depressive Disorder

- if there are at least 5 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Consider Other Depressive Disorder

- if there are 2-4 ✓s in the shaded section (one of which corresponds to Question #1 or #2)

Note: Since the questionnaire relies on patient self-report, all responses should be verified by the clinician, and a definitive diagnosis is made on clinical grounds taking into account how well the patient understood the questionnaire, as well as other relevant information from the patient.
Diagnoses of Major Depressive Disorder or Other Depressive Disorder also require impairment of social, occupational, or other important areas of functioning (Question #10) and ruling out normal bereavement, a history of a Manic Episode (Bipolar Disorder), and a physical disorder, medication, or other drug as the biological cause of the depressive symptoms.

To monitor severity over time for newly diagnosed patients or patients in current treatment for depression:

1. Patients may complete questionnaires at baseline and at regular intervals (eg, every 2 weeks) at home and bring them in at their next appointment for scoring or they may complete the questionnaire during each scheduled appointment.
2. Add up ✓s by column. For every ✓: Several days = 1 More than half the days = 2 Nearly every day = 3
3. Add together column scores to get a TOTAL score.
4. Refer to the accompanying **PHQ-9 Scoring Box** to interpret the TOTAL score.
5. Results may be included in patient files to assist you in setting up a treatment goal, determining degree of response, as well as guiding treatment intervention.

Scoring: add up all checked boxes on PHQ-9

For every ✓ Not at all = 0; Several days = 1;
More than half the days = 2; Nearly every day = 3

Interpretation of Total Score

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

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Generalized Anxiety Disorder (GAD) Screenings

- GAD is often unrecognized or misdiagnosed as a physical condition due to the range of clinical presentations, consequently about 50% of patients with GAD go untreated
- Co-morbidities include: migraine, rheumatoid arthritis, peptic ulcers, irritable bowel syndrome, coronary heart disease, hyperthyroidism, diabetes, asthma and COPD
- 20% of persons with GAD are first diagnosed after age 60; those with late anxiety onset more likely to have hypertension and rate their health and social functioning as poor

Table 2: Screening Tools for Anxiety

Characteristics	Generalized Anxiety Disorder (GAD-7)	Geriatric Anxiety Disorder Inventory (GAI)	Severity Measure for Generalized Anxiety Disorder
Year Released	1999	2007	2013
Target population	Adult screen for generalized anxiety symptoms during the past 2 weeks	Geriatric screen for generalized anxiety symptoms	Adult screen for severity of generalized anxiety disorder
How administered	Self –administered (assist if needed)	Self-administered (assist as needed)	Self-administered (assist as needed
# questions	7	20	10
Response choices	4 options	Unknown	5 options
Avg time to complete	< 5 min	< 5 min	< 5 min
Scoring time & complexity	3 min, simple	Unknown	3 min, simple
In public domain	Y	No, but available to licensed clinicians and academics free of charge	Y
Notes	Score has associated anxiety severity rating (none to minimal, mild, moderate, and severe); corresponding proposed actions related to need for further assessment to confirm diagnosis and determine a standard of care intervention are available	The measurements of somatic symptoms within the instrument are limited in order to differentiate between symptoms of anxiety and medical conditions.	Score provides a suspected severity rating (none, mild, moderate, severe, extreme)

The Generalized Anxiety Disorder 7-Item Scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

Total Score: ☐ = **Add Columns** _____+_____+_____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not at all	**Somewhat difficult**	**Very difficult**	**Extremely Difficult**
_____	_____	_____	_____

Interpreting the Score:

Total Score	Interpretation
≥10	Possible diagnosis of GAD; confirm by further evaluation
5	Mild Anxiety
10	Moderate anxiety
15	Severe anxiety

Post-Traumatic Stress Disorder (PTSD)

- Under-diagnosed, chronic BH disorder that follows overwhelming stressful events such as combat exposure, sexual assault and natural disasters
- Symptomology is often embedded in both psychiatric and medical co-morbidities; substance abuse, GAD with panic, persistent depression, bi-polar, personality disorders
- Persons with undetected PTSD frequently use ERs for healthcare, often presenting with emergent physical complaints

Table 3: Screening Tools for Post-Traumatic Stress Disorder (PTSD)

Characteristics	Primary Care PTSD Screen (PC-PTSD)	National Stressful Events Survey (NSESSS)	Short Post-Traumatic Stress Disorder Rating Interview (Sprint)
Year Released	2003	2013	2001
Target population	Adult screen for detection of PTSD in the general population	Adult screen for PTSD focused on symptoms within the prior 7 day	Adult screen focused on symptoms of PTSD over the previous 7 days.
How administered	Self-administered (assist as needed)	Self-administered (assist as needed)	Self-administered (assist as needed)
# questions	4	9	8
Response choices	Y/N	5 options	5 options
Avg time to complete	< 2 min	< 5 min	3-5 min
Scoring time & complexity	1 min, simple	1 min, simple	Unknown
In public domain	Y	Y	No; available to health care professionals through Duke University
Notes		Emerging PTSD screen identified as Severity of Post-traumatic Stress Symptoms (Adult) through the American Psychiatric Association	
Test # in Appendix	9 (follow link)	10 (follow link)	Not available to view

Primary Care PTSD Screen (PC-PTSD)

Description

The PC-PTSD is a 4-item screen that was designed for use in primary care and other medical settings and is currently used to screen for PTSD in veterans at the VA. The screen includes an introductory sentence to cue respondents to traumatic events. The authors suggest that in most circumstances the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any 3 items. Those screening positive should then be assessed with a structured interview for PTSD. The screen does not include a list of potentially traumatic events.

Scale

Instructions:

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:

1. Have had nightmares about it or thought about it when you did not want to?

   YES / NO

2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?

   YES / NO

3. Were constantly on guard, watchful, or easily startled?

   YES / NO

4. Felt numb or detached from others, activities, or your surroundings?

   YES / NO

Current research suggests that the results of the PC-PTSD should be considered "positive" if a patient answers "yes" to any three items.

LIFE EVENTS CHECKLIST (LEC)

Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it *happened to you* personally, (b) you *witnessed it* happen to someone else, (c) you *learned about it* happening to someone close to you, (d) you're *not sure* if it fits, or (e) it *doesn't apply* to you.

Be sure to consider your *entire life* (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Not Sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)					
2. Fire or explosion					
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)					
4. Serious accident at work, home, or during recreational activity					
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)					
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)					
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)					
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)					
9. Other unwanted or uncomfortable sexual experience					
10. Combat or exposure to a war-zone (in the military or as a civilian)					
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)					
12. Life-threatening illness or injury					
13. Severe human suffering					
14. Sudden, violent death (for example, homicide, suicide)					
15. Sudden, unexpected death of someone close to you					
16. Serious injury, harm, or death you caused to someone else					
17. Any other very stressful event or experience					

Bi-polar Screening

- Bipolar disorder considered chronic and disabling with significant risk of mortality(lifetime risk of suicide is 20 times more than general population)
- AVG. bipolar patient is misdiagnosed for 7.5 years and >1/3 misdiagnosed for > 10 years
- Few highly rated bi-polar screens; believed a reflection of these persons being poor historians with respect to hypomanic and manic states

Table 4: Screening Tools for Bipolar Disorder

Characteristics	Mood Disorder Questionnaire (MDQ)	Altmann Self-Rating Mania Scale (ASRM)	M3 Clinician
Year Released	2000	1997	2007
Target population	Adult screen for detection of Bipolar Spectrum Disorder (includes Bipolar I, Bipolar II and Bipolar NOS	Adult screen for bipolar disorder and to specifically assesses for the presence and severity of manic symptoms.	Adult screen for bipolar disorder
How administered	Self-administered (assist if needed)	Self-administered (assist if needed)	Self-administered (assist if needed)
# questions	17	5	27
Response choices	Yes/No	5 options	5 options
Avg time to complete	5 min	5 min	5 min
Scoring time & complexity	< 3 min, simple	< 3 min, simple	Immediate electronic scoring, simple
In public domain	Y	Y	Proprietary screening; screenings for health care professionals are made available through subscription
Notes			Incorporated into multi-dimensional tool that also addresses depression, anxiety, PTSD and alcohol abuse. M3 Clinician received NCQA approval as first screening tool endorsed for use in Patient-centered Medical Home model of care (PCMH).

Mood Disorder Questionnaire

Patient Name _____ Date of Visit _____

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	**YES**	**NO**
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found that you didn't really miss it?	☐	☐
...you were more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family in trouble?	☐	☐

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?

☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem

The Mood Disorder Questionnaire (MDQ) - Overview

The Mood Disorder Questionnaire (MDQ) was developed by a team of psychiatrists, researchers and consumer advocates to address the need for timely and accurate evaluation of bipolar disorder.

Clinical Utility

- The MDQ is a brief self-report instrument that takes about 5 minutes to complete.
- This instrument is designed for *screening purposes only* and is not to be used as a diagnostic tool.
- A positive screen should be followed by a comprehensive evaluation.

Scoring

In order to screen positive for possible bipolar disorder, all three parts of the following criteria must be met:

- "YES" to 7 or more of the 13 items in Question 1 **AND**
- "Yes" to Question number 2 **AND**
- "Moderate Problem" or "Serious Problem" to Question 3

Psychometric Properties

The MDQ is best at screening for bipolar I (depression and mania) disorder and is not as sensitive to bipolar II (depression and hypomania) or bipolar not otherwise specified (NOS) disorder.

Population /type	Sensitivity & Specificity
Out-patient clinic serving primarily a mood disorder population[1]	Sensitivity 0.73 Specificity 0.90
General Population[2]	Sensitivity 0.28 Specificity 0.97
37 Bipolar Disorder patients 36 Unipolar Depression patients[3]	Overall Sensitivity 0.58 (BDI 0.58-BDII/NOS 0.30) Overall Specificity 0.67
Primary care patients receiving treatment for depression[4]	Sensitivity 0.58 Specificity 0.93

1. *Hirschfeld RMA. et, al. Development and validation of a screening instrument for bipolar spectrum disorder: The Mood Disorder Questionnaire, Am J of Psychiatry, 2000, 157:1873-1875.*
2. *Hirschfeld RMA. The mood disorder Questionnaire: A simple, patient-rated screening instrument for bi-polar disorder. Journal of Clinical Psychiatry Primary Care Companion 2002; 4: 9-11.*
3. *Miller CJ et al, Sensitivity and specificity of the Mood Disorder Questionnaire for detecting bipolar disorder. J Affect Disorder 2004. 81: 167-171.*
4. *Hirschfeld RMA, et al. Screening for bipolar disorder in patients treated for depression in a family medicine clinic. JABFP 2005, 18: 233-239.*

Schizophrenia and Psychotic Disorder Screenings

- Although schizophrenia typically develops in the second and third decade of life, emerging number of patients (particularly women) are developing it during middle years and after 65
- Compelling evidence that SA is not only frequently co-occurring with schizophrenia psychotic disorders but, in many instances, was established prior to person's onset of psychotic symptoms

Schizophrenia and Psychotic Disorders (con't)

- Due to nature of schizophrenia and psychotic disorders, there are no recommended self-administered screening tools
- There are however clinician-assisted screening tools that are frequently used to help during diagnostic evaluations (these are not recommended for administration by para-professionals)

Table 5: Screening Tools for Schizophrenia and Psychotic Disorders

Characteristics	Clinician-Rated Dimensions of Psychosis Severity	Brief Psychiatric Rating Scale (BPRS)
Year Released	2013	1962
Target population	Adult screen to measure severity of mental health symptoms across psychotic disorders; including delusions; hallucinations; disorganized speech; abnormal psychomotor behavior; negative symptoms (i.e., restricted emotional expression or avolition);impaired cognition; depression and mania.	Screening instrument used by clinicians for assessing positive, negative, and affective symptoms of individuals who have, or suspected of having, schizophrenia or other psychotic disorders. Instrument designed to identify symptoms and/or assess admission to symptoms over the past 2- 3 days
How administered	Clinician-administered	Clinician-administered
# questions	8 areas assessed	18 areas covered in interview
Response choices	5 options on 0-4 scale (clinician rated)	8 options on 0-7 scale (clinician rated)
Avg time to complete	Estimate of 20-30 min (conducted within course of interview)	Estimate of 20-30 min (conducted within course of interview)
Scoring time & complexity	Clinician rates patient on a five point scale (0= no symptoms, 1=equivocal, 2= present, but mild, 3=present and moderate, 4 = present and severe); complex, results are weighed in relationship to other collected data and requires expertise in assessment of psychiatric disorders.	Clinician rates patient on a eight point scale, ranging from no evidence to extremely severe; complex, results are weighed in relationship to other collected data and requires expertise in assessment of psychiatric disorders.
In public domain	Y	Y
Notes	Follow-up with patient is made on the basis of clinical judgement.	Follow-up with patient is made on the basis of clinical judgment

Substance Abuse Screenings

- SA, contributes to or causes more that 70 conditions that require hospitalizations, complicating treatment of most illnesses, prolongs hospital stays, increases morbidity, and often co-occurs with other BH conditions
- Globally, alcohol abuse is 5th leading risk factor for premature death and disability, among those 15-49, it is # 1

SA Screenings (con't)

- CAGE, AUDIT and AUDIT-C are most utilized alcohol screening tools used due to their brevity and reliability
- NIDA has an updated on-line version for easy access, strong reliability rating and addresses drug use
- DAST -10, a screen to detect drug use, has built in severity rating; ASSIST V2.0 often used subsequent to positive score on DAST-10

Table 6: Screening Tools for Substance Abuse

Characteristics	CAGE-Aid	Alcohol Use Disorder Identification Test-C (AUDIT-C)	Alcohol Use Disorder Identification Test (AUDIT)	NIDA – Quick Screen Test v1.0	NIDA – Modified ASSIST v2.0	Drug Abuse Screen Test (DAST-10)
Year Released	1984	1982	1982	2009 (revised)	2009 (revised)	1982
Target population	Adult screening to detect for both alcohol and drug misuse particularly as it relates to alcohol and drug behavior	Adult screen to detect probable alcohol misuse	Adult screen to identify probably harmful and hazardous alcohol use	Adult screening to detect use of alcohol, tobacco products, prescription drugs for non-medical reasons, and illegal drugs during the previous 12 months	Adult screen to detect, to greater specificity and severity, individual's use of prescription drug for not related medical reasons and/ or illegal drug use	Adult and adolescent screen to detect drug use during the previous 12 months
How administered	Self-administered or interview with individual	Self-administered or interview with incividual	Self-administered or interview with individual	Quick screen completed by face-to face interview	Self-administered (assist as needed)	Self-administered (assist as needed)
# questions	4	3 to 5	10	4 (one per product)	8	10
Response choices	Yes/No	3 to 5 options	3 to 5 options	5 options	Varied: Yes/No; 3 and 5 options	Yes/No
Avg time to complete	1 min	< 3 min	3 to 5 min	< 3 min	5 to 10 min	< 8 min
Scoring time & complexity	< 1 min, simple	< 1 min, simple	1 min, simple	< 3 min, simple	5 min, some complexity	< 3 min, simple
In public domain	Y	Y	Y	Y	Y	Y
Notes	Positive score suggests further screening (AUDIT if alcohol, DAST-10 if drug) and/or clinical interview		Has a built-in alcohol severity scale corresponding to over-all score (low risk, harmful/hazardous, probable dependence/abuse)	If threshold score is positive screen for alcohol misuse, NIDA Quick Screen transitions to a clinical approach to "assess, advise, assist, and arrange" for further intervention; if threshold	Score provides a "substance involvement rating" and an associated risk category for drug abuse (lower risk,	Positive screen has built-in suspected drug use severity scales (no problem detected, low level, moderate level, substantial

Characteristics	CAGE-Aid	Alcohol Use Disorder Identification Test-C (AUDIT-C)	Alcohol Use Disorder Identification Test (AUDIT)	NIDA – Quick Screen Test v1.0	NIDA – Modified ASSIST v2.0	Drug Abuse Screen Test (DAST-10)
				score is a positive screen for tobacco, NIDA Quick Screen transitions to a clinical approach to address impact of use of product; if threshold score is positive for use of illegal drugs or prescription drugs for non-medical reasons, the screening transitions to the NIDA – Modified ASSIST V2.0 for further evaluation.	moderate risk and high risk)	level, severe level)

AUDIT

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential, so please be honest.

For each question in the chart below, place an X in one box that best describes your answer.

NOTE: In the U.S., a single drink serving contains about 14 grams of ethanol or "pure" alcohol. Although the drinks below are different sizes, each one contains the same amount of pure alcohol and counts as a single drink:

12 oz. of beer (about 5% alcohol) = **8-9 oz. of malt liquor** (about 7% alcohol) = **5 oz. of wine** (about 12% alcohol) = **1.5 oz. of hard liquor** (about 40% alcohol)

Questions	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 to 4 times a month	2 to 3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have 5 or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total	

Note: This questionnaire (the AUDIT) is reprinted with permission from the World Health Organization. To reflect drink serving sizes in the United States (14g of pure alcohol), the number of drinks in question 3 was changed from 6 to 5. A free AUDIT manual with guidelines for use in primary care settings is available online at *www.who.org*.

Drug Abuse Screening Test, DAST-10

The following questions concern information about your possible involvement with drugs *not including alcoholic beverages* during the past 12 months.

"Drug abuse" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions *do not* include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

In the past 12 months...		**Circle**	
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Do you abuse more than one drug at a time?	Yes	No
3.	Are you unable to stop abusing drugs when you want to?	Yes	No
4.	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5.	Do you ever feel bad or guilty about your drug use?	Yes	No
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7.	Have you neglected your family because of your use of drugs?	Yes	No
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	Yes	No
Scoring: Score 1 point for each question answered "Yes," except for question 3 for which a "No" receives 1 point.		**Score:**	

Interpretation of Score		
Score	**Degree of Problems Related to Drug Abuse**	**Suggested Action**
0	No problems reported	None at this time
1-2	Low level	Monitor, re-assess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

Mild Cognitive Impairment (MCI) Screen

- Often evident with many BH disorders including depression, bipolar, anxiety and SA
- Often associated with periods of illness, recovery from illness and surgery, and side effects of medication
- Mini-Cog is widely used to screen to detect MCI; a positive result is not conclusive, should generate referral to medical professional for further evaluation and possible administration of Mini Mental Status Exam (MMSE)

SAMHSA Link to BH Screenings

- SAMHSA (Substance Abuse and Mental Health Services Administration)

  http://www.integration.samhsa.gov/clinical-practice/screening-tools

Questions re: Behavioral Health Screening Instruments?

BH Screenings and PASRR

- Chief goal of PASRR is to ensure that all individuals who apply for admission to a Medicaid-certified nursing home are screened for BH (MI), ID and related conditions (if any, a recommended set of disability specific, individualized services are required to help individual retain or improve functioning, and return to community when possible)
- Level I PASRR screens are intended to be quick investigations of whether an individual “might” have a relevant diagnosis; in other words, results should err on side of finding “false positives”---individuals later found not to have a PASRR disability

BH Screening and PASRR (con't)

- BH screening literature review completed by PTAC concluded that self-administered and clinician-assisted screening tools can assist evaluators, through an evidence-based approach, detect probable BH disorders
- BH screenings are particularly valuable when BH conditions co-occur with individuals with chronic and acute medical conditions (detection rates often triple subsequent to application of validated screening to evaluation process)

BH Screening and PASRR (con't)

- BH screenings are well suited to augment an evaluation of individual's mental health when transition of care is anticipated or in progress
- It's anticipated that incorporation of selected, evidence-based BH screens into the PASRR Level I assessment process will identify individuals that have a previously unrecognized or emerging diagnosable mental illness

“Envision The Possibilities”

- Could validated instruments improve your Level I process?
- Could validated instruments be part of your Level II evaluation?
- Could validate instruments be of value when there are no psychiatric records?
- Could validated instruments help differentiate severity and support development of better plans of care?
- Could validated instruments be helpful in guiding “significant change in status” decisions?
- Could validated instruments be useful in quality assurance initiatives?

A reminder: PASRR Level II Evaluations

- If an individual with a positive BH screen is significant enough to generate a Level II does not meet PASRR eligibility requirements, the evaluator's report should "identify any specific intellectual or mental health services which are of a lesser intensity than specialized services that are required to meet the evaluated individual's needs" (PASRR evaluation criteria, 483.128 i,4)

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