



NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES
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Screening for Co-Occurring Disorders

User-Guide For the Modified Mini Screen (MMS)

**ADAPTED FOR NEW YORK CITY
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
QUALITY IMPACT INITIATIVE**



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Summary of the California Board of Corrections Mentally Ill Offender Crime Reduction Grant Project Manager's Meeting, presentation by Roger H. Peters, PhD and Richard K. Sherman, MS, October 4, 2001.

The Modified Mini Screen (MMS) is a 22-item scale designed to identify persons in need of an assessment in the domains of Mood Disorders, Anxiety Disorders and Psychotic Disorders. The questions are based on gateway questions and threshold criteria found in the Diagnostic and Statistical Manual IV¹ (DSM-IV), the Structured Clinical Interview for Diagnosis (SCID)² and the Mini International Neuropsychiatric Interview (M.I.N.I.).³

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

² Spitzer, R.L., Williams, J.B.W., Gibbon, M. & First, M.B. (1998). *Structured Clinical Interview for DSM-III-R Patient Version*. New York: New York State Psychiatric Institute, Biometrics Research Department.

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

WHAT ARE CO-OCCURRING DISORDERS?

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

HOW PREVALENT ARE CO-OCCURRING DISORDERS?

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

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

Psychiatric problems commonly found in persons with co-occurring disorders are categorized into four main areas:

- *Mood Disorders* are characterized by extreme emotions such as major depression, bipolar disorder (formerly called manic-depression) and dysthymia (a milder but chronic form of depression).
- *Anxiety Disorders* are characterized by powerful fears and avoidance behaviors. They include Post Traumatic Stress Disorder; Obsessive-Compulsive Disorder (obsessions are unavoidable thoughts and compulsions are unavoidable behaviors); Social Phobias (e.g., excessive shyness); Agoraphobia (fear of being in crowds or places with no easy exit); Panic Attacks; and generalized, non-specific anxieties.
- *Psychotic Disorders* include severe illnesses such as Schizophrenia. These disorders are characterized by unusual thoughts and beliefs, often at odds with evidence apparent to others and the behaviors that result from acting on those ideas. Visual or auditory hallucinations, extreme paranoia and delusional thoughts may be present.
- *Personality Disorders* are characterized by enduring and inflexible patterns of experience and behavior, across a broad range of personal and social situations, that markedly differ from the expectations of a person's culture, and that lead to either significant distress or impaired function in important life domains. (The Modified Mini Screen does not screen for personality disorders.)

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

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

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

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

Some specific characteristics are:

- More rapid progression from initial use to substance dependence
- Poor adherence to medication
- Decreased likelihood of treatment compliance
- Greater rates of hospitalization
- More frequent suicidal behavior, especially for clients with schizophrenia spectrum, major depressive or bipolar disorders
- Difficulties in social functioning
- Shorter time in remission of symptoms

In addition, individuals with severe disorders are:

- More sensitive to the effects of addictive substances
- Unlikely to develop medical signs of sustained, heavy use
- More likely to encounter addictive substances and pressure to use
- More likely to experience negative outcomes in treatment

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

People with mental disorders will have the characteristics of the disorder they suffer from.

Those with severe mental illness may have:

- Difficulty comprehending or remembering important information
- Inability to recognize the consequences of certain kinds of behavior, thereby affecting the client's ability to make plans
- Poor judgment
- Disorganization
- Limited attention span
- Poor response to confrontation

They are likely to use substances to:

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

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

Having three or more positive quality of life factors, such as:

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

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

The purpose of a screening instrument—such as the Modified Mini Screen—in chemical dependency treatment settings is to identify clients with high likelihood of having a mental illness that could compromise successful treatment outcomes. A high screen score will determine the need for a more thorough mental health assessment.

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

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

WHEN SHOULD SCREENING OCCUR?

Alcohol and substance abuse greatly influence symptoms of mental illness, and vice versa. Abuse of addictive substances like alcohol, opiates and cocaine may precipitate mental disorders like depression and psychotic disorders. On the other hand, withdrawal from substances may exacerbate symptoms of mental disorders when substance use has been a way for the person to cope with depression, loneliness, boredom or anxiety. When both disorders are identified, they should be considered as primary and should be treated simultaneously. In addition, HIV and

Hepatitis-C positive clients may exhibit symptoms, such as dementia, due to the disease itself or the medication regimen. Substance related affective symptoms (depression, mania) usually clear within two weeks of abstinence; psychotic symptoms usually clear within days to a week of abstinence while symptoms of anxiety may take up to six months to clear.

FOR THE NYC DOHMH AUDIT STANDARD REQUIREMENT, THE OBJECTIVE IS TO ADMINISTER THE MODIFIED MINI SCREEN TO ALL ADMITTED ADULTS BEFORE THE INITIAL TREATMENT PLAN (ITP) IS WRITTEN.

A clinician may re-screen throughout the treatment process as s/he deems appropriate.

It should be noted whether or not the client has been abstinent from alcohol or other drugs for at least two weeks prior to the screening. This information should be taken into account by the evaluating clinician if the client receives a mental health assessment.

A SCREENING TOOL SHOULD NEVER REPLACE CRITICAL OBSERVATIONS BY STAFF. FINAL DECISIONS REGARDING THE NEED FOR FURTHER MENTAL HEALTH ASSESSMENT AND TREATMENT SHOULD BE BASED ON BEST CLINICAL JUDGEMENT ON A CASE-BY-CASE BASIS TAKING INTO ACCOUNT THE INDIVIDUAL NEEDS OF THE CLIENT.

HOW ACCURATE IS SCREENING?

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

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

WHAT IS THE MODIFIED MINI SCREEN?

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

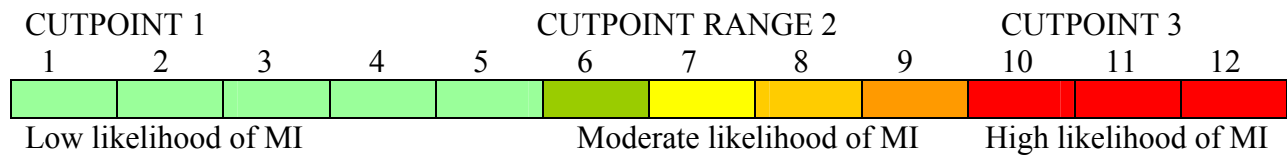
- Section A – Mood Disorders
- Section B – Anxiety Disorders
- Section C – Psychotic Disorders

HOW SHOULD THE MODIFIED MINI SCREEN BE SCORED?

Scoring of the Modified Mini Screen is straightforward and additive. A “YES” response to a question on the screen converts to 1 point. The clinician adds all the positive (yes) responses for a total score, which ranges from 1 to 22 points. Remember, if a client answers YES to questions, that does not mean they are mentally ill; it simply means that they are reporting distress.

WHAT SCORE DETERMINES PLAN OF ACTION FOR THE CLIENT?

There are three different cutpoints and each cutpoint determines a different plan of action for the client.



CUTPOINT 1 is ≤ 5 . No further action is needed. This plan of action is based only on the screen, but remember that a screening tool should never replace clinical judgment and critical observations by staff.

CUTPOINT RANGE 2 is **between 6 and 9**. The treatment team determines whether there is a need for a mental health assessment. If it is determined that a mental health assessment is not required, enhanced ongoing monitoring for mental health needs will be implemented as part of the initial comprehensive treatment plan. If it is determined that a mental health assessment IS needed, action proceeds as listed below for CUTPOINT 3.

CUTPOINT 3 is any one of the following:

- **Adults who scored ≥ 10**
- **Adults who answered “yes” to question # 4**
- **Adults who answered “yes” to both questions #14 and #15**

For cutpoint 3, the client will receive a mental health assessment, which means an evaluation to determine whether a client has unmet mental health needs and includes recommendations for treatment or further evaluation if indicated. This is to be done by a Qualified Health Professional as defined by OASAS regulations and deemed by the program to have the qualifications and experience to conduct such an assessment.

Question # 4 relates to suicidality. Any client who answers YES to this question should be referred for a mental health assessment regardless of the total score. **Questions #14 and #15** refer to Post-Traumatic Stress Disorder (PTSD). PTSD does not only address combat/war, but also addresses experiences of physical and sexual abuse, as well as other trauma. If **BOTH** questions 14 and 15 are answered YES, the client should be referred for a mental health assessment regardless of the client’s total score.