Screening Tools for Behavioral Health

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Cricket Mitchell, PhD
Senior Associate, CiMH

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Before we proceed…

- ***Exciting News!!***
  - As of next fiscal year, CiMH will officially merge with the Alcohol and Drug Policy Institute (ADPI)

    Creating the:

CENTER FOR

BEHAVIORAL HEALTH SOLUTIONS

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Overview of Workshop

- Screening vs. Assessment
- Selecting a Screening Tool
- Key elements to implementing a successful screening protocol
- Review* of Publicly Available Screening Tools by Domain
  - Anxiety, Behavior Problems, Depression, Mental Health or Psychiatric Disorders, Substance Abuse, Suicide Risk, Trauma

  **not an exhaustive review*

Screening vs. Assessment

- There is no absolute clarity about the difference between the two processes
- The distinction depends on who you ask and what instrument you're referencing
  - Some tools can be used for either
- Both processes are enhanced when standardized tools with sound psychometric characteristics are used

Assessment

- An in-depth, comprehensive process
- Conducted by a qualified professional
- Developmentally appropriate
- Matched to cognitive capabilities
- Culturally and linguistically appropriate
  - Taking into consideration the client and family's level of acculturation and assimilation; their cultural world views of health/wellness, illness, and treatment; and their values, traditions, beliefs, rituals, and practices
- Conducted in the preferred language of the client and family
- Conducted in a setting that is conducive to the most cooperation from, and ease for, the client and family

Screening

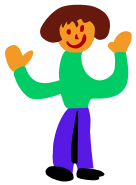
- Screening is brief
  - Determines whether further assessment is warranted
- Screening is the identification of immediate or current behavioral health (mental health or substance use) needs
  - Usually based on clinical, behavioral, or functional status that is:
    - immediate or current
    - Observable
- Screening can be done in a variety of settings by a variety of professionals and paraprofessionals

Screening

- One goal of screening is to address emergent or urgent needs in an identified population
- Another goal is to determine if the individual meets a clinical/behavioral/functional threshold to receive services and supports
- Whenever we screen and identify behavioral health needs, we have an **ethical responsibility** to either provide the necessary next steps (assessment or intervention) or refer to an appropriate source for follow up

Screening

Below Cutoff



Near Cutoff

Above cutoff

Professional Assessment

Diagnostic Criteria Met

Diagnostic Criteria Not Met

Continue to Monitor (Re-Screen)

- **Provide information, support, referrals as appropriate**

Selecting a Screening Tool

- Before choosing an instrument
  - Know its stated purpose, statistical properties (norming and standardization populations, reliability, validity)
  - Know your population of focus and purpose
- Individualize your choices based upon your population, purposes, and circumstances

Screening Test Features

- Sensitivity
  - Accuracy to identify the problem/issue
- Specificity
  - Accuracy to identify the absence of the problem/issue
- Validity
  - The ability to discriminate between the presence and absence of the problem/issue
- Reliability
  - The ability to produce consistent results

- Administration
- Scoring
- Training

Selecting a Screening Tool

- Select adequate screening tools
  - Sensitivity and specificity rates of at least 70%
  - Reliable, valid, and standardized on diverse populations
  - Feasibility issues (cost, time to complete, time to score)

Key Elements to Implementing a Successful Screening Protocol

- Assess current protocols
- Obtain buy-in and support from all staff
- Identify a “Champion”
- Identify the tool/s to be used
- Map the workflow
- Identify community partners and ensure appropriate referral pathways for assessment and treatment

Key Element: Assess Current Protocols

- "What are we doing now?"
  - A formal, standardized tool?
  - An informal checklist?
- "Are we screening routinely?"
  - If yes, under what circumstances?
  - Who are we missing?

Key Element: Full Staff Support

- Systems that are **most** successful in implementing and sustaining standardized screening and referral protocols are those that have **full** support and buy-in from staff at **all** levels

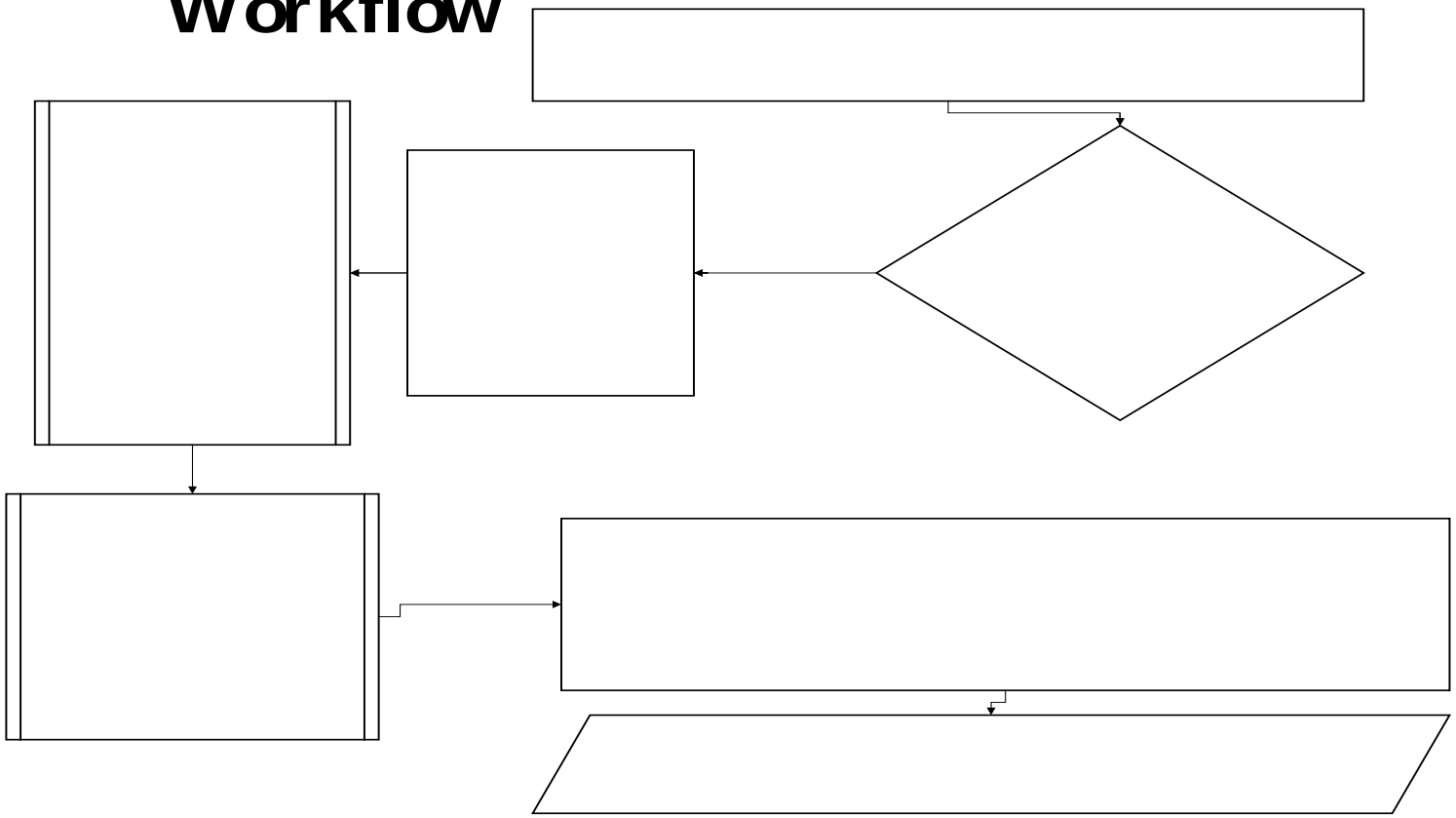
Key Element: Identify a “Champion”

- The “voice” of this “best practices” effort
- Could be within the setting or within the community
- Help facilitate communication with other staff, stakeholders and community partners, formally and informally, about the screening and referral system

Key Element: Map the Workflow

- Systematically integrating screening and referral into routine care/services is essential to success and sustainability
- Identify “key” staff who will help map workflow
  - Depending on size of setting, may want to include all staff
- Develop a flow chart that specifies each step in the process

Primary Care Practice Screening & Referral Workflow



Example of Mapping the Workflow from the Assuring Better Child Health and Development (ABCD) Screening Project, funded by Commonwealth Fund and Administered by the National Academy for State Health Policy

Key Element: Identify Community Partners

- When integrating screening into any setting, it is important to establish and/or enhance relationships with community partners and ensure appropriate pathways for further assessment and/or treatment

  e.g.,

  - Community Based Organizations
  - County Mental Health
  - First 5
  - Primary Care
  - Regional Centers
  - Schools

Standardized Screening Caveats

- Detection is not perfect, even with good screening tools
- First-level screens may over-identify
  - False positives
- Professional judgment plays a critical role
- Screenings should not be used to diagnose
- Screenings indicate that more information is needed
- Challenging, but rewarding, to implement successful screening protocols

Screening Tools by Domain

- Only tools with sound psychometric characteristics are presented
  - Good reliability, validity, sensitivity and specificity
- Only tools available in the public domain are presented
  - Links to each tool are provided
- Domains are presented alphabetically
  - Tools are presented alphabetically within each domain
- If the tool has been created for a certain age group or setting, this information is specified
- Not an exhaustive review of available options

Screening Tools for Anxiety Disorders

Child Stress Disorders Checklist – Short Form (CSDC-SF)

- 4 observer-report items
  - 4-point Likert scale responses range from 0 *"not true"* to 3 *"very true"* now or within the past month
- Developed for children and youth ages 2 – 18
- Derived from the 36-item Child Stress Disorders Checklist (CSDC)
  - Items that are fairly observable by others
- Screens for risk of having or developing Acute Stress Disorder and/or Posttraumatic Stress Disorder
- Total score ranges from 0 – 12
  - There is currently no clinical cutoff score; higher scores suggest greater risk
  - http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2862234/

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Generalized Anxiety Disorder (GAD-7)

- 7 self-report items
  - 4-point Likert scale responses range from 0 *"not at all"* to 3 *"nearly every day"* bothered by ___ within the last 2 weeks
- Screens for possible anxiety disorders
- Total score ranges from 0 – 21
  - Recommended cutoff score of 10
- http://www.phqscreeners.com/pdfs/03_GAD-7/English.pdf

Primary Care PTSD Screen (PC-PTSD)

- 4 self-report items
  - Yes/No response options
- Designed for use in primary care and other medical settings
- Screens for post-traumatic stress disorder
- Results should be considered “positive” if the respondent answers “yes” to any 3 of the 4 items
  - Cutoff score of 2 can be used if sensitivity is preferred over efficiency
- http://www.integration.samhsa.gov/clinical-practice/PC-PTSD.pdf

Short Form of the PTSD-Civilian Version (Short Form PCL-C)

- 6 self-report items
  - 5-point Likert scale responses range from 1 *"not at all"* to *5 "extremely"* bothered by ___ within the past month
  - 5-10 minutes to complete
  - 2 items from each DSM-IV PTSD symptom cluster that correlate most highly with the individual cluster score on the 17-item PCL-C
- Total score ranges from 6 – 36
  - Suggested cutoff score 14
- http://www.ptsd.va.gov/professional/assessment/screens/civilian-ptsd-checklist.asp
  - Note that the PCL-C is in the public domain; the short form is available by request

Screening Tools for Behavior Problems

Strengths and Difficulties Questionnaire (SDQ)

- 25 items available in three informant versions
  - 3-point Likert scale responses range from 0 *"not true"* to 2 *"certainly true"*
    - Some items are reverse-scored
  - Parent and teacher reports for ages 3-16
  - Adolescent self-report for ages 11-17
- Assesses five domains of behavioral attributes
  - Emotional symptoms; conduct problems; hyperactivity/inattention peer relationship problems; and, prosocial behavior
- Total difficulties scores range from 0 – 40
  - Cutoff score for parent report is 14-16
- http://www.sdqinfo.org/py/sdqinfo/b0.py

Student Risk Screening Scale (SRSS)

- First-level universal screening for school settings
- Lists the names of all students in a class and asks the teacher to check which of seven behaviors (if any) are characteristic of each student
  - 4-point Likert scale responses range from 0 *"never"* to 3 *"frequently"*
- Most teachers can screen an entire class in 10-15 minutes
  - Identifies externalizing problems
- Total difficulties scores range from 0 – 21
  - Three risk categories: Low (0-3) Moderate (4-8) High (9+)
- http://evaluation.ebrschools.org/eduWEB2/1000196/docs/scale_1__student_risk_ss_-_srss.pdf

Screening Tools for Depressive Disorders

Center for Epidemiological Studies Depression Scale (CES-D)

- 20 self-report items
  - 4-point Likert scale responses range from 0 *"rarely or none of the time (less than 1 day)"* to 3 *"most or all of the time (5-7 days)"* for how you felt or behaved during the past week
  - Four items are phrased positively to control for response bias and must be reverse-scored (Items 4, 8, 12 and 16)
- Items reflect six major dimensions of depression
  - Depressed mood; feelings of guilt and worthlessness; feelings of helplessness and hopelessness; psychomotor retardation; loss of appetite; and, sleep disturbance
- Used for screening, treatment planning, treatment monitoring and outcome evaluation
- Total scores range from 0 – 60
  - A score **≥ 16** indicates mild to moderate depressive symptomotology
  - A score **≥ 21** indicates significant depressive symptomotology
- http://www.bhevolution.org/public/screening_tools.page

Patient Health Questionnaire 9 Item (PHQ-9)

- 9 item self-report
  - 4-point Likert scale responses range from 0 *"not at all"* to 3 *"nearly every day"* how often have you been bothered by___ within the last 2 weeks
  - 10th item not scored, assesses functional impairment
- Items reflect the 9 symptoms of DSM-IV diagnostic criteria for depression
- Used for screening, treatment planning, treatment monitoring and outcome evaluation
- Total scores range from 0 – 27
  - Scores of 10 -14 indicate moderate depression
  - Scores of 15 or higher indicate moderately severe to severe depressive symptomotology
- http://www.integration.samhsa.gov/images/res/PHQ%20-%20Questions.pdf

PHQ-2

- 2 item self-report
  - First 2 items from the PHQ-9
  - 4-point Likert scale responses range from 0 *"not at all"* to 3 *"nearly every day"* how often have you been bothered by___ within the last 2 weeks
- Often used in primary care settings to determine the need for the PHQ-9
- Total score ranges from 0 – 6
  - Suggested cutoff score is 2-3
- http://www.cqaimh.org/pdf/tool_phq2.pdf

Geriatric Depression Scale

- 30 self-report items
  - Yes/No response options
- Specifically designed for use with older adults
- Screens for depression in the elderly
- Used for screening, treatment planning, treatment monitoring and outcome evaluation
- Total scores range from 0 – 30 (sum of “yes” responses)
  - Scores of 10-19 indicate mild depression
  - Scores of 20-30 indicate severe depressive symptomotology
- http://www.stanford.edu/~yesavage/GDS.english.long.html

Geriatric Depression Scale – Short Form

- 15self-report items
  - Yes/No response options
- Specifically designed for use with older adults
- Modified short form of the 30-item measure
- Total scores range from 0 – 15(sum of “yes” responses)
  - Scores of 5 or greater indicate the need for further assessment
  - Scores of 10 or greater are indicative of a depression diagnosis
- http://www.stanford.edu/~yesavage/GDS.html

Screening Tools for Mental Health or Psychiatric Disorders

Kessler-6 (K6) and Kessler-10 (K10)

- Brief mental health screening tools for use with a general adult population
  - 5-point Likert scale responses range from 1 *"all of the time"* to 5 *"none of the time"* how often did you feel___ within the past 30 days
  - Items are reverse-scored
  - Total scores range from 6-30 (K6) and 10-50 (K10)
    - Clinical cutpoint scores are 10-13 (K6) and 19-20 (K10)
- Developed for the National Health Interview Survey; also used in the National Comorbidity Studies, the CDC's Behavioral Risk Factor Surveillance System, and the World Health Organization's World Mental Health Initiative
- http://www.hcp.med.harvard.edu/ncs/k6_scales.php

Mental Health Screening Form (MHSF-III)

- 17 self-report items
  - Yes/No response options
- Screens for a range of mental health disorders:
  - Schizophrenia; depression; PTSD; phobias; intermittent explosive, delusional, sex/gender/identity, eating, manic, panic, obsessive-compulsive, and gambling disorders; learning disabilities; and, mental retardation
- "Yes" responses indicate the need for further assessment
- http://www.bhevolution.org/public/screening_tools.page

Modified Mini Screen (MMS)

- 22 self-report items
  - Yes/No response options
  - Approximately 15 minutes to complete
- Screens for mood, anxiety and psychotic spectrum disorders
- Total scores range from 0 – 22 (sum number of “yes” responses)
  - A score of 6 or greater indicates the likely presence of a psychiatric disorder
  - A “yes” to Q4 indicates potential suicidality
  - A “yes” to Q14 and Q15 indicates the need for further trauma assessment
- http://www.bhevolution.org/public/screening_tools.page

Pediatric Symptom Checklist – 35 items (PSC-35)

- 35 items
  - 3-point Likert scale responses range from 0 *"never"* to 2 *"often"*
  - Parent report for children ages 4-16
  - Youth self-report for ages 11-17
- Designed to help pediatricians in outpatient practice identify school-age children with difficulties in psychosocial functioning
  - Attention, internalizing, externalizing, developmental/academic functioning
- Scoring and interpretation varies by age
- http://pedstest.com/Portals/0/downloads/psc.pdf

Pediatric Symptom Checklist – 17 items (PSC-17)

- 17 items
  - 3-point Likert scale responses range from 0 *"never"* to 2 *"often"*
  - Parent report for children ages 4-16
  - Youth self-report for ages 11-17
- Modified short form of the 35-item measure
- Total scores range from 0 – 34
  - Cutoff score is 15
- http://www.massgeneral.org/psychiatry/assets/PSC-17_English.pdf

PRIME Screening Test for Early Psychosis / Schizophrenia

- 12 self-report items
  - 6-point Likert scale responses range from 1 *"definitely disagree"* to 6 *"definitely agree"*
- Screens for prodromal symptoms
- Based on the SIPS (Structured Interview for Prodromal Syndromes), an in-depth patient interview
- A positive result on the PRIME Screen is defined as
  - one or more scores of "6" (definitely agree) **OR**
  - three or more scores of "5" (somewhat agree)
- http://www.schizophrenia.com/sztest/primetest.pdf

Screening Tools for Substance Abuse

But first… SBIRT

- Screening, Brief Intervention and Referral To Treatment
  - A comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders
  - Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur
- The SAMHSA SBIRT home page includes curricula, online resources, and publications designed to help implement SBIRT initiatives
- http://www.samhsa.gov/prevention/SBIRT/index.aspx

Alcohol Use Disorders Identification Test (AUDIT)

- 10 self-report items
  - 7 of the 10 items are frequency of occurrence with 5-point Likert scale responses from 0 *"never"* to 4 *"daily or almost daily"*
- Screens for hazardous or harmful alcohol consumption
  - Developed by the World Health Organization (WHO), correctly classifies people who are alcoholics or non-alcoholics
- Appropriate for use with older adults
- Total score ranges from 0 – 40
  - Recommended cutoff score of 8
- http://www.integration.samhsa.gov/AUDIT_screener_for_alcohol.pdf

AUDIT-C

- 3 self-report items
  - 5-point Likert scale responses from 0 *"never"* to 4 *"daily or almost daily"*
- Modified short form of the 10-item AUDIT
- Total score ranges from 0 – 12
  - Recommended cutoff score for men is 4
  - Recommended cutoff score for women is 3
- http://www.integration.samhsa.gov/images/res/tool_auditc.pdf

CAGE

- Brief 4 questions administered orally as part of any medical, psychosocial or clinical interview (abbreviated below)
  - Can also be administered as independent self-report
- Identifies risk for alcohol abuse and dependence
  - **C** : ever tried to cut back
  - **A** : are you annoyed by others' complaints of your drinking
  - **G** : ever feel guilty about your drinking
  - **E** : ever drink eye-opener in morning to relieve shakes
- Further assessment is recommended if there are 2 positive endorsements
  - Some recommend further assessment if "yes" to 1 item
- http://www.mercycarehealthplans.com/ace-files/Alcohol%20DCM/ScreeningToolsCAGEASSESSMENT.pdf

CAGE-AID

- 5 self-report items
  - Yes/No response options
- Screens for the need for more thorough substance abuse assessment
  - Modified version of the CAGE to include other drugs
- Results should be considered “positive” if the respondent answers “yes” to 2 or more of the 5 items
  - Some recommend further assessment if “yes” to 1 item
- http://www.integration.samhsa.gov/images/res/CAGEAID.pdf

Drug Abuse Screen Test (DAST-10)

- 10 self-report items
  - Yes/No response options
- Modified short form of the original 28-item DAST
  - Separate 28-item forms for adolescents and adults
  - 10-item short form appropriate for older youth and adults
- Developed for multiple purposes:
  - Screening
  - Case Finding
  - Treatment outcome evaluation
- Total score ranges from 0 – 20
  - Further assessment and/or treatment is recommended for scores of 3-5 or higher.
- http://www.emcdda.europa.eu/attachements.cfm/att_61480_EN_DAST%202008.pdf

CRAFFT

- Brief 6 questions administered orally as part of any medical, psychosocial or clinical interview (abbreviated below)
- Specifically designed for use with adolescents younger than age 21
- Identifies risk for abuse and dependence for alcohol and other drugs
  - **C** : ridden in a car by driver under the influence
  - **R** : use alcohol or drugs to relax or fit in
  - **A** : ever used alone
  - **F** : ever forget things you did while using
  - **F** : friends or family tell you to cut down
  - **T** : ever gotten into trouble while using
- Further assessment is recommended if there are 2 positive endorsements
- http://www.ceasar-boston.org/CRAFFT/screenCRAFFT.php

Michigan Alcoholism Screening Test (MAST)

- 24 self-report items
  - Yes/No response options
  - Valence and scoring values vary by item
- Screens for lifetime alcohol-related problems and alcoholism
- Used for screening, treatment planning and treatment monitoring
- Total scores range from 0 – 53
  - Recommended cutoff score ranges from 7-12, depending on specific items endorsed (e.g., #s 18, 23 and 24 are highly indicative of alcoholism)
- http://adai.washington.edu/instruments/pdf/Michigan_Alcoholism_Screening_Test_156.pdf

Short Michigan Alcoholism Screening Test (S-MAST)

- 13 self-report items
  - Yes/No response options
  - Each “Yes” earns 1 point
- Modified short form of the 24-item MAST
- Total scores range from 0 – 13
  - Recommended cutoff score is 3-4
- http://www.projectcork.org/clinical_tools/pdf/ShortMAST.pdf

Short Michigan Alcoholism Screening Test – Geriatric Version (S-MAST-G)

- 10 self-report items
  - Yes/No response options
  - Each “Yes” earns 1 point
- Modified short form of the 24-item MAST
- Specifically designed for use with older adults
  - A 24-item MAST-G is also available:
  - http://www.ssc.wisc.edu/wlsresearch/pilot/P01-R01_info/aging_mind/Aging_AppB5_MAST-G.pdf
- Total scores range from 0 – 10
  - Recommended cutoff score is 2
- http://www.dbhds.virginia.gov/documents/scrn-OlderAd-Short-Michigan-Alc-ScreenTest.pdf

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

- 16 self-report items
  - Questions 1 and 5 are not scored
  - All scored items have Yes/No response options
- Screens for the need for more thorough substance abuse assessment
  - More items, therefore more specific, than the CAGE-AID
- Further assessment is recommended if there are 4 “yes” responses
- http://www.bhevolution.org/public/screening_tools.page

UNCOPE

- Brief 6 questions administered orally as part of any medical, psychosocial or clinical interview (abbreviated below)
- Identifies risk for abuse and dependence for alcohol and other drugs
  - **U** : used more than intended
  - **N** : neglecting responsibilities
  - **C** : wanted to cut down or stop
  - **O** : anyone objected to your use
  - **P** : preoccupied with wanting to use
  - **E** : use to relieve emotional discomfort
- Further assessment is recommended if there are 2 positive endorsements
- http://www.evinceassessment.com/UNCOPE_for_web.pdf

Screening Tools for Suicide Risk

ASK Suicide Questionnaire (ASQ)

- 4 questions
- Developed for use in pediatric emergency departments
  - Questions are asked by emergency department nurses or physicians to youth and young adults ages 10-21
- Identifies youth at risk for attempting suicide
- http://www.nimh.nih.gov/news/science-news/2013/asq_instrument_final.pdf

Suicide Behaviors Questionnaire (SBQ)

- 4 self-report items
  - Response options vary by item
- Each item taps into a different dimension of suicidality
    - Lifetime ideation and/or attempt
    - Frequency of ideation over last 12 months
    - Threat of suicide attempt
    - Self-reported likelihood of suicidal behavior in the future
- Total score ranges from 3 – 18
  - Recommended cutoff score of 7
  - Responses to each item should be reviewed carefully
- http://www.integration.samhsa.gov/images/res/SBQ.pdf

Columbia Suicide Severity Rating Scale (C-SSRS) – Screen Version

- 6 self-report items
  - Yes/No response options
- Training in the scale(s) is required, and no cost options are available (i.e., free downloadable videos)
- All types of gatekeepers or professionals can administer this scale, including physicians, nurses, psychologists, social workers, peer counselors, coordinators, research assistants, high school students, teachers and clergy
- Also available in longer versions for clinical settings and pediatric settings
  - Separate versions for ‘Ever’ and ‘Since Last Visit’

Screening Tools for Trauma

Child Trauma Screening Questionnaire (CTSQ)

- 10 self-report items
  - Yes/No response options
- Developed for children and youth ages 7-16
- Assesses for reexperiencing and hyperarousal symptoms (5 each)
- Respondents who answer “yes” to 5 items are identified as high risk for developing PTSD
- Interest in the measure must be registered with the developers and permission obtained before use in any setting
- http://www.som.uq.edu.au/childtrauma/ctsq.aspx

Life Events Checklist (LEC)

- 17 self-report items
  - Response options are on a 5-point nominal scale *(1=happened to me, 2=witnessed it, 3=learned about it, 4=not sure, 5=does not apply)*
- Assesses lifetime exposure to 16 events known to potentially result in PTSD or distress
  - 17th item for any other extraordinarily stressful event
- Endorsement of any items at a 1 or 2 indicate need for further assessment
- http://www.integration.samhsa.gov/clinical-practice/life-event-checklist-lec.pdf
- DSM-5 versions also available:
- http://www.ptsd.va.gov/professional/assessment/te-measures/life_events_checklist.asp

Multi-Domain Tools for Integrated Care

Duke Health Profile

- 17 self-report items
  - Response options vary
- Includes 6 Health Measures
  - Physical, Mental, Social, General, Perceived Health, Self-Esteem
- And Includes 4 Dysfunction Measures
  - Anxiety, Depression, Pain, Disability
- Total scores for each set of measures range from 0 – 100
  - Higher scores for Health Measures indicate better health status
  - Higher scores for Dysfunction Measures indicate worse health status
- Used for screening and measuring outcome of medical intervention and health promotion
- http://www.integration.samhsa.gov/clinical-practice/DukeForm.pdf

Patient Stress Questionnaire

- Self-report tool used in primary care settings to screen for behavioral health symptoms
  - Combines:
    - PHQ-9 (depression)
    - GAD-7 (anxiety)
    - PC-PTSD (post-traumatic stress)
    - AUDIT (alcohol abuse)
- http://www.integration.samhsa.gov/Patient_Stress_Questionnaire.pdf

Questions

Additional Resources

- SAMHSA-HRSA Center for Integrated Health Solutions

  http://www.integration.samhsa.gov/
- SAMHSA SBIRT Home page

  http://www.samhsa.gov/prevention/SBIRT/index.aspx
- SAMHSA Technical Assistance Partnership for Child and Family Mental Health

  http://www.tapartnership.org/

Contact Information

- **Cricket Mitchell, PhD**
  - Email: cmitchell@cimh.org
  - Cell phone: 858-220-6355

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