



The OASAS Clinical & Administrative Practice Improvement (CAPrI) Series

(Introductory Note: CAPrI is designed to communicate information to certified providers on effective clinical and administrative practices. At times, a CAPrI bulletin will accompany the release of a Local Services Bulletin (LSB) and provide additional detail and information on the subject of the LSB. On other occasions, OASAS may use CAPrI to distribute information on an evidence-based or best practice, and OASAS projects to promote its adoption.)

The Modified Mini Screen (MMS) A Validated Mental Health Screening Instrument

I. Description

SAMHSA's Treatment Improvement Protocol (TIP) 42, *Substance Abuse Treatment for Persons with Co-Occurring Disorders*¹, defines screening as "a formal process of testing to determine whether a client warrants further attention at the current time for a particular disorder and, in this context, the possibility of a co-occurring chemical dependence or mental disorder. The screening process for co-occurring disorders seeks to answer a 'yes' or 'no' question: Does the chemical dependence [or mental health] client being screened show signs of a possible mental health [or chemical dependence] problem. Note that the screening process does not necessarily identify what kind of problem the person might have or how serious it might be but determines whether further assessment is warranted. Screening activities may include scores on screening instruments, values from laboratory tests, clinical interviews, and other information offered spontaneously by the client."²

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 common to many screening, diagnostic and assessment tools, including the Diagnostic and Statistical Manual IV (DSM-IV)³, the Structured Clinical Interview for Diagnosis (SCID)⁴ and the Mini International Neuropsychiatric Interview (M.I.N.I.)⁵.

II. History

In its *Report to Congress on the Prevention and Treatment of Co-Occurring Substance Abuse Disorders and Mental Disorders*⁶, SAMHSA endorses, "... the growing consensus in the field that all mental health and substance abuse providers must be able to screen, assess and, as needed, provide or refer for treatment to meet the needs of individuals with co-occurring

substance abuse disorders and mental disorders without regard to disease severity, duration or symptomatology.” The National Report substantiates conclusions reached by the OASAS and OMH Joint Taskforce on Co-Occurring Disorders. In its 2001 report, the taskforce recommended that “OMH and OASAS should require screening and follow-up assessments for persons meeting Quadrant IV criteria at all points of entry within the OASAS and OMH systems”⁷.

OASAS has recognized a significant practice gap in providers’ activities to screen for mental health disorders. In a 2001 survey of mental health screening practices, 73% of the 651 Program Reporting Unit respondents affirmed that their program screened for mental health issues. When asked to identify the screening tool employed, however, 64% could not identify the tool they used. Review of client profiles from the PAS 44 submissions revealed a significant under-identification of persons with co-occurring mental health disorders, when compared with national survey data results. In 1999, only 16.34% of admitted patients to OASAS-certified programs were identified as having a co-existing psychiatric disorder (Question 32c on the PAS 44). Although the number of clients being identified with mental health disorders by OASAS providers has continued to rise since that time (approximately 30% in 2005), the importance of identification as an essential first step in providing care to persons with co-occurring disorders entering the OASAS system of care has not diminished.

III. The Modified Mini Screen Validation Study

To ensure that all clients with co-occurring disorders entering the substance abuse or mental health system would be identified and assessed, the two agencies, as part of the ongoing collaboration between OASAS and OMH, sponsored a validation study of two candidate screening instruments, the Modified Mini Screen (MMS), for use in the OASAS system, and the Dartmouth Assessment of Life Inventory⁸ (DALI), for use in the OMH system of care.

The two agencies engaged the Nathan Kline Institute’s Center for the Study of Issues in Public Mental Health (NKI) to conduct the study. 17 OASAS sites (2 Addiction Treatment Centers; 2 Methadone Treatment Programs; 3 Therapeutic Communities; 9 Medically Supervised Outpatient Programs; and 1 jail-based medically supervised outpatient program) participated in the validation study. Four sites were located in upstate New York; 4 in Long Island; 3 in Westchester County; and 6 in New York City. Overall, 485 clients were administered the MMS and the validation interview, 338 clients in the 17 OASAS-certified sites and 147 clients in “Quadrant IV” sites (a New York City shelter and a county jail in a New York City suburb). The validation criterion was the presence of a Mood, Anxiety, or Psychotic Disorder based on the Structured Clinical Interview for Diagnosis (SCID), which was administered by experienced SCID interviewers with additional study-specific training.

No screen is completely accurate. The validation study confirmed the value of the MMS as a screening tool for use by OASAS-certified providers. The overall accuracy (i.e., the percentage of “true positives” and “true negatives”) of the MMS ranged between .70 and .74, depending on the cut-point employed to define a positive result. The instrument performed equally well among men and women, among African Americans and Hispanics and Whites, and across all modalities, including prison and shelter settings. There is a Spanish version of the MMS as well, though that version was not specifically validated in this study.

The validation study also identified the “trade-offs” involved in selecting particular screen scores or cut points as thresholds for positive screens. As the threshold score or cut point is raised, fewer resources are required to conduct full assessments, however, fewer true cases are

identified. Based on the rate of psychiatric diagnoses found in the NKI study (43%), at cut point 6 (i.e., six positive responses on the 22 item MMS), 58% of those screened would require a further assessment, but the screen would miss 18% of true cases. At a cut point of 9, however, only 37% of those screened would receive further assessment, but 37% of the true cases would have been missed.

The results of the validation study underscore the importance of clinical judgment in making informed decisions about the need for further assessment of particular clients and not relying exclusively on a screen score to determine the decision.

The MMS study validated questions that identify a client's current distress in relation to the following disorders: Major Depressive Episode (2 questions); Dysthymia (1 question); Suicidality (1 question); (Hypo)Manic Episode (2 questions); Panic Disorder (1 question); Agoraphobia (1 question); Social Phobia (1 question); Obsessive-Compulsive Disorder (2 questions); Post-Traumatic Stress Disorder (2 questions); Psychotic Disorder (7 questions); and Generalized Anxiety Disorder (2 questions).

IV. The OASAS Adoption Pilot Study

Before concluding that the MMS is a useful and practical tool for clinicians in OASAS programs, OASAS conducted an implementation pilot study within three programs, two of which had participated in the validation study. An urban MTP, a suburban medically-supervised outpatient program and an upstate rural residential treatment program, which had not participated in the validation study, agreed to implement the MMS among new admissions. Key program staff received on-site training on the MMS. The materials from this training, the User's Guide for the MMS, the Implementation Plan Guidance Document and the MMS instrument are attached to this CAPrI report.

The evaluation of the pilot implementation project in three programs supported the use of the MMS in OASAS-certified programs. All sites viewed the MMS as one component of an assessment process, and recognized that counselors should not use the tool to draw any definitive conclusions about a client's mental health status. The respondents were overwhelmingly positive about the use of the tool, however, and the value of OASAS on-site training and ongoing involvement in the implementation project. Nevertheless, all three programs also placed a high value on the flexibility that allowed them to implement the MMS in a manner consistent with their needs and intake/assessment processes.

OASAS has incorporated the findings from this pilot implementation study into this statewide project to promote the adoption of the MMS.

V. Use of the Modified Mini Screen

It is imperative that a program intending to use the MMS complete a planning process that addresses the multiple clinical and programmatic issues that may arise as a result of regular screening for mental health disorders before introducing the instrument to clinical practice. Most obvious in this list is the determination of a "cut-point" threshold score, which, when achieved, will require that clients receive further assessment. There is a host of other issues, such as when to administer (and readminister) the screen, how to talk with clients about their results, what procedures must be modified or created to ensure that there is appropriate follow-up and how to

record the results and integrate them into the treatment plan. OASAS has intentionally left these determinations to providers, recognizing that each program may have both substantial and subtle differences in their assessment procedures and in the clinical and programmatic resources available to support them. The OASAS “*Provider Implementation Plan*”, which is attached, identifies some of the questions that a provider must address **prior to** introducing the screen. OASAS expects that every provider adopting the MMS will complete such a plan, and forward it to their Field Office liaison for review. For New York City providers participating in the Modified Mini Screen Quality Impact Project (QIP), completion of the QIP requirements fulfills this expectation, and thus no Implementation Plan is required of those providers.

As emphasized throughout the MMS Guidance Document (also attached), the screen is not a substitute for the exercise of clinical judgment, and reliance solely on a screening score to indicate that a person might have a mental health disorder, no matter how effective the instrument may have performed in clinical studies, is not an acceptable practice. Programs should guard against such simplistic approaches by integrating the MMS into its clinical supervision and in-service sessions for all staff, and incorporate the screening and assessment processes into its Policy and Procedures Manual.

VI. Contact Information

For more information on the MMS, please contact:

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