Using the Screening Measures and Scoring the Results

The following screening measures are available for use by a clinician or program. They can be filled out by patients or administered by the clinician during initial patient interviews.

Modified Mini Screen

The Modified Mini Screen (MMS) is a generic screening measure for mood, anxiety, and psychotic spectrum disorders. There are twenty-two questions with yes/no responses. It takes about fifteen minutes to complete. For more information, see chapter 4 of the clinician's guide.

To score the MMS, total the number of yes answers. A score of 6 or greater indicates the likely presence of a psychiatric disorder. A patient who answers yes to question 4 should be monitored for suicidality. A patient who answers yes to questions 14 and 15 should be assessed for trauma.

SOURCES

Modified Mini International Neuropsychiatric Interview

Alexander, M. J., G. Haugland, S. P. Lin, D. N. Bertollo, and F. A. McCorry. 2008. Mental Health Screening in Addiction, Corrections and Social Service Settings: Validating the MMS. *International Journal on the Addictions* 6 (1): 105–19.

Mental Health Screening Form–III

The Mental Health Screening Form–III (MHSF–III) is a generic screening measure for a range of disorders: schizophrenia; depression; PTSD; phobias; intermittent explosive, delusional, sex/gender/identity, eating, manic, panic, obsessive-compulsive, and gambling disorders; learning disabilities; and mental retardation. For more information, see chapter 4 of the clinician's guide.

The MHSF–III can be self-report, but the preferred mode of administration is for staff members to read each item to patients and get their yes and no responses. After completing all eighteen questions (question 6 has two parts), the staff member should inquire about any yes response by asking the following:

- "When did this problem first develop?"
- "How long did it last?"
- "Did the problem develop before, during, or after you started using substances?"
- "What was happening in your life at that time?"

The total number of yes responses does not necessarily indicate any specific disorder. A skilled clinician must evaluate each response carefully.

SOURCE

Carroll, J. F. X., and J. J. McGinley. 2001. A Screening Form for Identifying Mental Health Problems in Alcohol/Other Drug Dependent Persons. *Alcoholism Treatment Quarterly* 19 (4): 33–47.

CAGE Adapted to Include Drugs (CAGE-AID)

The CAGE-AID is a sensitive screen for alcohol and drug problems. CAGE is an acronym for

C - Ever try to **Cut back** on your drinking or drug use?

A - Ever been **Annoyed** by anyone about your drinking or drug use?

G - Ever felt **Guilty** or ashamed about your drinking or drug use?

E - Ever had an **"Eye-opener"** or used alcohol or drugs in the morning?

Answering yes to any of these questions indicates an alcohol or drug use problem.

SOURCES

CAGE Adapted to Include Drugs

Brown, R., and L. Rounds. 1991. *Conjoint Screening Questionnaires for Alcohol and Drug Abuse: Two Pilot Studies.* Unpublished study.

CAGE

Ewing, J. A. 1984. Detecting Alcoholism: The CAGE Questionnaire. *Journal of the American Medical Association* 252:1905–7.

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

The SSI-AOD consists of sixteen items and is therefore more specific than the CAGE-AID. It is simple to use, reliable, and valid.

Questions 1 and 15 are not scored. Answering yes to four or more questions indicates an alcohol or drug use disorder.

SOURCE

Center for Substance Abuse Treatment. 1994. Simple screening instruments for outreach for alcohol and other drug abuse and infectious diseases. *Treatment Improvement Protocol (TIP) Series 11. DHHS Publication No. (SMA) 94-2094.* Rockville, MD: Substance Abuse and Mental Health Services Administration.

Center for Epidemiological Studies Depression Scale (CES-D Scale)

The Center for Epidemiological Studies Depression Scale (CES-D Scale) was developed by L. S. Radloff and published in 1977. It has been widely used in medication, psychosocial treatment, and clinical setting prevalence studies. The CES-D Scale has twenty items about depressive symptoms. Items are rated on a 4-point scale as to how many days the respondent was bothered by these symptoms over the past week. A total score of 60 is possible, though scores of 16 or greater (mild to moderate depression) and 21 or greater (major depression) are considered clinically significant.

SOURCE

Radloff, L. S. 1977. The CES-D Scale: A Self Report Depression Scale for Research in the General Population. *Applied Psychological Measurement* 1:385–401.

Life Events Checklist and PTSD Checklist (PCL)

The **Life Events Checklist** is part of the screening measure used with the Clinician-Administered PTSD Scale (CAPS), a structured clinical interview to determine *DSM-IV* diagnosis of PTSD and symptom severity published by Western Psychological Services. The Life Events Checklist assesses a respondent's experience of seventeen possible negative life events. These life events often qualify as *DSM-IV* PTSD diagnosis Criterion A events. The respondent will indicate whether or not he or she experienced one or more of these events, and the clinician will review this list post-screening. Item 17 ("Any other very stressful event or experience") may not qualify as a Criterion A event.

Note: Criterion A for PTSD (from the *DSM-IV,* pages 427–428):

> The person has been exposed to a traumatic event in which both of the following were present: (1) The person experienced, witnessed, or was confronted with an event or events that involved actual or threatened death or serious injury, or

threat to the physical integrity of self or others; (2) the person's response involved intense fear, helplessness, or horror.

SOURCE

Blake, D. D., F. W. Weathers, L. M. Nagy, D. G. Kaloupek, D. S. Charney, and T. M. Keane. 1996. The Development of a Clinician-Administered PTSD Scale. *Journal of Traumatic Stress* 8:75–80.

The **PTSD Checklist (PCL)** is a seventeen-item instrument that respondents rate using a 5-point scale from 1 (not at all) to 5 (extremely), pertaining to how bothered they are by symptoms related to the traumatic event(s) listed on the Life Events Checklist. These items are rated as the respondent experiences them over the past month. These items tap into the *DSM-IV* PTSD B (re-experiencing), C (hyper-arousal) and D (avoidance) criteria. Scores of 44 or more, in conjunction with at least one qualifying Criterion A event on the Life Events Checklist, are associated with a diagnosis of PTSD. Higher scores are associated with increased symptom severity.

SOURCE

Blanchard, E. B., J. Jones-Alexander, T. C. Buckley, and C. A. Forneris. 1996. Psychometric Properties of the PTSD Checklist (PCL). *Behavior Research and Therapy* 34:669–73.

SIAS

The Social Interaction Anxiety Scale (SIAS) was developed and published by Mattick and Clarke in 1998 and has been used to assess prevalence, severity, and treatment outcomes of social phobia and social anxiety disorders. The SIAS is a twenty-item measure on which respondents rate their experiences in social situations associated with social anxiety and social phobia *DSM-IV* criteria. Experiences are rated on a 5-point scale from 0 (not at all characteristic of me) to 4 (extremely characteristic of me). Experiences are rated on a global period of what is typical. A total score of 60 is possible with cutoffs of 34 or more indicative of social phobia (specific situations of irrational social fears with avoidance and impairment) and 43 or more indicative of social anxiety (generalized irrational fears across numerous social situations with avoidance and impairment). Note that on items 5, 9, and 11 scoring is reversed (a 0 = 4, a 1 = 3) to assess for response validity.

SOURCE

Mattick, R., and C. Clarke. 1998. Development and Validation of Measure of Social Phobia Scrutiny Fear and Social Interaction Anxiety. *Behavior Research and Therapy* 36:455–70.