



**SCREENING FOR CO-OCCURRING
MENTAL HEALTH AND SUBSTANCE USE CONDITIONS
IN
THE VERMONT AGENCY OF HUMAN SERVICES
USER'S GUIDE**



Acknowledgements

This Users Guide was developed by the Vermont Integrated Services Initiative (VISI) which is a joint program of the Department of Mental Health and the Department of Health/Division of Alcohol and Drug Abuse Programs (ADAP). This Guide was edited and reviewed by the VISI Clinical Practices Committee and the staff of ADAP and the Department of Mental Health's adult and children's program.

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Vermont Agency of Human Services

TITLE: Protocol for screening for Co-Occurring Mental Health and Substance Use Conditions

In accordance with the Agency of Human Services emphasis on providing integrated services for people with co-occurring mental health and substance use conditions, and as part of the initial evaluation of individuals seeking services, it is *recommended* that appropriate AHS programs, divisions and departments and contractor agencies shall use standardized mental health and substance use screening instruments to facilitate the early and accurate identification of co-occurring mental health and substance use conditions. The screening instruments must be administered utilizing welcoming and recovery-oriented engagement techniques. The approach is to be person-centered, with respect for individual's strengths, hope, and wellness, and in support of the Agency's recovery-oriented approach. It is recommended that all AHS programs and contracted agencies have a protocol that demonstrates integrated screening and its connection to integrated assessment and integrated treatment planning. The completed screening results and/or instruments shall be placed in the person's treatment chart or clinical record.

WHAT ARE CO-OCCURRING CONDITIONS?

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

Screening as the First Step in Co-occurring Treatment Process

Definition

Screening determines the likelihood that a client has a co-occurring substance use and mental health condition or that his or her presenting signs, symptoms, or behaviours may be influenced by co-occurring issues. The purpose is not to establish the presence or specific type of such a condition, but to establish the need for an in-depth assessment. Screening is a formal process that typically is brief and occurs soon after the client presents for services.

The goal is to identify everyone who might have co-occurring condition and related service needs.

Rationale for Screening

High prevalence and under identification of co-occurring conditions in treatment settings highlight the need for better detection and assessment procedures. Incorporating an integrated screen and assessment into the treatment planning will lead to more positive patient/client outcomes. Screening demonstrates to the patient that the program is committed to identifying and addressing the full range of their health issues. The therapeutic relationship is initiated when these conditions are explored and treatment options and limits are discussed in a context of mutual respect and acceptance. When an effective screen is implemented properly, staff is more likely to identify someone who truly has a mental illness/substance use issue. Screening increases the likelihood of discovering high risk cases and will reduce the number of assessments that are conducted when they are not needed.

The capacity to screen for co-occurring issues is essential in matching people to needed services and to the establishment of a “no wrong door” policy.

Screening Implementation

Screening should be completed as soon as possible. The goal is to screen the patient when their sensorium is not clouded by alcohol or other drugs and/or the withdrawal of substances which may exacerbate symptoms of mental disorders. At a minimum, the patient should be stabilized prior to screening. Substance related affective symptoms (depression, mania) usually clear within days to a week 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. *Administration of a screening tool after two weeks of abstinence is recommended.* Thereafter, a clinician may conduct subsequent screens as appropriate based upon their clinical judgment and according to the program’s policies and procedures.

Clinical Observations by staff should never be replaced by any screening tool

Screenings can be conducted by any properly trained staff. Integrated screenings can occur in any health or human services context as well as within the criminal justice, homeless services and educational systems. The goal is to create a broad range of relevant contexts in which

screening occurs to increase the probability that people with COD will be identified and referred for further assessment and treatment.

The department, division or program can use this Guide to develop a written implementation plan that identifies the specific screening procedures that their program and staff will adhere to.

Utilization

Screening protocols must detail exactly what is to take place when the client scores in the range that indicates a need for referral for further assessment. The screening protocol should provide a format for recording the results of the screening and other relevant client information necessary for a good referral.

If the protocols for following up on the screening results are not in place or not acted on the integrated treatment process breaks down.

Summary

The screening process is the first level of providing accurate and integrated treatment to clients. To be effective the screening results need to be influential in the assessment and treatment process. Screening tools provide a standard and comparable format. They do not eliminate the importance of the circumstances of contact, the client's demeanour and behaviour, signs of acute intoxication, physical signs suggesting drug use or attempts at self-harm and information offered spontaneously by the client. Screening tools should be a part of the comprehensive information-gathering methods.

Recommendations

The following presents our recommendations for screening tools for mental health and substance use conditions. *This list is not exhaustive but recommends tools that have been validated through research and trial.* We have also included an Appendix with more detailed information on the screening process.

SCREENING TOOLS FOR MENTAL HEALTH, ALCOHOL AND SUBSTANCE USE DISORDERS

Key:

- 1) What does the tool screen for (mental illness, alcohol, drug use, etc.)?
- 2) What population is the tool used for (adults, adolescents)?
- 3) What is the typical service setting in which it is used (residential, inpatient, pediatric clinic, healthcare provider)?
- 4) How widely is the screening tool used (how was it developed, has it been validated—on what population)?
- 5) What are the administration characteristics (self-administered, reading level required, interview)?
- 6) Description of the screening tool (number of items, type of answers, length of time to complete, time frame measure, rating system).
- 7) What is the cost to purchase and use the tool?
- 8) What training and qualification are required to administer, score and interpret the tool?
- 9) Pertinent notes and comments on the tool.

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SCREENING TOOL	CONDIT-ION	POPULATION	SETTINGS	RELIABILITY/ VALIDITY	ADMINISTRATION	DESCRIPTION	COST	TRAINING	OTHER
Alaska Screening Tool	Drug, Alcohol, MH & TBI	Adults & Youth	Broad	Reliable, valid	Self-administered	38 items	No	Basic	
Alcohol Use Disorders Test (AUDIT)	High alcohol consumption	Adults	Court, Jails, DWI, ER Primary Care Armed forces	Reliable, Valid	Professional or paraprofessional. Training required.	10 items, 3 minutes	No	Users Manual and videotape training available	Linked to brief intervention with heavy drinkers
BAI Beck Anxiety Inventory	MH – anxiety	Adults & Youth	Broad	Reliable, Valid	Self-administered	21 item	No	Basi	
BDI Beck Depression	MH Depression	Adults and youth over 13 years of age	Broad	Reliable, valid	Paper/pencil – Self Administered or Verbally	4 questions 5 minutes	No	Basic	Good indicator for further assessment of

Inventory II									mental illness
BSI	Mental Health	Adults	Broad	Reliable, valid	Self-administered	53 questions 15 minutes	No	Basic	
CAGE	Alcohol	Adults & Youth over 13	Broad	Reliable, valid	Interview	4 questions	No	Basic	Does not separate past from current use. In health care settings
CAGE-AID	Drug, Alcohol	Adults & Youth	Broad	Reliable, valid	Interview	6 questions	No	Basic	Used in health care settings
CBCL Child Behavior Checklist	MH	Youth	Broad	Reliable, valid	Caregiver self-administered. Professional scored	120 items	Yes	Basic	ASEBA system includes other scales for completion by teacher, youth. Multiple languages, culturally normed
CDI Child Depression Inventory	MH – Depression	Youth	Broad	Reliable, Valid	Self-administered	27 items (short form 10-items for quick screen)	No	Basic	Maria Kovacs, PhD
Circumstances Motivation and Readiness Scales (CMR Scales)	Predicts retention in treatment for outpatient and residential	Adults	Broad	Reliable, valid	Self-administered, Interview	18 questions, 5-10 minutes	No	None	
Clinical Institute Withdrawal Assessment (CIWA-AR)	Measures severity of alcohol withdrawals	Adults	Broad	Reliable, valid	Interview	10 questions, 7-10 minutes	No	Advanced. Administered by doctors, nurses, detox staff	
CRAFFT	Drug, Alcohol	Youth over 13 years of age	Medicaid PCP's	Reliable, valid	Self-administered, Interview	6 questions, 5 minutes	No	Basic	Currently being used by PCP's
DALI	Drug, Alcohol	SPMI Adults	Broad	Reliable, valid	Interview	18 questions	No	Basic	

DAST-10	Drug	Adults & Older Youth	Broad	Reliable, valid	Self-administered, paper/pencil	10 questions	No	Basic	Use with SMAST
GAIN-Q	Drug, Alcohol & MH	Adults & Youth	EAP, SAP, Juvenile Justice, Criminal Justice	Reliable, valid	Self-administered or interviewer-administered & computer-assisted	30 minutes	No	Basic	Endorsed by ADAP, statewide training; has sister assessment and aftercare assessment (M90)
Impact of Events Scale	MH	Children & youth	Broad	Reliable, valid	Self-administered	8 items	No	Basic	
K6	Mental Health	Adults, Elderly	Broad	Reliable, valid	Interview	4 questions, 5 minutes	No	Basic	
Level of Care Utilization System (LOCUS)	Assesses immediate service needs and helps plans needs over time	Adults	Broad	Reliable, valid	Interview	50 minutes	No	Basic	
MAYSI-2	Drug, Alcohol & MH	Youth 12-17 years of age	Broadly used across children's services	Reliable, valid	Self-report	52 questions, 15 minutes	No	Basic	Endorsed by ADAP, statewide training
MHSF III	MH	Adults & Youth	Broad	Reliable, valid	Self-administered or interview	17 items	No	Basic	
MINI	Drug, Alcohol & MH	Adults	Broad	Reliable, valid	Interview	21 questions, 15-20 minutes	No	Basic	Used as follow-up to the MHSF III
MINI Kid	Drug, Alcohol & MH	Youth	Broad	Reliable, valid	Interview	46 questions	No	Basic	Used as follow-up to the MHSF III

MIDAS	Drug, Alcohol	Adults, SPMI	Broad	Reliable, valid	Self-administered	17 questions	No	Basic	Developed & endorsed by Ken Minkoff, M.D.
PHQ -9 Patient Health Questionnaire	MH Depression	Adults	Broad	Reliable, valid	Self-administered	9 questions	No	Basic	http://www.phqscreeners.com/
ProQol Professional Quality of Life Scale	Compassion Satisfaction, Burnout and Fatigue	Clinical providers	Direct service providers of many professions	Reliable, valid	Self-administered	30 items	No	Basic	Multiple languages. Idaho State University; http://www.isu.edu/~bhstamm/tests.htm#TEST%20NAME
Readiness to Change Questionnaire	Determines stage of readiness for change for alcohol use	Adults, Youth	Broad	Reliable, valid	Interview	12 questions 5-7 minutes	No	Basic	
SASSI	Drug	Adults & Youth	Broad	Reliable, valid	Self-administered individually or group	5-15 minutes	Yes	Basic	
SMAST	Alcohol	Adults & Youth	Broad	Reliable, valid	Self-administered	Few minutes	No	Basic	Use with DAST-10
Stressful Life Events Questionnaire	MH	Adults	Broad (non-clinical)	Reliable, valid	Self-administered	Few minutes 13 items	No	Basic	To obtain scale contact: Lisa A. Goodman Email: lgoodman@bss3.umd.edu
TSCC/ TSCYC Trauma Symptom Checklist for (Young) Children	MH - Trauma	Youth (8-16) and Children (3-12)	Clinical, Medical, psychosocial	Reliable, valid	Self-administered	10-20 min (54 items)	Yes	Basic	
TESI Traumatic Events Screening	MH - Trauma	Youth	Clinical, Medical, psychosocial	Reliable, valid	Interview	10-30 min (18 items)	No	Basic	http://www.ncptsd.va.gov/ncmain/ncdocs/assmnts/TESI-

Inventory									C.pdf. Dartmouth Child Trauma Research Group
Trauma Screening Questionnaire	MH - Trauma	Adults	Broad	Reliable, valid	Self-administered	10 items	NO		Based on items from the PTSD Symptom Scale – Self Report. Developed by Chris Brewin, PhD, London c.brewin@ucl.a c.uk
UNCOPE	Drug, Alcohol	Adults & Youth	Medical, Psychosocial, Clinical	Reliable, valid	Interview	6 questions	No	Basic	
University of Rhode Island URICA	Stages of Change/Rea diness	Adults	Inpatient, Outpatient	Reliable, valid	Interview	15 minutes	No	Basic	

SCREENING TOOLS FOR MENTAL HEALTH, ALCOHOL AND SUBSTANCE USE DISORDERS

		Disorder	Population
AAIS	Adolescent Alcohol Involvement Scale	Alcohol	Youth
ADI	Adolescent Diagnostic Interview	Drug	Youth
Adi	Adolescent Drinking Index	Alcohol	Youth
ADIS	Adolescent Drug Involvement Scale	Drug	Youth
ADS	Alcohol Dependence Scale	Alcohol	Adults & Youth
Alaska Screening Tool	For SA & TBI, MH & TBI, Dual Dx & TBI	Drug, Alcohol MH	Adults & Youth
ASI	Addiction Severity Index	Drug, Alcohol, MH	Adults & Youth
ATOD	Alcohol, Tobacco, Other Drugs Screening	Drug, Alcohol	Adults & Youth
AUDIT	Alcohol Use Disorders Identification Test	Alcohol	Adults & Youth
AUI	Adolescent Use Inventory	Alcohol	Youth
BEI	Behaviors and Experiences Inventory	MH	Adults
BMAST	Brief Michigan Alcohol Screening Test	Alcohol	Adults & Youth
BPRS	Brief Psychiatric Rating Scale	MH	Adults & Youth
BDI			
BSI	Brief Symptom Inventory	MH	Adults & Youth
CAAPE	Comprehensive Addictions & Psychol. Eval.	Drug, Alcohol, MH	Adults
CAGE	Alcoholism questionnaire (Cut Down, Annoyed, Guilty, Eye-opener)	Alcohol	Adults & Youth
CAGE-AID	Drug and alcoholism questionnaire (CAGE—Adapted to Include Drugs)	Drug, Alcohol	Adults & Youth
CDAP	Chemical Dependency Assessment Profile	Drug, Alcohol	Youth
CIWA	Clinical Institute Withdrawal Assessment	Measures severity of alcohol withdrawals	Adults
CMR Scale	Circumstances Motivation and Readiness Scales	Readiness to Change	Adults
CRAFFT	Alcohol and other drug screening (Car, Relax, Alone, Forget, Family or Friends, Trouble)	Drug, Alcohol	Youth
DALI	Dartmouth Assessment for Life Inventory	Drug, Alcohol	Adults
DAP	Drug and Alcohol Problem Quick Screen	Drug, Alcohol	Youth
DAST	Drug Abuse Screening Test	Drug	Adults & Youth
DAST-10	Drug Abuse Screening Test-10	Drug	Adults & Youth
DUSI-R	Drug Use Screening Inventory—Revised	Drug	Adults & Youth
GAIN-Q	Global Appraisal of Individual Needs—Quick	Drug, Alcohol, MH	Adults & Youth
MAST	Michigan Alcohol Screening Test	Alcohol	Adults & Youth
MAYSI-2	Massachusetts Youth Screening Instrument	Drug, Alcohol, MH	Youth
MHSF III	Mental Health Screening Form III	MH	Adults & Youth
MIDAS	Mental Illness Drug & Alcohol Screening	Drug, Alcohol	Adults
MINI	Mini International Neuropsychiatric Interview	Drug, Alcohol, MH	Adults
MINI	Mini International Neuropsychiatric Interview	Drug, Alcohol, MH	Youth
MMSE	Mini-Mental Status Examination	MH	Adults
PADDI	Practical Adolescent Dual Diagnostic Interview	Drug, Alcohol, MH	Youth
PBDS	Perceived Benefit of Drinking Scale	Drug, Alcohol	Youth
PESQ	Personal Experience Screening Questionnaire	Drug	Adults & Youth
PHQ-9	Patient Health Questionnaire	MH	Adults & Youth
POSIT	Problem Oriented Screening Instrument for Teenagers	Drug, MH	Youth
RAPI	Rutgers Alcohol Problem Index	Alcohol	Youth
SAAST	Self-Administered Alcoholism Screening Inventory	Alcohol	Adults & Youth
SASSI	Substance Abuse Subtle Screening Inventory	Drug	Adults & Youth
SF-36	Summary of Functioning	Health & MH	Adults & Youth
SMAST	Short Michigan Alcohol Screening Test	Alcohol	Adults & Youth
SQLS	The Schizophrenia Quality of Life Scale	Schizophrenia	Adults
TAAD	Triage Assessment for Addictive Disorders	Drug, Alcohol	Adults & Youth
TAPD	Triage Assessment for Psychiatric Disorders	MH	Adults & Youth

T-ASI	Teen-Addiction Severity Index	Drug	Youth
UNCOPE	Used, Neglected, Cut down, Objections, Preoccupied, Emotional Distress	Drug, Alcohol	Adults & Youth
University of Rhode Island URICA	Stages of Change		Adults
YAAPST	Youth Adult Alcohol Problems Screening Test	Alcohol	Adult

Appendix: Information Relating to Co-occurring Conditions

HOW PREVALENT ARE CO-OCCURRING CONDITIONS?

- According to a face-to-face survey of people in randomly sampled households across the U.S., thirty-seven percent of alcohol users and fifty-three percent of drug users also have at least one mental health condition.
- 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 use disorder and conversely, people with substance use disorders are at increased risk for developing a mental health condition.

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

Psychiatric issues commonly found in persons with co-occurring conditions can be arranged under four main categories:

- *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 (obsession 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.

WHAT ARE THE GENERAL CHARACTERISTICS OF PATIENTS WITH CO-OCCURRING CONDITIONS?

- Substance use and mental health conditions 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 conditions occur across the lifespan in both men and women.
- When one or both disorders are severe, consequences include inability to maintain stable housing or to stay employed, repeated cycles through treatment, 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 PATIENT WITH CO-OCCURRING CONDITIONS?

Patients with one or more severe co-occurring conditions 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.
- Fifteen to 25% of suicides are committed by persons who abuse alcohol. Suicide may also be associated with intoxication or withdrawal from addictive substances.
- Difficulties in social functioning
- Shorter time in remission of symptoms

In addition, individuals with severe disorders are:

- More sensitive to substance effects
- Unlikely to develop dependence or medical signs of sustained, heavy use
- More likely to encounter substances and pressure to use
- More likely to experience negative outcomes

WHAT ARE THE BEHAVIORAL CHARACTERISTICS OF PATIENTS WITH CO-OCCURRING CONDITIONS?

People with mental health conditions will have the characteristics of the conditions they suffer from. Those with severe mental illness may have:

- Difficulty comprehending or remembering important information
- Inability to recognize the consequences of behavior, thereby affecting the ability to plan
- 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 PATIENTS WITH CO-OCCURRING CONDITIONS?

- 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 CONDITIONS?

The purpose of a screening instrument is to identify patients with a high likelihood of having a mental illness that could compromise successful treatment outcomes. A high screen score will prompt a referral for a more thorough assessment. Screening should be completed in a timely manner to assist in developing a comprehensive treatment plan. It should be noted that **screening** is a process for evaluating the possible presence of a problem while **assessment** is a process for defining the nature of that problem and developing specific treatment recommendations to address that problem. While screening can be conducted by any trained clinician, assessments can **only** be conducted by licensed practitioners.

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 patient with a substance abuse disorder has a mental disorder as well. If a problem is identified, the patient should be referred for a more detailed assessment and an appropriate referral. Adequate assessment of the full picture of a patient's co-occurring disorder 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 patients with co-occurring disorders. Screening demonstrates to the patient that the program is committed to identifying and addressing the full range of their problems. 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.

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 are sometimes secondary to use of crack cocaine, hallucinogens, alcohol, and ecstasy. 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. In addition, HIV and Hep-C positive patients 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. Administration of the Modified Mini Screen after two weeks of abstinence is recommended. The goal is to screen the patient when their sensorium is not clouded by alcohol or other drugs and/or the withdrawal of substances—at a minimum, the patient should be stabilized prior to screening. Thereafter, a clinician may conduct subsequent screens as appropriate based upon their clinical judgment and as per the program's policies and procedures. **CLINICAL OBSERVATIONS BY STAFF SHOULD NEVER BE REPLACED BY ANY SCREENING TOOL.**

It is the program's responsibility to develop a written implementation plan that identifies the specific screening procedures that the provider will adhere to. A suggested implementation guide has been developed to assist in this process which identifies a range of issues relative to implementation.

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 identifying and incorporating 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.