**Clinical Problem**

A need for better recognition of PTSD and co-occurring disorders (COPSDs) of the served client population. Recognition begins with identification.

**Inquiry Question**

In new adult clients initiating outpatient mental health services, does implementing a new intake screening procedure affect the identification and diagnosis of persons with PTSD and/or co-occurring disorders (COPSD)?

**Objective**

Does disorder symptom identification through self-report and observer-rated screening lead to its provisional diagnosis by licensed clinical staff?

**Framework**

Iowa Model of Evidence-Based Practice

**Decision Point(s)**

**Methods**

**Design—Quality Improvement (QI)**

**Participants**

**Setting:** A rural CMHC, composed of two outpatient clinics that serve the Anderson and Cherokee Counties of Texas.

**Target Population:** Adults seeking new mental health services via the open intake process.

**Sample Size:** One-hundred, fifty-one (n = 151) adult persons meeting inclusion criteria who completed an open intake screening between August 1 and December 1, 2017.

**Screening-Into-Intake-Procedure (SIIP)**

**Measurement Methods**

**Variables:** Traumatic stress response symptoms that may be indicative of PTSD, Substance use, and current use level.

**Stage One: Client Self-Assessment (CSA)**

- PTSD Checklist, 6 Questions (PCL-6)

**Stage Two: Needs Assessment Screening (NAS)**

- Texas Christian University Drug Screen, DSM-5 (TCUDS-5)

**Results**

**Statistical Analysis—Chi-Square**

**Decreasing identification of PTSD via the CSA**

<table>
<thead>
<tr>
<th>Group</th>
<th>CSA</th>
<th>NAS</th>
<th>IA</th>
<th>PE</th>
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</thead>
<tbody>
<tr>
<td>Inconclusive (29.5%) v. Diagnosed (21%)</td>
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<tr>
<td>25.5%</td>
<td>24.6%</td>
<td>19.5%</td>
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**Decreasing identification of PTSD via the NAS**

<table>
<thead>
<tr>
<th>Group</th>
<th>NAS</th>
<th>IA</th>
<th>PE</th>
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</thead>
<tbody>
<tr>
<td>Inconclusive (29.5%) v. Diagnosed (21%)</td>
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<tr>
<td>22.2%</td>
<td>20%</td>
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**Conclusions**

Increased sensitivity and specificity in symptom identification and diagnosis of disorders.

AND

Non-licensed staff and clinicians failing to identify a portion of their clients with PTSD, substance use, COPSDs, and/or co/PTSD.

**Practice Implications**

- By raising awareness about the need for their assessment, the SIIP assisted in the early recognition and identification of PTSD and COPSDs.
- Further training needed to improve screener competency and standardization of process.

Many future project opportunities:

- Development of a SIIP Training protocol.
- Determining the impact of staff licensing status on SIIP effectiveness.
- Determining which qualifying diagnoses are more likely to co-occur with PTSD.
- Developing a logistical regression model after increased sample size.

**Limitations**

- Small sample size
- Time delay between screening completion and data analysis of the screening process limited measurable correction to the process.
- Multiple incompletions of the NAS for unidentifiable reasons, limiting overall sample size.
- The need for improved and continual training of staff about the SIIP process.
- A strict reliance by screeners on cut-off scores to determine if additional screening was needed.
- The failure to further screen for substance use although scored positive on the CSA.

**Conclusion**

A New Screening Procedure to Identify Co-Occurring Psychiatric and Substance Use Disorders

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