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

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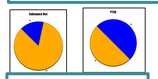
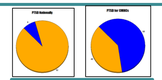
Clinical Problem

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



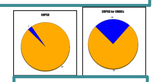
Nationally, up to 16% w/S/A.

w/ S/A, up to 50% PTSD.



Nationally, PTSD at 8%.

Up to 60% at CMHCs.



Nationally, 3% COPSD;

Up to 24% At CMHCs.

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)?

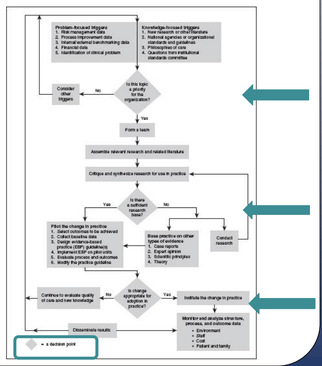
Objective

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)



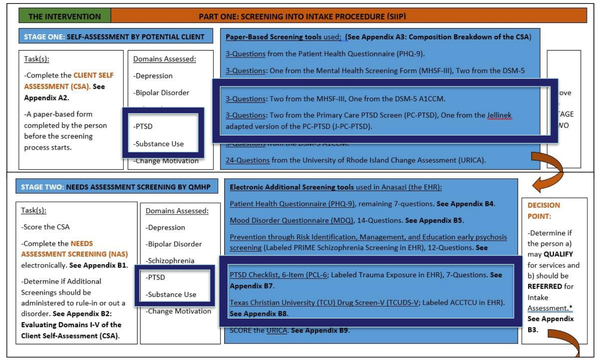
Methods

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

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

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

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

- PTSD Checklist, 6 Questions (**PCL-6**);
- Texas Christian University Drug Screen, DSM-5 (**TCUDS-5**)

Results

Statistical Analysis—Chi-Square

Chi-Square Crosstabulation for PTSD Disorder

DIAGNOSIS	STAGE	CONGRUENT STAGE	ASSESSMENT	Congruent Positive Screens		Congruent Negative Screens		Incongruity		Total	
				n -	% of Total	n -	% of Total	n -	% of Total	n -	%
PTSD	I-CSA	I	CSA	-	-	-	-	-	-	-	-
		II	NAS	29*	29.7%	57*	58.1%	12*	12.2%	98	100%
		III	IA	23*	22.5%	51*	50.0%	28*	27.5%	102	100%
		IV	PE	15*	19.7%	37*	48.7%	24*	31.6%	76	100%
PTSD	II-NAS	I	CSA	-	-	-	-	-	-	-	-
		II	NAS	-	-	-	-	-	-	-	-
		III	IA	21*	22.3%	49*	52.2%	24*	25.5%	94	100%
		IV	PE	13*	20.0%	36*	55.4%	16*	24.6%	65	100%

Note. PTSD, Post-Traumatic Stress Disorder; CSA, Client Self-Assessment; NAS, Needs Assessment Screening; IA, Intake Assessment; PE, Psychiatric Evaluation.
*p < .001. Analyzed using Fisher's Exact Test, 2-sided.

Decreasing identification of PTSD via the **CSA**

CSA → NAS → IA → PE

29.7% 22.5% 19.5%

Increasing disagreement between stages

CSA → NAS → IA → PE

12% 27.5% 31.6%

Inconclusive (29.5%) v. Diagnosed (21%)

Decreasing identification of PTSD via the **NAS**

NAS → IA → PE

22.2% 20%

Ongoing disagreement between stages

NAS → IA → PE

25.5% 24.6%

Inconclusive (25%) v. Diagnosed (21%)

Most COPSD, and all co/PTSD, results were statistically insignificant

Conclusions

Increased sensitivity and specificity in symptom identification and diagnosis of disorders.
AND
Non-licensed staff and clinicians failing to identify a portion of its 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.

Atkins, 2014; Berenz & Coffey, 2012; Gotham, 2014; Guerrero et al., 2015; Hazelden, 2013; Nash et al., 2011; Titler et al., 2001

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