

TARDIVE DYSKINESIA SCREENING INITIATIVE

Advancing Screening for Tardive Dyskinesia

Promoting early detection and care across state mental health systems for individuals with serious mental illness

NASMHPD

Advancing Screening for Tardive Dyskinesia:

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Contents

Executive summary ..... *iv*

Introduction *4*

The impact of abnormal involuntary movements **6**

History of antipsychotic medication and the AIMS **7**

The policy problem **9**

Clinical overview *9*

Types of abnormal involuntary movements **9**

Role of screening in identifying TD **12**

Evidence base for routine screening 12

Clinical guidelines for screening 13

Clinical interventions 15

Current screening gaps in public mental health systems *16*

Survey results **17**

Screening practices 17

Workforce/training 19

Data/accountability 19

Survey limitations 22

Role of peer support **22**

Special considerations for older adults **24**

Proposed screening standards *26*

Policy considerations *28*

Policy and leadership strategies **32**

Educational and workforce development strategies **35**

Structural and technical strategies **37**

Person-centered engagement strategies **41**

Future directions *44*

Conclusion *46*

Executive summary

Tardive dyskinesia (TD) is a serious but often overlooked movement disorder associated with the use of dopamine receptor–blocking agents, such as antipsychotic medications often prescribed to people with serious mental illness. Tools such as the Abnormal Involuntary Movement Scale (AIMS) can help identify TD early in its progression and monitor symptoms over time; however, screening practices are inconsistent across states and care settings. This paper describes findings from a survey of NASMHPD members highlighting differences in state policies and practices related to screening, documentation, staff training, and accountability.

State mental health authorities can play an important role in strengthening the identification and management of TD. Establishing clear screening standards, embedding formal and routine clinical observation into care, supporting workforce training, and using electronic reminders and performance monitoring can help enable consistent screening. Advancing these strategies can promote earlier identification of TD, reduce the risk of preventable functional impairment, and support informed and shared decision-making between clinicians and individuals served. Ultimately, more consistent attention to TD screening can improve the quality of care and quality of life for people served by public behavioral health systems.

Introduction

Individuals with serious mental illness (SMI) who are prescribed antipsychotic medications are at ongoing risk for developing tardive dyskinesia (TD), a serious and sometimes irreversible involuntary abnormal movement disorder that emerges after prolonged exposure to dopamine receptor–blocking agents (DRBAs).[1,2,3] TD remains relatively common despite the widespread use of second-generation antipsychotics (SGAs), with an estimated annual incidence of approximately 2%–5% and an overall prevalence of roughly 15%–30% among patients receiving long-term antipsychotic therapy.[4,5] Established risk factors include older age, longer duration, and higher cumulative doses of antipsychotic medication, as well as female sex, mood disorder diagnosis, and simultaneous exposure to other similar

TD Facts

- TD affects roughly 15%–30% of patients receiving long-term antipsychotic therapy.
- Although newer antipsychotic medications lower the risk of TD, they do not eliminate it.
- Only two in five patients are screened before receiving a TD diagnosis.

medications, indicating that many individuals may have multiple, overlapping comorbidities.[6] Routine screening for abnormal involuntary movements using validated screening tools, such as the Abnormal Involuntary Movement Scale (AIMS), is therefore critical, yet implementation remains inconsistent across care settings.[7] Neurocrine Biosciences estimates only two in five TD patients are screened prior to being diagnosed with TD, and similar proportions have their symptom progression monitored at every visit.[8]

The TD screening gap is increasingly important because the population at risk for TD is broadening. Indicated and off-label antipsychotic use has expanded beyond schizophrenia to include bipolar disorder, major depression, dementia-related behavioral symptoms, anxiety-related conditions, and other conditions, increasing the number of people who may require monitoring.[9,10,11] Paradoxically, the increased tolerability of SGAs has expanded the market for these therapies, increasing the number of individuals at risk while simultaneously reducing attention to the risk of and screening for TD.[12] National utilization data show that millions of U.S. adults now use antipsychotics, including many with chronic physical and behavioral health comorbidities that complicate care.[13]

Although newer antipsychotics generally carry lower TD risk than older agents, they do not eliminate risk; therefore, broader prescribing can translate into a larger population needing routine surveillance.

The impact of abnormal involuntary movements



The burden of TD is particularly striking in public mental health populations who are served by state systems, where patients often experience chronic psychotic or mood disorders, recurrent hospitalizations, and continuous antipsychotic treatment.[14,15] In such settings, overlooked signs of early TD can allow symptoms to progress and may limit options for adjusting treatments without risking psychiatric stability.[16] Improving systematic TD screening within state mental health systems could facilitate earlier detection, shared and informed decision-making, and more timely treatment decisions for high-risk groups.[17]

TD has a substantial impact on individuals, not only through its motor symptoms, but also on health-related quality of life and social functioning. Data from the RE-KINECT study show that higher patient-rated impact of TD is strongly associated with poorer health utility scores and greater disability on the Sheehan Disability Scale, particularly among individuals who are aware of and distressed by their involuntary movements.[18] Both patients and clinicians report that TD negatively affects daily functioning, social activities, and overall quality of life. Patients often emphasize emotional and psychosocial consequences, such as anxiety, sadness, and social withdrawal, almost as much as the burden of physical manifestations.[19]

TD also generates significant systemic costs that extend to families, caregivers, and service systems. Caregivers frequently report persistent psychological burden, including high levels of anxiety, sadness, feeling overwhelmed, and subjective overwork related to supporting individuals with TD.[20] TD caregiving responsibilities can interfere with social and leisure activities and limit caregivers' ability to leave the house, participate in social events, or maintain schedules, accentuating the broader social constraints.[21] Among employed caregivers, TD-related duties contribute to activity impairment and may adversely affect work productivity, suggesting unrecognized economic and occupational consequences.[22] Work productivity is affected by a combination of missed work hours and reduced effectiveness while working, both by caregivers and those diagnosed with TD.[23] Together, these findings indicate that TD is a serious public health concern and highlight the need to strengthen systematic screening and TD management within public mental health systems.[24,25,26]

First-Person Account

The impact of TD is highly individual and is often shaped by more than the involuntary movements themselves. As one interviewee with lived experience of TD emphasized, involuntary movements may occur alongside other side effects. This individual also experienced weight gain, moisture/eye issues, sedation, and other side effects. They also shared that the presence or severity of movements may not always correspond with how much they affect the individual experiencing them. Sometimes, the movements concern others, such as family members or caregivers, more than they do the patient. It is important to consider how, or whether, the movements affect the aspects of life that matter to the individual.

History of antipsychotic medication and the AIMS

The discovery of pharmacological treatments for psychosis in the mid–20th century was transformative for individuals with SMI, their loved ones, and the mental health care system. Before effective treatments were available, people with SMI were often confined to institutional settings. State hospital populations reached their peak during this period, while mass media increasingly drew attention to the grim conditions of many of these institutions. The introduction of pharmacological treatments made it possible for many to reduce and manage their symptoms enough to return to living in their communities. This

not only offered relief to patients and their families but also transformed the mental health care system and the field of psychiatry.[27]

However, it was soon discovered that the new medications carried a risk of drug-induced movement disorder (DIMD) side effects, including TD. As the use of first-generation antipsychotic medications expanded, TD began to emerge as a major clinical concern after prolonged exposure. Of particular concern was the potential for TD symptoms to persist even after the antipsychotic medication was reduced or discontinued. The development of second-generation, or atypical, antipsychotic medications was a major advance in the field, as they were associated with fewer side effects, including fewer DIMDs. This began with clozapine, which entered the market in 1989, to be followed by many others in the 1990s. Although SGAs were originally thought to carry no risk for TD, subsequent evidence demonstrated that they reduce the annualized incidence of TD to about one-third of that of first-generation antipsychotics but do not eliminate the risk. According to a meta-analysis, TD affects about 13%–21% of individuals taking SGAs and 30%–32% of people taking first-generation antipsychotics.[28]

Originally developed as a research tool in the 1970s,[29] the AIMS was later adopted as a clinical tool to screen for abnormal involuntary movements.[30] The scale provides a structured method for evaluating involuntary movements across multiple body regions and documenting symptom severity over time. Although AIMS administration was routinely part of clinical practice in the late 1980s for individuals prescribed first-generation antipsychotic medications, the development of SGAs reduced attention to TD. As a result, screening became less routine and received less emphasis in clinical training.[31]

> "The development of a specific treatment led to a rediscovery of TD, and a whole lot has changed in the world since then regarding TD screening."
>
> —Interview with Mark Munetz, MD

A major turning point came in 2017 with the approval of the first medications specifically indicated for the treatment of TD.[32] Because clinicians could now offer targeted interventions for TD symptoms, clinical attention to TD rose again. However, routine screening remains inconsistent, and significant barriers to accessing treatment persist. Food and Drug Administration (FDA)–approved medications to treat TD are expensive, may be subject to prior authorization requirements, and have variable insurance coverage. Therefore, early and routine screening remains essential to support early intervention and prevent the development or progression of TD.



The policy problem

Despite clinical recommendations for routine monitoring for TD, structured assessments such as the AIMS are not always completed or documented at recommended intervals, and clinicians may rely instead on episodic observation after movements have become apparent.[33,34,35,36] Limited provider time, insufficient training, unclear screening responsibilities, lack of a billing code for screening, and inadequate electronic and organizational supports can further contribute to delayed recognition of TD.

This gap is increasingly important as antipsychotic use expands across diagnoses and as the population served by public mental health systems ages. Research suggests early detection is critical to promoting better outcomes.[37,38,39] State mental health agencies (SMHAs) have an opportunity to promote the establishment of clear screening expectations, support workforce training, embed reminders and documentation into clinical workflows, and ensure that concerning findings lead to diagnostic evaluation and informed treatment discussions.

Clinical overview

Types of abnormal involuntary movements

TD is one of several DIMDs associated with exposure to DRBAs, including antipsychotic medications and some antiemetic or gastrointestinal medications. TD is often underrecognized and potentially persistent, yet treatable when identified early.

DIMDs include TD, dystonia, akathisia, and drug-induced parkinsonism (DIP). Although these conditions have historically been referred to as extrapyramidal symptoms, the term *DIMD* is now preferred because it more accurately describes the full range of medication-related movement syndromes, including TD.

Although distinct DIMDs may have some clinical overlap, treatment options differ, making accurate diagnosis important. TD is generally characterized by involuntary, repetitive, irregular, and often purposeless movements. These movements most commonly involve the mouth, tongue, jaw, and face, but they may also affect the trunk, arms, legs, fingers, toes, neck, respiratory muscles, or swallowing muscles.[40] Patients may present with lip-smacking, tongue movements, grimacing, chewing movements, finger movements, rocking, pelvic thrusting, or other involuntary movements. Limb and truncal involvement without orofacial movements may be common in younger individuals, whereas orofacial

movements may predominate in older individuals.[41] Symptoms often become more apparent when the patient is distracted or when activating techniques are used and typically disappear during sleep. TD has an insidious onset and often initially goes unnoticed.

TD should be distinguished from other drug-induced and neurologic movement disorders. DIP is often more rhythmic and may include tremor, rigidity, slowed movement (bradykinesia), reduced facial expression, and shuffling gait. Akathisia is characterized by subjective inner restlessness and observable motor restlessness, such as pacing or inability to sit still. Dystonia involves sustained muscle contractions or abnormal postures, which may be focal or generalized.

The differential diagnosis of TD is broad and includes mannerisms, stereotypies, tics, myoclonus, tremor (including tremor associated with other psychotropic medications, such as lithium or valproate), dystonia, akathisia, parkinsonism, withdrawal-emergent dyskinesia, Huntington disease, functional movement disorders, and other neurologic conditions (**Table 1**). Withdrawal-emergent dyskinesia is particularly important to distinguish from TD because dyskinetic movements may appear or worsen after an antipsychotic dose reduction or discontinuation. Conversely, increasing the dose of a dopamine receptor–blocking medication may temporarily suppress or "mask" TD movements while increasing long-term risk.

TD is also part of a broader group of tardive syndromes, which can include tardive dystonia, tardive akathisia, tardive tourettism, tardive tremor, tardive myoclonus, and tardive parkinsonism. These conditions vary in presentation but share a delayed onset following exposure to DRBAs and may persist after the medication is reduced or discontinued.[42] Some patients may also have a mixed clinical presentation, which can include features of both TD and parkinsonism.[43]

Table 1: Differential Diagnosis of TD

Condition	Description	Key distinction from TD
Mannerisms	Semipurposeful or idiosyncratic movements	Often embedded in behavior or communication rather than persistent involuntary movements
Stereotypies	Repetitive, patterned, coordinated movements	Can resemble TD; developmental history and medication exposure help differentiate
Tics	Sudden, quick, repetitive movements or vocalizations	Often preceded by an urge and may be briefly suppressible
Myoclonus	Sudden, brief, shock-like jerks	Usually faster and less patterned than TD
Dystonia	Sustained muscle contractions or abnormal postures	More sustained posturing; may be painful
Tremor	Rhythmic oscillatory movement	More rhythmic and regular than TD
Akathisia	Inner restlessness, often accompanied by pacing, rocking, or shifting position	Movements are driven by a compelling urge to move and difficulty remaining still, rather than involuntary movements
Drug-induced parkinsonism	Tremor, rigidity, bradykinesia, reduced facial expression, or shuffling gait	More hypokinetic and rhythmic; often dose-related
Withdrawal-emergent dyskinesia	Dyskinesia that appears or worsens after dose reduction or discontinuation of a DRBA	Temporal relationship to medication reduction is central

Role of screening in identifying TD



Routine screening is the primary mechanism for systematic identification and early detection of TD. Early detection matters because TD can affect speech, eating, swallowing, walking, social functioning, employment, stigma, self-esteem, medication adherence, and quality of life.[44] Some patients may not recognize the movements themselves or may avoid discussing them because of embarrassment. Family members, caregivers, nurses, pharmacists, case managers, and front-desk staff may notice movements before the prescriber does.

Evidence base for routine screening

Although randomized trials have not directly evaluated whether routine TD screening programs improve long-term TD outcomes, routine screening is supported by several converging lines of evidence: TD is common enough to warrant monitoring; it may be persistent and cause functional impairment; it is often underdiagnosed or misdiagnosed; structured tools improve recognition and longitudinal tracking; and effective treatments are now available.

Routine screening also creates accountability. In naturalistic clinical settings, documentation of TD screening assessments is often inconsistent, even among patients receiving long-term antipsychotic treatment. In one five-year outpatient study, AIMS data

were documented in the medical records of 51% of both adults and children prescribed antipsychotic medications.[45] In an analysis of medical records of individuals served by the U.S. Department of Veterans Affairs, AIMS screenings are charted at a rate of 58.9%.[46]

It is important to distinguish formal screening from informal screening. Informal screening involves routine clinical observation and patient or caregiver inquiry during usual care, whereas formal screening uses a structured tool such as the AIMS or the Dyskinesia Identification System: Condensed User Scale (DISCUS) to systematically assess, document, and track abnormal movements over time. Even when conducting a formal screening such as the AIMS, providers may use findings from informal observations such as walking a patient from the waiting area to an office to inform the AIMS assessment.

Clinical guidelines for screening

The American Psychiatric Association Practice Guideline for the Treatment of Patients with Schizophrenia recommends clinical assessment for akathisia, dystonia, parkinsonism, and other abnormal involuntary movements, including TD, at each visit with an individual prescribed any antipsychotic medications (**Figure 1**).[47] It also recommends use of a structured instrument such as AIMS at least every 6 months for patients at high risk for TD, and at least every 12 months for other patients, or when movements are known to be present. These recommendations are particularly relevant to schizophrenia care, but the same monitoring principles apply more broadly to patients receiving antipsychotic medications for other diagnoses. A modified Delphi consensus panel has similarly recommended that patients receiving DRBAs be screened for TD at every clinical encounter.[48] Although the U.S. Department of Veterans Affairs/U.S. Department of Defense schizophrenia guideline uses the broader historical term "extrapyramidal symptoms"—or EPS—it specifically includes TD in this category and recommends monitoring movement status at every follow-up visit.[49]

Figure 1: APA Recommendations for TD Screening

TABLE 2. Suggested physical and laboratory assessments for patients with schizophrenia (continued)		
	Initial or baseline assessments[a]	**Follow-up assessments[b]**
Assessments related to other specific side effects of treatment (continued)		
Antipsychotic-induced	Clinical assessment of akathisia, dystonia, parkinsonism, and other	Clinical assessment of akathisia, dystonia, parkinsonism, and other abnormal involuntary movements,

movement disorders	abnormal involuntary movements, including tardive dyskinesia[n]	including tardive dyskinesia, at each visit[n]
	Assessment with a structured instrument (e.g., AIMS, DISCUS) if such movements are present	Assessment with a structured instrument (e.g., AIMS, DISCUS) at a minimum of every 6 months in patients at high risk of tardive dyskinesia[o] and at least every 12 months in other patients[p], as well as if a new onset or exacerbation of preexisting movements is detected at any visit
[o]Patients at increased risk for developing abnormal involuntary movements include individuals older than 55 years; women; individuals with a mood disorder, substance use disorder, intellectual disability, or central nervous system injury; individuals with high cumulative exposure to antipsychotic medications, particularly high-potency dopamine D_2 receptor antagonists; and patients who experience acute dystonic reactions, clinically significant parkinsonism, or akathisia (Carbon et al. 2017, 2018; Miller et al. 2005; Solmi et al. 2018a). Abnormal involuntary movements can also emerge or worsen with antipsychotic cessation.		

Clinical interventions



The first-line defense against TD is reducing avoidable risk. Antipsychotic medications should be used only when clinically indicated, with clear documentation of the target symptoms and expected benefit. Whenever possible, clinicians should use the lowest effective dose for the shortest duration needed, while avoiding abrupt discontinuation that could destabilize psychiatric illness or precipitate a condition known as withdrawal-emergent dyskinesia. For patients who require long-term antipsychotic treatment, regular reassessment of the dose, ongoing indication of the need for medication continuation, and screening for DIMDs are essential.

For patients with schizophrenia or schizoaffective disorder with persistent positive symptoms, the SGA clozapine could be a consideration. Clozapine is the gold-standard medication for treatment-resistant schizophrenia though significantly underutilized in the United States.[50] Recent changes to the FDA's safety monitoring may alleviate some of the administrative, provider, and patient burdens, but challenges remain to make clozapine easier for patients to access, despite the medication's efficacy. Switching to clozapine may reduce TD risk and may improve existing TD in some patients,[51] although clozapine is generally no longer considered a primary TD treatment option since the advent of VMAT2 inhibitors.

If TD is suspected, clinicians should review the medication history, dose changes, duration of exposure, other DRBAs, anticholinergic medications, and contributing factors. A structured TD screening assessment should be performed and repeated over time. Family or caregiver input can be helpful to establish its onset, progression, and functional impact.

Medication reduction or discontinuation may be considered when clinically feasible, but this is not always possible and may worsen the underlying psychiatric condition. Increasing the antipsychotic dose to suppress TD movements should generally be avoided because it may mask symptoms in the short term while worsening long-term risk. Anticholinergic medications such as benztropine, which may be appropriate for DIP or acute dystonia, do not treat TD and may worsen it.

Two VMAT2 inhibitors, valbenazine and deutetrabenazine, have the strongest evidence among pharmacologic treatments and are FDA-approved for TD.[52] These medications reduce involuntary movements and are added with the individual's existing antipsychotic medication. They are particularly important for patients whose TD is moderate, severe, disabling, distressing, or associated with psychosocial impairment. VMAT2 inhibitors may also be considered for milder TD when symptoms affect functioning, social interaction, stigma, adherence, or patient preference. However, some individuals may have difficulty getting VMAT2 inhibitors given the high cost, the need for prior authorization, or a lack of insurance coverage.

Other agents including clonazepam, tetrabenazine, ginkgo biloba, vitamin E, amantadine, and botulinum toxin have been studied with varying and generally less robust evidence. These may have a role in selected circumstances, but they should not displace access to evidence-based VMAT2 inhibitor treatment when indicated.

Current screening gaps in public mental health systems

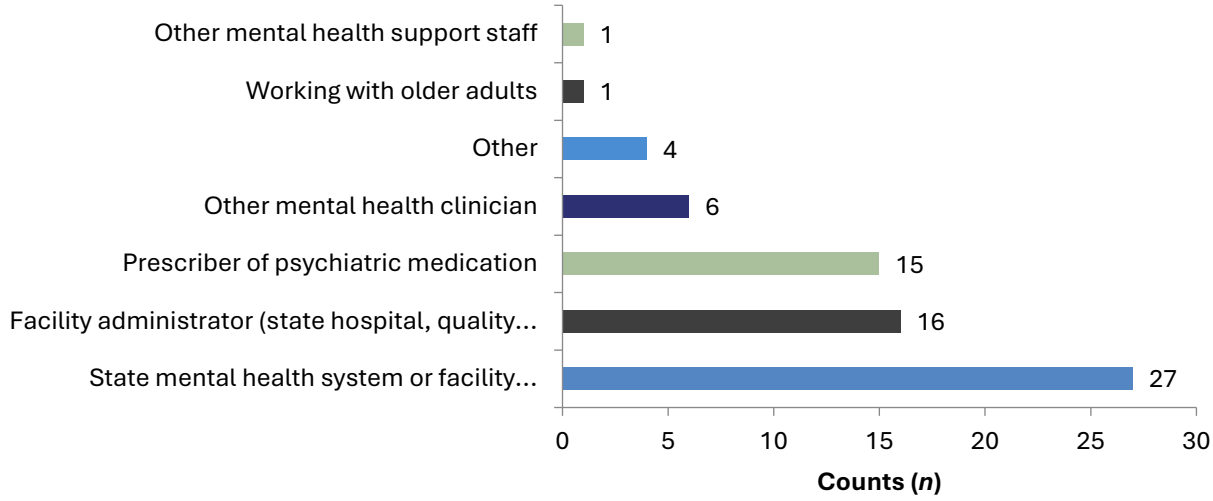
SMHA approaches to screening for abnormal involuntary movements among individuals receiving DRBAs vary considerably. State mental health leaders play a critical role in establishing policies, financing services, developing infrastructure, and coordinating systems of care to improve the identification and management of TD and other drug-induced movement disorders.

To better understand current screening practices and perceived barriers, the National Association of State Mental Health Program Directors (NASMHPD) conducted a brief

survey of SMHA leaders regarding the use of the AIMS and other screening tools. The survey was distributed to NASMHPD's divisions, including the Medical Directors, Legal, Forensic Directors, Older Persons, Finance Policy, Children, Youth and Families, and Housing Divisions, as well as all the directors of all SMHAs. The survey was distributed on February 23, 2026, and was open for four weeks. A total of 70 unique responses were received from 31 states.

Most respondents represented SMHA administrators, state psychiatric hospital administrators, or psychiatric prescribers. Fewer respondents represented nonprescribing health clinicians or other members of the care team (**Figure 2**). To complement the survey findings, qualitative interviews were conducted with individuals with lived experience of TD and peer support service leaders.

Figure 2: Primary Role of Survey Respondents (total *n* = 70)



Survey results

Screening practices

Survey responses suggest that routine screening for abnormal involuntary movements is inconsistent across public mental health care settings. Respondents were nearly evenly split on whether data on these movements are routinely collected, indicating no clear consensus on current practice across states (**Figure 3**). Although many reported that their SMHA or facility has a policy or protocol related to screening, early detection, prevention, treatment, or monitoring of TD, formal implementation appears irregular (**Figure 4**). The AIMS was the most used screening tool, but its use does not appear to be

paired with regular, standardized training (**Figure 5**). Training on AIMS or other screening instruments was far from unanimous, with 72% of respondents indicating no provider training on AIMS administration (**Figure 6**). This pattern suggests that screening expectations exist, but actual practice varies.

Figure 3: Data collection on abnormal involuntary movements (total *n* = 44)

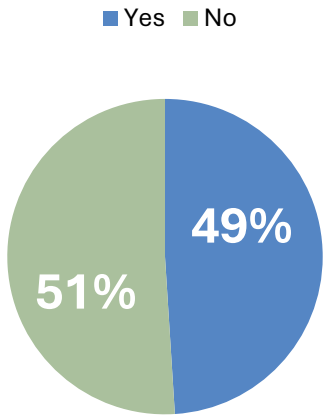


Figure 4: State/facility policy on AIMS (total *n* = 66)

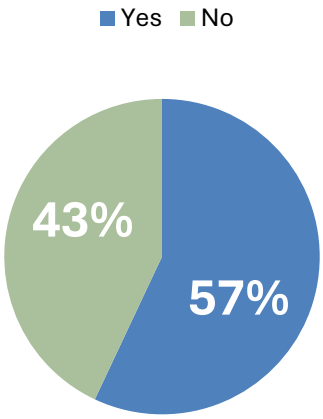


Figure 5: Utilization of AIMS (total *n* = 66)

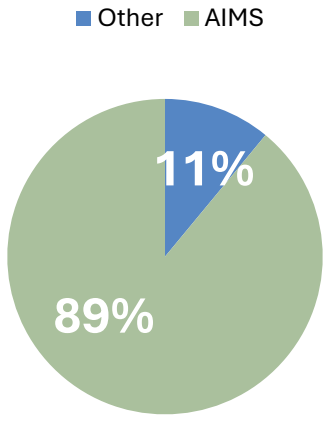
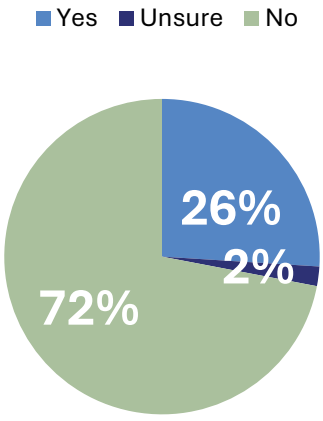


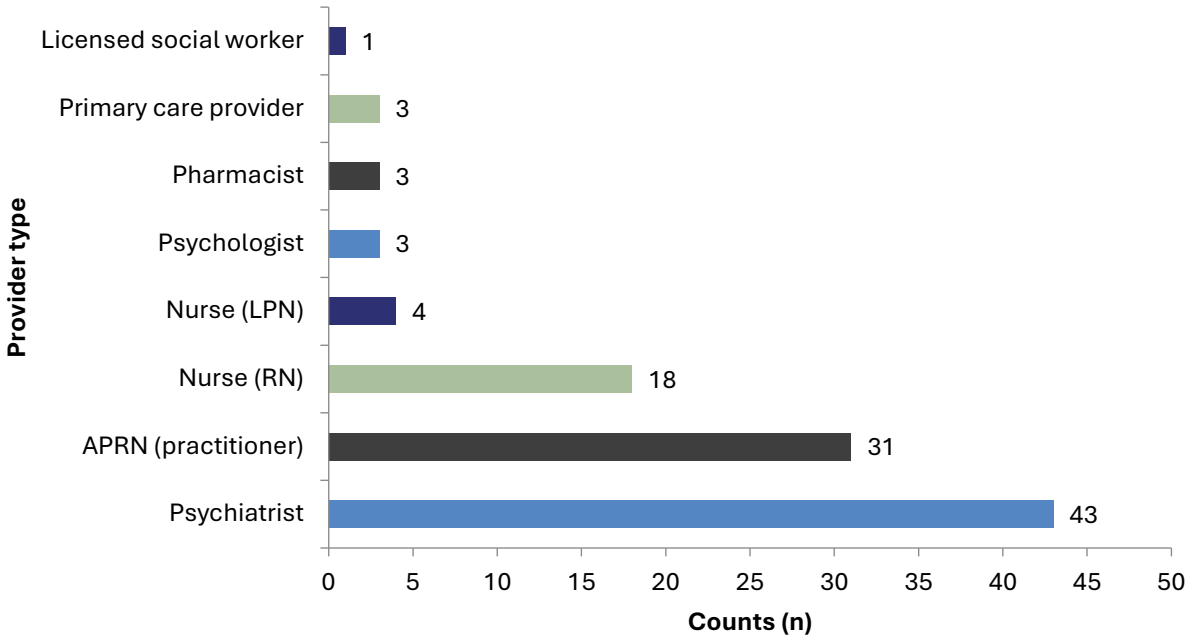
Figure 6: Provider training on administration of AIMS (total *n* = 43)



Workforce/training

Screening responsibilities appear to fall most heavily on psychiatrists and advanced practice registered nurses, followed by registered nurses, while other disciplines such as psychologists, pharmacists, primary care providers, and social workers are utilized less frequently. No respondents indicated that licensed professional counselors or nurse aides formally administer screening in their state or facility, suggesting that formal screening is not broadly distributed across the workforce **(Figure 7**). This concentration of responsibility raises concerns about sustainability and consistency of screening. At the same time, the low rate of reported training indicates that many providers may be expected to use screening tools without adequate preparation. Together, these findings point to a workforce gap that includes both limited role sharing and insufficient training structure.

Figure 7: Type of Care Providers Formally Screening for Abnormal Involuntary Movements (total *n* = 57)



Data/accountability

The survey results also suggest weaknesses in data systems and accountability instruments that support routine screening. Formal screening with the AIMS or another validated tool was most often reported at admission or intake and at fixed intervals, such as annually, biannually, or every 3 months (**Figure 8**). In contrast, informal observation by eye was more broadly distributed across points of care, especially when symptoms

appeared or were based on clinical judgment (**Figure 9**). This pattern suggests that many encounters rely on episodic monitoring rather than systematic documentation. Respondents identified limited provider time, lack of screening protocols, low awareness, limited treatment knowledge, and workforce shortages as the main barriers to routine screening, which are largely system-level constraints **(Figure 10**). In support of improvement, respondents highlighted provider training, electronic health record (EHR) prompts or reminder flags, clear written policies, and adequate time and access as the most important strategies for strengthening screening and accountability in their respective states (**Figure 11**).

Figure 8: Points Of Care Where Individuals with SMI on Antipsychotics are Formally Screened for Abnormal Involuntary Movements (total *n* = 66)

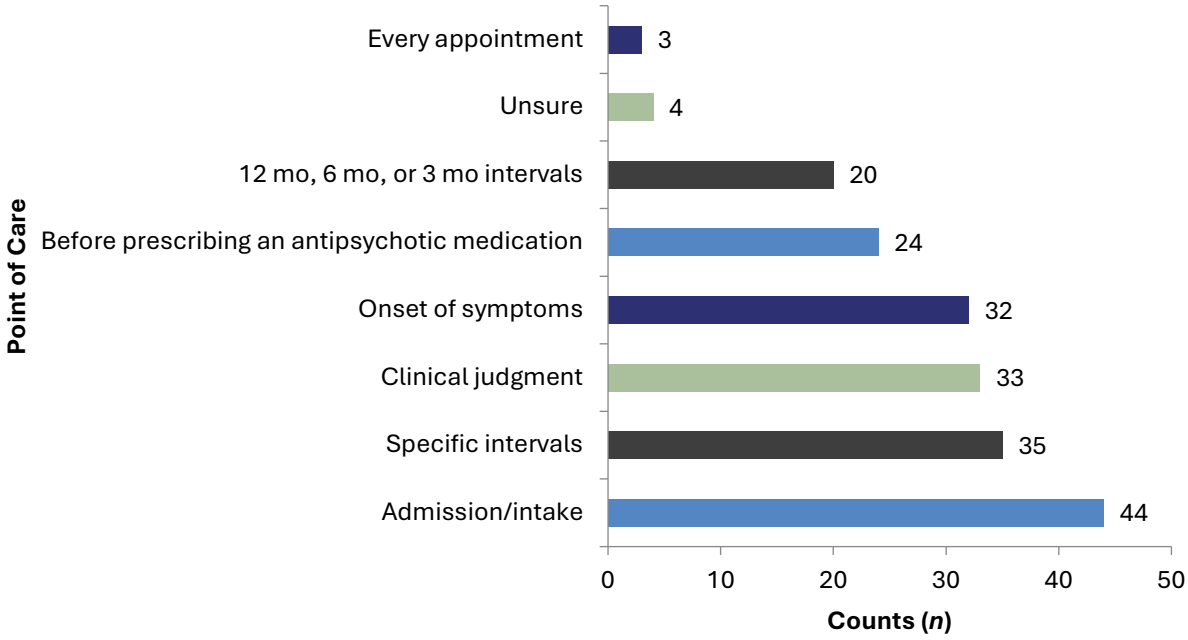


Figure 9: Points Of Care Where Individuals with SMI on Antipsychotics are Informally Screened for Abnormal Involuntary Movements (total *n* = 66)

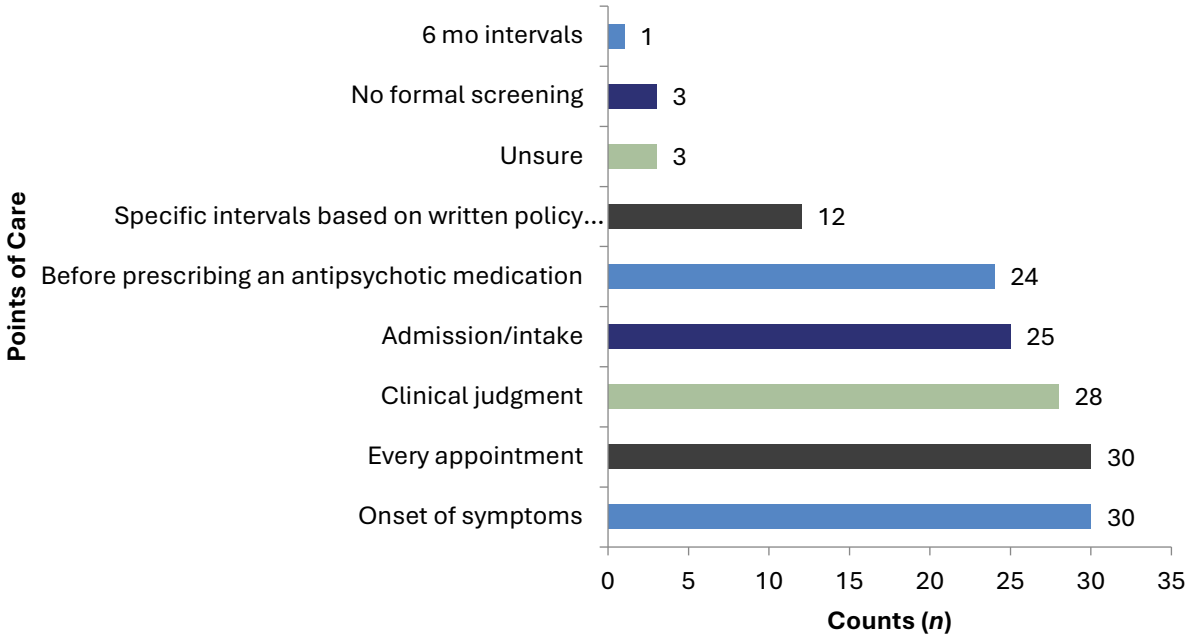


Figure 10: Barriers to Routine Screening, Identification, and Usage of Validated Screening Tools for Abnormal Involuntary Movements (n= 70)

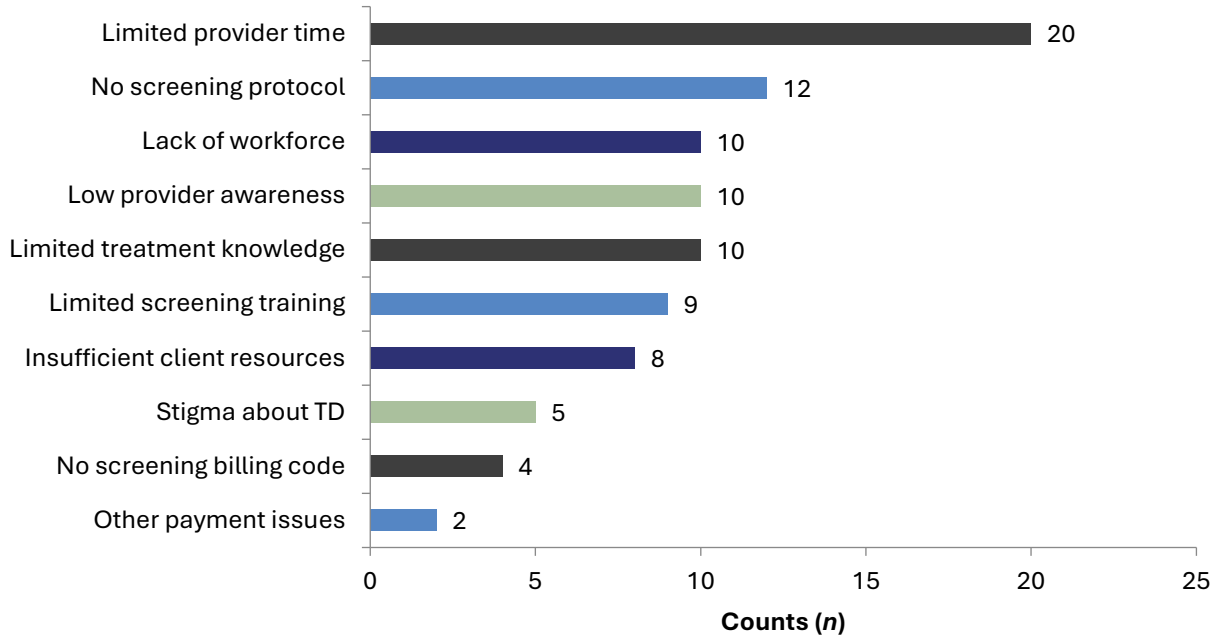
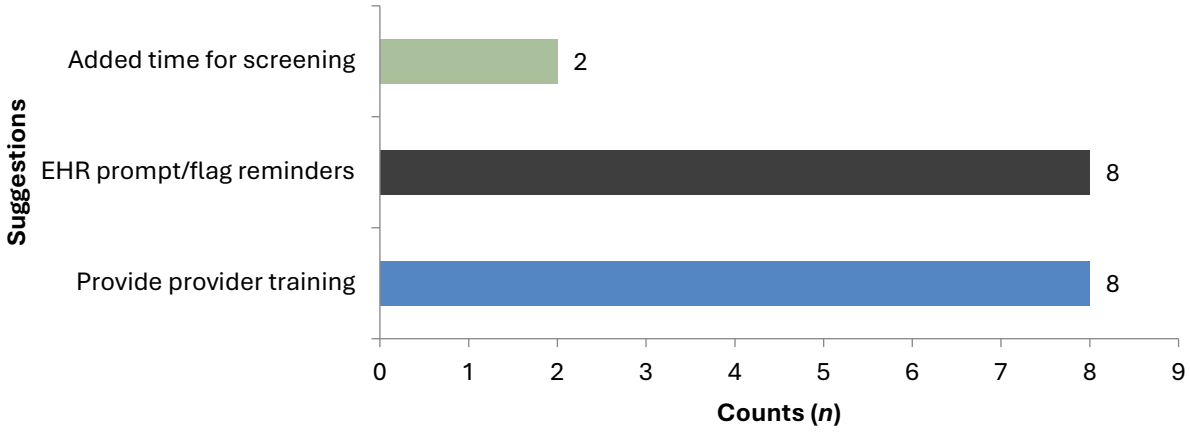
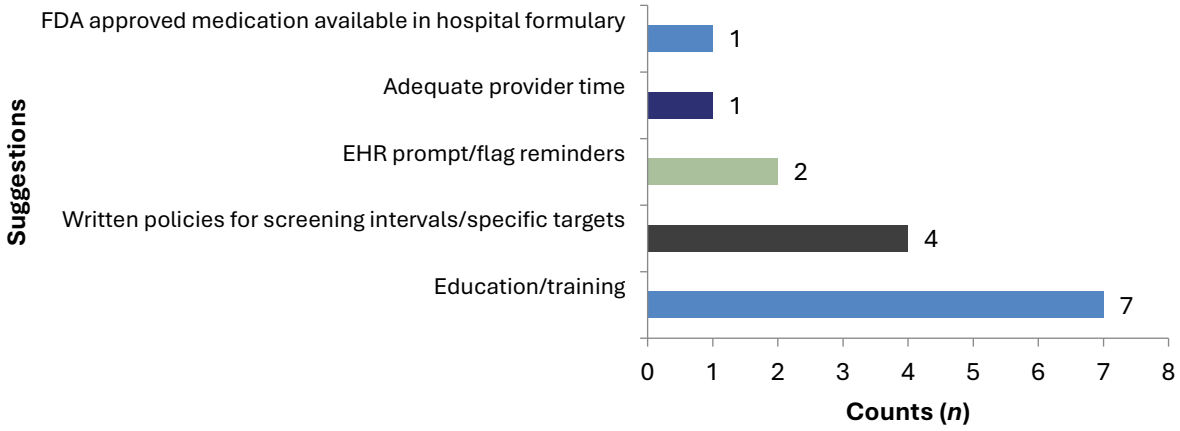


Figure 11: (a) Suggestions to Encourage More Regular/Broad Use of AIMS; (b) Suggestions to Improve Awareness and Encourage Screening of AIMS





Survey limitations

The survey findings should be interpreted in the context of several limitations, including convenience sampling, an unknown response rate, and variation in respondents' roles and knowledge of state-level practices. Since multiple responses were received from some states, the results reflect individual respondents' perspectives and should not be interpreted as representative estimates of SMHA policies or practices nationwide.

Role of peer support

Peer support specialists (PSSs) are an important part of the public mental health workforce serving individuals with SMI. PSSs draw on lived experience of mental health and/or substance use conditions to provide nonclinical support, including social support, group

facilitation, skill building, goal setting, and recovery-oriented engagement. The peer workforce has grown rapidly, reaching more than 82,000 certified peers as of 2024.[53]

Most states use certified peer services in their public mental health systems,[54] though structures vary. Most SMHAs have offices of recovery and consumer affairs that oversee peer certification, training, and workforce development. To better understand the role of peers in TD screening, awareness, and education, the study authors conducted semistructured interviews with five members of NASMHPD's Division of Recovery Support Services (DRSS). Recurring themes are summarized here:

- **Awareness:** Many interviewees felt that there is strong awareness of TD among peer workers because of their own experience or that of someone they know. One DRSS member felt that a large percentage of peer support persons may have dealt with abnormal involuntary movements, equating it to the experience of hearing voices.
- **Education:** All interviewees felt that little to no education around TD occurs in peer training or certification. However, the interviewees differed in their views of the value of training or education of the peer workforce around TD. Some felt that education about the topic is important, including signs of TD, how to engage in conversation about TD symptoms and their impact on the individual, and supporting individuals to advocate for themselves in the clinical setting. Others felt that TD should not be discussed in peer training because it is a clinical distinction, and topics of diagnoses and side effects of medications are outside the scope of peer workers. If included in training or education materials, most interviewees felt that information regarding TD can be framed in a way that remains within the scope of peer practice, such as being included in broader education around medication side effects and/or encouraging individuals to discuss side effects with their doctor.
- **Stigma:** All DRSS members interviewed discussed the stigma associated with TD and how it affected their work or the individuals they serve. Because these movements are external and can be visible to others, stigma and shame are prevalent. As one interviewee shared, the abnormal movements allowed the individual to be "spotted right away." This stigma and shame can lead individuals to wish to discontinue their prescribed medications.
- **Scope:** Protecting the role integrity of PSSs was a large theme of the discussions with all DRSS members interviewed.[55] There is a significant threat of "peer drift," which occurs when peer support workers are expected to operate outside of their intended scope of practice. For example, interviewees shared that various administrative tools or assessments may be delegated to peers inappropriately. It is



important for PSS supervisors to protect and work with other providers to have clarity of roles for all team members involved.

One of the more important functions of peer support is helping individuals communicate more effectively with their clinical providers. A PSS can discuss side effects or symptoms that an individual has identified as concerning. A key aspect of the peer role is asking questions, including probing questions like "Have you noticed that you have been clenching your jaw?" However, clear protocols must be in place to guide how the peer should document or communicate that information.

In situations where peers are working for a community treatment provider on a multidisciplinary team, the PSS can more easily share relevant observations or information from conversations they had with the individual they are serving, as appropriate and in accordance with organizational policies.

All interviewees emphasized the role of peers in helping individuals build self-efficacy and advocate for themselves. This can include helping them formulate questions to discuss with their doctor, writing lists of side effects or symptoms to discuss during appointments, and preparing for clinical visits with prompts like "Remember, you wanted to talk to your doctor about the movements you have been experiencing."

Special considerations for older adults

The aging of the American population further heightens the urgency for consistent screening. Older age is one of the strongest risk factors for TD, and TD may emerge in older adults after shorter exposure and at lower antipsychotic doses than in younger adults. This is due in part to greater cumulative medication exposure, medical comorbidities, polypharmacy, neurologic vulnerability, and care transitions across psychiatric, primary care, long-term care, and hospital settings.[56,57]

Antipsychotic medications are often used off-label for dementia-related psychosis and aggression, particularly in nursing homes or assisted-living facilities. Data suggest that one-third of individuals residing in nursing homes or assisted-living facilities are given antipsychotic medication, most often for off-label indications.[58] For example, one study found that, of 300,000 nursing home residents, 23% received at least one SGA, and 86% of those prescriptions were for off-label use.[59] In 2012 and 2013, the Centers for Medicare & Medicaid Services issued guidelines against this practice, and while rates of off-label antipsychotic medication prescribing have declined as a result,[60] the practice remains prevalent. Continuous monitoring and consistent enforcement is needed to sustain improvements.

In addition to being at an increased risk, TD can have a more significant impact on quality of life among older adults. TD can affect eating, speaking, walking, balance, and social functioning, making older adults uniquely vulnerable to falls, choking, or tooth loss.[61] Older adults can also be more negatively affected by the social and emotional effects of TD symptoms, such as social isolation and depression.[62]

To better understand the unique impacts of TD on older adults served in the public mental health system, NASMHPD conducted a focus group discussion with the executive committee of NASMHPD's Older Persons Division to identify barriers, solutions, and any other special considerations for routine TD screening of older adult populations.

The primary barrier to TD screening and monitoring among older adults identified by the focus group was around diagnosis. Diagnosis can be more challenging in older adult populations because other types of movement disorders may also be present. TD can be mistaken for Parkinson's disease, age-related motor changes, denture-related oral movements, restless legs syndrome, or other movement-related abnormalities. Conversely, symptoms of these disorders could also be incorrectly attributed to TD. One focus group participant suggested that a practice guide exploring differential diagnosis in older adults could be a useful training tool.

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Another focus group participant noted that most medical providers in long-term care facilities serving older adults are family practice physicians or nurse practitioners who may have limited formal training in prescribing antipsychotic medications. The participant suggested that education and awareness-building around appropriate and inappropriate use of antipsychotic medications for clinicians, case managers, therapists, behavioral consultants, and family members in these settings could be helpful, as well as establishing a clear and consistent screening protocol tied to care quality.

As the population served by the public mental health systems ages, failure to standardize TD screening risks delayed recognition, missed treatment opportunities, and preventable impairment. Particularly when considered cumulatively, inconsistent screening, broadening antipsychotic exposure, and aging service populations point to a need for SMHA- and facility-level strategies to enable routine and consistent TD monitoring and treatment across public mental health service settings.

Proposed screening standards



Any person with a history of exposure to a DRBA or another medication known to cause TD should be considered for screening. This includes people currently receiving antipsychotic medications as well as those with prior exposure, because TD can emerge during treatment, after long-term exposure, or after dose reduction or discontinuation. Screening standards should apply across provider types, diagnoses, and settings, not only to people with schizophrenia.

A comprehensive, practical screening standard should include elements of both formal and informal screening. Informal screening should occur at every clinical encounter and can be built into routine observation. Clinicians and staff can observe the patient walking into the room, sitting, speaking, holding still, using their hands, or engaging in conversation. In telehealth encounters, clinicians can ask patients to sit back from the camera, show their face and hands, and briefly describe whether they or family members have noticed new or unwanted movements. Informal screening is low burden, can be performed by many members of the care team, and reinforces that movement monitoring is part of routine medication safety.

Conversely, formal screening should use a structured instrument. The AIMS is the most commonly used tool for TD screening and allows clinicians to rate movements across body regions, document severity, and track change over time. Other tools include the DISCUS,

the Extrapyramidal Symptom Rating Scale (ESRS), the Maryland Psychiatric Research Center scale, the Matson Evaluation of Drug Side-Effects (MEDS), and other drug-induced movement disorder rating scales. For implementation purposes, systems should generally select one preferred tool, train staff to use it reliably, and embed it into routine workflow.

Recommended frequency dictated by a policy should include both ongoing informal monitoring and periodic formal assessment. In addition, a structured AIMS or comparable tool should be completed at baseline or soon after initiation of a dopamine receptor–blocking medication, when abnormal movements are suspected, after clinically meaningful medication changes, and at regular intervals thereafter. A reasonable minimum standard is to conduct structured screening at least every 12 months for patients receiving ongoing DRBAs and at least every 6 months for patients at higher risk. Patients who may warrant more frequent assessment include older adults, women, individuals with prior TD or other drug-induced movement disorders, those receiving first-generation antipsychotics or with higher cumulative antipsychotic exposure, and patients with mood or substance use disorders, intellectual disability, or diabetes.[63,64]

Screening administration should not be limited to psychiatrists. With training, physicians, nurse practitioners, physician assistants, nurses, pharmacists, psychologists, care managers, as well as other clinical staff can help formally or informally screen for possible abnormal movements or play a role in identification. Patient- and caregiver-facing questionnaires can also help prompt discussion, although they should not replace clinician assessment. Families and caregivers may notice movements before the patient does, especially when movements are subtle or intermittent. Screening programs should therefore include patient and family education about what TD can look like and how to report concerns.

Screening standards should apply across inpatient, outpatient, emergency, residential, forensic, long-term, and community-based care settings. In inpatient and crisis settings, a baseline movement assessment is especially important because medication regimens are often initiated or altered rapidly. Discharge planning should include documentation of whether abnormal movements were present and whether follow-up screening is needed. In outpatient care settings, including primary care settings that prescribe antipsychotic medications and integrated behavioral health settings, TD screening should be incorporated into routine medication management visits. In forensic, correctional, and state psychiatric hospital systems, TD screening is particularly important because patients may have long cumulative exposure to antipsychotic medications, limited ability to seek outside evaluation, and high risk for care transitions where side effects can be missed.

Communicating screening results and next due dates in transfer or discharge orders or notes is encouraged.

For clinically significant TD, evidence-based treatment should be accessible. Valbenazine and deutetrabenazine should be available when symptoms are distressing, disabling, or associated with functional impairment. Screening without access to treatment is insufficient; the goal is to identify, document, and discuss TD with patients, then review the causative medication, and offer a VMAT2 inhibitor when clinically indicated.

"Screening without access to treatment is insufficient; the goal is to identify, document, and discuss TD with patients, then review the causative medication, and offer a VMAT2 inhibitor when clinically indicated."

Establishing a screening standard is a key first step, but implementation requires coordinated policy, workforce, technical, and person-centered supports. The following policy considerations describe strategies that SMHAs can use to translate these standards into routine practice.

Policy considerations



For SMHAs seeking to enable consistent TD screening, evidence from the broader preventive health and quality improvement literature suggests that strategies should

include strong commitment from leadership and reflective policy development and dissemination, provider and patient education and ongoing support, and tools to embed screening into routine clinical workflows.[65,66,67,68] Many of these strategies can be enacted to overcome the implementation barriers identified by NASMHPD members via the aforementioned survey. We suggest that solutions and strategies fall into four domains, which we will refer to as policy strategies, educational strategies, technical strategies, and person-centered engagement strategies. **Table 2** outlines these key strategies and indicates which barriers they primarily address. The solutions are further elaborated in the text following the table.

Table 2: State Policy and Practice Recommendations for Widespread Sustained Screening

Barrier	Category	Strategy
Lack of screening protocol	Policy and leadership strategies	**Identify champions and establish a policy.** Identify a clinical champion and person or family with lived experience to establish a TD screening policy and quality improvement time-limited work group or subcommittee within an existing advisory board or quality and policy committee structure. Facilitate the organization of grand rounds or provider/medical staff meetings addressing TD, TD screening, TD treatment, existing liability and ethical concerns, and best practices. Seek volunteers to develop a draft policy or standard protocols. Meet with the state's regulation and licensure agency leaders to establish, by state licensure, who can perform the TD screening and who, under state licensure, could perform discrete portions of the screening with appropriate education and training. Specify this in a policy to encourage providers to leverage all available workforce. **Measure and monitor performance.** Identify performance metrics and outcomes for tracking adherence to screening and treatment protocols and health outcomes, and develop incentives for provider screening adherence tied to annual reviews. **Identify reimbursement mechanisms that support TD screening activities.** Collaborate and partner with clinician staff, payers, managed care organizations, and



		accountable care organizations to align or expand payment/reimbursement codes, reimbursement for screening technology applications, and screening delivery models that support sustainable screening protocols, practices, and initial and annual training.
Limited provider awareness; limited knowledge of screening and treatment; no or limited screening training opportunities	Educational and workforce development strategies	**Facilitate continuing education and training opportunities.** Develop or implement continuing education programs through universities; professional associations such as the American Psychiatric Association; medical associations; and state and local subject matter experts. Promote educational programming through professional organizations, newsletters, and online/anytime training with CEUs or CME whenever possible. Develop or implement provider training focused on how to conduct the exam and how to score the exam, including item-by-item scoring to ensure inter-rater reliability. Partner with the National Alliance on Mental Illness and other support and advocacy organizations to promote awareness and annual TD education, and to share personal stories about individuals' reluctance to be screened and to seek treatment and stories where early detection and treatment improved an individual's quality of life. Partner with medical associations or rural health associations, and seek out state and federal grants to support a small stipend for clinicians in small or solo practices to step away from busy practices to attend educational opportunities. **Facilitate peer learning and mentorship.** Support screening and treatment precepting, mentorship, peer learning, and collaborative training initiatives such as grand rounds, state annual behavioral health conferences, annual medical association conferences, etc. Explore creating and funding a Project ECHO or similar hub-and-spoke model for tardive dyskinesia and movement disorders that mentors clinicians. Partner to identify funding sources, including federal and state health grants, rural health grants, universities, large healthcare associations, telehealth grants and organizations, and philanthropy or foundations.



		Establish consultation programs. Establish a network of experts to refer screened individuals for treatment or differential diagnosis, and/or phone consultation lines to assist clinicians.
Limited provider time; workforce shortages	Structural and technical strategies	**Implement electronic health record (EHR) screening reminders.** Invest in EHR and AI prompts and reminders to support and plan for screening during scheduled and follow-up visits. **Review screening reimbursement policies.** Ensure the identification of inclusion in and utilization of allowable billing codes for extended-time screening and testing within visits. **Implement team-based screening models and tiered screening pathways.** Create or expand the allowance for nurses and nursing or medication aides who see the patient early in the visit, before the prescriber, to assist with observations during the screening process. Develop and implement a tiered screening care path flow to maximize the use of existing staff who can be trained to become competent in the components of the screening process, when to use each component (pre-visit, during the visit, between visits), and which technology tools or apps are appropriate during the tiered screening process. **Leverage Certified Community Behavioral Health Clinics (CCBHCs) and collaborative care models.** Develop or expand screening and treatment into CCBHCs through the development of designated collaborative organizations. Develop and expand screening and treatment into collaborative care models.
Limited or insufficient resources for people served to improve their TD awareness and address screening and	Person-centered engagement strategies	**Facilitate patient education to promote shared decision-making.** Identify and/or develop TD signs and symptoms educational resources that engage individuals in their treatment choices. Engage peer specialists and families as codesigners of the resources. Engage individuals and families in developing education campaigns regarding TD screening, TD screening and observation tools and apps, and self-advocacy. **Leverage peer support.** Expand access to peer and caregiver support and resources, including peer and family specialists and digital and phone resources.



treatment reluctance		**Engage families and caregivers.** Encourage providers to involve families and caregivers in care planning through education and virtual consultations. **Normalize conversations about TD and engage in motivational interviewing.** Encourage providers to normalize TD awareness discussions within all medication check visits. Offer motivational interviewing, shared decision-making, or self-efficacy training, including PSS trainers to help clinic staff identify individuals' goals and take steps to address reluctance. Partner with subject matter experts and universities to develop and provide continuing education related to screening and treatment options, functional impairment evaluation, and shared decision-making, including a full range of risk/benefit analyses and ethical considerations for providers and prescribers. **Address financial barriers.** Engage in state and clinic formulary development with state behavioral health agencies, Medicaid agencies, managed care organizations, and state hospitals to provide a range of the most appropriate, affordable, and effective medications for addressing psychiatric disorders and treating TD and movement disorders. **Address social determinants.** Partner with social service agencies to identify and address transportation and financial needs and resources. Expand access to peer and caregiver support and resources, including peer and family specialists and digital and phone resources.

CEU = continuing education unit; CME = continuing medical education; ECHO = Extension for Community Healthcare Outcomes.

Policy and leadership strategies

Healthcare organizations that establish formal policies, implementation teams, and quality improvement structures are more likely to sustain clinical practices over time than organizations that rely solely on initiative taken by the individual clinician.[69] Examples from other screening initiatives demonstrate the effectiveness of policy-driven approaches. Statewide depression screening initiatives in primary care settings have successfully increased screening rates through the combination of policy expectations, quality



measures, provider training, and performance feedback.[70] Similar strategies could be adapted to support routine TD screening in public behavioral health systems.

It is therefore important that SMHAs have an **established policy for consistent TD screening** in their service systems, and that providers are aware of that policy. For further discussion, see the earlier subsection "Proposed screening standards." If such a policy does not already exist, or if it needs review and updating, SMHAs can consider establishing time-limited, dedicated work groups within existing advisory board or quality and policy committee structures, charged with developing TD screening policies. The work group should ideally be led by a person or family member with lived experience and a clinical champion. Empowering individuals and family members with lived experience of TD or SMI to lead such work groups will help ensure that policies reflect patient priorities and experiences.[71] A systematic review of healthcare implementation initiatives found that clinical champions were consistently associated with improved adoption and sustainability of evidence-based practices.[72]

Sample State TD Screening Policy Frameworks for Consideration

"Directive: Tardive Dyskinesia, Tardive Dystonia and Tardive Akathisia," New York State Office of Mental Health

"Resources and Options Regarding Tardive Dyskinesia," Utah Department of Health and Human Services

"Monitoring for Abnormal Involuntary Movements (Tardive Dyskinesia)," Connecticut Developmental Services

"Recommended Updates to Clinical Practice Guidelines for Tardive Dyskinesia Screening, Assessment, and Treatment," California Department of Health Care Services Medi-Cal Managed Care Entities

"Tardive Dyskinesia, Assessment and Treatment: Information for Providers," Illinois Department of Healthcare and Family Services Information for Medicaid Providers

Galvanizing support and consensus from groups of clinical staff, and **identifying champions** to lead this work, is another strategy. SMHAs can consider convening a grand rounds or other convening of medical staff to discuss issues related to TD screening, treatment, shared decision-making, liability concerns, and best practices. Volunteers could be identified from this meeting to draft or update a policy of TD screening for the

state mental health system. State regulation and licensure agency leaders should be consulted to clarify, and expand when appropriate, who can perform complete or discrete portions of TD screening with appropriate education and training. SMHAs can consider specifying these scope parameters in a policy to encourage providers to leverage all available workforce.

To assess the effectiveness of policy implementation and allow for targeted implementation support moving forward, SMHAs can consider identifying **performance measures and monitoring processes**, such as EHR reviews at specific intervals, as part of their policy. Reimbursement can be a powerful lever to influence provider and organizational behavior. Tying reimbursement to quality measures or organizational performance goals can influence clinical practice patterns.[73] SMHAs may consider partnering with their Medicaid managed care organizations, accountable care organizations, and other payers to identify reimbursement mechanisms that support TD screening activities, workforce training, and follow-up care. The expansion of value-based payment models provides an opportunity to incorporate TD screening into broader quality improvement and medication safety initiatives.[74]

The Medicare Physician Fee Schedule Final Rule issued October 31, 2025, and effective January 1, 2026, modified an existing Merit-based Incentive Payment System (MIPS) Quality Improvement Activity that was previously limited to diabetes screening to instead require comprehensive monitoring for all patients prescribed antipsychotics. It explicitly includes routine TD screening as part of the expanded scope.

See this change in the Federal Register here.

An existing billing code that can be used as an add-on code is CPT Code 96127 for administering a standardized instrument like the Abnormal Involuntary Movement Scale. It can be billed up to four units per patient, per date of service.

SMHAs may also consider **reviewing screening reimbursement policies** to ensure that providers can bill appropriately for the time required to conduct screening assessments. Studies have consistently found that financial incentives and reimbursement structures influence the adoption and sustainability of preventive care practices.[75,76,77] Identifying existing billing codes and communicating about the availability of such codes to clinicians or developing reimbursement mechanisms that support screening activities may increase provider willingness and organizational capacity to incorporate routine TD screening into clinical practice.

Educational and workforce development strategies

Provider knowledge and confidence remain among the most frequently reported barriers to TD screening. Studies evaluating TD screening practices have found significant variation in clinicians' knowledge of TD risk factors, screening recommendations, and treatment options.[78] Educational and training strategies are an important component of improving screening rates and ensuring clinicians can appropriately identify and manage TD.

Continuing education programs are among the most widely used approaches for improving provider knowledge. SMHAs can consider partnering with universities and professional associations to develop educational offerings focused on early TD identification, AIMS or other validated screening tool administration, treatment options, and shared decision-making.

Training should focus on both how to conduct the exam and how to score the exam, as scoring can be subjective by individual providers. Training within a system or facility should include item-by-item scoring to ensure inter-rater reliability and validity of measuring changes over time with multiple raters. Video-based education can be helpful for clinicians and staff learning to distinguish TD from other movement disorders.[79] Given the burgeoning role of telehealth in medication monitoring, states may also consider implementing continuing education focused on telehealth TD screening processes, limitations of telehealth screenings, and any specific adaptations or enhancements necessary.

SMHAs may also consider partnering with support and advocacy organizations for annual TD education efforts to ensure that continuing education incorporates personal stories of lived experience and communicates the importance of early detection to improve quality of life. Offering continuing education units for antipsychotic prescribers, nurses, medical assistants, pharmacists, peer specialists, and other support staff who can play a role in TD identification and management may be an effective incentive. Educational programs are particularly effective when they incorporate practical demonstrations and opportunities for skills practice. One quality improvement initiative conducted in an outpatient psychiatry clinic increased AIMS screening rates substantially through provider education, workflow redesign, and ongoing performance monitoring, demonstrating the value of practical implementation-focused training.[80] States may consider partnering with medical associations or rural health associations or seeking out state and federal grants to support a small stipend for clinicians in small or solo practices to step away from busy practices to attend training and mentorship opportunities.



Peer learning and mentorship programs may be particularly effective to increase provider knowledge and self-efficacy.[81] Learning collaboratives and peer-to-peer training models can offer opportunities for clinicians to share experiences, troubleshoot challenges, and learn from one another, particularly in terms of navigating complex clinical decision-making. Grand rounds presentations, statewide behavioral health conferences, and professional association meetings can serve as venues for disseminating TD-related best practices and engaging in peer-to-peer learning. Project ECHO (Extension for Community Healthcare Outcomes) may be a particularly promising model for expanding TD expertise, especially in rural and underserved areas. Project ECHO uses virtual hub-and-spoke networks to connect specialists with community providers through case-based learning and mentorship. A systematic review found that ECHO programs can improve clinician knowledge, confidence, and adherence to evidence-based practices to address behavioral health disorders.[82,83]

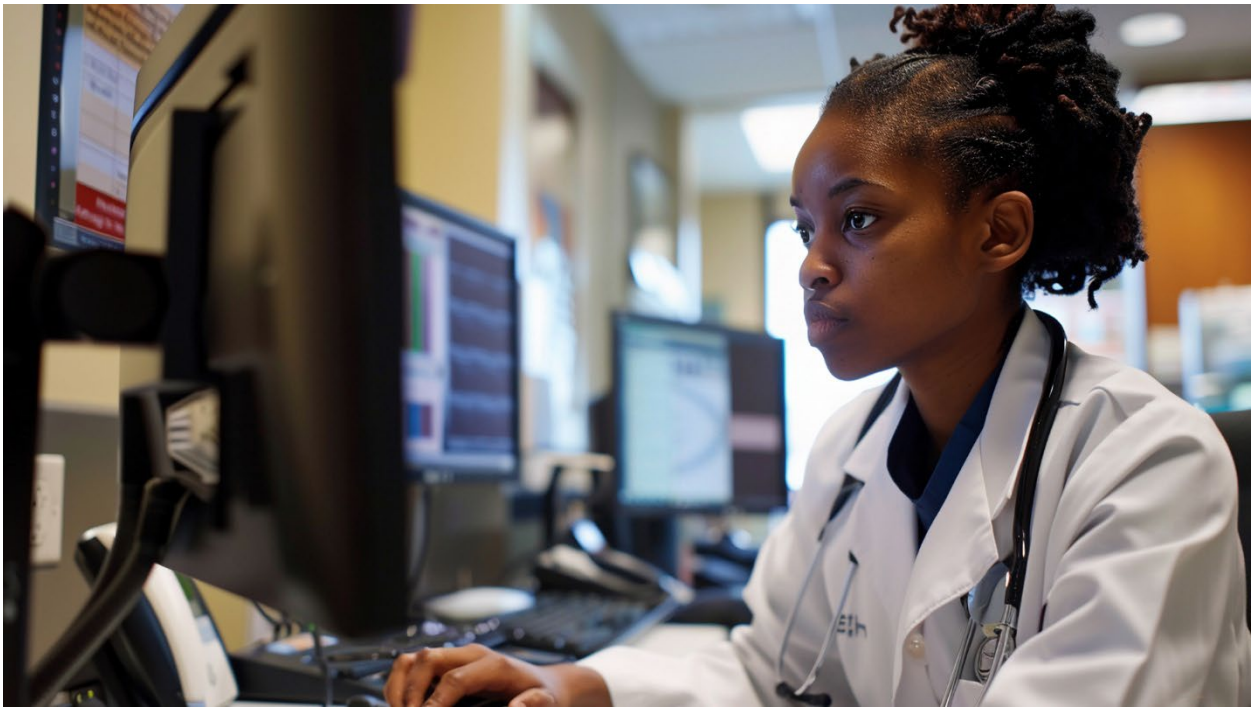
Important Considerations for the Role of Peer Support Specialists in TD Screening

- The role of peer workers in identifying abnormal involuntary movements or providing education to the individuals they are serving will differ by state.
- Incorporating basic training about the risk of abnormal involuntary movements, what to look for, and how to address into peer support training and certification can be included in state curriculum.
- It is important to establish protocols and lines of communication between PSSs and the clinical team about abnormal involuntary movements or the impact they are having on the quality of life of the individuals being served.

States may also consider **establishing consultation programs** that provide clinicians—particularly primary care or other prescribers who may have lower levels of expertise in antipsychotic medication management—with real-time access to movement disorder specialists. Similar consultation programs have successfully increased access to psychiatric expertise in pediatric and maternal health settings while improving provider confidence and patient outcomes.[84,85] Such programs may be particularly valuable in regions where in-person access to specialists is limited.



Structural and technical strategies



Although provider education is an important component of improving TD screening, research consistently demonstrates that education alone is insufficient to produce sustained changes in clinical practice.[86] Structural and technical interventions that embed screening into routine workflows are often necessary to ensure long-term adherence to evidence-based practices. Studies across healthcare settings have found that system-level interventions, including electronic reminders, workflow redesign, and team-based care models, produce larger and more sustainable improvements in screening rates than educational interventions alone.[87,88,89]

One of the most effective strategies is the use of **electronic health record reminders** and clinical decision support tools. A systematic review of computerized clinical reminder systems found that automated prompts significantly improved adherence to preventive care recommendations and screening protocols.[90] By incorporating automated reminders into EHR systems, behavioral health organizations can prompt clinicians when patients are due for TD screening or follow-up assessment. Similar approaches have successfully increased rates of depression screening, suicide risk assessment, metabolic monitoring, and immunization delivery.[91]

Measurement-Based Care

Measurement-based care can provide a practical framework for improving TD screening. Measurement-based care is the systematic use of validated assessment tools to track symptoms, evaluate treatment response, and inform clinical decision-making. The Meadows Mental Health Policy Institute 2024 report *Increasing Measurement-Based Assessment and Care for People With Serious Mental Illness* details how utilizing the AIMS with a measurement-based care approach can help clinicians identify TD and monitor the effects on daily functioning and quality of life to support more informed treatment decisions. Integrating the AIMS into EHRs can help make the process more efficient in allowing providers to track AIMS scores over time. The report identifies several barriers to broader adoption of measurement-based care for TD screening, including limited technology infrastructure, inadequate reimbursement, and gaps in training and awareness.

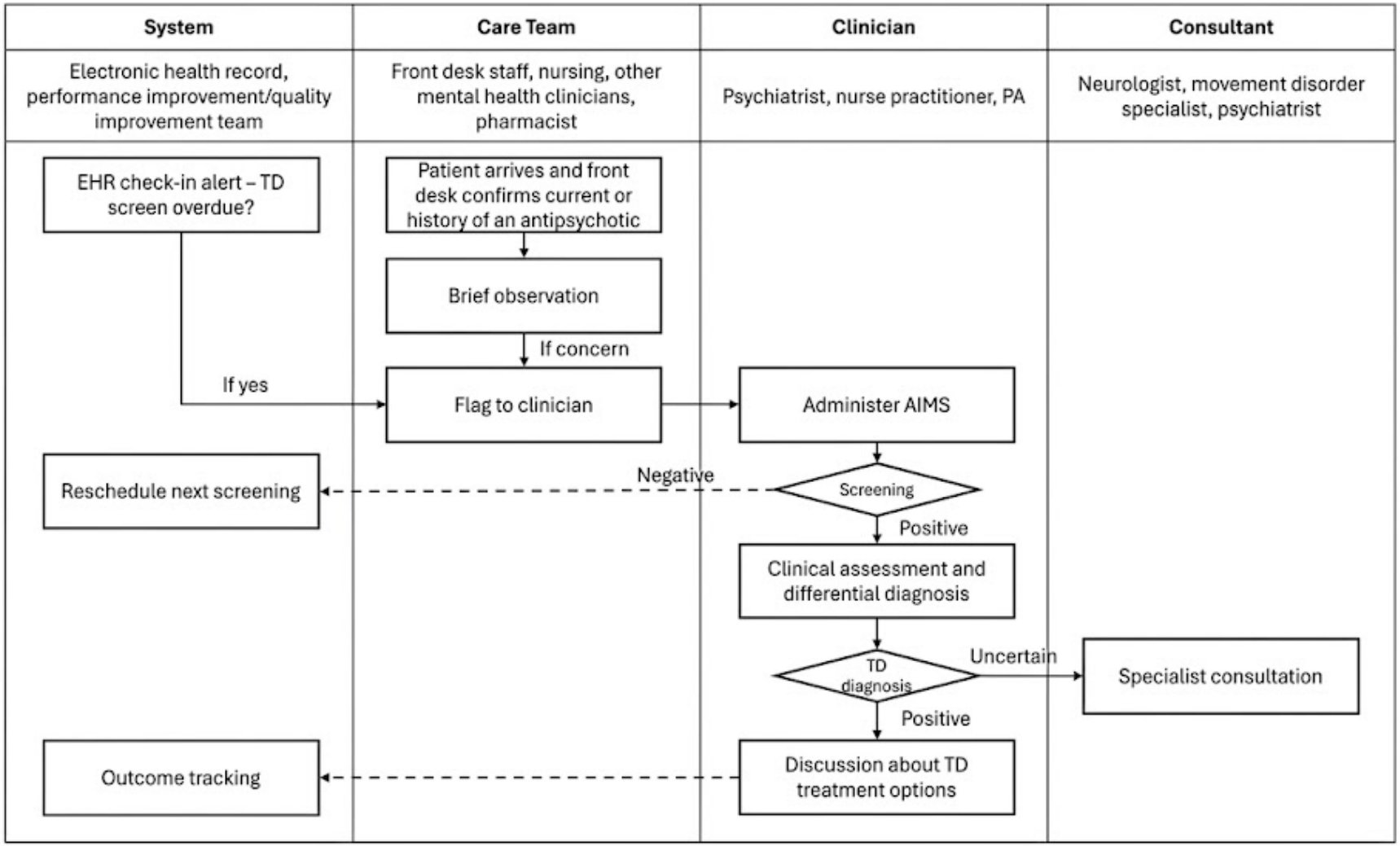
States can further support screening implementation by promoting the use of **team-based models** that distribute screening responsibilities across multiple members of the care team. Workforce shortages and increasing service demands often limit the amount of time prescribers can devote to screening activities and have reduced the frequency of psychiatric appointments for medication management. Research has demonstrated that appropriately trained nurses, medical assistants, pharmacists, and other nonphysician healthcare team members can effectively assist with preventive screening activities, improving efficiency while maintaining quality of care.[92,93,94] For TD screening, nonprescribing staff could provide patient education, conduct preliminary observations, administer portions of screening tools, and document findings prior to the prescriber's evaluation.

Tiered screening pathways could further maximize workforce capacity. For example, clinic staff could be trained to conduct an initial movement observation and administer a

TD screening assessment, while prescribing clinicians focus on interpretation, differential diagnosis, and treatment planning. Such approaches reduce workflow burden while increasing the likelihood that screening is completed consistently. Training exercises on conducting an AIMS assessment and scoring the exam, including reliability testing and item-by-item score review, by team member, are essential to this team-based approach and insuring inter-rater reliability.[95]

Figure 12 illustrates how these standards could be operationalized through coordinated roles for the EHR, care team, treating clinician, and specialist consultants. The workflow links EHR reminders and routine observation with structured assessment, diagnostic evaluation, treatment discussions, and outcome monitoring

Figure 12: Multidisciplinary Workflow for Tardive Dyskinesia Screening and Management in an Outpatient Mental Health Setting



Certified Community Behavioral Health Clinics (CCBHCs) provide a particularly promising infrastructure for implementing routine TD screening. CCBHCs emphasize measurement-based care, quality improvement, integrated services, and population health management, all of which support systematic screening practices.[96] Because CCBHCs are already required to collect and report quality measures, incorporating TD screening into existing monitoring systems may be a relatively efficient strategy for expanding screening rates within public behavioral health systems.

Similarly, **collaborative care models** may offer opportunities to integrate TD screening into existing care management workflows. Collaborative care has demonstrated effectiveness in improving behavioral health outcomes through the use of multidisciplinary care teams and structured measurement-based approaches.[97] Embedding TD screening within these established systems may increase consistency while minimizing additional burden on providers.

Person-centered engagement strategies



Even when screening programs are available and providers are adequately trained, patients may be reluctant to participate in screening or TD treatment due to stigma, fear, limited awareness of TD, concerns about medication changes, or uncertainty about treatment options. Research across healthcare settings demonstrates that individual engagement, health literacy, and trust significantly influence participation in preventive screening and

treatment decisions.[98,99,100] Consequently, strategies that address barriers related to the social context and engagement of individuals served are essential for achieving widespread and sustained TD screening.

Patient education to promote shared decision-making is one of the most important approaches for increasing screening acceptance. Individuals who fully understand the purpose and benefits of screening are more likely to participate in preventive care activities.[101] Collaborative, engaged decision-making rooted in a trusting care relationship is crucial to informed screening consent and next steps, should treatment be warranted. Educational materials and conversations with individuals should explain the signs and symptoms of TD but also should address the importance of early detection, available treatment options, and the potential consequences of delayed recognition, with an emphasis on patient choice and promoting quality of life. In developing and sharing educational resources, SMHAs should keep in mind that they are often most effective when they are written in plain language and developed with input from individuals who have lived experience with the condition being addressed.[102,103]

There are a variety of educational materials available to help support patients and providers regarding tardive dyskinesia screening and management:

- Mental Health America provider guide on talking with patients about medication side effects
- Mental Health America patient resource that includes a section on how to talk with your doctor
- National Alliance on Mental Illness resource guide on TD

PSSs can play a particularly important role in increasing awareness and reducing reluctance to screening. **Peer support interventions** have been associated with improved engagement, self-efficacy, activation, and treatment participation among individuals with SMI.[104,105] Because peer specialists have personal experience navigating behavioral health systems, they may be uniquely positioned to discuss concerns regarding TD screening, address misconceptions, and help individuals understand the benefits of early identification and treatment. Most SMHAs have successfully integrated peer specialists into behavioral health care teams and state offices of recovery to support patient education, care coordination, and treatment engagement, providing a model that could be adapted for TD awareness initiatives. States can consider engaging peer specialists in specific training or integrating screening awareness into existing peer-training efforts,

including awareness discussions at state planning/advisory councils around TD to equip them to engage in these conversations.

Family and caregiver engagement represents another evidence-based strategy for improving screening participation. Family members or caregivers are often among the first to observe subtle movement changes associated with TD and can provide valuable information during the screening process. Family and caregiver involvement can improve treatment adherence, symptom monitoring, and healthcare outcomes among individuals with SMI.[106,107] SMHAs can encourage providers to include caregivers in educational discussions, treatment planning, and follow-up monitoring when appropriate and aligned with preferences of individuals served.

Normalizing conversations about TD during routine medication management visits may also reduce stigma and increase screening acceptance. Research on shared decision-making suggests that patients are more likely to engage in discussions about risks and benefits when providers routinely incorporate these conversations into standard care practices.[108,109] Rather than presenting TD screening as an indication that a problem is suspected, providers can frame screening as a standard component of medication safety and side effect monitoring for all individuals receiving antipsychotic medications. This approach may reduce anxiety and reinforce the perception that screening is a routine part of high-quality care.

Motivational interviewing and shared decision-making techniques offer additional tools for addressing screening reluctance. Motivational interviewing is an evidence-based communication approach that helps individuals explore ambivalence and identify personal reasons for engaging in health-related behaviors.[110] Numerous studies have demonstrated that motivational interviewing improves healthcare engagement, treatment adherence, and health behavior change across a variety of clinical populations.[111,112,113] Applying these techniques to TD screening discussions may help clinicians address concerns regarding medication changes, stigma, or treatment consequences while promoting patient autonomy. SMHAs can seek to ensure that providers are comfortable applying motivational interviewing techniques to conversations about TD and medication management through ongoing training or continuing education opportunities.

Financial barriers may also discourage individuals from pursuing further evaluation or treatment following a positive screening result, and **addressing financial barriers** may improve receptivity to screening and accessibility of treatment. States can support providers by ensuring that information regarding formulary options, medication assistance programs, and financial support resources is readily available during clinical encounters.

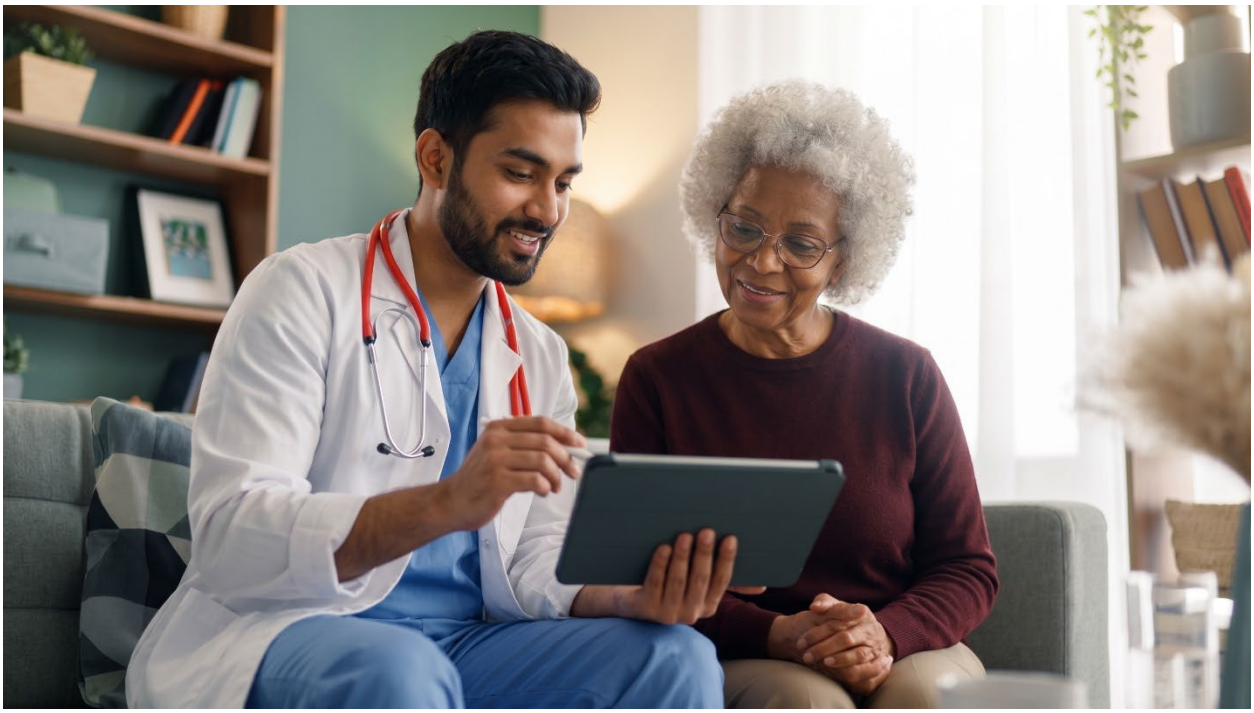


Increasing provider awareness of available treatment options may also help reduce misconceptions about treatment affordability.

Finally, states can support broader efforts to **address social determinants** that may hinder access to care. Transportation challenges, limited access to specialty providers, unstable housing, and financial hardship can all reduce the likelihood that individuals receive recommended screening and follow-up care.[114] Partnerships with and warm hand-offs to social service agencies, transportation programs, and community-based organizations can help address such barriers and improve continuity of care. Expanding access to peer support, family support services, digital resources, and care coordination programs may further strengthen engagement and facilitate timely follow-up after screening.

These engagement strategies recognize that increasing TD screening requires more than provider behavior change alone. Sustainable improvement depends on building trust, improving awareness, reducing stigma, and supporting informed decision-making with individuals served. By addressing these factors, SMHAs can help foster environments that support screening participation, long-term treatment engagement, and improved quality of life for individuals served.

Future directions



Artificial intelligence and digital tools have the potential to assist with TD identification (1) through automated chart review of patients who are overdue for screening, (2) using natural-language processing tools to identify movements possibly consistent with TD in the EHR, or (3) through video-based movement analysis.

Early studies suggest these approaches may help address gaps in TD detection. Loughlin et al. applied a natural-language processing tool to a database of 164,417 patients treated with antipsychotic medication to detect TD in clinical notes.[115] In another study, a computer-vision-based AI tool was used for TD detection across three sequential cohorts with a total of 356 individuals treated with antipsychotics and performed better than human raters.[116] As a follow up, in a separate dataset of 69 videos, this same technology could generalize across video protocols with promising diagnostic accuracy (AUC 0.854).[117] Related patient-facing video-based tools may allow individuals to complete a brief assessment on their own devices, with results categorized by level of risk. However, these tools remain emerging and should be used only as adjuncts to appropriate clinical assessment and follow-up. AI has potential and could help flag patients who are overdue for screening, identify documentation gaps, or support clinician review of video-based assessments, but final clinical interpretation should remain with trained professionals.

"To a child, these abnormal involuntary movements were frightening. He couldn't sit still and moved in ways that felt unfamiliar and confusing to me – repeatedly jutting out his chin and constantly moving his mouth. It wasn't until I got older that my mother explained these movements were a medical condition caused by his medication... Years later, I found myself trapped in my own imaginary world, unable to function at home or at work. I was in full psychosis, talking to the made-up characters in my head. I remember saying goodbye, thinking, I can't live in this world anymore. Finding the right medication for me was a long and winding road, but I did eventually find the right combination, and it includes an antipsychotic. I am happy to report that a decade later, I am still in recovery. For me, that means living happily with my family and working in a meaningful, fulfilling job.I still experience psychosis at times, but it doesn't impact the quality of my life. I also have not developed TD. Importantly, I now know what symptoms to watch for and understand that, unlike when my uncle first developed TD, there are treatment and management options available, including medication adjustments and FDA-approved treatments. Knowing that—and knowing I have the right support—means I am no longer afraid."

-excerpt from "Overcoming My Fear of Tardive Dyskinesia. The full post can be found here.

Conclusion

TD remains a significant and often underrecognized complication of treatment with DRBAs. Findings from the NASMHPD survey suggest substantial variation exists in screening practices, provider training, and system-level supports, although these exploratory results reflect individual respondents' perspectives and should not be interpreted as representative estimates of state practices nationwide.

SMHAs are well positioned to promote more consistent screening through clear policies, workforce education, team-based workflows, electronic reminders, and meaningful engagement of patients, families, and PSSs. A practical standard should combine clinical assessment for abnormal movements during routine encounters with periodic structured screening using the AIMS or a comparable instrument, followed by diagnostic evaluation and discussion of treatment options when concerning movements are identified. By embedding this approach into routine practices and measuring its implementation, public mental health systems can improve the recognition and management of TD while supporting person-centered, evidence-informed care.

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