Research brief

Screening tools for co-occurring mental health and substance use disorders

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Screening and *assessment* are key components of care for people with co-occurring mental health and substance use disorders. These processes aid in the identification of multiple concerns that may otherwise be overlooked if each condition is considered in isolation, and are critical in ensuring that people with co-occurring conditions receive timely, effective, and integrated care. Screening is one of the most widely identified clinical strategies that can be implemented to enhance integration between alcohol and other drug (AOD) and non-AOD services (1), and screening throughout care has been proposed as a guiding principle for managing co-occurring conditions (2).

Standardised screening and assessment provide a reliable view of the client's difficulties and current life situation. When conducted appropriately, the process of standardised assessment can also be a source of rapport building (3). A range of different tools has been developed for this purpose: while some of these are well-established and have been comprehensively evaluated for validity and reliability, others have been developed for a specific purpose because they are more practical or easier to use, and it is not yet clear how accurate or consistent they are.

The purpose of this research brief is to provide an overview of screening tools for individuals with co-occurring conditions. Pages 1-3 explain why screening and assessment are important for people with co-occurring conditions, define key terms, and highlight important considerations for the use of screening tools in this population. Pages 4-7 include information on specific tools that can be used to screen for AOD disorders (pages 4-5) and mental health disorders (pages 6-7).

The importance of screening and assessment for people with co-occurring conditions

In Australia, the prevalence of current mental health disorders among clients in substance use treatment settings has been estimated to range from 47% to 100% (4). In mental health treatment settings, estimates of the prevalence of past 12-month problematic substance use (including abuse, dependence, and substance use disorder) range from 7% to 53% (5). These findings highlight the importance of ensuring that all individuals who present for treatment of either a substance use or a mental disorder are, at a minimum, screened for a potential co-occurring disorder.

Despite this, approaches to screening and assessment of substance use disorders vary considerably. A review of routine practice in adult mental health services found that assessment was inconsistent, and generally insufficient to explain diagnostic decision-making (6), while the most recent National Survey of Mental Health and Wellbeing found that only 27% of people with substance use disorders receive treatment in their lifetime (7). Similarly, it is not unusual for mental health conditions to be overlooked in AOD services (8). Many of the signs and symptoms of common mental health conditions are not immediately visible, and may be overlooked if not specifically asked about (3).

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Definitions

Screening is an initial process of testing to identify whether a person may be experiencing concerns that warrant further attention.

The screening process does not necessarily identify the type or the severity of the condition, only whether or not the condition is likely to be present, and when additional assessment is needed. In contrast, assessment is a process for clarifying the existence and nature of the problem that has been identified during screening. Assessment involves a more comprehensive exploration of the nature, severity, and impact of those concerns to inform diagnosis, care planning, and the delivery of (or referral to) appropriate treatment.

Screening tools are generally short and easily administered. All workers* can be trained to screen for co-occurring disorders—workers in substance use treatment settings can screen for mental disorders, and workers in mental health treatment settings can screen for substance use disorders. In contrast, assessment is comparatively lengthy and more time-consuming, and typically needs to be completed by a clinician with skills and training in how to administer a particular assessment.

Considerations for screening and assessment for people with co-occurring disorders

Screening tools are not diagnostic. While some tools can suggest the severity of the problem (i.e., mild, moderate, or severe) if its cut points have been validated in a particular population, they cannot establish the presence of a mental health or substance use disorder. When screening identifies potential symptoms or concerns that may require further attention, this should be followed by a comprehensive assessment conducted by a suitably qualified and trained health professional.

Terminology

Validity
Whether a tool measures what it is intended to measure. A valid tool accurately reflects the condition, symptom, or outcome being assessed.

Reliability
How consistently a tool produces the same result when used under similar conditions. A reliable tool gives stable and repeatable results over time or between different users.

Acceptability
How comfortable, appropriate, and manageable a tool is for the people using it. A tool with high acceptability is more likely to be completed accurately and used routinely in practice.

Feasibility
Whether a tool can realistically be used in a particular setting, given the available time, workforce, training, and resources. A feasible tool is practical to implement in routine care.

Cultural equivalence
Whether a tool works in a similar and appropriate way across different cultural or language groups. A tool with good cultural equivalence measures the same concept accurately across populations, rather than being affected by differences in language, context, or interpretation.

**Screening tools are not routinely administered by peer workforces – services should think about where they'll get screening data from if they have a frontline peer workforce. Link to intentional peer support model (https://intentionalpeersupport.org/).*

Additional considerations for people with co-occurring conditions

- Intoxication, withdrawal, and acute psychiatric distress affect the accuracy of self-report and the validity and reliability of results. It is not necessary to wait until a person is symptom-free but avoid times of crisis, such as an emergency room visit or a recent increase in level of care (9).
- Clients may have concerns about potential negative consequences of disclosure regarding drug use (e.g., impacts on housing or childcare; discharge from treatment; changes in entitlements or medications). Establishing an accepting and non-judgemental atmosphere, explaining why sharing this information is important and helpful for the client, and addressing confidentiality concerns can improve the accuracy of self-reported substance use (9, 10).
- Consider how symptoms change and interact over time: Mental health and substance use problems can influence each other, so screening should be followed by assessment that considers when symptoms started, how they have changed, and whether they may be substance-induced, part of a primary mental disorder, or both (6).

For further support on how to have conversations about co-occurring disorders in a non-judgmental, inclusive manner, consider Hamilton Centre's online modules:

- Module 2 - Therapeutic relationships
- Module 6 - Understanding stigma in mental health and addiction care
- Module 7 - Addressing stigma in mental health and addiction care

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Screening tools for AOD disorders in mental health services

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Name	Purpose	Length	Administration	Setting	Special populations
Alcohol Use Disorders Identification Test (AUDIT) (11) **Links** AUDIT WHO guidelines	A brief and easily applied screening tool for past-year problematic alcohol use in adults.	10 items (2-3 min)	Self or clinician	Suitable for use in primary and other health settings by a range of workers and health professionals. No specific training is required to administer or score the AUDIT (3).	Developed using data from a range of cultures, languages, and incomes (12). However, some questions may not capture information on alcohol use by priority populations (e.g., in Indigenous communities, where alcohol may be consumed in culturally specific ways). The AUDIT has been validated in young people <25 years (13), and is accurate in older adults if cut-offs are tailored to this age group (14).
Drug Use Disorders Identification Test (DUDIT) (15) **Link** DUDIT (including DUDIT manual and translated versions)	Screens for problematic use of drugs other than alcohol over the past year.	11 items (5-10 min)	Self or clinician	As with the AUDIT, suitable for use by a range of workers across different settings. However, decisions based on particular score profiles should be made only by experienced clinicians following an appropriate clinical examination (3).	Validated for use in a range of populations (16), but may have similar limitations to the AUDIT in regard to how specific populations use drugs. Validity in adolescent populations demonstrated by a small number of studies; may be a more reliable screening tool for cannabis than the ASSIST-Y (17).

Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) (18) **Links** ASSIST and ASSIST manual (WHO) eASSIST and eASSIST Lite Screening portal and resources	Used to determine presence of problematic AOD use over the last three months. Available in electronic (eASSIST) and ultra-brief versions (eASSIST Lite)	8 items (5-10 min) 5 items (3-5 min)	Clinician Self	Originally designed for primary care settings. Can take longer to complete than other screening tools if a client has used multiple substances (18). eASSIST can be self-completed and provides personalised feedback to explore options for change	Has a strong evidence base supporting its use across a range of populations and settings (18). However, there is a lack of systematic reviews/meta-analyses integrating these findings. A version has been developed for youth (ASSIST-Y)(19) as ASSIST risk cut-offs are not appropriate for adolescent (<18 years) populations (20). Limited validation among older adults (21). Validity and reliability as a measure of severity of dependence is excellent (23); less evidence in versions adapted for other cultures/populations.
Fagerström test for nicotine dependence (FTND) (22) **Link** Available at the source reference here	Assesses the intensity of physical addiction to nicotine.	6 items (<5 min)	Self	Quick to complete. Can be used to guide prescribing medication for nicotine withdrawal, and other decision making.	Items in the FTND may not be appropriate for assessing the early signs of nicotine dependence that typically characterise adolescent smoking (24).
Severity of Dependence Scale (SDS) **Link** SDS	Indicates severity of psychological dependence (past 12 months) on various legal and illegal drugs	5 items	Self	A short and easily administered instrument that has also been found to be a useful instrument to measure treatment outcomes (12).	Validated in Australian populations and across a range of substances, including heroin, cannabis, cocaine, amphetamines and benzodiazepines (12, 25). Is a reliable and valid measure of severity of cannabis dependence in adolescents (14-18)(26), and can detect medication misuse and dependence among hospitalised older patients (27).

A more extensive list of standardised screening tools is available in the Australian Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (3rd edition). ***https://comorbidityguidelines.org.au/resources/tools***

Screening tools for mental health (MH) disorders in AOD services

Hamilton Centre

Name	Purpose	Length	Administration	Setting	Special populations
Kessler Psychological Distress Scale (28) **Links** K-10 Translations	Measures psychological distress (anxiety and depression) over the past 4 weeks.	10 items (5 min)	Self or clinician	Designed to detect high-prevalence disorders in the general population. Often used as a screening and outcome measure in primary care and MH settings (29); has good reliability and validity in AOD-using samples (3).	Widely translated, but inconsistent evidence of cultural equivalence (29). A culturally modified scale (MK-K5) is validated for use in Australian Aboriginal and Torres Strait Islander populations (30). The K-10 is a valid measure of psychological distress in Australian adolescents (from 11 years)(31) and older adults (65 years+)(32). In adolescents, use of a single screening value may result in false positives (31); in adults over 75, lower screening cut-offs may be appropriate (32).
Depression Anxiety Stress Scale (DASS-21) (33) **Links** DASS-21 Translations	Measures the severity of depression, anxiety, and stress over the past week; can also recognise general distress (34).	21 items (5-10 min)	Self	Validated in drug and alcohol treatment settings. Can reliably screen for symptoms of depression (35) and PTSD (36) among people with AOD use disorders.	Validated in a range of cultures (12), and in Korean and Hindi (37). A shortened version (DASS-18) has been developed for use in Asian populations (Indonesia, Malaysia, Singapore, Sri Lanka, Taiwan and Thailand) (38). In adolescents, there is stronger evidence for reliability and validity of the DASS-21 total score than the depression, anxiety, and stress subscales (39). Total scores can accurately identify internalising disorders in adolescents seeking AOD treatment (40).

Camberwell Assessment of Need (CAN)(41) **Links** CAN and CANSAS-P	Comprehensive needs assessment tool. Assesses general health and functioning (no specific timeframe).	22 items (5 min)	Self or clinician	Can be used in clinical practice without staff training (3). Due to discrepancies in clinician and client assessments, a client-rated short-form measure (CANSAS-P) has been developed.	Translated and validated in a range of countries, particularly across Europe (12). There is evidence to support its use among people with MH conditions (3).
Posttraumatic Stress Disorder (PTSD) Checklist (PCL-5) (42) **Link** PCL-5	Screens for the presence of PTSD symptoms in adults over the past month.	20 items (5-10 min)	Self		Performs well among refugees and asylum-seekers; optimal cut-offs may vary based on cultural background (43). Translated into Arabic, Kurdish, Chinese (Mandarin), and Dutch (37). Validated in adults receiving inpatient AOD treatment (44), and Malaysian adolescents (45).
Indigenous Risk Impact Screener (IRIS) (46) **Link** IRIS	Assists with early identification of AOD problems and MH risks in Indigenous Australian populations.	13 items (5 min)	Clinician	A simple and reliable screening tool, suitable for adults from an Aboriginal or Torres Strait Islander background with a basic understanding of English.	Validated for use in Indigenous Australian prison populations (47, 48).

A more extensive list of standardised screening tools is available in the Australian Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (3rd edition). *https://comorbidityguidelines.org.au/resources/tools*

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