

**Screening for and assessment
of
co-occurring substance use and mental health disorders
by
Alcohol & Other Drug and Mental Health Services**



Victorian Dual Diagnosis Initiative

Author

Gary Croton: Eastern Hume Dual Diagnosis Service, Northeast Health Wangaratta

Suggested reference

Croton, G. (2007), *Screening for and assessment of co-occurring substance use and mental health disorders by Alcohol & Other Drug and Mental Health Services*, Victorian Dual Diagnosis Initiative Advisory Group, Victoria.

Acknowledgements

The author would like to thank the members of the Victorian Dual Diagnosis Screening Tools working group, namely:

Owen Connolly	Paul Hurnall	Mark Powell
Gary Croton	Chris Hynan	Dr Tim Rolfe
Sharon Galligan	Greg Logan	Kathleen Ryan
Jillian Gleeson	Stephen Mihaly	Andree Sellars
Jurgen Hemmerling	Simon Milton	Rodney Soar
Michael Hodge	Jennifer Overfield	Shane Sweeney

Developed with support from the Mental Health and Drug Policy and Services Branches of the Department of Human Services.

This document will be subject to revisions and changes as the Victorian approach to screening and assessment evolves — please note the date and version number below. The most recent version of this document will be available on the *Dual Diagnosis Australia and New Zealand* website — www.dualdiagnosis.org.au .

Feedback

We are keen to hear your comments, feedback and experiences with using this guideline. Please contact your local dual diagnosis clinician. Contact details of the dual diagnosis teams can be found in Appendix 6.

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Published in 2007

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Version 1.00, September, 2007.

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Possible approaches to screening, assessment and integrated treatment planning by service setting					
Treatment setting	High prevalence of co-occurring...	Screening	Assessment	Integrated Treatment Planning	
A O D	AOD	<ul style="list-style-type: none"> Anxiety & depression Post traumatic stress disorder (PTSD) Personality disorder Risk 	<ul style="list-style-type: none"> K10 PsyCheck MH screening form MINI 	Low threshold for referral to Mental Health for risk assessment/management	AOD clinician or team addresses both disorders OR agrees & implements an individual treatment plan with mental health
	PDRSS	<ul style="list-style-type: none"> All substances 	<ul style="list-style-type: none"> ASSIST 	In-house OR with clinical mental health or AOD	MH clinician or team addresses both disorders OR agrees & implements an individual treatment plan with AOD service 'Integration needs to continue beyond acute intervention & through recovery by way of formal interaction & co-operation between agencies in reassessing & treating the client' DHS 2007
M e n t a l H e a l t h	CAMHS/ Early Psychosis	<ul style="list-style-type: none"> All substances Cannabis Alcohol 	<ul style="list-style-type: none"> Ongoing screening/ high index of suspicion ASSIST for all people 13-years & older Sensitive questioning for younger people 	In-house, integrated AOD assessment in response to positive AOD screen	
	Adult Community	<ul style="list-style-type: none"> All substances 	<ul style="list-style-type: none"> ASSIST 	In-house, integrated AOD assessment in response to positive AOD screen	
	Adult Inpatient	<ul style="list-style-type: none"> All substances Substance withdrawal 	<ul style="list-style-type: none"> ASSIST 	<ul style="list-style-type: none"> If positive ASSIST response Withdrawal scales 	
	Aged	<ul style="list-style-type: none"> Alcohol Prescription meds abuse 	<ul style="list-style-type: none"> AUDIT ASSIST Sensitive questioning re prescription drugs 	Full AOD assessment if positive AUDIT or ASSIST response	
	Primary Mental Health	<ul style="list-style-type: none"> Alcohol abuse Alcohol dependence 	<ul style="list-style-type: none"> AUDIT ASSIST 	Full AOD assessment if positive AUDIT or ASSIST response	

How to use this guide

Evidence shows that people with mental health or substance use disorders are at increased risk of also developing the other disorder. Early recognition of co-occurring disorders leads to the development of the most effective possible treatment. Yet even very experienced mental health clinicians often fail to recognise a co-occurring substance use disorder. Similarly, many substance use disorder treatment clinicians struggle to recognise – let alone assess and respond to – the presence of co-occurring mental health disorders in their clientele.

This guide aims to equip treating mental health (MH) and alcohol and other drug (AOD) treatment clinicians and agencies to recognise co-occurring disorders and provide **effective responses**.

The section **Screening and assessment in practice** provides guidelines for screening and assessment in practice, and addresses the main challenges confronting clinicians and managers seeking to implement routine screening in MH or AOD treatment settings. These include: why, who, how and when screening should take place; when not to screen; the difference between assessment and screening for co-occurring disorders; barriers to routine integrated screening, assessment and treatment; issues in screening with younger people; and steps to take after screening has occurred.

Screens for mental health symptoms and disorders outlines four key tools available for use in screening for mental health symptoms and disorders and is aimed at clinicians currently working in the Victorian AOD sector. These include:

- K10
- PsyCheck
- Modified Mini Screen
- Mental Health Screening Form.

Screens for substance use disorders introduces Victorian MH clinicians to four key tools that may be used when screening for substance use disorders. These include:

- Sensitive questioning
- AUDIT
- ASSIST
- Cage / CageAid.

Screening tools are generally available online. The table on page iii of this guide provides an overview of the range of possible approaches to screening, assessment and integrated treatment planning by service setting and how screening tools may be used.

These guidelines provide only a brief profile of some of the available tools and approaches supported by the Victorian Dual Diagnosis Initiative (VDDI). Readers wishing for more detailed information will find a wealth of valuable resources listed in the **References** section of this guide. Also included are sample proformas and protocols for use by clinicians and agencies, and contact details for the Victorian Dual Diagnosis Teams. These teams role includes assisting with complex dual diagnosis presentations in collaboration with senior clinical staff or case managers and assisting individual services to plan how they will establish quality dual diagnosis practices within their services and meet the requirements of the state-wide Dual Diagnosis Action Plan 2007-2010.

Key directions and priorities for Victorian services

The Victorian Department of Human Services 2007 policy *Dual diagnosis: Key directions and priorities for service development* outlines key directions and priorities for Victorian dual diagnosis service development.

- Dual diagnosis is systematically identified and responded to in a timely, evidence-based manner as core business in mental health and AOD services.
- All clients to be screened for co-occurring disorders by 2008.
- By 2010 all positive screens should trigger a full assessment of likely co-occurring disorders.
- All mental health and AOD workers to be **dual diagnosis capable** by 2010.
- Dual diagnosis capability is defined as able to screen and assess co-occurring disorders. Advanced practitioners will also be able to treat co-occurring disorders.

Implications for clinicians and services

A pivotal strategy in the Victorian DHS policy has been the attribution of primary responsibility for achieving the mandated Service Delivery Outcomes to mental health and AOD service managers. These guidelines have been drafted to:

- Assist busy managers to achieve the screening and assessment goals mandated in the DHS Victorian Service Delivery Outcomes.
- Enable clinicians and their services to recognise and respond to co-occurring disorders.
- Improve effectiveness of treatment for 'target' disorders.
- Provide tools and possible strategies/approaches for routine detection, assessment and integrated treatment planning in both mental health and AOD services.
- Improve detection of common co-occurring disorders and increase the likelihood of earlier intervention with lower input, more effective treatments.

It is not intended that either mental health or AOD services should vary their primary criteria for entry to their service system. Rather that, where people who **do** meet criteria for their services **also** have a co-occurring disorder, this will be routinely detected and assessed, and an Integrated Treatment Plan developed that responds to both mental health and substance use disorder treatment needs.

Where workers encounter a person who **does not** meet the criteria for service from their agency, they should work with that person to establish where they are likely to get the most useful service and to actively assist the person to obtain that service. This is what's known as a 'no wrong door' service system (DHS, 2006).

Introduction

Internationally, the past two decades has seen substantial interest and investment in resolving the question of how treatment systems can deliver more effective treatment to people presenting with both a mental health and a substance use disorder. This question has occupied researchers, clinicians, service managers, central planning and policy bodies in primary care, mental health and drug treatment settings.

It has been driven by the compelling evidence around two key areas:

- the prevalence of co-occurring disorders in mental health and drug treatment settings – they are the *'expectation not the exception'* (Minkoff and Cline, 2004)
- the harms strongly associated with having both disorders compared to having only one of the disorders.

It has received further impetus from:

- growing consumer and carer demand
- the potential for both AOD and mental health treatment sectors to be more effective in treating their target disorders by increasing their recognition of, and developing their response to, co-occurring mental health and substance use disorders.

Dual diagnosis – the expectation not the exception

People presenting with co-occurring mental health and substance use disorders are the *'expectation not the exception'* in both drug treatment and mental health settings – albeit often with different predominant mixes of disorders, severity and treatment needs in either sector.

When an individual experiences both a mental health and a substance use disorder, the disorders tend to influence each other in their development, their severity, their response to treatment and their relapse circumstances (Croton, 2005). If a clinician attempts to treat either disorder without recognising and responding to the co-occurring disorder, the treatment of the 'target' disorder is likely to be less effective. Recognising and responding to co-occurring disorders is likely to improve the effectiveness of treatment of 'target' disorders.

A range of factors may contribute to clinicians failing to recognise co-occurring disorders. Both substance use and mental health disorders are often not immediately evident, especially when they are **high-prevalence, low-impact** type disorders. A dedicated effort by an assessing clinician may be required in order to establish whether a co-occurring disorder exists. As both disorders are so highly stigmatised, a person receiving assessment may be reluctant to disclose information indicative of a co-occurring disorder. Substance use treatment or mental health clinicians may lack confidence in their ability to provide treatment for a co-occurring disorder and hence be reluctant to ask questions that could detect that disorder.

Regardless of the reason for service systems or clinicians not recognising co-occurring disorders, the implementation of a routine screening protocol will increase the likelihood of treatment-impacting co-occurring disorders being detected and responded to. In those cases where the clinician lacks the skills, training or time to assess for a particular co-occurring disorder, use of a validated screening tool will increase case detection and enhance treatment planning. The recognition of a co-occurring disorder is a necessary prelude to assessment of the disorder in order to inform the development of an Integrated Treatment Plan (see Appendix 4) that addresses both disorders.

The importance of screening for co-occurring disorders

Globally, there is substantial anecdotal and research evidence and concern about people with co-occurring disorders tending to 'fall between the gaps' – their co-occurring disorder going unrecognised and hence failing to receive treatment from either service system (Senate Select Committee on Mental Health, 2006). There is good evidence that even very experienced mental health clinicians may often fail to recognise the presence of a co-occurring substance use disorder (Ley, Jeffery, Ruiz, McLaren & Gillespie, 2002; Barnaby, Drummond, McCloud, Burns & Omu, 2003; Ries, Dyck, Short, Srebnik, Snowden & Comtois, 2002). Similarly, many substance use treatment clinicians may struggle to recognise, let alone assess and respond to, the presence of co-occurring mental health disorders in their clients. While much is still to be learned about what constitutes effective treatment, there is general agreement that, in order to provide **any** treatment, it is first necessary for treating clinicians and agencies to recognise that a co-occurring disorder exists.

The case for routine screening in Victorian services

Both mental health and substance use disorders may be broadly divided into high-prevalence/lower-impact disorders **or** low-prevalence/higher-impact disorders (Table 1). As a general rule the treatment of **high-prevalence/low-impact**-type disorders is likely to be more effective, with lower inputs, than the treatment of **low-prevalence/high-impact**-type disorders. However **high-prevalence/low-impact**-type disorders are often less visible and more difficult to detect – especially when there is not a screening protocol or tools to support the detection and assessment of co-occurring disorders.

	Mental health disorder	Substance use disorder
High-prevalence/ low-impact disorders	- Anxiety - Depression	- Harmful use (ICD10) - Abuse (DSM-IV)
Low-prevalence/ high-impact disorders	- Psychosis - Major mood disorder	- Dependence (ICD & DSM)

Table 1: High-prevalence/low-impact and low-prevalence/high-impact mental health and substance use disorders

As you'd expect, the actual numbers of people with **high-prevalence/low-impact**-type disorders are greater than the actual numbers of people with **low-prevalence/ high-impact**-type disorders.

The exciting and large-scale potential human and financial savings that may be achieved with low-cost interventions with people who have the **high-prevalence/low-impact**-type disorders are dependent on increasing our recognition of these disorders. Routine screening for co-occurring disorders of people who present to either mental health or AOD agencies is likely to contribute substantially to improved detection of common co-occurring disorders, and increases the likelihood of earlier intervention with lower-input, more effective treatments.

These are some of the reasons why a guiding principle of routine screening for co-occurring disorders by mental health and substance treatment agencies is evolving in a number of treatment systems around the world.

Treatment systems are attempting to improve the effectiveness of their response to co-occurring substance use and mental health disorders (dual diagnosis) because of:

- prevalence – the '*expectation not the exception*' in treatment settings
- harms associated with having both disorders
- consumer and carer demand
- potential to be more effective in treating 'target' disorders.

Research indicates that integrated treatment of co-occurring disorders will often be more effective than non-integrated treatment. The Victorian Department of Human Services 2007 policy *Dual diagnosis: Key directions and priorities for service development* defines integrated treatment as occurring when a clinician or treating team within the one service addresses both a person's substance use & mental health problems. The policy states that integrated treatment can also occur when staff of separate agencies work together to agree and implement an individual treatment plan. It notes that 'integration needs to continue beyond acute intervention & through recovery by way of formal interaction & co-operation between agencies in reassessing & treating the client' (DHS 2007). Different service settings and clinicians will have differing capacities to provide integrated treatment to the various possible combinations of disorders that people will present with.

Screening may contribute to the development of a common language and understanding between mental health and AOD treatment agencies. Where agencies have collaborated on selection of screening tools, joint training in their use and agreed protocols around responses to and priority of positive screens, there may be less potential for interagency tensions and disappointments and greater potential for the provision of effective integrated treatment.

A potentially substantial gain, likely to be derived from implementing routine screening for co-occurring disorders, is that earlier, low-input, more effective treatment interventions are made possible as the disorders are recognised at an earlier stage, before they have become established and collateral damage, losses and dependence have occurred.

Screening is part of assessment

Screening is a component of an assessment. A screen is only a brief method of determining whether a particular condition is present. A positive screen should trigger a detailed assessment that will confirm whether the condition or disorder is indeed present. In turn, assessment of both disorders will inform and develop integrated treatment planning for all detected disorders.

The aim of screening is to increase the detection of co-occurring disorders and to indicate when a detailed assessment of co-occurring disorders is warranted. The aim of assessment of co-occurring disorders is to garner information that will inform effective integrated treatment planning.

In practice, the distinction between screening and assessment is not and should not be clear-cut. Many screening tools also provide useful assessment information. Once a clinician has incorporated routine screening into their practice the transition from screening to assessment will be imperceptible to the client. Screening processes, sensitively deployed, provide a further opportunity to build engagement with clients.

A guiding principle of routine screening for co-occurring disorders by mental health and substance treatment agencies has evolved because:

- often co-occurring disorders are not recognised, even by experienced clinicians
- under-recognised, under-treated co-occurring disorders reduce the effectiveness of the treatment of 'target' disorders
- there is potential for large-scale human and financial savings in increasing our recognition of and developing our response to co-occurring disorders
- there is a need to improve the effectiveness of responses to high-prevalence disorders (anxiety, depression, and hazardous rather than dependent substance abuse).

Screening of young people

Both mental health and substance use disorders are highly prevalent among young people. One in ten young people aged 15–17 have a mental health disorder (AIHW, 2006) Around a quarter of young people aged 12–14 years drink alcohol to some extent (AIHW, 2006). By age 15, nearly a third of Australian children report binge drinking (5 or more drinks on a single occasion) within the past fortnight (Murdoch Children's Institute, 2007).

Compared to adults, younger people will tend to:

- be more likely to see substance use as a solution rather than a problem
- be more likely to be experimenting with a range of substances
- be **less** likely to meet the criteria for substance dependence (however will frequently meet the criteria for harmful use – see Appendix 5).

Issues around screening for co-occurring substance use or mental health disorders in young people include:

- confidentiality and disclosure
- the age at which screening should be instituted
- screening approaches.

The international context

In the USA, the federal Substance Abuse Mental Health Services Administration (SAMHSA) includes in their [2006/2007 strategic plan](#) a measure to 'Increase the percentage of prevention and treatment settings that:

- screen for co-occurring disorders
- assess for co-occurring disorders'

Minkoff and Cline developed the influential Comprehensive **Continuous Integrated System of Care (CCISC)** model for organising services for individuals with co-occurring psychiatric and substance disorders. The model is designed to improve treatment capacity for these individuals in systems of any size and complexity, ranging from entire states to regions or counties, networks of agencies, individual complex agencies, or even programs within agencies.

One of the strategies of the CCISC model for addressing co-occurring disorders is to establish policies and procedures for universal screening for co-occurring disorders at initial contact throughout the system. CCISC is being deployed in a number of sites in the USA and Canada.

The Australian context

In New South Wales, the Mental Health Outcomes and Assessment project (MH-OAT) has implemented uniform assessment protocols across the state in order to strengthen the mental health assessment skills of clinical staff. The NSW [standardised CAMHs, Adult and Aged mental health](#) assessment forms all contain a reasonably detailed substance use assessment that clinicians are mandated to use with people receiving mental health assessment.

The Victorian Department of Human Services 2007 policy *Dual diagnosis: Key directions and priorities for service development* mandates that:

'Dual diagnosis is systematically identified and responded to in a timely, evidence-based manner as core business in mental health and AOD services. A priority is to establish mechanisms and processes that ensure that dual diagnosis is systematically recognised and assessed in both mental health (clinical and PDRSS) and alcohol and other drug services. A screening approach should be incorporated in early assessment activities that provides sufficient information to identify the need for further more detailed assessment.'

Developing capacity in Victoria

The Victorian dual diagnosis policy sets out the expectation that all Victorian mental health and drug treatment staff are '*dual diagnosis capable*'.

Dual diagnosis capability is defined as:

- **At the most basic level** – to be able to administer a screening tool appropriate to their service age group, undertake a dual diagnosis assessment, and consult others with more advanced knowledge and skills in making decisions about the most appropriate course of action to be taken.
- **At the advanced level** – to be able to both assess and effectively treat co-occurring disorders within service and practice guidelines.

A pivotal strategy in the Victorian DHS policy has been the attribution of primary responsibility for achieving the mandated Service Delivery Outcomes to mental health and AOD service managers.

What's next after screening?

Once a co-occurring disorder has been detected, the challenge facing mental health and AOD services and clinicians is to decide how best they can achieve integrated treatment of both disorders. Is it within the clinician's or their agency's capacity to provide integrated treatment of both disorders? If not, what is the most efficient means of engaging another service in the development of a single Integrated Treatment Plan addressing both disorders?

Three key concepts can assist in the development of the most effective possible responses to the various treatment needs of people with co-occurring disorders:

1. **Cohorts of people with co-occurring disorders within the service system**– the Victorian dual diagnosis policy proposes a three-level schema that attributes responsibility for providing treatment to the various cohorts of people with dual diagnosis to different sectors of the service system – primary care, specialist AOD or specialist mental health services.
2. **Integrated treatment** – the available evidence indicates that integrated treatment of co-occurring disorders often tends to be more effective than non-integrated treatment for many people with dual diagnosis.
3. **'No wrong door' service system goals** – all people with co-occurring disorders are actively and meaningfully assisted to obtain appropriate treatment from within the service system **by the service to which they present**, even if they don't meet that service's criteria for treatment.

These three concepts are explored in detail in the **After screening – the next steps** section of these guidelines.

Guiding principles

A set of principles has evolved to guide mental health and substance use disorder treatment clinicians and agencies in routinely screening for co-occurring disorders.

- All people receiving mental health or substance use treatment should be screened or assessed for a co-occurring disorder. An exception may be young people under the age of 13.

Routine screening represents an efficient method for services to increase their recognition of co-occurring disorders, where they do not possess the necessary expertise, supports or time to routinely, adequately, assess co-occurring disorders. However, screening is not necessary where comprehensive routine dual diagnosis assessment is provided.

- Screening and/or assessment for a co-occurring disorder should take place at or near a person's first contact.

Early detection and assessment of co-occurring disorders contributes to effective, targeted treatment planning.

- Screening and assessment should not be attempted when the client is intoxicated, distressed, in pain, in need of emergency treatment or acutely psychotic.
- Younger people should receive some level of screening for a co-occurring disorder at each contact.
- All people with co-occurring disorders should be actively and meaningfully assisted to obtain appropriate treatment from within the service system **by the service to which they present**, even if they don't meet that service's criteria for treatment (the '**no wrong door**' service system approach).
- Where possible, clients should receive integrated treatment of co-occurring mental health and substance use disorders.

Integrated treatment occurs when a clinician provides treatment for both a client's substance use and mental health problems. Integrated treatment also occurs when staff of separate agencies work together to agree and implement an individual treatment plan. This integration needs to continue beyond acute intervention & through recovery by way of formal interaction & co-operation between agencies in reassessing & treating the client.

Screening and assessment in practice

This section addresses some of the questions clinicians and managers may face when incorporating routine screening into their own or their agency's practice, whether in MH or AOD treatment settings.

What is the difference between screening and assessment?

Screening is a component of an assessment. A screen is a **brief** method of determining whether a particular condition (such as domestic violence) or disorder (such as substance use or mental health) may or may not be present. A positive screen will usually trigger a more detailed assessment of the condition.

Assessment is a more time-intensive process that may:

- confirm whether the condition or disorder is present
- assess its severity, impact and relevance, and the client's perceptions, attitudes and beliefs about the condition or disorder
- inform and develop integrated treatment planning around the disorder (in dual diagnosis, around both disorders).

In practice, the distinction between screening and assessment is not so clearly defined. Many screening tools also provide useful assessment information. Once a clinician has integrated routine screening into their practice, the transition from screening to assessment will usually be imperceptible to the client. When sensitively deployed, screening processes can provide a further opportunity to build engagement with clients.

Who should we screen?

Like anyone else, clinicians may be vulnerable to assumptions about the type of person who is likely to have a particular disorder. This can lead a clinician to screen only those people who they consider fit the 'profile'. All people with either a mental health or a substance use disorder are at substantially more risk of also developing the other disorder. If we only screen clients with a certain profile, we are likely to fail to detect co-occurring disorders in a number of our clients. Our guiding principle should be that **all people receiving mental health or drug treatment services should be screened or assessed** for a co-occurring disorder.

When should we screen?

It is not uncommon for mental health or AOD treatment to have been underway for some time before it becomes apparent that a co-occurring mental health or substance use disorder exists, and that it is impacting negatively on treatment. If the co-occurring disorder had been recognised earlier, a treatment plan could have been developed that recognised the interplay of both disorders and their treatment needs. This potentially could mean a quicker return to healthy functioning for the client. Early recognition aids the development of the most useful possible treatment plan. Our guiding principle should be that all people receiving mental health or AOD treatment

services should be screened or assessed for a co-occurring disorder **at or near their first contact with the treating service.**

Engagement is paramount, however. While early screening is best practice, there will be situations in which screening for a co-occurring disorder may compromise the clinician's best efforts to engage a client (for example, if a client states: *'I came here because my wife wants me to address my depression and irritability. I am going to walk out the door if you ask me about my use of alcohol'*). In those situations, screening should be deferred until rapport and the patient's understanding of the rationale for screening permits screening.

Young people presenting with either mental health or substance use symptoms or disorders are at particularly high risk of also developing the other disorder. Even if they are not positive for a co-occurring disorder on initial contact, they may well develop that disorder during engagement with your service. Hence, with younger people, there should be some level of screening for a co-occurring disorder **at each contact.**

When shouldn't we screen?

Screening should be deferred when other treatment needs are more immediate. One would usually not screen for a co-occurring disorder when the client is intoxicated, distressed, in pain, in need of emergency treatment (Henry-Edwards, Humeniuk, Ali, Poznyak and Monteiro, 2003) or acutely psychotic.

It is unethical to screen for any condition when there isn't an accessible treatment pathway available to respond to a positive screen. This does not imply that the person conducting the screening or their service should necessarily be able to provide all of the required treatment themselves. Rather, where completely integrated treatment is not possible, the screening clinician should be confident in knowing where and how to link the client who screens positive to appropriate, evidence-based treatment of the screened-for disorder.

What are the criteria for choosing a screening tool?

There are a number of screening tools available to screen for either mental health or substance use disorders. The sections **Screens for mental health symptoms and disorders** and **Screens for substance use disorders** describe some of the screening tools currently used in Victorian mental health or AOD services.

When selecting screening tools for your service useful criteria may be:

- The tool's :
 - **reliability** (ability to consistently detect the disorder)
 - **validity** (how accurate the screen is in detecting the disorder)
 - **specificity** (the degree to which the screen accurately identifies those people who *do not* have the disorder)
 - **sensitivity** (the degree to which the screen accurately detects people who **do** have the disorder).
- How quickly and easily the tool can be used, scored and interpreted
- If the tool screens for substance use disorders, is it sensitive to **harmful use** as well as **dependence**?

-
- Does the tool screen for the gamut of possible disorders (for example, AUDIT only screens for alcohol use disorders whereas ASSIST screens for all substance use disorders / many mental health screens do not indicate possible psychotic disorders).
 - Is the tool acceptable to, and understood by, other services that your agency relies on for consultation about, and treatment of, the target disorder? For example, if an AOD service regularly uses K10 as a mental health screen, it is desirable that local mental health services also understand K10 scoring and the tool's strengths and limitations.
 - Can the client complete the tool or must it be administered by a clinician?
 - Is the tool in the public domain? Do you have to possess particular qualifications in order to use the tool?
 - Has the tool been well validated? Has the tool been validated with populations of people with mental health disorders, for example, with people with serious mental illness (SMI)?

Our service already assesses all clients for co-occurring mental health/substance use disorders. Should we be screening them as well?

Screening is best viewed as a quick yes/no guide as to whether a detailed assessment is warranted. If a service has the capacity, time and expertise to incorporate assessment of likely co-occurring disorders into their routine assessment process, then screening is superfluous. The reality is that many services and clinicians do not possess the necessary expertise, supports or time to routinely and adequately assess co-occurring disorders.

A pivotal question with assessment-only protocols is how adequate is the assessment of the co-occurring disorder? A number of older mental health assessment proformas contain some limited substance use assessment criteria. In general these do not provide the depth of fine-grained information necessary to inform effective integrated treatment planning for clients presenting with co-occurring mental health and substance use disorders.

Appendix 3: Sample substance use assessment form includes the minimum criteria necessary to include in a comprehensive substance use assessment. Such assessment proformas should be supported by training in conducting an accurate substance use assessment, policy, managerial 'buy-in' and file audit procedures.

What are the barriers to routine integrated screening, assessment and treatment?

There are a number of addressable factors that may mediate against mental health and AOD agencies developing routine screening, assessment and treatment of co-occurring disorders. The following chart lists some of these potential barriers and possible strategies to address them.

Barrier	Possible strategies
<p>Lack of awareness of:</p> <ul style="list-style-type: none"> • prevalence and harms associated with co-occurring disorders • likely interactions between disorders • treatment implications. 	<p>Provide this information in multiple formats, for example:</p> <ul style="list-style-type: none"> • training sessions • staff orientation procedures and manuals • client and carer education packages. <p>Build agency capacity to record dual diagnosis data (screening results).</p>
<p>Perception of added work, especially when clinicians may feel overwhelmed by multiple demands, stresses and paperwork, perhaps change-weary and change-wary!</p>	<p>Promote view that the goal is more effective rather than added work – that recognising and addressing co-occurring disorders is likely to lead to more successful treatment of our target disorders.</p> <p>When introducing a new screening or assessment form, take the opportunity to review and simplify existing assessment forms and processes and remove some of the existing paperwork burden.</p>
<p>Lack of familiarity with using screening tools and difficulty integrating their use into routine practice.</p>	<ul style="list-style-type: none"> • Provide information about the rationale for screening and assessment. • Provide training, modelling and clinical supervision around seamlessly integrating screening into routine practice. • Include careful explanation to clients of the rationale for and confidentiality of screening.
<p>Clinician concerns that client engagement may be compromised by formal screening for a disorder that the client hasn't presented for help with.</p>	
<p>Clinicians may lack skills, knowledge and confidence in their ability to provide appropriate treatment for a co-occurring disorder and so be reluctant to ask questions that would lead to the identification of that disorder.</p>	<ul style="list-style-type: none"> • Provide education, training and realistic evidence for optimism about effectiveness of treatment. • Address clinician 'self-efficacy' about providing effective treatment.
<p>Lack of clarity about scope of practice. For example, some AOD workers may have anxiety about whether it is within their scope of practice to conduct a detailed risk assessment?</p>	<ul style="list-style-type: none"> • Clarify explicit scope of practice guidelines and treatment manuals. • Promote tools which contain an integrated risk assessment, e.g. PsyCheck
<p>Implication of current 'wrong practice'.</p>	<p>Reframe the development of integrated screening, assessment and treatment as an evolutionary step towards more effective treatment approaches.</p>

<p>Changes to practice, language, beliefs, values, exclusion criteria.</p>	<p>Use policy to reinforce that addressing co-occurring disorders is core business for both mental health and AOD treatment agencies</p>
<p>Stigma of client group – two relapsing, highly stigmatised disorders in the one individual.</p>	<p>Encourage treatment providers to identify their own attitudes and feelings evoked by dealing with the disorder.</p>
<p>The clinician’s own cognitive dissonance: for example, to address my client’s substance use or mental health issue, it is necessary (at some level) to examine my own substance use or mental health issues.</p> <p>History of own substance-related or mental health-related trauma.</p>	<p>Provide integrated treatment-oriented clinical supervision.</p>
<p>Lack of knowledge of the ‘opposite’ treatment system, its strengths, differences and constraints on service.</p>	<p>Provide opportunities for understanding and maximise formal and informal contacts through:</p> <ul style="list-style-type: none"> • Rotations and placements with the opposite service • Joint training • Routine provision of service from the opposite agency. • Worker-developed protocols. • Co-location. • Scheduled, regular interagency managerial and clinician meetings

What are the issues in screening with younger people?

Compared to adults, younger people will tend to:

- be more likely to see substance use as a solution rather than a problem
- be more likely to be experimenting with a range of substances
- be **less** likely to meet the criteria for substance dependence (but will frequently meet the criteria for harmful use – see Appendix 5).

Key issues around screening for co-occurring substance use or mental health disorders in young people include:

1. **Confidentiality and disclosure** – in what circumstances should the results of a positive screen and assessment be shared with the young person's carers? In general, your agency's policies around consent and disclosure with 'target disorders' will also guide you around consent and disclosure about co-occurring disorders.
2. **The age at which screening should be instituted** – around one in four young people aged 12–14 years drink some alcohol and nearly a third of Australian children report binge drinking by age 15. The emerging consensus, among Victorian youth mental health services that have implemented substance use screening, is that around 12 years is an appropriate age to commence screening for co-occurring substance use issues.

Mental health disorders are highly prevalent among young people. Youth AOD service clinicians should be alert to the possibility of co-occurring mental health disorders, whatever the age of their clients.

3. **Screening approaches** – which tools are appropriate for use and when? Tools being used to screen for mental health disorders in young people presenting to Victorian youth AOD services include the K10 and the Youth Mental Health Screener, currently under development and evaluation by ORYGEN Research Centre and their partners: more details at <http://www.orygen.org.au/contentPage.asp?pageCode=SUBUSE>

Tools being used to screen for substance use disorders in young people presenting to Victorian mental health services include:

- ASSIST
- AUDIT (alcohol only)
- CRAFFT

The CAGE is not recommended for use among adolescents.

After screening – the next steps

Once a co-occurring disorder has been detected (through screening) and an assessment completed, the challenge facing mental health and AOD services and clinicians is to determine how they can best achieve the most effective treatment of both disorders.

Developing the most effective possible response to both disorders

An understanding of three key concepts can assist in the development of the most effective possible treatment for people with co-occurring disorders.

1. Locus of treatment responsibility
2. Integrated treatment
3. A 'no wrong door' service system

1. Locus of treatment responsibility

The predominant mix of co-occurring disorders tends to be different in AOD treatment and mental health settings. Most Clinical Mental Health Services and Psychiatric Disability Rehabilitation and Support Services (PDRSS) have a necessary focus on people with the highest acuity of need and/or more complex treatment needs as a result of having a Serious Mental Illness. People with these disorders are at high risk of either harmful use or dependence involving a wide range of substances. A different predominant cohort of people with co-occurring disorders is found in primary mental health settings, which tend to focus on people with high-prevalence, low-impact disorders or mental health disorders (such as anxiety and depression). People receiving treatment for anxiety and depression have a high prevalence of co-occurring alcohol harmful use or dependence.

In contrast, the primary focus of AOD treatment services tends to be on people with severe substance use disorders. People with severe substance use disorders often also experience anxiety and depression symptoms or disorders and/or personality disorder.

There is great variability in the treatment needs of the various cohorts of people with co-occurring disorders. Guidance about which sector of the treatment system should have treatment responsibility for the various cohorts can be found in the 2007 Victorian DHS Policy, *Dual Diagnosis: Key directions and priorities for service development*. This policy proposes a three-level schema for responding to dual diagnosis (see Figure 1).

This schema assigns treatment responsibility for the various cohorts of people with dual diagnosis to either specialist mental health (*Tier 3: People with Serious Mental Illness with or without a substance use disorder*), specialist drug treatment (*Tier 2: People with severe substance use disorders with or without symptoms of mental illness*) or primary care (*Tier 1: People experiencing lower severity mental health problems and lower severity drug and alcohol problems*).

2. Integrated treatment

The development of the most effective possible treatment responses to the needs of people with co-occurring disorders rests on providing or facilitating integrated treatment for both presenting disorders. Integrated treatment can be defined as one clinician or agency providing treatment of both a client's substance use and mental health disorders. Integrated treatment also occurs when clinicians from separate agencies collaborate to 'develop a single treatment plan addressing both sets of conditions and the continuing formal interaction and cooperation of these providers in the ongoing reassessment and treatment of the client' (CSAT, 2005) – that is, an **Integrated Treatment Plan**.



Integrated treatment may be provided by a clinician who treats both the client's substance use and mental health problems.

Integrated treatment can also occur when clinicians from separate agencies agree on an **individual treatment plan addressing both disorders** and then provide treatment.

This integration needs to continue after any acute intervention by way of formal interaction and co-operation between agencies in reassessing and treating the client.

Table 2: Integrated treatment defined
Dual Diagnosis: Key directions and priorities for service development
(2007 Victorian DHS)

The strongest indications, if not evidence, that we have from research suggest that integrated treatment of co-occurring disorders tends to be more effective than non-integrated treatment for many people with co-occurring disorders. On face value alone, it would appear to make sense not to require a client to have the skills and motivation to engage with and negotiate two different service systems; that is, to have the ingenuity and flexibility to compartmentalise their disorders sufficiently to work on them with separate clinicians in separate systems.

It is a reality of most service systems that the various clinicians, agencies and sectors have differing capacities to provide 'in-house', 'one-stop-shop', integrated treatment for the variety of mental health and substance use disorders. In fact, at this point in our evolution, few mental health or AOD agencies have the capacity to provide in-house, mono-agency, integrated treatment for the whole gamut of possible mental health and substance use disorders. Some services do have the capacity to provide such treatment for some of the cohorts of people with co-occurring disorders. All services should be actively developing their capacity to routinely develop integrated treatment plans with services from the 'other' sector. All services, if they do not already, should be rapidly developing their capacity to routinely develop integrated treatment plans with services from the 'other' sector.

Generally, mental health services do not have, and are unlikely to have, the capacity to provide routine opiate pharmacotherapies or to provide routine home-based, substance detoxification services; though they may at times need to dispense pharmacotherapies and routinely manage withdrawal in people undergoing psychiatric admission. Similarly AOD services cannot be expected to oversee the safety needs of a person who is acutely suicidal or to provide mental health treatment for a person with acute Serious Mental Illness, though they may at times provide drug treatment services to people with psychosis or continue engagement with a person who is suicidal while mental health services respond to the person's acute mental health needs.

However, in all of these cases:

- Screening by each sector increases the likelihood that co-occurring disorders will be recognised.
- Assessment of co-occurring disorders informs treatment planning and makes it more likely that treatment planning will be effective.
- Collaboration on an Integrated Treatment Plan increases the likelihood that treatment of all disorders will be effective.

The 2007 Victorian DHS Policy, *Dual Diagnosis: Key directions and priorities for service development*, provides guidance about optimal integrated and collaborative treatment responses to people with co-occurring disorders by AOD and mental health clinicians and services.

<p>Tier 3: People with severe mental health problems and disorders (Serious Mental Illness) with or without a substance use disorder</p>	<p>Dual diagnosis capable staff in specialist mental health services should:</p> <ul style="list-style-type: none"> • provide integrated treatment to the majority of clients with severe mental disorders and substance use • collaborate with drug and alcohol services in joint service provision for those whose needs are best met through collaboration across rather than within the service • provide secondary consultation to staff in other sectors regarding the treatment of mental health disorders
<p>Tier 2: People with severe substance use disorders with or without symptoms of mental illness</p>	<p>Dual diagnosis capable staff in drug and alcohol services should:</p> <ul style="list-style-type: none"> • provide integrated treatment to clients who experience severe substance use problems and lower severity mental health problems; • collaborate with mental health services in service provision; and • provide secondary consultation regarding the treatment of problematic drug and alcohol use to other sectors.

Table 3: Scope of practice for Victorian AOD and Mental Health clinicians and services in responding to the treatment needs of persons with dual diagnosis

Case examples: Integrated treatment

Integrated
Treatment
Examples

1.

AOD
agency

Multi
agency
integrated
treatment:

1 clinician
/ agency
treating
both
problems:

Client: Adam - 42 year old, separated, employed male referred from General Practitioner for help with Alcohol Dependence

Mental Health Screening: (with PsyCheck)

- no past treatment for any mental health disorder
- no suicidal ideation
- some mild symptoms of depression & anxiety

Treatment provided by AOD worker:

- Completed home based alcohol withdrawal
- Relaxation training
- Cognitive Behavioral Therapy addressing symptoms of depression
- Relapse Prevention plan developed for both disorders

Client: Eve - 22 year old, single unemployed female self-referred for assistance with Methamphetamine Abuse

Mental Health Screening: (with PsyCheck) indicated

- Sporadic episodes of treatment for anxiety since 17 years old (by local GP & private psychologist)
- moderate suicide risk
- marked symptoms of depression & anxiety

Further assessment indicated:

- Eve presents as irritable and suspicious with concerns that others can read her thoughts.

Treatment:

The AOD worker initiated a telephone consult with local Clinical Mental Health Service triage with the outcome that Eve agreed to an immediate joint appointment with the mental health worker and AOD worker. At that appointment a safety plan was negotiated involving support from Eve's parents and daily contact with mental health worker. At a subsequent joint appointment a Individual Service Plan, signed off by both services and the client, was developed which involved

- the mental health worker/service monitoring and managing Eve's suicidality
- AOD worker providing counselling around Eve's amphetamine use (Motivational Interviewing / Goal Setting / Relapse Prevention)
- Both workers communicating with the other after each contact with Eve and her family (consent forms signed by Eve)
- Further joint session when either service was planning discharge

Integrated Treatment Examples

2.

Clinical Mental Health

1 clinician / agency treating both problems:

Client: Darby - 22 year old male with a 5 year history of schizophrenia. Receiving treatment from GP only for past year and taking psychotropic medication as prescribed. Now presents with recurrence of auditory hallucinations and paranoid ideation. Nil suicidal ideation or history

AOD Screening: (with ASSIST)

- Showed, in the past 3 months, daily use of tobacco, weekly use of alcohol and weekly use of amphetamines
- Nil other recent substance use

Treatment provided by Mental Health clinician:

- Medication review with psychiatrist
- Detailed Substance Use Assessment completed including stage of change in regards to both treatment of psychosis (in Action) and use of amphetamines (Contemplative / ambivalent). Nil substantial issues with withdrawal
- ICD 10 substance use diagnoses recorded alongside ICD 10 psychiatric diagnoses
- Individual Service Plan developed that addressed both psychotic symptomatology and amphetamine use
- Brief Intervention and psycho-education provided around association between amphetamines and psychosis
- In the course of treating Darby's psychosis the mental health clinician used Motivational Interviewing strategies to address his use of amphetamines
- By discharge an integrated relapse prevention plan had been developed which addressed both psychotic symptomatology and amphetamine use.

Multi agency integrated treatment:

Client: Joan - 69 year old widowed woman referred to Aged Psychiatry by her GP with a 4 year history of social withdrawal, depression and possible dementia

AOD Screening: (with AUDIT)

- Score of 27 indicated likely Alcohol Dependence

Further assessment indicated:

- Memory clinic and diagnostic investigations did not reveal significant cognitive impairment
- Detailed Substance Use History revealed some abuse of prescribed medications and a 5-year history of alcohol abuse (since the death of her husband). Nil other substance use.

Treatment provided:

Mental Health worker sought consultation with local AOD service. An outcome was that the AOD and mental health worker conducted a joint home visit. An Individual Service Plan, signed off by both services and the client, was developed which involved:

- Local AOD service facilitating and supporting Joan through a hospital based alcohol withdrawal
- Mental Health service reviewing and monitoring Joan's medication, increasing social supports and discharge planning
- Each worker/ service regularly communicating with the other (and referring GP)

Integrated Treatment Examples

3.

Psychiatric Disability Support Service

1 clinician / agency treating both problems:

Client: Jill - 39 year old single woman with long standing engagement with the PDRS service and a 15 year diagnosis of Borderline Personality Disorder

AOD Screening: (with ASSIST)

- Revealed, in the past 3 months, weekly use of alcohol, sedatives or sleeping pills and monthly use of opioids

Treatment provided by PDRSS worker:

- Completed a detailed substance use history
- In counseling Jill examined the links between substance use and periods of maximum distress.
- With her worker Jill refined her Individual Treatment Plan to put in place further, substance use related, early warning signs of self-destructive behavior as well as suggestions of how she would prefer workers to respond when these early warning signs occur

Multi agency integrated treatment:

Client: Jack - 42 year old, divorced, unemployed man with 15 year history of schizoaffective disorder. Lives in independent accommodation with near daily support from the PDRS service

AOD Screening: (with ASSIST)

- Revealed daily use of tobacco, cannabis and alcohol over the past 3 months

Further assessment:

- PDRSS worker completed a detailed substance use assessment which recognised that Jack was keen to moderate his use of alcohol but had found this difficult due to withdrawal symptoms. Precontemplative about use of tobacco and cannabis.

Treatment provided :

PDRSS worker sought consultation with local AOD service and then accompanied Jack to an initial appointment with the local AOD service. An Individual Treatment Plan, signed off by both services and the client, was developed which involved:

- the AOD and PDRS worker jointly supporting Jack through a home-based withdrawal
- Both AOD & PDRS workers opportunistically deploying Motivational Interviewing strategies addressing Jack's cannabis use
- Frequent communication between the workers / services and a date set to again review Jack's progress and Individual Treatment Plan
- AOD agency providing the PDRS staff with education on Motivational Interviewing and withdrawal.
- PDRS service providing the AOD staff with education on Psychiatric Disability and strengths-based interventions

3. 'No wrong door' service system

The 2007 Victorian DHS Policy, *Dual Diagnosis: Key directions and priorities for service development* prioritises the further development of a No Wrong Door service system. This goal has been developed around the recognition that people with both a mental health and a substance use disorder are at high risk of 'falling through the gaps' and missing out on receiving an appropriate service from anywhere in the service system.

In a No Wrong Door service system, in those cases where a person is assessed and it is deemed that they do not meet the criteria for a service from the agency that they have presented to, but that service from another agency is indicated, then that person should still be warmly welcomed and actively and meaningfully assisted in gaining a service from the most appropriate treatment agency (Croton, 2004).

The chief implication for workers in either system is that, when they encounter a person who does not meet the criteria for service from their own agency, their next step should be to work with that person to establish where they are likely to get the most useful service and to actively assist the person to obtain that service.

No wrong door case example

Paul

John, a mental health worker, was called out at 2 am to assess Paul. Paul had been found alcohol intoxicated, walking on a bridge over a railway line, with contusions from an earlier altercation. Due to the location in which he had been found, emergency department staff had concerns that Paul may have been suicidal.

On assessment Paul is a 36-year-old, separated, unemployed male with two children. He is cooperative, pleasant, alcohol affected but lucid and convincingly denies past or present suicidal ideation. He has a breathalyser reading of 1.4. John quickly established that Paul meets the criteria for alcohol dependence.

John engaged well with Paul and was successful in getting Paul to agree to come and see him early the following afternoon. In that session, they discuss the previous night's events. John assists Paul to develop his decisional balance around alcohol use and establishes that Paul is interested in making some changes to his alcohol consumption.

Paul agrees to John's proposal of a further appointment (still in the mental health service office). He also agrees that John will ask a colleague from the local AOD service to their next meeting, who would be better placed to assist Paul with working on his alcohol use goals.

Are we going to have to treat more people?

We are a mental health service. Does all this mean that we are going to have to treat people with substance use disorders AS WELL as people with mental health disorders?

We are an AOD service. Does all this mean that we are going to have to treat people with mental health disorders AS WELL as people with substance use disorders?

It is not intended that either mental health or AOD services should vary their primary criteria for entry to their service system. Rather, that where people who do meet criteria for their services **also** have a co-occurring disorder, that co-occurring disorder will be routinely detected and assessed, and a Integrated Treatment Plan developed that responds to both mental health and substance use treatment needs. The goal is to have mental health workers highly attuned to co-occurring substance use issues and substance use treatment workers highly attuned to co-occurring mental health issues.

Mental health services will not be treating people who have a substance use disorder alone. AOD services will not be treating people who have a mental health disorder alone.

In pursuit of a No Wrong Door service system, both AOD and mental health services may, in some circumstances, briefly invite someone without the necessary substance use disorder criteria (in the case of AOD) or mental health criteria (in the case of mental health services) into their systems with the sole aim of linking that person as efficiently as possible to the service system that best meets their particular treatment needs.

Screens for mental health symptoms and disorders

What are they and where can I get them?

K10

The K10 is a screening tool that can also be used as a rating scale/outcome measure.

The K10 was primarily designed to detect high-prevalence mental health disorders, but there is also an argument that high K10 scores may be an indicator of possible Serious Mental Illness.

The K10 is now in widespread Australian and international use - for example, as a Victorian Service Coordination Tool, a NSW mental health routine outcome measure, and by organisations such as the Armed forces, Beyond Blue and by doctors in General Practice. The K10 was used in the 1997 Australian National Survey of Mental Health and Wellbeing.

Scores range from 10 to 50:

K10 score	Level of anxiety or depressive disorder	SCT K10 version recommended responses
10 to 15	Low or no risk	-----
16 to 29	Medium risk	Refer for primary care mental health assessment
30 to 50	High risk	Refer for specialist mental health assessment

Screens for: Distress

Time to complete and score: 10 items – 2 minutes

Public domain? Yes

Can client complete it? Yes. The K10 can also be interviewer-administered to people with poor reading ability.

Where can I get it?

Service Coordination Tool Templates (SCTT) version:

http://www.health.vic.gov.au/pcps/downloads/coordination/tool_profile_psychosocial_may02.pdf

Online electronic version and scoring: http://www.beyondblue.org.au/index.aspx?link_id=1.237

More information:

<http://www.crufad.com/K10/k10info.htm>

Strengths:

- Brief
- Very easy to use
- Well known
- Client can complete
- SCTT version contains graduated guidelines about need for mental health assessment
- Can be used as a outcome measure.

Possible limitations:

- Non-specific measure of psychological distress only; still requires clinician judgment as to whether a person needs mental health treatment.
- Most specialist mental health services are orientated primarily around Serious Mental Illness – the K10 is less sensitive to these disorders.

PsyCheck

'The PsyCheck Screening Tool is a mental health screening instrument designed for use by non-mental health specialists. It is not designed to be a diagnostic assessment and will not yield information about specific disorders' (Lee et al., 2007).

Now that PsyCheck is in the public domain, it may well become the 'gold standard' for Australian AOD services.

PsyCheck is comprised of:

- Self Reporting Questionnaire (WHO mental health screen)
- Suicide risk assessment
- Brief mental health history
- Mental health probes.

In sites where the PsyCheck project was rolled out as a demonstration project, workers were skilled up in deploying a linked cognitive behavioural intervention in response to positive PsyCheck screens.

Screens for:

- Likely presence of mental health symptoms that may be addressed within specialist AOD treatment services.
- Primarily screens for anxiety and depression but also provides some indication of suicide risk and history of psychotic illness.

Public domain?

Yes

More information:

Lee, N., Jenner, L., Kay-Lambkin, F., Hall, K., Dann, F., Roeg, S., Hunt, S., Dingle, G., Baker, A., Hides, L. & Ritter, A. (2007), *PsyCheck: Responding to mental health issues within alcohol and drug treatment*, Canberra, ACT: Commonwealth of Australia.

Can client complete it?

No

Strengths:

- Attached optional risk assessment
- Likely to be in wide-spread use in Australian AOD services once in the public domain
- Linked cognitive behavioural intervention
- Australian developed.

Possible limitations:

- Not yet in widespread use

Modified Mini Screen (MMS)

Screens for:

The MMS is designed to identify people in need of an assessment in the domains of mood disorders, anxiety disorders and psychotic disorders. It is not diagnostic per se, but is intended as an indicator of when more thorough mental health assessment is required.

Time to complete and score: 10 to 15 minutes

Public domain?

Yes

Can client complete it?

Yes (not scoring)

Where can I get it?

OASAS – MMS Tool: <http://www.oasas.state.ny.us/hps/research/documents/MMSTool.pdf>

OASAS – Screening for co-occurring disorders using the Modified Mini Screen (MMS) – User's Guide: <http://www.oasas.state.ny.us/hps/research/documents/MINIScreenUsersGuide.pdf>

Connecticut Department of Mental Health and Addiction Services:

<http://www.dmhas.state.ct.us/cosig.htm#screening>

(English and Spanish versions paired with CAGE-AID AOD screen.)

Mental Health Screening Form

Screens for:

17-item screen that examines lifetime history. Questions 1–4 are about client's history of psychiatric treatment. Each of questions 5–17 is associated with a particular mental health diagnosis. Positive responses to these items suggest the need for more intensive assessment or consultation with a mental health professional.

Time to complete and score: About 10 minutes

Public domain?

Yes

Can client complete it?

Yes (not scoring)

Where can I get it?

Versions available at:

<http://www.asapnys.org/Resources/mhscreen.pdf>

http://pathwayscourses.samhsa.gov/bully/pdfs_bully/bully_supps_pg40.pdf

Connecticut Department of Mental Health and Addiction Services:

<http://www.dmhas.state.ct.us/cosig.htm#screening>

(English and Spanish versions paired with Simple Screening Instrument for Alcohol and Other Drugs).

Screens for substance use disorders

What are they and where can I get them?

Sensitive Questioning

Clinician concerns about introducing screening tools into their practice are common (see FAQs section, **What are the barriers to routine integrated screening, assessment and treatment?**). Clinicians may feel that the use of a validated screen will impede their engagement with the client, disrupt the client's narrative or be unwelcome by the client when s/he has presented due to concerns other than substance use.

Clinicians may already routinely incorporate questions about substance use into their mental state assessments. Whether such questions will be effective in detecting co-occurring substance use disorders will depend on a number of factors, including:

- clinician's attitude to and beliefs about people with (highly-stigmatised) substance use disorders
- clinician's orientation to detecting and responding to less visible substance abuse as well as substance dependence
- clinician's recognition of the prevalence of co-occurring substance use disorders in people with mental health disorders
- clinician's understanding of likely impacts on treatment effectiveness of a co-occurring substance use disorder
- clinician's confidence and competence in providing or obtaining treatment for any co-occurring substance use disorder detected
- how the questions are worded.

Useful strategies:

For initial screening purposes, all questions should be open-ended and non-judgemental. '*Do you have a problem with your use of alcohol or other drugs?*' is both close-ended and judgemental. A better strategy would be to normalise possible substance use (e.g. '*Many people experiencing all this would have a drink to help them cope*') before asking an open-ended question (*Could you tell me about your use of alcohol?*).

In general, clinicians should ask about all drugs, naming them individually, and provide clear timelines for their enquiry. Question 2 of the ASSIST screen provides an ideal template for such questioning (i.e. *Could you tell me about your use, in the past 3 months of Tobacco / Alcohol / Cannabis / Cocaine / Amphetamine-type stimulants / Inhalants / Sedatives or Sleeping Pills / Hallucinogens / Opioids*).

Incorporate questions about substance use into routine lifestyle questioning. An explanation to the client around the common interacting effects of substance use with mental health issues may increase the likelihood of the client providing accurate information.

Principle: If the client is reluctant to disclose information about their substance use, this is important feedback to the assessing clinician about the client's perception of the clinician's attitude and language (i.e. the client's may perceive that the clinician is negatively judging their substance use) and an indicator that the clinician should be at pains to convey a neutral, inquisitive attitude to the client's substance use

Sensitive questioning, as with other screening methods, should be supported by the clinician's knowledge of physical and behavioural presentations that may indicate possible substance use disorders. Clinicians should be alert to the reports of significant others and, where available, note relevant pathology/laboratory reports.

Jumping into providing advice or commenting on a client's substance use in the screening/assessing phase of client engagement is likely to impede their willingness to provide further information.

Some possible questions:

Has a relative, friend, doctor or other health worker been concerned about your drinking or other drug use, or suggested that you may want to cut down?

Have you ever said "No, I don't have an alcohol or drug problem" when, around the same time, you questioned yourself and felt, "Maybe I do have a problem"?

Strengths:

- May dovetail more smoothly with strictly narrative assessment approaches.

Possible limitations:

- Where clinicians lack comfort and confidence in detecting and responding to co-occurring substance use issues, ineffective questioning approaches can become a strategy to avoid dealing with client's co-occurring substance use disorders.

AUDIT

Screens for:

- Alcohol use disorders (past-year time frame).
- 'Gold standard' for providing an indication of both hazardous/harmful alcohol use as well as alcohol dependence.

Created by:

World Health Organisation.

Time to complete and score:

- 10 items, each with a 5-point likert scale.
- 2 minutes to complete & 1 minute to score.
- May well prompt a brief intervention.

Scoring:

- 0-7: Low risk
- 8-15: Harmful or hazardous drinking
- >15: High risk of harm & possible alcohol dependence
- >20: Definite harm and likely to be dependant

Sub-scores:

- High scores on items 1-3 suggests hazardous use
- High scores on items 4-6 suggests dependence
- High scores on items 7-10 suggests harmful use.

Treatment responses:

- Scores between 8 and 15 are most appropriate for simple advice focused on the reduction of hazardous drinking.
- Scores between 16 and 19 suggest brief counseling and continued monitoring.
- Scores of 20 or above clearly warrant further diagnostic evaluation for alcohol dependence (2001, Babor, Higgins-Biddle, Saunders, Monteiro)

Public domain? Yes

Can client complete it? Yes

Where can I get it?

This tool is available from many websites.

The WHO's *Alcohol Use Disorders Identification Test Guidelines for Use in Primary Care* is downloadable from http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf

Australian Government Department of Veterans' Affairs has a very well-constructed example (with scoring guidelines) available at <http://www.therightmix.gov.au/pdfs/HealthProviderAUDIT.pdf>

Strengths:

- Screens for the whole range of possible substance use disorders (particularly suitable for specialist mental health services)
- Indicates both likely abuse and dependence
- Also generates detailed assessment information
- Has a linked brief intervention that is likely to be effective with people with problematic or risky substance use (rather than dependence).

Possible limitations:

Requires some concentrated effort to incorporate seamlessly into routine practice.

ASSIST

Screens for:

- substances people ever used (lifetime use)
- substances used in past three months
- problems related to substance use
- risk of harm (current or future)
- dependence
- intravenous drug use.

The ASSIST can ...

- warn people of their risk of developing problems related to their substance use
- provide an opportunity to start a discussion about substance use
- identify substance use as a contributing factor to the presenting illness
- be linked to a brief intervention to help high-risk substance users to cut down or stop their drug use and avoid the harmful consequences of their substance use.

The ASSIST can distinguish between three main groups:

- low-risk substance users or abstainers
- those whose patterns of use put them at risk of problems/who have already developed problems/who are at risk of developing dependence
- those who are dependent on a substance.

Time to complete and score:

An experienced clinician can conduct an ASSIST screen and deliver the integrated brief intervention in 10 to 20 minutes.

Public domain? Yes

Can client complete it? No. This tool is clinician administered.

Where can I get it?

The ASSIST questionnaire is available from: http://www.who.int/substance_abuse/activities/assist/en/index.html
(Versions in English, German, Hindi, Portuguese)

Manual: [ASSIST: Guidelines for Use in Primary Care \[PDF 244kb\]](#)

Manual: [Brief Intervention for Substance Use: A Manual for Use in Primary Care \[PDF 164kb\]](#)

Manual: [Self-Help Strategies for Cutting Down or Stopping Substance Use: A Guide \[PDF 424kb\]](#)

Project fact sheets and validation report.

Strengths:

- Indicates both likely abuse and dependence
- Generates some assessment information
- Has a linked brief intervention that is likely to be effective with people with problematic or risky substance use (rather than dependence).

Possible limitations:

- Requires some concentrated effort to incorporate into routine practice.

CAGE / CAGEAID

Screens for:

CAGE is a 4-item screen useful for detecting alcohol dependence.

CAGEAID (Adapted to Include Drugs) has been developed to screen for severe drug use disorders.

Time to complete and score: 1 minute

Public domain? Yes

Can client complete it? No. This tool is clinician administered.

Where can I get it?

Right here:

CAGE:

- Have you ever felt you should cut down on your drinking?
- Have people annoyed you by criticising your drinking?
- Have you felt bad or guilty about your drinking?
- Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)?

CAGEAID:

- Have you felt you ought to cut down on your drinking or drug use?
- Have people annoyed you by criticising your drinking or drug use?
- Have you felt bad or guilty about your drinking or drug use?
- Have you ever had a drink or used drugs first thing in the morning to steady your nerves, get rid of a hangover or to get the day started?

Scoring: Two positive answers indicate need for more detailed assessment.

Strengths:

- No training necessary to be able to administer
- Easily memorised.

Possible limitations:

- Only indicates dependence. Not sensitive to abuse
- Not suitable for use with younger people.

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Appendix 1: Sample screening protocol for a mental health service

Protocol Screening for co-occurring Substance Use Disorders

Agency:

This service:

- Recognises that people receiving treatment for a mental health disorder are at substantially increased risk of also experiencing a substance use disorder.
- Considers that mental health and substance use disorders most often, where they co-occur in an individual, will influence each other and are likely to impact on the individual in regard to development of the disorders, their severity, their response to treatment and their relapse circumstances.
- Recognises that recognising, assessing and developing Integrated Treatment Plans that address co-occurring substance use disorders is core business for this service.
- Considers that improving our detection of co-occurring substance use problems is likely to improve the effectiveness of our treatment of mental health disorders.
- Prioritises timing the screening for and assessment of co-occurring substance use disorders as close as practicable to a client's initial contact with the service.
- Supports the following range of approaches to the detection and assessment of co-occurring substance use problems.

Approach 1:

- When providing a mental health assessment, clinicians from this service will routinely incorporate detailed questioning about substance use in the past three months. They will ask specifically about use of each of:

Substances	Used in past three months?
Tobacco	
Alcohol	
Cannabis	
Cocaine	
Amphetamine-type stimulants	
Sedatives	
Hallucinogens	
Inhalants	
Opioids	
Other drugs	

- Positive response to any of the latter nine items will trigger the delivery of a full substance use assessment.
- Identification of any substance use disorder in assessment triggers integrated recording of substance use disorder diagnosis/es alongside mental health diagnosis/es and integrated treatment planning around both disorders.

Approach 2:

- Routine screening using WHO ASSIST screen.
- Utilise ASSIST guide to type of intervention being determined by ASSIST score (below). Tempered by clinician judgement/immediate treatment priorities.

THE TYPE OF INTERVENTION IS DETERMINED BY THE PATIENT'S SPECIFIC SUBSTANCE INVOLVEMENT SCORE

	Record specific substance score	no intervention	receive brief intervention	more intensive treatment *
a. tobacco		0 - 3	4 - 26	27+
b. alcohol		0 - 10	11 - 26	27+
c. cannabis		0 - 3	4 - 26	27+
d. cocaine		0 - 3	4 - 26	27+
e. amphetamine		0 - 3	4 - 26	27+
f. inhalants		0 - 3	4 - 26	27+
g. sedatives		0 - 3	4 - 26	27+
h. hallucinogens		0 - 3	4 - 26	27+
i. opioids		0 - 3	4 - 26	27+
j. other drugs		0 - 3	4 - 26	27+

- If the person qualifies for either a **brief intervention** or **more intensive treatment**, then this should trigger a full substance use assessment (see Appendix 3).

- If assessment confirms diagnosis of a substance use disorder, then this will usually trigger

- i) integrated recording of substance use disorder diagnosis/es alongside mental health diagnosis/es, and
- ii) integrated treatment planning around both disorders.

Approach 3:

- Routine detailed substance use assessment of all people receiving a mental health assessment.

- Identification of any substance use disorder in assessment triggers:

- i) integrated recording of substance use disorder diagnosis/es alongside mental health diagnosis/es, and
- ii) integrated treatment planning around both disorders.

Situations where routine screening should be deferred:

Routine screening will be deferred when the client is intoxicated, distressed, in pain, in need of emergency treatment or acutely psychotic.

Appendix 2: Sample screening protocol for an AOD treatment service

Protocol Screening for co-occurring Mental Health Disorders

Agency:

This service:

- Recognises that people receiving treatment for a substance use disorder are at increased risk of also experiencing a mental health disorder.
- Considers that substance use and mental health disorders most often, where they co-occur in an individual, will influence each other and impact on the individual in regard to the development of the disorders, their severity, their response to treatment and their relapse circumstances.
- Recognises that recognising, assessing and developing Integrated Treatment Plans that address co-occurring mental health symptoms and disorders is core business for this service.
- Considers that improving our detection of co-occurring mental health problems is likely to improve the effectiveness of our treatment of substance use disorders.
- Prioritises timing screening co-occurring mental health symptoms and disorders as close as practicable to a client's initial contact with the service.
- Supports the following range of approaches to the detection of co-occurring mental health problems:

Approach 1:

- Use of K10 (SCTT tool).

Approach 2:

- Use of Mental Health Screening Form.

Both approaches:

- Identification of a possible mental health disorder triggers:
 - i) decision about whether assessment of likely mental health disorder is feasible in-house, or whether referral to or consultation with specialist mental health provider is warranted.
 - ii) mental health assessment.
 - iii) recording of mental health diagnosis/es alongside substance use disorder diagnosis/es, and
 - iv) integrated treatment planning around both disorders.

Situations where routine screening should be deferred:

Routine screening will be deferred when the client is intoxicated, distressed, in pain, in need of emergency treatment or acutely psychotic.

Appendix 3: Sample substance use assessment form

Substance use assessment									
Assess each of caffeine / tobacco / alcohol / cannabis / cocaine / amphetamine-type stimulants / sedatives / hallucinogens / inhalants / opioids / other drugs (e.g. steroids)									
Tip: Start with legal, 'innocuous' substances first. Normalise substance use. Consider multiple sources of information.									
Substance →									
Age of first use:									
Age of first regular use:									
Usual method of use:									
Ever used I.V.? Age of first I.V.?									
Average daily use: (\$ / std. drinks / grams / bongs /points / hits)									
Days used in past 7 days									
Days used in past month									
Date and time of last use:									
How long has use been daily?									
Periods of abstinence:									
Apparent stage of change:									
Stage of change: Precontemplation ... Contemplation ... Action ... Maintenance ... Lapse ... Relapse									

Risk of withdrawal: Yes No

Action in response:

.....

.....

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ICD 10 substance use diagnosis/es: (also record with mental health diagnosis/es)

.....
.....
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.....

Brief intervention: Yes No

Details:

.....
.....
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.....
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.....
.....
.....

Integrated treatment planning: Yes No

Wholly in-house treatment planned: Yes No

If not, other agencies /workers to be involved:

.....
.....

Consent signed: Yes No

Their roles:

.....
.....


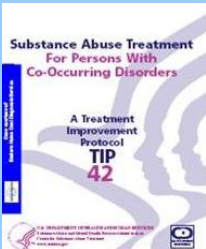
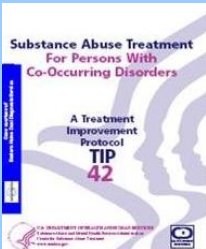
Consent for workers from each agency to communicate and share notes after each contact:

Yes **No**

Where is service to be delivered: (often preferable to all be from the one agency)

.....
.....

Appendix 4: Integrated Treatment Plans

Context:	
<p>Dual diagnosis: Key directions & priorities for service development.</p> <p>(2007, Victorian DHS)</p> 	<ul style="list-style-type: none"> • Integrated treatment may be provided by a clinician or treating team within the one service addressing both a person's substance use and mental health problems. • It can also be provided by staff of separate agencies working together to agree and implement an individual treatment plan.
<p>TIP 42: Substance Abuse Treatment for Persons with Co-Occurring Disorders</p> <p>(SAMHSA, 2005)</p> 	<ul style="list-style-type: none"> • Integrated treatment can also occur when clinicians from separate agencies agree an individual treatment plan addressing both disorders and then provide treatment. • This integration needs to continue after any acute intervention by way of formal interaction and co-operation between agencies in reassessing and treating the client.
<p>TIP 42: Substance Abuse Treatment for Persons with Co-Occurring Disorders</p> <p>(SAMHSA, 2005)</p> 	<ul style="list-style-type: none"> • Integration requires the participation of providers trained in both substance abuse and mental health services to develop a single treatment plan addressing both sets of conditions and the continuing formal interaction and cooperation of these providers in the ongoing reassessment and treatment of the client. • The threshold for integration relative to collaboration is the shared responsibility for the development and implementation of a treatment plan that addresses the co-occurring disorders

Integrated Treatment Plan (sample proforma)

Integrated Treatment Plan (sample proforma)							
Purpose: Plan and deliver integrated treatment when multiple agencies are involved (when it is not possible for a single agency to provide integrated assessment and treatment of both mental health and substance use needs).							
Name: John Smith				Address: Beyond the black stump			
AOD agency identifier: 123456				Mental health identifier: 654321			
Agencies involved: - Black Stump Primary Mental Health - Black Stump Alcohol & Other Drug Service				Consent – has client consented to interagency referral?		Yes	No
				Interagency communication: AOD & mental health workers agree to communicate <ul style="list-style-type: none"> In person / per phone / per letter After each client contact <input type="checkbox"/>Yes <input type="checkbox"/>No On the/...../..... at 			
Participants involved: (client, carers, workers) - John (client) - Jane (wife) - Jill (Counsellor – Black Stump Primary Mental Health) - Jim (Counsellor – Black Stump Alcohol & Other Drug Service)							
Need category	Current situation	Identified Goals	Strategy / Responsibility	Timing/dates	Outcome	Outcome date	
Emotional and mental wellbeing	In treatment for anxiety and depression associated with alcohol dependence	John aims to drink only two nights per week	Supervise home-based alcohol withdrawal and initial month of alcohol abstinence (Jim / John / Jane / GP)	Commence after next GP appointment (tomorrow)			
		Reduction in symptoms of anxiety & depression	Practice stress management techniques (John / Jane / Jill)	Daily			
			Continue CBT counselling / monitor mental state (John / Jill)	Next appointment in one week			

Appendix 5: ICD 10 Substance use disorder diagnoses ready reckoner

Suggestion: print (double-sided) & laminate the following 2 pages as a desktop aid to assist mental health clinicians to accurately record co-occurring substance use disorders

ICD 10 Ready Reckoner	Mental and behavioural disorders due to psychoactive substance use
A tool to assist in the recording of co-occurring substance use disorders diagnoses	ICD 10 – Mental and behavioural disorders due to psychoactive substance use can be found (full-text) at http://www3.who.int/icd/vol1htm2003/fr-icd.htm
<i>Dual diagnosis best practice:</i>	Substance use diagnosis/es are routinely recorded alongside mental health diagnoses

ICD 10 Disorders due to psychoactive substance use		Clinical state								
		.0 Acute intoxication	.1 Harmful use	.2 Dependence syndrome	.3 Withdrawal state	.4 Withdrawal state with delirium	.5 Psychotic disorder	.6 Amnesic syndrome	.7 Residual and late-onset psychotic disorder	.8 Other mental and behavioural disorders
<div style="display: flex; flex-direction: column; align-items: center;"> <div style="margin-bottom: 10px;">→</div> <div style="margin-bottom: 10px;">Substance involved</div> <div style="margin-bottom: 10px;"><i>Mental and behavioural disorders due to use of ...</i></div> <div>→</div> </div>	F10 ALCOHOL	F10.0	F10.1	F10.2	F10.3	F10.4	F10.5	F10.6	F10.7	F10.8
	F11 OPIOIDS	F11.0	F11.1	F11.2	F11.3	F11.4	F11.5	F11.6	F11.7	F11.8
	F12 CANNABINOIDS	F12.0	F12.1	F12.2	F12.3	F12.4	F12.5	F12.6	F12.7	F12.8
	F13 SEDATIVES or HYPNOTICS	F13.0	F13.1	F13.2	F13.3	F13.4	F13.5	F13.6	F13.7	F13.8
	F14 COCAINE	F14.0	F14.1	F14.2	F14.3	F14.4	F14.5	F14.6	F14.7	F14.8
	F15 Other STIMULANTS, <i>inc. caffeine</i>	F15.0	F15.1	F15.2	F15.3	F15.4	F15.5	F15.6	F15.7	F15.8
	F16 HALLUCINOGENS	F16.0	F16.1	F16.2	F16.3	F16.4	F16.5	F16.6	F16.7	F16.8
	F17 TOBACCO	F17.0	F17.1	F17.2	F17.3	F17.4	F17.5	F17.6	F17.7	F17.8
	F18 volatile SOLVENTS	F18.0	F18.1	F18.2	F18.3	F18.4	F18.5	F18.6	F18.7	F18.8
	F19 MULTIPLE drugs & OTHER substances	F19.0	F19.1	F19.2	F19.3	F19.4	F19.5	F19.6	F19.7	F19.8

Chapter V ICD 10: ‘This block contains a wide variety of disorders that differ in severity and clinical form but that are all attributable to the use of one or more psychoactive substances, which may or may not have been medically prescribed. The third character of the code identifies the substance involved, and the fourth character specifies the clinical state. The codes should be used, as required, for each substance specified, but it should be noted that not all fourth-character codes are applicable to all substances.’

Eastern Hume Dual Diagnosis Service



Checklist criteria for the various clinical states

Clinical state	Criteria	Check	
.0 Acute intoxication <i>A condition that follows the administration of a psychoactive substance resulting in:</i>	Disturbances in level of consciousness, cognition, perception, affect or behaviour, or other psycho-physiological functions and responses		
	The disturbances are directly related to the acute pharmacological effects of the substance and resolve with time, with complete recovery, except where tissue damage or other complications have arisen.		
	Complications may include trauma, inhalation of vomitus, delirium, coma, convulsions and other medical complications. The nature of these complications depends on the pharmacological class of substance and mode of administration.		
.1 Harmful use	A pattern of psychoactive substance use that is causing damage to health.		
	The damage may be physical (e.g. <i>hepatitis from injecting</i>) or		
	mental (e.g. <i>episodes of depressive disorder secondary to heavy alcohol consumption</i>).		
.2 Dependence syndrome	A cluster of behavioural, cognitive and physiological phenomena that develop after repeated substance use and typically include ...	a strong desire to take the drug	
		difficulties in controlling its use	
		persisting in its use despite harmful consequences	
		a higher priority given to drug use than to other activities and obligations	
		increased tolerance	
		sometimes, a physical withdrawal state.	
.3 Withdrawal state	A group of symptoms of variable clustering and severity occurring on absolute or relative withdrawal of a psychoactive substance after persistent use of that substance.		
	Onset and course of the withdrawal state are time-limited and are related to the type of substance and dose being used immediately before cessation or reduction of use.		
	The withdrawal state may be complicated by convulsions.		
.4 Withdrawal state with delirium	A condition where the withdrawal state (as defined in .3 above) is complicated by delirium.		
	Convulsions may also occur.		
.5 Psychotic disorder <i>A cluster of psychotic phenomena that occur during or following psychoactive substance use</i>	Not explained on the basis of acute intoxication alone.		
	Does not form part of a withdrawal state.		
	The disorder is characterised by ...	hallucinations (typically auditory, but often in more than one sensory modality)	
		perceptual distortions	
		delusions (often of a paranoid or persecutory nature)	
		psychomotor disturbances (excitement or stupor)	
		abnormal affect, which may range from intense fear to ecstasy.	
The sensorium is usually clear but some degree of clouding of consciousness, though not severe confusion, may be present.			
Excludes: alcohol or other substance-induced residual and late-onset psychotic disorder.			
.6 Amnesic syndrome <i>A syndrome associated with chronic prominent impairment of recent and remote memory</i>	Immediate recall is usually preserved and recent memory is characteristically more disturbed than remote memory.		
	Disturbances of time sense and ordering of events are usually evident, as are difficulties in learning new material.		
	Confabulation may be marked but is not invariably present.		
	Other cognitive functions are usually relatively well preserved and amnesic defects are out of proportion to other disturbances.		
.7 Residual & late-onset psychotic disorder	A disorder in which alcohol- or psychoactive substance-induced changes of cognition, affect, personality or behaviour persist beyond the period during which a direct psychoactive substance-related effect might reasonably be assumed to be operating.	Onset of the disorder should be directly related to the use of the psychoactive substance.	
		Cases in which initial onset of the state occurs later than episode(s) of such substance use should be coded here only where clear and strong evidence is available to attribute the state to the residual effect of the psychoactive substance.	
		Flashbacks may be distinguished from psychotic state partly by their episodic nature, frequently of very short duration and by their duplication of previous alcohol- or other psychoactive substance-related experiences.	
.8	.9		
Other mental and behavioural disorders	Unspecified mental and behavioural disorder		

Appendix 6: Victorian Dual Diagnosis Teams – Contacts:

VDDI Education and Training Unit	
VDDI Education & Training Unit (State-wide) St Vincent's Hospital Nicholson St (PO Box 2900) Fitzroy VIC 3065 T: 03 9288 2383	
Metropolitan Lead Agencies	
Addiction Consulting Eastern Dual Diagnosis Team Ground Floor, 43 Carrington Rd Box Hill VIC 3128 T: 03 9843 1277	Metro: Central East, Outer East Rural: Eastern Hume
Northern NEXUS St Vincent's Hospital P.O. Box 2900 Fitzroy VIC 3065 T: 03 9288 3824	Metro: Yarra, Boroondara, Banyule, Nilumbik Rural: Loddon and Northern Mallee
Southern Dual Diagnosis Service c/- SEADS 2/229 Thomas St, Dandenong VIC 3175 T: 03 8792 2330	Metro: Port Phillip, Kingston, Bayside, Greater Dandenong, Casey, Cardinia, Mornington Peninsula, Frankston, parts of Monash, Glen Eira, Stonington Rural: Gippsland and La Trobe Valley
SUMITT (Western) 3-7 Eleanor St, Footscray VIC 3011 T: 03 8345 6682	Metro: Maribyrnong, Wyndham, Brimbank, Hobsons Bay, Melton, Moonee Valley, Moreland, Hume, Darebin, Melbourne City, and Whittlesea Rural: Grampians, Barwon, South West and Goulburn Valley
VDDI Rural Services	
Barwon Barwon Health, Drug Treatment Service 40 Little Malop St Geelong VIC 3220 T: 03 5273 4000	Gippsland Gippsland Dual Diagnosis Box 424, Traralgon VIC 3844 T: 03 5128 0009
Glenelg South West Health Care Lava St (PO Box 197) Warrnambool VIC 3280 T: 03 5561 3813	Goulburn - Monash St, Shepparton VIC 3630 T: 03 5832 2111 - PO Box 800, Seymour VIC 3660 T: 03 5735 0333
Grampians Grampians Psychiatric Services P.O Box 577 Ballarat VIC 3356 T: 03 5320 4100	Loddon Bendigo Health Care Group PO Box 126, Bendigo 3550 VIC T: 03 5454 7608
Eastern Hume Eastern Hume Dual Diagnosis Service Box 1225 Wangaratta VIC 3677 T: 03 5722 2677 www.dualdiagnosis.org.au	Northern Mallee Ramsay Health, Mildura Base Hospital 107 Pine Ave, Mildura 3500 VIC T: 03 5018 7917