Enhancing concurrent capability:
A toolkit for managers and staff

A standard approach to screening

Contents

Alberta Health Services

Addiction and Mental Health

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Introduction

How was this toolkit chapter created?

The content of this chapter is based on a literature review of screening for concurrent disorders (Alberta Health Services, 2010) and discussions within Addiction and Mental Health (AMH) to identify the requirements of a standard approach to screening for concurrent disorders. This resulted in the development of the Standard Approach to Screening document, (Addiction and Mental Health ECC Screening Sub-group, 2012) which lays out the framework for a standard approach.

In addition, further research was consulted to identify concrete implementation and practice issues. The Screening Toolkit Subgroup Committee reviewed each draft of this toolkit chapter and provided feedback. We would like to acknowledge the hard work of this committee. Their suggestions and direction have greatly contributed to this chapter.

We are committed to matching the toolkit content to the needs of the people who will be using it. We welcome any feedback, questions or suggestions for content additions or revisions. We wish to learn from the experiences at the front-line, so please let us know how well this toolkit works for you by emailing us at concurrent.disorders@ahs.ca

Reference group participants

Sponsors

Barry Andres, Executive Director, Provincial AMH

Jill Mitchell, Director, Provincial AMH

Screening chapter sub-group members

April Nelson-Siu, Kathie Campbell-Gavin, Nico Scholten, Rehabilitation and Concurrent Disorders, Provincial AMH

Beata Kurpinski, Cathy Work, Cindy Nestmann, Terah Jans, Teresa Simmons, Health Marketing

Candice Boxshall, Mental Health Therapist, Student Health Program, AMH

Donna Kerr, Writer, Kerr Creative

George McBride, Manager, Adult Addiction Services, AMH

Laura-Lee Shaw, Program Facilitator, Centennial Centre for Mental Health and Brain Injury

Panteha Khalili, Senior Research Officer, Knowledge and Strategy, Provincial AMH

Reggie Jackson, Mental Health Therapist, AMH

Stephanie Phare, Senior Research Officer, Knowledge and Strategy, AMH

Tanya Backstrom, Community Addiction Services Administrator, AMH

What you will learn in this chapter

This chapter will introduce you to the purpose and benefits of screening and the steps to effective screening, highlighting the GAIN-SS (CAMH modified) tool with a focus on administration, scoring and interpreting the tool to guide clinical decision making.

The following topics are covered in this chapter

- screening as part of clinical decision-making
- a standard approach to screening and what it means for you
- the steps of the standard approach to screening are covered in detail at the front-line level (i.e., what do I have to do?)

Welcome and engage:	How to build engagement while screening
Observe and gather:	Where does concurrent disorder screening fit with other intake/screening tasks?
Screen for concurrent disorders:	The who, what, where, when, why and how of screening for concurrent disorders This section includes details of how to administer, score and interpret the Global Appraisal of Individual Needs—Short Screener (GAIN-SS CAMH Modified). This section was designed so that if you have no access to other training materials, you will be able to accomplish these tasks.
Keep and consult:	What to do with the results of the concurrent disorder screen

What is screening?

The intent of screening is to identify areas for further exploration. A concurrent disorder screen acts as a flag to signal that an individual warrants further attention with respect to a mental health issue or an addiction issue, or both issues. It forms an important part of the clinical decision-making process and helps you support the person in setting their goals for recovery.

> *Screening does not diagnose. Screening only gives the clinician insight into concerns that can be flagged and followed up in the form of an assessment* (Addiction and Mental Health ECC Screening Sub-group, 2012).

In a concurrent capable program, screening is the first step to

- flag mental health issues in people entering the addiction door
- flag addiction issues in people entering the mental health door

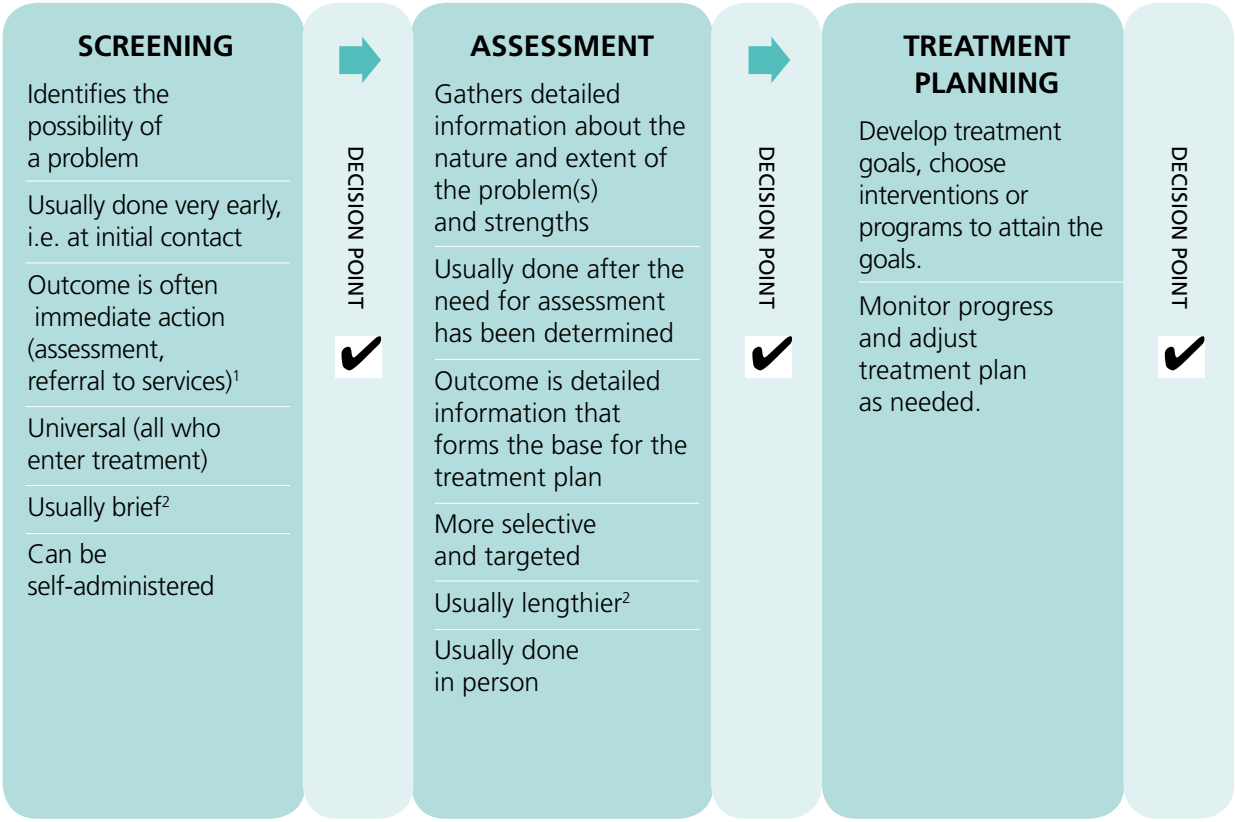
Clinical decision-making

Screening, assessment and treatment planning are separate processes, but they do overlap and sometimes the boundaries between them can get a bit blurry. When you think about it, they are really part of the clinical decision-making process. They help you make clinical decisions that assist people and families in getting the services they need, use resources wisely and improve outcomes (which means they are more likely to have successful recoveries).

> *Screening, assessment and treatment planning constitute three interrelated components of a process that, when properly executed, informs and guides the provision of appropriate, client-centered services to persons receiving services* (State of Alaska, 2011).

> *While screening, assessment and treatment planning can overlap somewhat, they have unique qualities and follow a progressive timeline. The sequencing of the three activities makes sense—each process builds on the other process as shown below. Between each process is a decision point where the clinician, in collaboration with the client, decides what to do next.*

Clinical Decision-Making Process



1 While assessment may identify immediate needs, it is usually more concerned with longer-term treatment planning and service co-ordination.

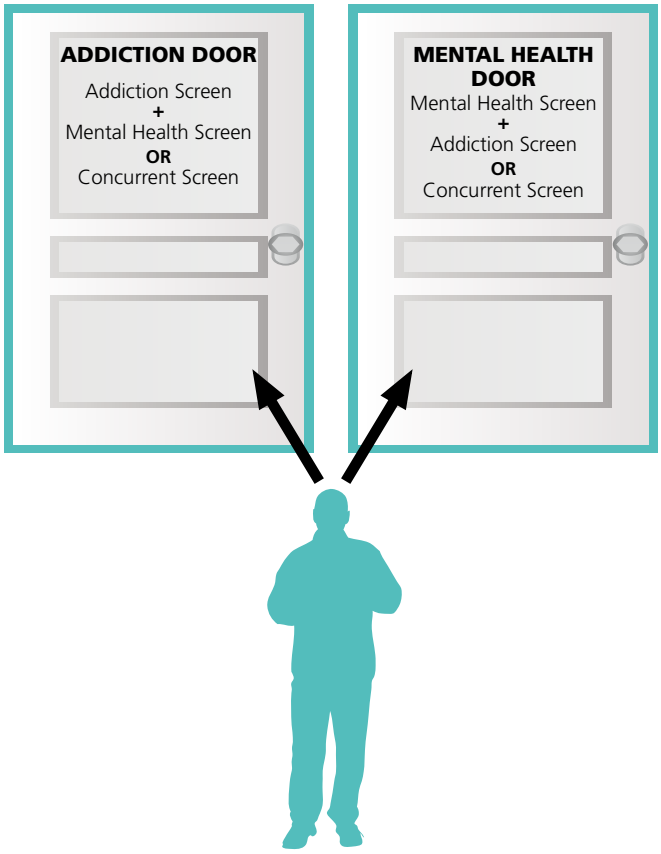
2 Some assessment tools may actually be briefer than some screening tools if the assessment tool focuses only on specific disorders, and the screening tool is multidimensional in its coverage.

A seamless process

Screening, assessment and treatment planning should ideally be a seamless process. Unfortunately, the transition points between the three components can sometimes be interrupted or completed at different times and by different clinicians. It is easy to lose people at these transitional points if there is not a continuous process (Skinner, 2005). When the transition involves more than one professional, continuity can be improved when clinicians assist and accompany people, and provide relevant information. In this way, individuals and families are introduced to a new clinician and don't have to tell their stories all over again. We call this a "warm hand-off."

You're already screening

Many services already screen people for their service areas. Mental health service providers usually screen for mental health disorders. Addiction treatment providers usually screen for addiction issues. Screening for concurrent disorders means building on the knowledge and expertise you already have about screening to ensure that people with concurrent disorders will have them recognized.



The need for a standard approach to screening

The above picture highlights a potential trouble spot for concurrent disorder screening. If each site uses its own combination of addiction and mental health screens, the result will be less than optimal. With different screens at different sites, people will have to answer more questions and complete more paperwork. Sites can't easily share or compare data since they are collecting different information.

A standard approach to screening within concurrent capable practice

The purpose of developing a standard approach to screening and providing a menu of evidence-based tools is to ensure early recognition of both addiction and mental health issues consistently across the service continuum. AHS-AMH has adopted Health Canada's (2001) recommendation that all individuals and families who seek help from mental health services be screened for addiction issues and all people who seek help from addiction services be screened for mental health problems. Routine screening for both disorders is an important step in ensuring that individuals and families are welcomed at any door and the system provides seamless access to services.

Benefits of a standard approach

A standard approach to screening for all AMH services and staff means that a person-centred, consistent method is employed at any point of entry into the healthcare system. The benefits of a common approach to screening can be

- a more consistent experience with services
- promotion of a common language among addiction and mental health service providers
- strengthened integrated care through enhanced communication and collaboration within and between services, including community service providers
- more appropriate referral to services that best match the need, intensity and urgency for treatment, and individual's desires and goals

Key steps to a standard approach to concurrent capable practice

Since the processes of screening, assessment and treatment planning are not always easy to separate in real-life practice, they are included in the key steps.

Welcome and engage individuals and families into service as the first and most important priority, recognizing the impact trauma has on people.

Observe and gather information on the person's appearance, behaviour and cognition (ABC) on intake, including reviewing any potential safety risks and taking into account information from referral notes, previous assessments and diagnoses, prescribed medications and treatment history, if any, for people new to the service or returning for support.

Screen for concurrent disorders: Conduct a brief screen with the most appropriate method, preferably using a valid and reliable tool, e.g. the GAIN-SS (CAMH Modified). The method chosen will be dependent on the service setting, agreed upon program protocols and the information already available, clinical judgment and issues regarding the safety and urgency of the situation.

Keep and consult: When results of screening indicate that a concurrent disorder is likely to be present, the next step would be to consider the need for

- a brief intervention only
- a consultation and collaboration with an appropriate colleague
- a more comprehensive assessment that targets the area of concern as identified in the screen
- a co-ordinated referral (warm hand-off) to a concurrent capable addiction or mental health service

Do a comprehensive assessment in consultation or collaboration with the other service (depending on door entered)

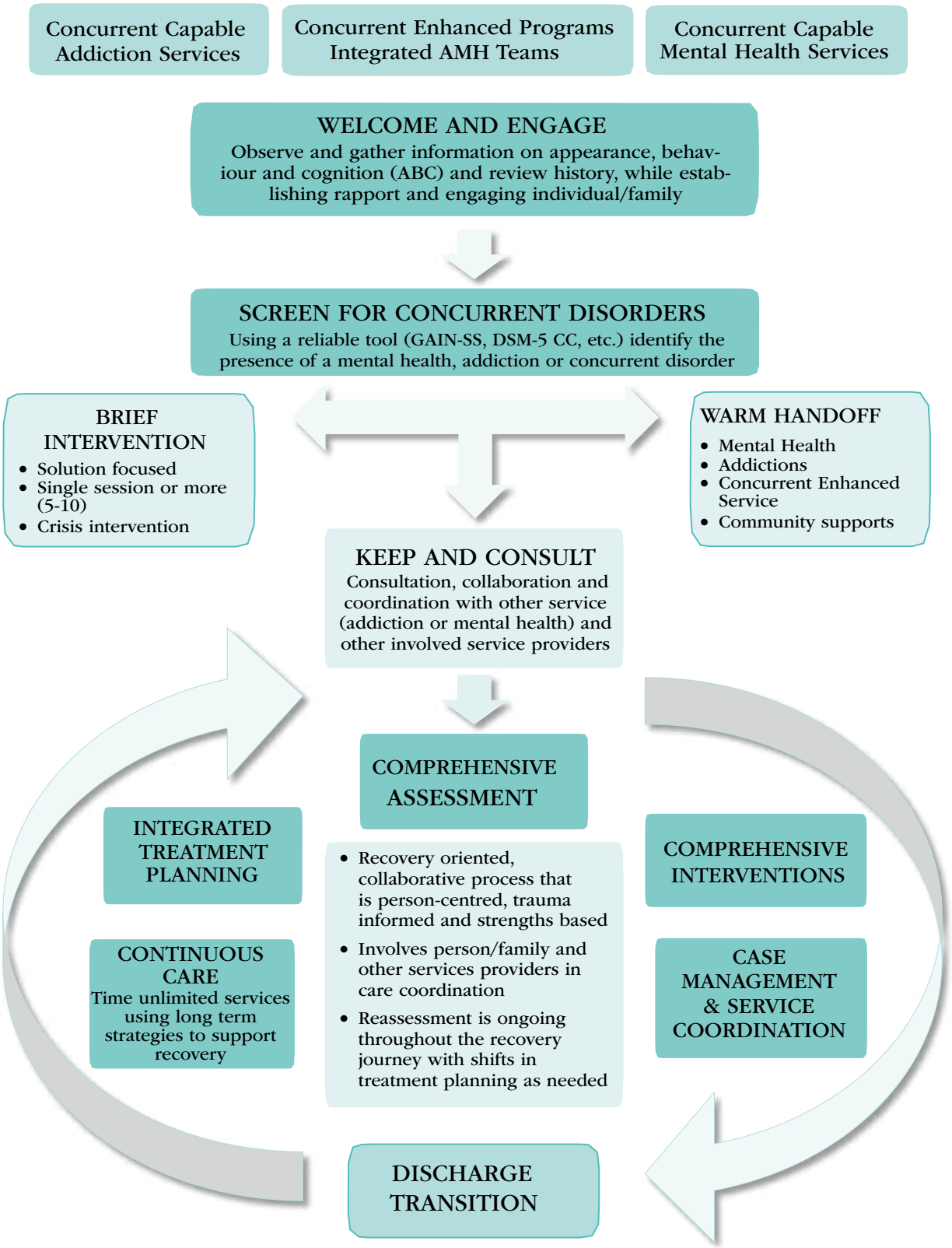
Develop an integrated treatment plan with the person, family and in collaboration with the other service that is recovery-oriented and focused on the individual's strengths, preferences, and desires for recovery. If additional concurrent concerns become apparent during assessment or treatment planning phases, mental health and addiction services continue to consult and collaborate to provide the most appropriate care.

The steps are illustrated on the next page.

A standard approach to concurrent capable practice

First contact with a person

EVERY DOOR IS THE RIGHT DOOR…



note section

Welcome and engage

Screening as engagement: The art of screening

While we need the technical knowledge of how to administer a screening tool, the art of screening is to gather the needed information while building rapport and engagement. In this section, we look at how we can build engagement while administering screening tools—the art of screening.

The risk of using any tool is to lose sight of the big picture—of how the tool supports integrated treatment planning. The key thing to remember is that screening is a process that leads to something else. The "something else" can include assessment and treatment planning, a brief intervention or a supportive referral to an appropriate service. Whether an individual will continue receiving services is influenced by the quality of their early experiences with the treatment system.

There are many screening tools (as you will see later in this chapter). No matter which tool is used, what really counts is how it's put into practice. The same tool can be administered in a mechanical, de-personalized manner or it can be delivered in a warm supportive manner that is engaging.

> *Screening is often the initial contact between a person and the treatment system, and the client forms their first impression of treatment during screening and intake. For this reason, how screening is conducted can be as important as the actual information gathered, as it sets the tone of treatment and begins the relationship with the client* (Croton, 2007).

First contact

Screening is often done on "first contact" with people. It is this first contact that is crucial in determining whether a person will continue with treatment. Addictions and mental health services have an average

In the TV series Star Trek, "first contact" refers to the first time the space explorers encounter a new species. They have lots of rules about how to conduct themselves in these first contacts as they know the contact will set the tone for all future dealings with the species. In "first contacts" with treatment systems (which may seem like a different planet for some persons), you set the tone for future treatment experiences. If it is a positive, welcoming, helpful experience, the person is much more likely to continue. If it's a de-personalized, rushed, less than helpful experience, the person is much more likely to drop-out.

50% drop-out rate (Duncan et al., 2010). If a person does not feel heard or is not engaged, they often drop out of treatment.

What do people say?

When asked what they think of screening, the majority are fine with answering screening questions. What really comes out loud and clear is that it isn't the questions, it's the way they are asked and the approach of the clinician.

> *During one particular focus group, all participants expressed the importance of being set at ease by the person conducting the screening. Several participants in this focus group indicated that the person performing the screening helped them overcome their reluctance towards answering certain questions and about discussing their feelings and experiences. This topic was addressed in a subsequent focus group; individuals in this group agreed that the role of the person doing the screening is extremely important in building trust and making individuals comfortable, especially since screening is often the first contact people have with a provider* (Connecticut Department of Mental Health and Addiction Services, 2007).

suggested activity

By yourself or with your team answer each of the questions for two styles of screening.

	Mechanical, de-personalized	**Warm, supportive**
What might it look like? What would the clinician do and NOT do?		
How might the person feel? What would help them be less or more comfortable?		
What would be the likely outcome?		

What is engagement?

From a treatment perspective, engagement speaks to the degree to which individuals are involved and participating in treatment. But individuals and families do not engage with treatment or a program, they engage with people. The quality of engagement is directly related to the quality of the relationships they have with the staff they encounter. Whether it is a brief intake encounter or a long-term counselling relationship, the quality of the relationship has a huge impact on outcomes.

Good relationship = good outcome

Research has found that the individual-clinician relationship (sometimes called the alliance) accounts for 38% to 54% of treatment outcome. In addition, therapist effects account for 46% to 69% of treatment outcomes. And what are "therapist effects?" It is a fact that some clinicians get better outcomes than others and it's strongly related to how well and how quickly the therapist can form a good alliance (Duncan et al., 2010).

The first chapter in this toolkit has some great information on welcoming and engaging. These processes do not stop once the person sees you. Welcoming and engaging continue throughout the entire treatment process.

Elements of a good relationship

After an extensive review of the research, the American Psychology Association Interdivisional Task Force on Evidence-Based Therapy Relationships (2011) found the following empirically-supported elements of the individual-clinician relationship.

Demonstrably effective

- the alliance (the quality of the partnership and mutual collaboration)
- empathy
- the collection of feedback from the person receiving service

Probably effective

- goal consensus
- collaboration
- positive regard

The key to building engagement during screening is to incorporate as many of the above elements as possible.

You might not remember the individual and family, but they will remember you.

Even if you have only short contact with people, how you relate to them can make an impression far beyond the time involved. They often remember seemingly small kindnesses or words that made a huge impact that the clinician may not even remember.

> | *suggested activity* | <

Spend a few moments either alone or with a colleague thinking of a time when you were involved with the healthcare system and experienced something a helping clinician, receptionist, etc. said or did that made a huge positive impact on you.

What was it?

How did you feel about the clinician?

How did it make you feel about the agency?

Think of a time you were told that something you said or did had a positive impact—but you were not aware of the impact, or you don't remember it.

Tips for engaging while screening

The following tips are for when you are administering a screen.

Accept people for where they are

If the screen is part of first contact, people may not feel comfortable enough to answer a lot of questions. We often want them to be open and honest, but for some people it is way too early. In addition, the questions can sometimes bring up bad memories or things they do not want to discuss. Asking for permission to ask questions is a nice way of communicating acceptance that they might not be ready.

In a study that asked people about their screening experiences, some people expressed concerns that the questions evoked memories of negative events that occurred in the past and were associated with substance use (Rush et al., 2005).

A note about honesty

Honesty can be an issue in screening—when clinicians think that individuals are not being honest when they answer screening questions. Mental health clinicians often find people are not honest with substance abuse answers (Croton, 2007). Honesty is an engagement issue—does the person feel safe enough with you (or with the larger system) to be honest? Are we using a trauma-informed approach that allows us to recognize the impact trauma has on lives? It may take more time to establish trust with some people than with others. The quality of early engagement will either speed up or slow down this process.

Avoid judging individuals when you feel they are not being honest. Work with what you have and base the next steps on what is presented to you at the time of screening.

Find a point of "quick connection"

It's amazing how two strangers can find an almost instant point of connection and chat like they've known each other for ages. It happens at parties, on trains and in grocery lines. A point of connection can be many things:

- Thanking and affirming can create connection. Thank people for coming to see you. Affirm that it takes courage and determination. Affirm that you admire them for taking the chance to seek treatment. Affirmations must be genuine and require that you notice things you can affirm.
- Find a common interest – what do you like to do for fun or when you have some free time? A brief chat about a TV show, reading, sports or other leisure activity can break the ice and form a connection. People light up when they talk about what they love doing—not a bad start to further conversation!
- Place some interesting photos/posters in your office to generate interest and comments.

You can find other ideas in Chapter 1: Welcoming and Engagement.

>| suggested activity |<

Spend a few moments either alone or with a colleague thinking about which "quick connection" ideas you could use.

How would you implement the idea?	What other ideas do you have for creating a quick connection?

Share the screen

If possible, sit beside the person and let them see the screen while you fill it out. Or let them write the answers. This communicates partnership, involves them in a more active role and reduces their fear around "what are you writing about me?"

Seeing the written questions can help if mental illness or a cognitive disability causes lack of concentration during a conversation or difficulty in understanding oral questions (Rush et al., 2005).

Discuss results of the screen

Most screens consist of a list of closed questions which must be asked as written to ensure reliability of the screen. After you finish administering the screen, make sure you explain the results of the screen so people don't feel like they are being kept in the dark about the screening results. Using open-ended questions can help build engagement when people discuss what the screening results mean for them, and encourages active participation in developing their recovery journey.

Be open to answering questions

People may ask you why you're asking a question or more about it. Answer their questions openly and encourage them to ask more.

Introduce the screen

Some screens are designed to be completed without any clinician involvement. Others require a clinician to administer and score them. Regardless of which type of screen is used, it should be given with an introduction which can enhance engagement with screening.

People want to engage

In a study that asked about their screening experiences, some people stated they did not like that questions were predominantly closed-ended, without the possibility to give an elaborated answer (Rush et al., 2005).

Things to mention in the introduction

- Explain that we ask these questions of everyone who comes for service so they do not feel singled out.
- Remind individuals of confidentiality if you think it might be helpful (assuming you've already reviewed confidentiality with them).
- Explain the reasons for asking the screen—to gain complete information about their situation and to better match them with the most helpful services.

Some participants expressed discomfort with the questions, but their discomfort was not long lasting once they understood why the questions were being asked (Connecticut Department of Mental Health and Addiction Services, 2007).

- Inform them of how much time it will take—give a range as some people will complete the screen faster than others.
- Explain the process—scoring, further assessment, referral, etc.
- It can be helpful to show a picture or chart of how screening fits into the entire treatment process. If your site does not have such a resource, Appendix 4 includes a team activity called Develop a Visual Guide to Treatment which you might find useful).

The good news is that people entering helping services usually expect to be asked questions. In a study that asked mental health people about their screening experiences, 90% of people were comfortable or very comfortable with answering the screening questions about their substance use (Rush et al., 2005).

Ask for permission

After introducing the screen, a respectful way to build rapport immediately is to simply ask for permission to ask the screening questions:

"Would it be okay if I ask you these questions?"

Most people will give you permission (even if somewhat reluctantly) to proceed with screening. If they refuse, honour it. Asking about their wishes and following through with action builds trust, even if you can't complete the screen. You can always ask again at a later time.

>| essential task: |<

In your own words, write an introduction for a screen you administer following the guidelines below

- Explain that we ask everyone these questions
- Do you want to do a confidentiality reminder? (if you sense this might be important for the person)
- Reasons for the screen
- How long it will take
- What will be done as a result of the screen
- Ask for permission

Example:

"We ask everyone who comes in to see us some questions that help us understand your situation better. The questions also help us make sure you get the best help from us. It takes about five to 10 minutes and after we're done, we'll talk about how the answers to these questions will help us figure out our next steps. Would this be okay?"

Challenges to engaging while screening

Lack of time

Probably the biggest challenge to engagement is the lack of time. If systems do not allow adequate time for screening, clinicians can feel like they just have to get the forms filled out and move on to the next task or person. Sometimes systems have to adjust work flows to allow for engagement.

It is also the perception of time. Clinicians often feel like they don't have time for engagement. Yet, experienced nurses can give an immunization shot to an infant and screen mom at the same time, all in a warm, engaging manner. It takes practice and skill.

People vs. paper

Heavy workload and competing priorities mean treatment systems are often faced with overwhelming numbers of persons seeking services and paperwork sometimes takes precedence over the human being.

> *The screening and assessment procedures used in many agencies tend to focus on formal data collection and documentation. In such circumstances, it is easy to forget to look for the unique qualities of each client. As a result, the diverse characteristics of people who have concurrent disorders are reduced to a category that is processed in a rote manner* (Skinner, 2005).

I'm not going to be their counsellor

Sometimes, intake and screening are done in central locations by intake staff who will not be the assigned counsellor. The systems are not set up to allow for much relationship building as the person will be referred to another staff member. Even in these settings, however, engagement is very important as it determines the person's first impression of the agency and whether they will return for ongoing services.

Too many screens

People can lose patience if they are required to complete more than several screens, if they have to repeat screens at different sites and if they feel they are not able to speak about their own concerns (rather than the system's concerns). This is one of the reasons that AHS is moving to a standard approach to screening.

Assuming literacy

If individuals are asked to self-administer a screen, it can create a lot of stress if they cannot read or understand the writing on the form. People will often not tell you they have difficulty reading due to feelings of shame and embarrassment. Higher stress and feelings of shame and embarrassment do not contribute to engagement.

Some signs of literacy issues

People have usually developed coping strategies such as saying things like… You write it… I don't have my glasses… I can't focus, could you write it down… I'll take the information home and figure it out. Sometimes people rush through forms answering in a random manner with no consistency. Others look at the paper for a long time, sometimes without eye movement (Ottawa Community Coalition for Literacy, 2007).

Many people with mental health and substance abuse issues are not literate. One survey found 50% of mental health individuals had literacy issues and that completion of school grades was not related to literacy level (Ottawa Community Coalition for Literacy, 2007).

suggested activity

Spend a few moments either alone or with a colleague thinking about which "challenges to engagement" apply to your site.

For each challenge, identify several strategies to reduce or eliminate the challenge.

note section

note section

Observe and gather

Screening for concurrent disorders is part of the intake and screening process. Each site will have its own protocols and procedures for intake and screening. There are likely other screens you will use within your practice, especially for the first time. You may also need to gather relevant demographic/background information. Remember that people need to be informed of the limits to confidentiality before gathering any information.

- Observe the appearance, behaviour and cognition (ABC) on intake, including reviewing and identifying any potential safety risks. The full ABC Checklist can be found in Appendix 3: Recommended screening tools.
- Gather information from referral notes, previous assessments and diagnoses, prescribed medications and treatment history, if any, for both new and returning people.
- Other areas that need to be checked out include literacy level and cognitive impairment. Both of these factors impact whether individuals can self-administer screens and other information forms.

Safety first

The safety of the person seeking services and yourself is your first priority. Observing is one way to continually monitor for risk situations. You may use various screens, as well as any relevant information you have gathered to identify safety risks (e.g., suicide, violence).

Timing of concurrent disorder screening

Screening for concurrent disorders is best done at the initial point of access to the healthcare system. However, there may be situations where immediate needs of people take precedence over screening. We must ensure that safety is the number one priority. Times when it may not be appropriate to proceed with screening can include:

- when there is immediate risk of the individual harming himself or herself, or harming other people
- when there is immediate risk of physical harm or abuse from others
- when the person is in a state of severe distress or crisis, it is essential to address the distress or crisis first

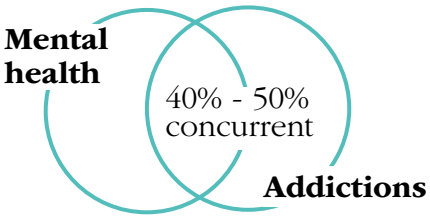
- when the person is displaying acute and severe mental disorder symptoms (e.g., mania, psychosis), and cannot function or communicate effectively
- when the person is intoxicated or obviously under the influence of drugs to the extent that functioning is impaired
- when screening will negatively impact engagement, e.g. "I'm not here to talk about my drinking! If you want to talk about it, I'll leave right now!"
- physical pain or urgent medical issues that need attention
- if the person is in need of emergency care or is unable to provide for basic self-care

note section

Screen for concurrent disorders

Why screen for concurrent disorders?

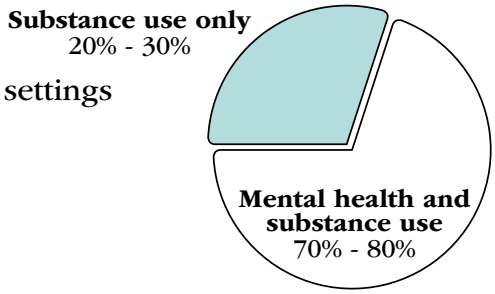
The simplest answer to the question "Why screen for concurrent disorders?" is "because it is more often than not present". People in addiction or mental health services have significant rates of concurrent disorders. We know this, and to ignore it is like ignoring the "elephant in the living room."



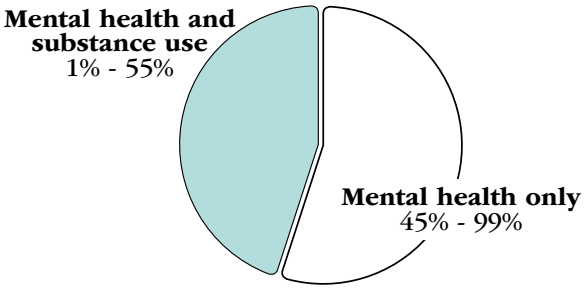
Among treatment populations, the overall lifetime prevalence rate of concurrent disorders is often quoted in the research at about 40% to 50% (Currie, 2011).

In separate addiction and mental health treatment systems, there is a large overlap of people with both disorders (the large range of estimates is due to the way in which concurrent disorders are defined, the treatment setting and which disorders are included). It is thought that youth may have even higher rates than adults (Centre for Addiction and Mental Health, 2009).

Substance abuse treatment settings



Mental health treatment



When we screen for concurrent disorders within addiction and mental health services, we are not trying to find a new client group, but to do a better job of serving the clients who are already coming through our doors (Addiction and Mental Health ECC Screening Sub-group, 2012).

Benefits of screening for concurrent disorders

There are many benefits for screening for concurrent disorders. Benefits of screening for concurrent disorders include

- improved outcomes
- improved follow-through
- better match to appropriate treatment
- improved satisfaction of those seeking services
- earlier intervention
- better use of valuable resources
- better organizational planning
- common language and increased co-operation between systems

The most valuable five minutes

Using a screen could be the most valuable five minutes in the clinical experience of a person seeking help, considering the costs to the person and the cost to society when a co-existing [concurrent] disorder goes unrecognized (Cherry, 2007).

Improved treatment outcomes

The most compelling reason to screen for concurrent disorders is that it will benefit those seeking service and result in improved treatment outcomes. Improved outcomes translate to improved functioning, increased well-being and a better quality of life. It is why most of us are in the helping professions—to support individuals through the recovery journey to live happier and more satisfying lives.

Improved follow-through

When we fail to detect concurrent problems early on, people are less likely to be successful in following through on a treatment plan that does not take into account the complexity of their issues. Worse yet, they may be bounced back and forth between the addiction and mental health systems and may frequently visit the emergency department or be hospitalized (Centre for Addiction and Mental Health, 2006).

For example, a person receiving treatment for a mood disorder may also have a substance use problem that interferes with his or her ability to benefit from therapy. Or a person being treated for an alcohol problem may also have a trauma-related problem; if the person uses alcohol to "self-medicate," he or she may not respond to substance use treatment until the trauma issue is also recognized and

addressed (Centre for Addiction and Mental Health, 2006).

Better match to appropriate treatment

When concurrent disorders are identified from the start, we can better match the person's needs to treatment resources. This can save a lot of time and effort. It can also prevent clinicians and individuals and families from becoming discouraged by lack of progress when an undiagnosed disorder is interfering with single-disorder treatment.

> *It is not uncommon for mental health or AOD [Alcohol and Other Drug] treatment to have been underway for some time before it becomes apparent that a co-occurring [concurrent] 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* (Croton, 2007).

Improved satisfaction

When we screen for concurrent disorders, we get a more accurate and holistic picture of the issues that a person may be struggling with and can better identify their needs.

> *Individuals with a co-occurring [concurrent] disorder reported the lowest satisfaction with care. They were four to seven times more likely to report unmet needs compared to those with either a substance use or mental disorder alone* (Urbanoski et al., 2007)

Earlier intervention

When screening occurs in a broad range of contexts, the probability that individuals will be identified and supported at an earlier stage is greater. This can prevent further harm from developing.

> *A potentially substantial gain, likely to be derived from implementing routine screening for co-occurring [concurrent] 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* (Croton, 2007).

Children and youth have higher rates of concurrent disorders than adults. The earlier the onset of either substance abuse or mental disorders increases the odds of lifetime difficulties. More effective preventive interventions can be delivered earlier if the issues are recognized (Centre for Addiction and Mental Health, 2009).

Better use of valuable resources

Early recognition of concurrent disorders can result in savings, both human and financial. Screening helps to better utilize staff resources for the more time-consuming assessment process.

> *In most service delivery settings it would be a waste of scarce resources to implement a full mental health and/or substance use assessment for everyone presenting for help* (Rush et al., 2005).

The Victorian Department of Human Services (Australia) is hoping that by detecting the presence of high-prevalence/low-impact-type disorders earlier, there will be substantial human benefits to the individual and financial savings to the system. They use the following framework to conceptualize concurrent disorders:

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

Treatment of high-prevalence/low-impact-type disorders is likely to be more effective, with fewer resources, than the treatment of low-prevalence/high-impact-type disorders. As there are many more people who have the high-prevalence/low-impact-type disorders, significant savings are possible when the disorders are recognized early.

> *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 [concurrent] 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* (Croton, 2007).

Better organizational planning

A standard approach to screening for concurrent disorders can produce valuable information about the numbers, severity, and trends and shifts in individual needs. This information can help organizations better plan and allocate resources.

Common language and increased co-operation between systems

Screening may contribute to the development of a common language and understanding between mental health and addiction treatment services.

> *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 inter-agency tensions and disappointments and greater potential for the provision of effective integrated treatment* (Croton, 2007).

suggested activity

Spend a few moments either alone or with a colleague thinking about how the above benefits can apply at multiple levels. For each benefit, check which level it applies to:

Benefit	Individual	Clinician	System
Improved individual outcomes	❑	❑	❑
Improved follow-through	❑	❑	❑
Better match to appropriate treatment	❑	❑	❑
Improved individual satisfaction	❑	❑	❑
Earlier intervention	❑	❑	❑
Better use of valuable resources	❑	❑	❑
Better organizational planning	❑	❑	❑
Common language and increased co-operation between systems	❑	❑	❑

Who should be screened and when?

Ideally, all individuals at first point of contact with the healthcare system, whether it is primary care services, emergency departments or any other service, should be consistently screened for addiction and mental health issues.

Criteria for choosing a screening tool

After reviewing the research literature, AHS found consensus for the following selection criteria for a standard screening tool (AHS, 2010)

- simple
- brief
- quick to administer (no more than 10 to 15 minutes)
- inexpensive (composed of items or instruments found within the public domain or with inexpensive licensing fees)
- user friendly; able to be self-administered
- evidence-informed
  - reliable (stability of measurements over time)
  - sensitive (correct identification of people who meet the criteria for a particular diagnosis or problem)
  - specific (correct identification of people who do not meet the criteria for a particular diagnosis or problem)
  - valid (the degree to which a test measures what it is intended to measure)

For a more detailed discussion of these criteria, please refer to Appendix 2: Screening criteria in detail.

What screens can I use?

The GAIN-SS (CAMH Modified) screener is one in a menu of suggested tools for screening for concurrent disorders. The DSM-5 Cross-Cut (CC) Symptom Measure is another tool that can be used (see Appendix 3). Asking a few standard questions around mental health or addiction is helpful when it may not be feasible to complete a full screen (outreach, emergency departments, remand facilities, etc).

In this section, we will take a detailed look at the GAIN-SS (CAMH Modified). Other recommended screens are reviewed in Appendix 3: Recommended screening tools.

note section

Using the GAIN-SS (CAMH Modified)

The GAIN-SS was developed by Chestnut Health Systems, a non-profit behavioural health organization. It is a brief screening tool designed for three primary purposes

- To serve as a potential screener for addiction and mental health programs to quickly and accurately identify persons who are likely to have one or more behavioural health disorders and who would benefit from further targeted assessment and/or referral. It also rules out those who would not be identified as having behavioural health disorders.
- To serve as an easy-to-use quality assurance tool across diverse field-assessment systems for staff with minimal training or direct supervision.
- To serve as a periodic measure of change in behavioural health over time (Dennis et al., 2006).
-

What can it flag?

Remember that a screen does not diagnose; it simply flags areas for further exploration.

The original tool with four sub-scales addresses the following

- internal disorders (attention-deficit/hyperactivity disorder, conduct disorder)
- behavioural disorders (attention-deficit/hyperactivity disorder, conduct disorder)
- substance use disorders (abuse, dependence)
- behavioural crime/violence (interpersonal violence, property crime, drug-related crime)

The GAIN-SS (CAMH Modified) has six additional questions that were added (with permission from Chestnut Health Systems) by the Centre for Addiction and Mental Health (CAMH) to gather information on some diagnostic categories that were not covered in the original GAIN-SS. These additions were made after pilot testing the GAIN-SS in real-life settings and include

- problematic eating
- traumatic stress

- disordered thinking
- gambling
- video game and Internet use

Why recommend the GAIN-SS (CAMH Modified)?

It could be argued that the reason to use the GAIN-SS is because it's one of the few concurrent screening tools in existence. It meets evidence-informed selection criteria for screening tools and has additional benefits as discussed below.

The following table summarizes how the GAIN-SS meets various evidence-informed screening tool selection criteria (for detailed information on these criteria, see Appendix 2: Selection criteria in detail):

Selection criteria	How the GAIN-SS meets the criteria
Simple	Easy to administer and score
Brief	29 items
Quick to administer	10 to 15 minutes
Inexpensive	$100 provincial license $500 training subscription fee, which includes unlimited access to online training Both valid for 5 years
User friendly; able to be self-administered	Can be self or staff-administered on paper, on a computer or on the web. Reading level is Grade 6 and 8.8 for the mental health sections and Grade 10.2 for the substance use questions (Godin et al., 2009)
Evidence-informed reliable sensitive specific valid (For details on what these factors mean, see Appendix 2: Selection criteria in detail).	The GAIN-SS has very good to excellent reliability, sensitivity, specificity, and is a valid tool. These results were obtained by comparing the short screener with the full GAIN assessment. When compared directly to other measurements, including a full alcohol/drug assessment, and the Mini-International Neuropsychiatric Interview (MINI), the GAIN-SS showed high sensitivity and negative predictive value for both alcohol/drug dependence, and mental illness at a cut-off score of 2 (Voss et al., 2007). Note: The added questions in the CAMH Modified version have not been validated. They are used for information only and should not be incorporated into the total scoring of GAIN-SS (CAMH).

Additional benefits of the GAIN-SS (CAMH Modified) include:

- It is a concurrent disorder screen. It covers in one brief screen what can often take two to four separate screens to identify. This can cut down on paperwork and the number of questions one must answer.
- It can be used with youth and adults (ages 12 and up).
- The GAIN-SS flags the same items as the full GAIN assessment, which takes two hours to administer.
- It is being used in other Canadian addiction and mental health systems. This can enable future learning and sharing of trends, outcomes and resource utilization. It is widely used in the U.S., which allows for even more learning opportunities.

How to administer the GAIN-SS (CAMH Modified)

Get ready checklist

Before administering the GAIN-SS (CAMH Modified), make sure you have the following on-hand

>| *checklist* |<

- ❑ GAIN-SS (CAMH Modified) forms (more than one in case of errors)
- ❑ Calendar for the previous year – it can help to print a year's calendar for the 12 months before the month you are administering the GAIN-SS (CAMH Modified). It is easy to do this from the website www.timeanddate.com. You can customize and print calendars for any 12-month range. It helps to include holidays as they can serve as time anchors to help people remember dates.
- ❑ A quiet, private place to administer it.

Introduce the screen

Use the following points to introduce the GAIN-SS (CAMH Modified). Remember to engage with the person as you administer the screen. The information below must be given to ensure reliability of the GAIN-SS (CAMH Modified).

- This instrument is designed to find out how you are doing in terms of your mental health and behaviour. It takes about five minutes to answer.
- The information is private. It will be used only for your treatment and to help us evaluate our services.
- If you are not sure about an answer, please give us your best guess.
- You can say that you do not know or that you do not want to answer a question.
- If you simply do not know the answer to a question, you can tell me and I'll enter "DK" (Don't Know) for that item.
- You may refuse to answer any question, and I'll enter "RF" (Refused) for the answer.
- Please ask if you do not understand a question or a word. At the end of the interview I will check to make sure that everything is complete, and I'll answer any additional questions.
- Do you have any questions before we begin?
- Is it OK if we go ahead?

Ask the questions: Time frames

The GAIN-SS (CAMH Modified) asks questions with five time frames: past month, two to three months ago, four to 12 months ago, one or more years ago, or never. This helps to track issues over time.

Introduce the time frames as follows

- Several questions will ask you about things that have happened during the past month, two to three months ago, four to 12 months ago, one or more years ago, or never. To help you remember these time periods, please look at this calendar. Give the person a calendar.

If persons are unable to recall any events, find a time anchor

Anyone can have difficulty remembering things that happened up to, or more than, a year ago. If individuals have trouble remembering, try

to come up with an anchor or significant event to help. It could be a holiday or birthday.

- Do you remember any birthdays, holidays, sporting or other special events that happened around (DATE 30 DAYS/12 MONTHS AGO)? Did anything change in terms of where you were living, who you were with, whether you were in treatment, work, school or jail? Where were you living then? Were you in treatment, working, in school or involved with the law then?

If they have trouble remembering the last time something happened, ask them to give their best estimate.

Ask the questions: The domains

The GAIN-SS (CAMH Modified) is organized into five domains or sub-scales (the first four are the GAIN-SS domains and the fifth is the CAMH modifications). For each, ask the questions as worded on the screen (this helps to maintain reliability of the instrument). Here are some tips from the GAIN-SS Administration and Scoring Manual version 3 (Dennis et al., 2013) for how to ask the domain questions:

- Read the first item, document the response and continue in order.
- Please read each item carefully to avoid any misunderstanding. Be sure to follow the dotted line to the response choices.
- Be sure to choose only one response. Make sure that the responses are marked clearly.
- If you have to make any corrections, be sure to cross out the original response and write the new response neatly.
- Ask the person to answer as accurately as possible. If the person has trouble remembering the last time something happened, ask for their best estimate.
- Note that a question cannot be answered with "Sometimes" or "Sort of" or "Maybe." If this happens, ask the person to choose the response that comes closest to how they feel.
- If they really can't choose between responses, doesn't know the answer, or simply does not want to answer, leave the response blank. Those items will not be considered in the scoring.
- Don't forget to read the stem at the beginning of each section (e.g., "When was the last time…"). You should also repeat the

stem before an item if you get interrupted and have to repeat or restart a question.

Internal disorders screener (IDScr): mood, sleep, anxiety, trauma, suicide, hallucinations/disordered thinking

IDScr 1.	**When was the last time** that you had **significant** problems with…					
	a. feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	4	3	2	1	0
	b. sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?	4	3	2	1	0
	c. feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?	4	3	2	1	0
	d. becoming very distressed and upset when something reminded you of the past?	4	3	2	1	0
	e. thinking about ending your life or committing suicide?	4	3	2	1	0
	f. seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts?	4	3	2	1	0

Externalizing disorders screener (EDScr): attention-deficit/hyperactivity, conduct, and gambling

EDScr 2.	**When was the last time** that you did the following things **two or more times**?					
	a. Lied or conned to get things you wanted or to avoid having to do something	4	3	2	1	0
	b. Had a hard time paying attention at school, work, or home.	4	3	2	1	0
	c. Had a hard time listening to instructions at school, work, or home.	4	3	2	1	0
	d. Had a hard time waiting for your turn.	4	3	2	1	0
	e. Were a bully or threatened other people.	4	3	2	1	0
	f. Started physical fights with other people	4	3	2	1	0
	g. Tried to win back your gambling losses by going back another day.	4	3	2	1	0

Substance use disorders screener (SDScr): abuse and/or dependence

SDScr 3.	**When was the last time** that…					
	a. you used alcohol or other drugs weekly or more often?	4	3	2	1	0
	b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (e.g., feeling sick)?	4	3	2	1	0
	c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	4	3	2	1	0
	d. your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home, or social events?	4	3	2	1	0
	e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or avoid withdrawal problems?	4	3	2	1	0

Crime/violence screener (CVScr): interpersonal violence, property crime and drug-related crime

CVScr 4.	**When was the last time** that you…					
	a. had a disagreement in which you pushed, grabbed, or shoved someone?	4	3	2	1	0
	b. took something from a store without paying for it?	4	3	2	1	0
	c. sold, distributed, or helped to make illegal drugs?	4	3	2	1	0
	d. drove a vehicle while under the influence of alcohol or illegal drugs?	4	3	2	1	0
	e. purposely damaged or destroyed property that did not belong to you?	4	3	2	1	0

Scoring the GAIN-SS

The GAIN-SS is scored by counting the number of participant responses for each time frame, not by summing the response values (i.e., the numbers that appear in the time frame columns).

For example, suppose that a person gave these responses in the Internalizing Disorders Screener (items 1a–f):

	The following questions are about common psychological, behavioral, and personal problems. These problems are considered **significant** when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
		4	3	2	1	0
IDScr 1.	**When was the last time** that you had **significant** problems with…					
a.	feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	4	3	2	(1)	0
b.	sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?	(4)	3	2	1	0
c.	feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?	4	(3)	2	1	0
d.	becoming very distressed and upset when something reminded you of the past?	4	(3)	2	1	0
e.	thinking about ending your life or committing suicide?	4	3	2	1	(0)
f.	seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts?	4	3	2	1	(0)

The "Items" column in the scoring table shows which items to score for that screener, and the responses to be counted for each time frame appear in parentheses in the four time frame columns. Thus, to score the Internalizing Disorders Screener, start with items 1a–f on the GAIN-SS and count the number of past-month responses, or the number of 4s. In this case, the participant reported only one past-month problem (in item 1b), so enter 1 (not 4, which is simply the response value) in the corresponding column in the IDScr row:

Screener	Items	Past month (4)	Past 90 days (4, 3)	Past year (4, 3, 2)	Ever (4, 3, 2, 1)
IDScr	1a – 1f	1			

Next, for the "Past 90 days" column in the scoring table, count the number of 4s and 3s reported in items 1a–1f. The participant had two "2 to 3 months ago" responses (items 1c and 1d) in addition to the one past-month response, so enter 3 in the "Past 90 days" column:

Screener	Items	Past month (4)	Past 90 days (4, 3)	Past year (4, 3, 2)	Ever (4, 3, 2, 1)
IDScr	1a – 1f	1	3		

Follow the same pattern for the "Past 12 months" and "Ever" time frames in the scoring table. Remember that the numbers in parentheses in the top of each column denote which response codes should be counted from the GAIN-SS. In this example, for items 1a–1f the participant reported no problems in the 4-to-12-month range, so the total number of "Past 12 months" problems on the scoring sheet is still 3 (because the participant's three past-90-day problems carry over into the past-year count). The participant reported one problem last occurring more than 12 months ago (item 1a), so that problem is added to the running total, for a total of four problems occurring within the participant's lifetime (the "Ever" column on the scoring sheet). "Never" responses are not counted in the scoring table.

Thus, the participant's completed Internalizing Disorders Screener score looks like this:

Screener	Items	Past month (4)	Past 90 days (4, 3)	Past year (4, 3, 2)	Ever (4, 3, 2, 1)
IDScr	1a – 1f	1	3	3	4

This process is repeated for each screener in the scoring table. Any DK or RF response or accidentally skipped item should be excluded from the scoring.

The bottom row, the Total Disorder Screener (TDScr), is scored by totaling the numbers reported in all the preceding rows. If the participant continued with the rest of the GAIN-SS and reported problems in several life areas, their completed GAIN-SS screening table would look similar to this:

Screener	Items	Past month (4)	Past 90 days (4, 3)	Past year (4, 3, 2)	Ever (4, 3, 2, 1)
IDScr	1a – 1f	1	3	3	4
EDScr	2a – 2g	0	1	1	1
SDScr	3a – 3e	2	2	3	3
CVScr	4a – 4e	0	0	0	1
TDScr	1a – 4e	3	6	7	9

CAMH Modified Questions: problematic eating, traumatic stress, disordered thinking, gambling and video game or internet use

Additional questions (CAMH modified)

After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

AQ5. **When was the last time** you had **significant** problems with… **(not related to alcohol/drug use)**

a. missing meals or throwing up much of what you did eat to control your weight? 4 3 2 1 0

b. eating binges or times when you ate a very large amount of food within a short period of time and then felt guilty? 4 3 2 1 0

c. being disturbed by memories or dreams of distressing things from the past that you did, saw, or had happen to you? 4 3 2 1 0

d. thinking or feeling that people are watching you, following you, or out to get you? 4 3 2 1 0

e. videogame playing or internet use that caused you to give up, reduce, or have problems with important activities or people of work, school, home or social events? 4 3 2 1 0

f. gambling that caused you to give up, reduce, or have problems with important activities or people at work, school, home, or social events? 4 3 2 1 0

5. Do you have other **significant** psychological, behavioural, or personal problems that you want treatment for or help with? (If yes, please describe below) .... Yes 1 No 0

v1. _____

_____

Record the GAIN-SS (CAMH Modified) Supplemental Questions

Use the table on the GAIN-SS (CAMH Modified) form to record the responses. The CAHH Modified responses are not added to the total score of the GAIN-SS, but contribute to the overall clinical picture.

Screener	Items	Past month (4)	Past 90 days (4, 3)	Past year (4, 3, 2)	Ever (4, 3, 2, 1)
Supplemental questions	AQ5a-f				

GAIN-SS CAMH Modified Example

AQ5. **When was the last time** you had **significant** problems with… **(not related to alcohol/drug use)**

a.	missing meals or throwing up much of what you did eat to control your weight?	4	(3)	2	1	0
b.	eating binges or times when you ate a very large amount of food within a short period of time and then felt guilty?	4	(3)	2	1	0
c.	being disturbed by memories or dreams of distressing things from the past that you did, saw, or had happen to you?	4	3	(2)	1	0
d.	thinking or feeling that people are watching you, following you, or out to get you?	4	3	2	1	(0)
e.	videogame playing or internet use that caused you to give up, reduce, or have problems with important activities or people of work, school, home or social events?	4	3	2	1	(0)
f.	gambling that caused you to give up, reduce, or have problems with important activities or people at work, school, home, or social events?	4	3	2	1	(0)

Recording instructions for CAMH Modified Supplemental Questions.

Each response receives a value of 1.

1. Place a "0" in the first column, as there are no past month responses.
2. Place a "2" in the second column, as there are a total of 2 responses in the past month and 2-3 months ago timeframes.
3. Place a "3" in the third column, as there are a total of 3 responses in the past month, 2-3 months ago and 4-12 months ago timeframes.
4. Place a "3" in the last column, as there are no additional responses in the 1 or more years ago timeframe.

Screener	Items	Past month (4)	Past 90 days (4, 3)	Past year (4, 3, 2)	Ever (4, 3, 2, 1)
Supplemental questions	AQ5a-f	0	2	3	3

Interpreting the scores

To screen for possible diagnoses, it is recommended that the domain and total scores from the completed GAIN-SS be triaged into three groups based on the number of reported past-year symptoms:

Low (0 past- year symptoms): Unlikely to have a diagnosis or need services.

Moderate (1 to 2 past-year symptoms): A possible diagnosis and possibly in need of services; likely to benefit from a brief assessment and brief intervention.

High (3+ past-year symptoms): High probabilities of a diagnosis and need for services; likely to need more formal assessment and intervention, either directly or through referral.

- Moderate (1 or 2) to high (3+) scores on the Internalizing Disorder Screener suggest the need for mental health treatment related to somatic complaints, depression, anxiety, trauma, suicide, and, at extreme levels, more serious mental illness (e.g., bipolar, schizoaffective, schizophrenia).
- Moderate (1 or 2) to high (3+) scores on the Externalizing Disorder Screener suggest the need for mental health treatment related to attention deficits, hyperactivity, impulsivity, conduct problems, and, in rarer cases, for gambling or other impulse control disorders.
- Moderate (1 or 2) to high (3+) scores on the Substance Disorder Screener suggest the need for substance use disorder treatment and, in more extreme cases, detoxification or maintenance services.
- Moderate (1 or 2) to high (3+) scores on the Crime and Violence Screener suggest the need for help with interpersonal violence, drug-related crimes, property crimes, and, in more extreme cases, interpersonal or violent crimes.

What to do after scoring

Once the GAIN-SS (CAMH Modified) is scored, there are two main tasks:

- Review the scores with the person. Explain what the scores mean, answer any questions and inform them of the next steps.
- Decide on the next steps in the treatment process. When the GAIN-SS (CAMH Modified) flags a possible issue, Keep and Consult (see the next section for more details).

Keep and consult

With the integration of AMH and the motto: "Every door is the right door," AHS is moving towards a system that focuses on supportive, effective and efficient care to reduce the duplication of services. We also want to reduce the frequency of individuals and families being bounced between services for mental health and addictions. We are not there yet, but we are striving to get there with the concept of "keep and consult."

The "keep" part means that every addiction and mental health professional will be, at the minimum, concurrent capable. Except for cases at the extreme severity level, most clinicians will keep and continue to work with people with concurrent disorders.

The "consult" part means that clinicians will consult with colleagues when questions arise about working with the "other disorder." For example, an addictions worker will consult with a mental health colleague for ideas to address someone experiencing a low severity depression. Or a mental health worker will consult an addictions colleague for advice in addressing a person's alcohol use.

When results of screening indicate that a concurrent disorder is likely to be present, the next step would be to consider the need for

A brief intervention only

- For example, if the screen shows no evidence of any disorder, answering any questions and providing requested information may be all that is needed.

A consultation and collaboration with an appropriate colleague

- When you are working with someone experiencing a concurrent disorder, you can consult with colleagues/resource people at any time for ideas and advice.

A more comprehensive assessment that targets the area(s) of concern as identified in the screen

- When screening flags an area, assessment is usually the next step to gather the information needed to verify or rule out the area flagged. Once the assessment is completed, a decision can be made as to the next steps.

A co-ordinated referral to a concurrent capable addiction or mental health service

- In cases of very high severity where you feel you are not able to provide services, a referral to specialized treatment may be indicated. Providing people with as much support as possible to ensure they are connected with the new service before discharging is crucial. Waiting lists for these services can be frustrating, but the recognition of a concurrent disorder opens the door to have a conversation and initiate some interim treatment planning.

Conclusion

We hope you have found this chapter to be helpful. If you have any questions, comments or stories to share, please contact concurrent.disorders@ahs.ca

The next steps in the concurrent capable treatment process are assessment and treatment planning. These are covered in detail in the next toolkit chapters.

note section

APPENDIX 1

Types of screens

Time frame

Behavioral health can change over time and so will the results of the same screening tool.

Screens can measure current, 12-month and/or lifetime occurrences of mental health and addiction issues. While the current time frame might be of most concern in many treatment settings, the presence of lifetime occurrences is also relevant. If someone flags for a past issue with addiction or mental health, it warrants further exploration as to its impact on changes in the present. For example, a person who had problems with depression in the past could experience a return of depression when they quit using substances. It would be wise to explore the relationship between the depression and use of substances (the role of assessment). It is the screen that can flag the past issue for this further exploration.

> *What do we mean by 'concurrent?' This is probably the most confusing aspect of concurrent disorders. When referring to a concurrent disorder it is important to specify the time frame. The main choices for time frames are lifetime, current, and 12-month (although variations on these have appeared in the literature). Lifetime means the two (or more) disorders occurred sometime during the individual's lifespan but not necessarily during the same time period. For example, an individual who experienced a major depressive disorder in their 20's and then developed cannabis dependence in their 30's (after the depression resolved) would be labeled as having a lifetime concurrent disorder. Twelve-month comorbidity means the two disorders occurred within the same 12-month time period, but not necessarily during the same month. This is a common definition of concurrent disorder used in epidemiology and can be used as an estimate of current comorbidity. In the strictest terms, however, a 'current' concurrent disorder means the two disorders happened during exactly the same time period* (Currie, 2011).

General vs. specific screens

General vs. specific screens speak to how finely tuned the screen is for detecting problems (broad or specific). These screens are sometimes used sequentially.

Some mental health and substance use screening tools are designed to identify the possibility that a person has any disorder (these are called general screens). For example, a general screen (e.g., GAIN-SS) may be used to flag the possibility of a mental disorder, yet not identify exactly which disorder.

Other screening tools are much more specific and aim to tentatively identify one or more specific disorders in one instrument (Centre for Addiction and Mental Health, 2009). For example, the Psychiatric Diagnostic Screening Questionnaire (PDSQ) can identify which mental disorder is likely.

The level of the screen is often dictated by the care setting. For example, primary care settings would usually use a general screen; whereas, a specialized mental health setting might use more specific screens.

General screens can be very helpful to flag concurrent disorders. For example, an addiction service can use a general screen to flag the possibility of a mental disorder or a mental health agency can use a general screen to flag the possibility of a substance abuse problem. Once an issue is flagged by the screen, a decision can be made as to the next step.

Level I and Level II screens

Health Canada (2001) identified two levels of screening. Their use depends on the setting, and the time and resources available.

Level I screening requires little time or effort on the part of the clinician during initial contact. While a Level I screen can be used in a variety of settings, it is often most appropriate where there is high volume and limited time, such as primary care, emergency or community health settings. Most Level I screens do not have a research base.

Level II screening requires more time, effort and the use of a more detailed standardized tool, but potentially yields greater benefits in terms of reliability and validity. A screening tool is classed as Level II if it has too many items to commit to memory (Health Canada, 2001).

>| examples |<

Level I Informal screening examples	Level II Formal tool examples
• A simple checklist of clinical indicators (sometimes called Index of Suspicion) • Asking a few questions • A brief screening instrument (CAGE-AID) • Case manager judgment	• Global Appraisal of Individual Needs-Short Screener (GAIN-SS) • Drug Abuse Screening Test (DAST) • Alcohol Use Disorders Identification Test (AUDIT) • Dimensional vs. diagnostic DSM-5 CC Symptom Measure • Personal Health Questionnaire (PHQ9)

While it is important to have screening tools that have excellent psychometric properties, a distinction can be made between what is needed for clinical decision-making, compared to what might be needed for a highly controlled research study. In other words, even though there may be no proven screening tool available at present which will work in all settings, there is still value in asking a few simple questions, or otherwise having a high index of suspicion using readily available information (Health Canada, 2001).

Dimensional vs. diagnostic

Dimensional tools measure things like quantity and frequency of alcohol/drug consumption, problem areas, functional status, mental well-being or service use history (Centre for Addiction and Mental Health, 2006).

Diagnostic tools, such as the DSM-5 Cross-Cut (CC) Symptom Measure measure diagnostic criteria and indicate if a psychiatric disorder is likely to be present.

In the mental health field there is an important distinction between diagnostic screening instruments and those based on psychological distress/functioning. Similarly, for substance use disorders, there are diagnostic screening instruments and there are those based on consequences or patterns of substance use (Health Canada, 2001).

Target population

Screens are usually designed for specific populations. The broadest target populations are age-based: screens for adults and those for children and adolescents. Screening tools designed for adults will not necessarily be appropriate and useful when used with children and adolescents. There are few screens for cultural and other population sub-groups.

Screening for youth

Mental disorders of adolescents, including substance use disorders, are not just "less mature" versions of adult disorders (or "older" versions of childhood disorders). They vary at different stages in the life course, and these differences evolve over time. The main implications of the developmental perspective for screening tools and processes are:

- Emotions or thoughts that might be considered "normal" at one age may be "abnormal" at another.
- Some disorders of childhood and adolescence may continue into adulthood if untreated, but other disorders will not (discontinuity). Discontinuity also applies to emotional states independent of a specific mental disorder, with the instability of mood in adolescence being particularly noteworthy. One implication is the need for periodic rather than one-time screening and assessment.
- The likelihood of identifying more than one mental disorder is thought to be much higher in children and adolescents compared to adults. This may be a function of how disorders are defined for children and adolescents, and also that psychopathology is just more complex.
- Factors such as gender differences are particularly critical (e.g., boys are more likely to experience externalizing disorders and girls are more likely to have internalizing disorders). Gender differences also increase with age, with girls overtaking boys in terms of prevalence of a mental disorder as they move into the later years of adolescence. Cultural and socio-economic differences are also important (Centre for Addiction and Mental Health, 2009).

APPENDIX 2

Screening criteria in detail

After reviewing the research literature, AHS found consensus for the following selection criteria for a standard screening tool (AHS, 2010)

Practical

- simple
- brief
- quick to administer (no more than 10 to 15 minutes)
- inexpensive
- user-friendly and able to be self-administered

Evidence-informed

- reliable
- sensitive
- specific
- valid

Simplicity

Screening for concurrent disorders can get complicated quickly. Screens measure different things and can identify

- mental disorders, but not substance abuse
  - mental disorder screens do not always identify all disorders and may leave some out
- substance abuse, but not mental disorders
  - some tools identify alcohol use, but not other drugs
  - other screens identify only drugs and not alcohol
  - some screens detect harmful use vs. dependence
- both mental disorders and substance abuse (concurrent disorder screen)

All people in AHS-AMH must be screened for concurrent disorders. This can be accomplished by using a concurrent disorder screen or a combination of more specific screens. For example, if you use a screen for mental health disorders (e.g., PHQ9), you will have to use another tool to screen for addiction issues. If you use a tool that screens only for alcohol use, you will have to use additional tools to screen for other addiction and mental health issues. This can get complicated! A key reason why AHS is moving to a standard approach to screening is

to simplify the screening process. A person-centred approach means people are not repeatedly asked the same or similar questions from site to site.

At the system level, a concern is the transferability of different screens to different sites. All services within AHS-AMH and related agencies must be able to understand a screen's scoring, its strengths and limitations, as well as find the information useful and relevant.

Number of questions and time required

Screening tools should have the briefest number of questions as possible to detect the intended issues. The more questions, the more reluctant individuals might be to complete the screen and the longer it will take. Ideally, screens should be quick to administer. The time involved in administering a screen is also a key factor in its practicality. The total time required is not only the time needed to administer the screen, but also the time required to score and interpret the results.

Affordability

Organizations must be able to afford any screening tools they use. Screens should be free or have inexpensive licensing fees. It helps if there are not particular staff qualifications required in order to use the tool. This can limit implementation of the tool to certain sites and increase the overall expense of administration. Screening tools that can be self-administered can save a lot of staff time and expense, especially over an entire system.

User friendly

One measure of user-friendliness is if the screen is simple and clear enough that it can be self-administered by the person seeking services. Many of the above criteria contribute to helping screening tools be user-friendly

- simplicity: questions that are easy to understand and answer, screens should be targeted towards lower literacy levels, and use "non-jargony" language and easy-to-read formatting
- the fewer number of questions, the better
- the less time it takes, the better it is for people

Evidence-informed

Validity

While no screen is perfect, we should be reasonably confident in a screen's results. There are several technical measures that help to determine if a screen can be trusted to measure what it's supposed to (i.e., its validity). While no screen is perfect, some are closer to the "Gold Standard" than others.

The "Gold Standard"

Stewart and Connors (2005) explained the gold standard as follows:

> *A gold standard is a measure that (ideally) correctly identifies every person with the disorder as well as all people without the disorder. Such a test typically is too time consuming or expensive to use for mass screening, but is perfect for establishing a definitive diagnosis and for judging the validity of screening tests. During this validation process, a group of people with and without a specific disorder complete a screening test and undergo testing using the gold standard. Assuming the gold standard always makes the correct diagnosis, respondents then can be classified into four groups:*
>
> *True positives: People who have a positive screening result and who have the disorder according to the gold standard test.*
>
> *False positives: People who have a positive screening result but do not have the disorder according to the gold standard.*
>
> *True negatives: People who have a negative screening result and do not have the disorder according to the gold standard.*
>
> *False negatives: People who have a negative screening result but who actually have the disorder according to the gold standard.*
>
> *An ideal screening test would provide only true positive and true negative results—that is, it would be as accurate as the gold standard for diagnosis. However, screening tests rarely if ever are perfect. In addition, when interpreting the results of screening test evaluations, it is important to keep in mind that often no perfect, or even nearly perfect, gold standard exists.*

Sensitivity and specificity

A screen should be able to detect the presence of whatever problem(s) is being screened. This avoids false negatives, where, for example, a drinking problem is not identified. The sensitivity of a screening tool refers to its ability to detect the condition or health concern that it is intended to detect (Health Canada, 2001).

At the same time, it shouldn't detect things that are not there—a false positive, where a drinking problem would be identified but it really is not a problem. The specificity of a screening tool refers to its ability to avoid saying that someone may have the problem or health concern when in fact they do not (Health Canada, 2001).

Sensitivity and specificity are expressed as numbers ranging in value from zero to one (or equivalently, from 0% to 100%). The higher the number, the more accurate the screen. As discussed in the Gold Standard sidebar, no screen will ever be one (or 100 %).

Sensitivity and specificity are determined for each disorder being measured. For example, if a screen measures substance use and mental health, the sensitivity and specificity values would likely be different for each.

Cut-off scores

A cut-off score is the score that determines a "positive" screen (i.e., that the person is likely to have the measured disorder). Research-based screening tools usually have established cut-off scores developed through piloting the tool with different populations. This takes the guesswork out of interpreting the screen.

It can be tricky to set cut-off scores. There is a trade-off between sensitivity and specificity related to the cut-off scores.

> *Lowering the cut-off score for a positive test result on a screen can increase the test's sensitivity—that is, the number of people with a problem classified as having a positive test result would go up. But because the increase in positive tests would include not only people who actually meet the criteria for having the problem, (i.e., are true positives) but also some who do not meet those criteria (i.e., are false positives), it also would mean a decrease in the test's specificity* (Stewart and Connors, 2005).

The general consensus in the research is that, in most service settings, it is better to lean towards a lower cut-off score to avoid missing those who really have a disorder.

Reliability

Reliability means a screen delivers consistent results.

- A screen should produce the same results no matter who administers it. If four clinicians administer the screen to the same person, the scores should be the same. This is called inter-rater reliability.
- This should also hold if the same clinician administers the screen more than once to the same person within the same time period. This is called test-retest reliability.
- The questions asked on the screen about the same topic should produce similar answers. This is called internal consistency reliability. This is why there are often similar questions on a screen.

GAIN-SS by the numbers

GAIN-SS has no official cut-off scores. It divides the possible scores into low (unlikely diagnosis), moderate (possible diagnosis) and high ranges (probable diagnosis).

Psychometric Analyses of the GAIN-SS Screeners

- The psychometrics of the GAIN-SS have been created using data from a consumer population.
- Information is available for specific subgroups of people, including those categorized by age, gender, race and ethnicity. Tables with the full array of psychometrics and scale norms can be found on the GAIN Coordinating Center's website (http://www.gaincc.org/resources).

Alpha reliability

The Total Disorder Screener has excellent internal consistency for both adolescents (0.87) and adults (0.88). For adolescents, all four screeners demonstrate good internal consistency as indicated by reliability coefficients greater than or equal to 0.70. For adults, three of the four screeners demonstrate good internal consistency (Internalizing

Disorders, Externalizing Disorders, and Substance Disorders), with Crime and Violence falling just shy of the 0.70 cutoff. The slightly reduced Crime and Violence internal consistency could be accounted for by adult experiences of criminal and violent behavior, which may be more varied than that represented by the items on the Crime and Violence Screener.

Note: The CAMH Modified items have not been validated

Appendix 3

Recommended screening tools

The GAIN-SS (CAMH Modified) is one option for screening for concurrent disorders. The DSM-5 CC Symptom Measure is another tool that can be used (see Appendix 3).

1. Informal (Level I) Screening

We learned in Appendix 1 that Level 1 screens are more informal, usually do not have a research base and take little time to administer. They can still be useful in clinical situations and can supplement the use of more formal screening tools.

a) ABC Checklist

The ABC Checklist is an informal screen that helps determine current mental status.

Appearance

- ☐ Appearance: General appearance, hygiene and dress
- ☐ Alertness: What is the level of consciousness?
- ☐ Affect: Elation or depression: gestures, facial expression and speech
- ☐ Anxiety: Is the individual nervous, phobic or panicky?

Behaviour

- ☐ Movements: Rate (hyperactive, hypoactive, abrupt or constant?)
- ☐ Organization: Coherent and goal-oriented?
- ☐ Purpose: Bizarre, stereotypical, dangerous or impulsive?
- ☐ Speech: Rate, organization, coherence and content

Cognition

- ☐ Orientation: Person, place, time and condition
- ☐ Calculation: Memory and simple tasks
- ☐ Reasoning: Insight, judgment and problem solving
- ☐ Coherence: Incoherent ideas, delusions and hallucinations?

b) Asking a few questions

The most basic approach to screening involves AMH staff asking a few direct questions in an attempt to screen for concurrent disorders. The Centre for Addiction and Mental Health (2006) provides the following examples that staff may use if their approach to screening is to simply ask about possible mental health or substance use problems.

Questions about substance use

- "Have you ever had any problems related to your use of alcohol or other drugs?"
- "Has a relative or friend, or a doctor or other health worker, been concerned about your drinking or other drug use, or suggested you cut down?"
- "Have you ever said to another person, 'I don't have a problem' (with alcohol or other drugs) when, around the same time, you wondered whether you did have a problem?"

Questions about mental health

- "Have you ever been given a mental health diagnosis by a qualified health professional?"
- "Have you ever been hospitalized for a mental health-related illness?"
- "Have you ever harmed yourself or thought about harming yourself, but not as a direct result of alcohol or other drug use?"

c) CAGE-AID

An informal four question screening tool to identify problem alcohol use among adults and youth

1. Have you ever thought you ought to Cut down on your drinking or drug use?
2. Have people Annoyed you by criticizing your drinking or drug use?
3. Have you felt bad or Guilty about your drinking or drug use?
4. Have you ever had a drink or used other drugs first thing in the morning (Eye-opener) to steady your nerves, get rid of a hangover or get the day started?

2. Formal (Level II) Screening Tools

Each of the tools in the following chart meets the selection criteria identified by AHS (2010):

Practical

- simple
- brief
- quick to administer (10 to 15 minutes)
- inexpensive
- user-friendly and able to be self-administered

Evidence-based

- reliable
- sensitive
- specific
- valid

The chart on the following page gives information on the recommended tools. For detailed background, administration and scoring information, please refer to the resource listed for each tool.

Source: Centre for Addiction and Mental Health (2006).
Permission to reproduce granted by CAMH.

Tool	Purpose	Target Population	Administration Time
Screening tools for both substance use and mental health problems			
GAIN-Short Screener (GAIN SS) More information: www.chestnut.org/LI/gain/index.html	Quickly and accurately identifies problems with mental health, substance use and gambling along with crime and violence indicators.	Adolescents and adults	3–5 min. (20 items)
Screening tools for mental health problems			
Modified Mini Screen (MMS) More information: www.oasas.ny.gov/hps/evaluation/documents/MINIScreenUsersGuide.pdf	Brief screening tool for mood, anxiety and psychotic disorders based on psychiatric interview.	Adults	15 min. (22 items)
DSM-5 Cross-Cut Symptom Measure (DSM-5 CC) More information: DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure, Adult	Uses a dimensional approach to measure child or adult age individual's subjective report of their symptom experiences based on DSM-5 criteria	Children age 6-17 and Adults	10 minutes
Addiction Severity Index (ASI) Psychiatric sub-scale More information: www.tresearch.org/resources/instruments.htm	Overview of psychiatric status.	Adults	15 min. (13 items completed by indivdual, 9 items completed by interviewer)
Patient Health Questionnaire (PHQ-9 and PHQ-A) More information: www.cqaimh.org/pdf/tool_phq9.pdf www.ohsu.edu/xd/education/schools/school-of-medicine/departments/clinical-departments/psychiatry/divisions-and-clinics/child-and-adolescent-psychiatry/opal-k/upload/PHQ-A-Severity-Measure-for-Depression.pdf	Multipurpose tool for screening diagnosing, monitoring and measuring the severity of depression.	Adolescents and adults	2-3 min. (9 items)

Tool	Purpose	Target Population	Administration Time
Screening tools for substance use problems			
CAGE-AID More information: http://bit.ly/CAGE-AID_inst	Screens for alcohol and other drug problems.	Adults	1 min. (4 items)
GAIN Substance Use Disorder Scale (GAIN-SUD) More information: www.chestnut.org/LI/gain/index.html	Initial screening for substance use severity using the DSM-V substance use disorder and substance dependence disorder criteria.	Adolescents and adults	5-10 min. (16 items)
Psychiatric Diagnostic Screening Questionnaire (PDSQ) Alcohol and Drug Sub-scales More information: http://portal.wpspublish.com/portal/page?_pageid=53,70444&_dad=portal&_schema=PORTA	Sub-scales screen for substance abuse and substance dependence disorders.	Adults	2-3 min. (12 items)
Alcohol Use Disorders Identification Test (AUDIT) More information: www.who.int/substance_abuse/publications/alcohol/en	Screens for harmful or hazardous alcohol consumption.	Adults	2-5 min. (10 items)

*Source: Centre for Addiction and Mental Health (2006). Permission to adapt granted by CAMH.

Appendix 4

Team activities

In addition to the Suggested Activities throughout the chapter (which can be done as a team), the following are four additional activities for teams.

Activity one

Develop a visual guide to treatment

It can help individuals and families to see the "big picture" of the treatment process since it is their personal recovery journey. In simple words, what are they wanting help with? This can help them understand where screening fits into the larger process of treatment. It also lets them know what will be next and they can track their progress through the various stages of the treatment process.

As a team, develop a visual guide (picture, mind map or flow chart) to the entire treatment process for your site including intake, screening, assessment, treatment planning, treatment and aftercare.

Before drawing a picture of the treatment process for your site, you must get very clear on what it looks like.

Make sure the visual is user-friendly and inviting! Do not make it look like a formal corporate flow chart. For some ideas

- Google the term "infographics" and you will find many sites that showcase all kinds of infographics. You can get some great ideas.
  - If you Google "infographics + mental health and/or addiction," you'll get more specific ideas.
- Microsoft Word 2010 has a new drawing feature called SmartArt that can help with infographics. On the Insert tab, in the Illustrations group, click SmartArt. A range of different types of graphics will be shown that you can choose from.
- Microsoft Visio is a diagramming software that may be available at your site. It has templates and samples that can help generate ideas.
- Free mind-mapping software is available—Google "free mind-mapping software" to find it. Just looking at examples of mind maps at the software sites can generate ideas.

Activity two

Debate: To screen or not to screen

Staff reluctance to implement concurrent disorder screening may stem from concerns about the lack of available resources. To surface some of these concerns (especially in areas where there are fewer resources), you could have a debate as described below. This can be a good activity for a staff meeting or retreat.

Form two teams and debate the following statement. One team argues in favour of the statement and the other team argues against it. Give the teams enough time to prepare their arguments. Be prepared for lively discussion!

> *Statement: It is unethical to screen for any condition when there isn't an accessible treatment pathway available to respond to a positive screen* (Croton, 2007).

Debrief questions:

After the debate, you can use the following questions to encourage solution-finding

- what would the treatment pathway be for that person?
- even if there are few resources, what can we do now?
- what resources are needed and how might we create them?

>| *examples* |<

Challenge (Service Level)	Strategies
❑ Lack of awareness and understanding of • prevalence and harms associated with concurrent disorders • interaction between addiction and mental health disorders • treatment implications	
❑ Clinicians who feel they lack skills, knowledge and confidence in their ability to screen and provide appropriate treatment for concurrent disorders are reluctant to ask questions that would lead to the identification of the disorders.	
❑ Perception of added work, especially when clinicians may feel overwhelmed by multiple demands, stresses and paperwork. They may also feel change-weary and change-wary.	
❑ Lack of familiarity with using screening tools and difficulty integrating their use into routine practice.	
❑ Clinician concerns that engagement may be compromised by formal screening.	
❑ Lack of clarity around scope of practice. For example, addiction counsellors may have anxiety about whether or not it is within their scope of practice to conduct a detailed mental health assessment.	
❑ Changes to practice, tools, language, beliefs, values, culture and exclusion criteria.	
❑ Stigma – two relapsing, highly stigmatized disorders in one person.	
❑ Clinicians own history of substance-related or mental health-related trauma and resulting cognitive dissonance.	
❑ Lack of knowledge of the "other" treatment system, its strengths, differences and constraints in service.	

Answer Key

Challenge (Service Level)	Strategies
Lack of awareness and understanding of • prevalence and harms associated with concurrent disorders • interaction between addiction and mental health disorders • treatment implications	Provide this information through multiple channels • staff orientation procedures and manuals • training and professional development sessions • information resources
Clinicians who feel they lack skills, knowledge and confidence in their ability to screen and provide appropriate treatment for concurrent disorders are reluctant to ask questions that would lead to the identification of the disorders.	Reframe the concurrent capability challenge as one of clinicians working together differently and more corroboratively rather than everyone needing to have all the expertise. Provide education, training and concrete methods of accommodating people and working together as professionals. Address clinician "self-efficacy" about providing effective treatment. Reinforce the skills clinicians already have and how they can be applied to concurrent disorders (i.e., it's not that different).
Perception of added work, especially when clinicians may feel overwhelmed by multiple demands, stresses and paperwork. They may also feel change-weary and change-wary.	Promote the view that the goal is increased effectiveness rather than added work, and that recognizing and addressing concurrent disorders is likely to lead to more successful treatment of our target disorders. It will save time in the longer run when concurrent disorders are recognized as treatment is likely to go more quickly with fewer setbacks and better outcomes. When introducing new screening tools, take the opportunity to review and simplify existing forms and processes to remove some of the paperwork burden.

Lack of familiarity with using screening tools and difficulty integrating their use into routine practice.	Provide information about the purpose and rationale for screening and assessment Practise using and scoring the recommended screens so use becomes seamless.
Clinician concerns that engagement may be compromised by formal screening.	Provide training, modelling and clinical supervision around integrating welcoming and screening into routine practice in a manner that does not compromise individual engagement. Reinforce that, if done well, screening can build engagement. Include careful explanation to people of the rationale for and confidentiality of screening.
Lack of clarity around scope of practice. For example, addiction counsellors may have anxiety about whether or not it is within their scope of practice to conduct a detailed mental health assessment.	Ensure that all clinical staff • have a basic level of concurrent capability, including basic knowledge of addiction and mental disorders and interactions between the disorders. • have the ability to welcome and screen everyone presenting for services. • can establish relationships with professional colleagues that allow for consultation and collaborative treatment planning or co-ordination of smooth referral, if necessary Clarify scope of practice guidelines pertaining to assessment and more specialized treatment interventions.
Changes to practice, tools, language, beliefs, values, culture and exclusion criteria.	Use policy to reinforce that addressing concurrent disorders is core business for mental health and addiction treatment services.
Stigma – two relapsing, highly stigmatized disorders in one person	Encourage treatment providers to identify their own attitudes and biases evoked by supporting someone experiencing a concurrent disorder.

> | *Answers* | <

Clinicians own history of substance-related or mental health-related trauma and resulting cognitive dissonance.	Emphasize the considerable benefits (to the person, clinician and system) of addressing concurrent disorders. Provide integrated recovery-oriented clinical supervision.
Lack of knowledge of the "other" treatment system, its strengths, differences and constraints in service.	Provide opportunities for building relationships and collaborative practice through • rotations and placements with the opposite service • joint training • routine provision of service from the opposite service • worker-developed protocols • co-location • scheduled, regular clinical case conferences and managerial meetings to ensure program protocols support collaboration

Activity three

Screening walk-through

Imagine you are presenting to your program seeking service. Using the Concurrent Disorder Screening checklist on page 65, "walk-through" your agency from making an appointment to completing the screening process (including knowing what the next step is).

- What are your first impressions?
- What does your site do well to engage people in screening?
- How could engagement during screening be improved?
- How could the screening process be improved?

Concurrent disorder screening checklist

QUESTIONS	ALREADY DO THIS	COULD EASILY DO	THIS WILL TAKE TIME	THIS WILL BE HARD	COMMENTS AND REFLECTIONS
1. Program structure					
Do policies and procedures describe a clear screening protocol?	❑	❑	❑	❑	
Is the GAIN-SS (CAMH Modified) used?	❑	❑	❑	❑	
If the GAIN-SS (CAMH Modified) is not being used, are there clearly stated clinical reasons why not?	❑	❑	❑	❑	
Are other recommended screens used instead?	❑	❑	❑	❑	
Are there mechanisms in place to observe and evaluate clinician screening practice?	❑	❑	❑	❑	
2. Welcome and engage					
Are all people welcomed to the service?	❑	❑	❑	❑	
Is confidentiality and its limitations explained in a way people can understand?	❑	❑	❑	❑	
Do staff engage individuals while screening using the following methods?					
find a way to connect	❑	❑	❑	❑	
accept if they do not want to answer screening questions	❑	❑	❑	❑	
encourage questions and answer them in a way everyone can understand	❑	❑	❑	❑	
3. Observe and gather					
Do staff identify the following before proceeding with concurrent disorder screening?					
suicide risk	❑	❑	❑	❑	
violence risk (harm to self or others)	❑	❑	❑	❑	
literacy level (if screen is to be self-administered)	❑	❑	❑	❑	
cognitive disability (if screen is to be self-administered)	❑	❑	❑	❑	
any other factor that would prevent the administration of the concurrent disorder screen (intoxication, acute psychosis or other disorder, acute physical health condition, severe distress or crisis)	❑	❑	❑	❑	
Is all relevant and required information gathered?	❑	❑	❑	❑	

Concurrent disorder screening checklist

QUESTIONS	ALREADY DO THIS	COULD EASILY DO	THIS WILL TAKE TIME	THIS WILL BE HARD	COMMENTS AND REFLECTIONS
4. Introduce the screen					
Do staff introduce the screen?	❑	❑	❑	❑	
Are the following points covered?					
Explain that we ask these questions of everyone who comes for service so they do not feel singled out.	❑	❑	❑	❑	
Explain the reasons for asking the screen – to gain complete information about their situation and to better match them with the most helpful services.	❑	❑	❑	❑	
Inform individuals of time needed to complete – give a range as some people will complete the screen faster than others.	❑	❑	❑	❑	
Inform individuals what will be done as a result of the screen –scoring, further assessment, referral, etc.	❑	❑	❑	❑	
Do staff ask for permission to proceed with the screening?	❑	❑	❑	❑	
5. Administer and score the screen					
Do staff prepare for screening by having…					
extra forms on hand?	❑	❑	❑	❑	
a previous year's calendar available?	❑	❑	❑	❑	
a quiet, private place?	❑	❑	❑	❑	
Do staff follow all instructions for administration of the screening tool?	❑	❑	❑	❑	
Do staff ask screening questions as required?	❑	❑	❑	❑	
Are staff able to answer questions about the screen?	❑	❑	❑	❑	
Do staff thank the individual for completing the screen?	❑	❑	❑	❑	
Are staff proficient in scoring the screen?	❑	❑	❑	❑	
Do staff know how to interpret the results of the screen?	❑	❑	❑	❑	
Do staff discuss the scores with people and explain what they mean?	❑	❑	❑	❑	
6. Keep and consult					
Are staff able to identify the next steps based on screen results?	❑	❑	❑	❑	
Do staff explain to people what the next steps are and answer questions?	❑	❑	❑	❑	

Appendix 5:

GAIN-SS (CAMH Modified) practice scenarios

John

John is a 23-year-old single male who works as a plumber's assistant. John has an active social life with his friends who all use substances. Last year John tested positive for HIV, but he does not know how he got it as he was always careful about his needles. John often gets angry and in fights when he is high on speed. He also uses alcohol and marijuana occasionally. John feels pretty low a lot of the time and has been thinking of suicide lately, although he probably would never carry through as he hates the thought of dying. As a child, John always had trouble in school and found it difficult to pay attention. He enters treatment at an addiction outpatient unit.

John's GAIN-SS (CAMH Modified)

To be filled out by the interviewer

Client Name: a. John (First name) b. __ (M.I.) c. _____ (Last name)

Date: |__|__| / |__|__| / 20 |__|__| (MM/DD/YYYY)

GAIN Short Screener (GAIN-SS)

Version [GVER]: GAIN-SS ver. 3.0 CAMH

The following questions are about common psychological, behavioural, and personal problems. These problems are considered **significant** when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0
IDScr 1. **When was the last time** that you had **significant** problems with…					
a. feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	(4)	3	2	1	0
b. sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?	4	3	2	1	(0)
c. feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?	4	3	2	1	(0)
d. becoming very distressed and upset when something reminded you of the past?	(4)	3	2	1	0
e. thinking about ending your life or committing suicide?	(4)	3	2	1	0
f. seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts?	4	3	2	1	(0)
EDScr 2. **When was the last time** that you did the following things **two or more times**?					
a. Lied or conned to get things you wanted or to avoid having to do something	4	3	2	(1)	0
b. Had a hard time paying attention at school, work, or home.	4	3	(2)	1	0
c. Had a hard time listening to instructions at school, work, or home.	4	3	(2)	1	0
d. Had a hard time waiting for your turn.	4	3	(2)	1	0
e. Were a bully or threatened other people.	(4)	3	2	1	0
f. Started physical fights with other people	(4)	3	2	1	0
g. Tried to win back your gambling losses by going back another day.	4	3	2	1	(0)
SDScr 3. **When was the last time** that…					
a. you used alcohol or other drugs weekly or more often?	(4)	3	2	1	0
b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (e.g., feeling sick)?	(4)	3	2	1	0
c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	(4)	3	2	1	0
d. your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home, or social events?	4	(3)	2	1	0
e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or avoid withdrawal problems?	(4)	3	2	1	0

(Continued) After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

CVScr 4. **When was the last time** that you…

a. had a disagreement in which you pushed, grabbed, or shoved someone?	(4)	3	2	1	0
b. took something from a store without paying for it?	4	3	2	1	(0)
c. sold, distributed, or helped to make illegal drugs?	4	3	2	1	(0)
d. drove a vehicle while under the influence of alcohol or illegal drugs?	4	3	(2)	1	0
e. purposely damaged or destroyed property that did not belong to you?	4	3	2	1	(0)

Additional questions (CAMH modified)

After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

AQ5. **When was the last time** you had **significant** problems with… **(not related to alcohol/drug use)**

a. missing meals or throwing up much of what you did eat to control your weight?	4	3	2	1	(0)
b. eating binges or times when you ate a very large amount of food within a short period of time and then felt guilty?	4	3	2	1	(0)
c. being disturbed by memories or dreams of distressing things from the past that you did, saw, or had happen to you?	4	3	2	(1)	0
d. thinking or feeling that people are watching you, following you, or out to get you?	4	3	2	1	(0)
e. videogame playing or internet use that caused you to give up, reduce, or have problems with important activities or people of work, school, home or social events?	4	3	2	1	(0)
f. gambling that caused you to give up, reduce, or have problems with important activities or people at work, school, home, or social events?	4	3	2	1	(0)

Score John's GAIN-SS (CAMH Modified):

GAIN-SS Domains and total:

IDScr (items 1a-1f)
EDScr (items 2a-2g)
SDScr (items 3a-3e)
CVScr (items 4a-4e)
TDScr (items 1a-4e)

CAMH-Modified items:

a (Problematic eating)
b (Problematic eating)
c (Traumatic stress)
d (Disordered thinking)
e (Video game and internet use)
f (Gambling)

Given the scenario and the GAIN-SS (CAMH Modified) scores, what would you do next?

Answer key for John

Scores for John's GAIN-SS (CAMH Modified)

GAIN-SS Domains and total:

Scoring					
Screener	**Items**	**Past month (4)**	**Past 90 days (4, 3)**	**Past year (4, 3, 2)**	**Ever (4, 3, 2, 1)**
IDScr	1a – 1f	3	3	3	3
EDScr	2a – 2g	2	2	5	6
SDScr	3a – 3e	4	5	5	5
CVScr	4a – 4e	1	1	2	2
TDScr	1a – 4e	10	11	15	16
Supplemental questions	AQ5a-f	0	0	0	1

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Given the scenario and the GAIN-SS (CAMH Modified) scores, what would you do next?

As part of the intake procedures and general screening, John's suicidal ideation is acknowledged and followed up with a Suicide Risk Review. This review identified that there is no plan or serious intention; therefore, it is decided that no further action is needed at this time.

John flags high for substance abuse and given the information in the case, substance abuse treatment is indicated. So the counsellor and John agree to proceed with assessment/treatment planning for the substance abuse issue. Part of this assessment will focus on the links between John's fighting and his use of meth.

The GAIN-SS flagged for depression items and given his suicidal thoughts, further assessment for depression is indicated. The GAIN-SS also flagged the items related to attention and during the debrief, a history of school failure and difficulties became evident. Therefore, further exploration is indicated here as well.

After consulting with a mental health colleague, the counsellor decides to conduct an assessment for concurrent disorders, including depression and ADHD screens and to consult further once more information is gathered.

Mike

Mike is in his twenties and has been diagnosed with schizophrenia. He suffered his first psychotic episode when he was 17 after a period of heavy marijuana use. He has been in and out of mental health treatment for years and does not always take his meds as prescribed. He continues heavy marijuana use and experiences hallucinations and disordered thoughts as a result. He has had several hospital admissions for drug-induced psychosis. He has participated in some addiction treatment and knows the danger of continued marijuana use, but he has always returned to using. Mike was referred to your outpatient mental health clinic after discharge from a residential mental health unit.

Mike's GAIN-SS V.3.0 (CAMH Modified)

To be filled out by the interviewer

Client Name: a. Mike (First name) b. __ (M.I.) c. _____ (Last name)

Date: |__|__| / |__|__| / 20 |__|__| (MM/DD/YYYY)

GAIN Short Screener (GAIN-SS)

Version [GVER]: GAIN-SS ver. 3.0 CAMH

The following questions are about common psychological, behavioural, and personal problems. These problems are considered **significant** when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0
IDScr 1. **When was the last time** that you had **significant** problems with…					
a. feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	4	3	2	(1)	0
b. sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?	(4)	3	2	1	0
c. feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?	4	(3)	2	1	0
d. becoming very distressed and upset when something reminded you of the past?	4	3	2	(1)	0
e. thinking about ending your life or committing suicide?	4	3	2	1	(0)
f. seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts?	4	(3)	2	1	0
EDScr 2. **When was the last time** that you did the following things **two or more times**?					
a. Lied or conned to get things you wanted or to avoid having to do something	4	3	2	(1)	0
b. Had a hard time paying attention at school, work, or home.	4	3	(2)	1	0
c. Had a hard time listening to instructions at school, work, or home.	4	3	(2)	1	0
d. Had a hard time waiting for your turn.	4	3	(2)	1	0
e. Were a bully or threatened other people.	4	3	2	1	(0)
f. Started physical fights with other people	4	3	2	1	(0)
g. Tried to win back your gambling losses by going back another day.	4	3	2	1	(0)
SDScr 3. **When was the last time** that…					
a. you used alcohol or other drugs weekly or more often?	(4)	3	2	1	0
b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (e.g., feeling sick)?	(4)	3	2	1	0
c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	(4)	3	2	1	0
d. your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home, or social events?	4	3	2	(1)	0
e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or avoid withdrawal problems?	4	3	2	1	(0)

(Continued) After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

CVScr 4. **When was the last time** that you…

a. had a disagreement in which you pushed, grabbed, or shoved someone?	4	3	2	1	(0)
b. took something from a store without paying for it?	4	3	2	1	(0)
c. sold, distributed, or helped to make illegal drugs?	4	3	2	1	(0)
d. drove a vehicle while under the influence of alcohol or illegal drugs?	4	3	2	1	(0)
e. purposely damaged or destroyed property that did not belong to you?	4	3	2	1	(0)

Additional questions (CAMH modified)

After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

AQ5. **When was the last time** you had **significant** problems with… **(not related to alcohol/drug use)**

a. missing meals or throwing up much of what you did eat to control your weight?	4	3	2	1	(0)
b. eating binges or times when you ate a very large amount of food within a short period of time and then felt guilty?	4	3	2	1	(0)
c. being disturbed by memories or dreams of distressing things from the past that you did, saw, or had happen to you?	4	3	2	1	(0)
d. thinking or feeling that people are watching you, following you, or out to get you?	(4)	3	2	1	0
e. videogame playing or internet use that caused you to give up, reduce, or have problems with important activities or people of work, school, home or social events?	4	3	2	1	(0)
f. gambling that caused you to give up, reduce, or have problems with important activities or people at work, school, home, or social events?	4	3	2	1	(0)

Score Mike's GAIN-SS (CAMH Modified):

GAIN-SS Domains and total:

IDScr (items 1a-1f)
EDScr (items 2a-2g)
SDScr (items 3a-3e)
CVScr (items 4a-4e)
TDScr (items 1a-4e)

CAMH-Modified items:

a (Problematic eating)
b (Problematic eating)
c (Traumatic stress)
d (Disordered thinking)
e (Video game and internet use)
f (Gambling)

Given the scenario and the GAIN-SS (CAMH Modified) scores, what would you do next?

Answer key for Mike

GAIN-SS (CAMH Modified) Domains and total:

Scoring					
Screener	**Items**	**Past month (4)**	**Past 90 days (4, 3)**	**Past year (4, 3, 2)**	**Ever (4, 3, 2, 1)**
IDScr	1a – 1f	1	3	3	5
EDScr	2a – 2g	0	0	3	4
SDScr	3a – 3e	3	3	3	4
CVScr	4a – 4e	0	0	0	0
TDScr	1a – 4e	4	6	9	13
Supplemental questions	AQ5a-f	1	1	1	1

Given the scenario and the GAIN-SS (CAMH Modified) scores, what would you do next?

Given his schizophrenia diagnosis and recent discharge from residential treatment, a supplementary mental health assessment is warranted to see where Mike is at currently and what mental health treatment options will be appropriate.

You also decide to revisit the detailed substance abuse assessment with the view of helping Mike to discover the links between marijuana use and his mental health symptoms and his readiness to pursue further addictions treatment. When completed, you will consult with an addictions colleague to determine the best course of action for his marijuana use.

Jane

Jane is a 22-year-old female who lives with her boyfriend. She grew up in a home with domestic violence and witnessed the physical and verbal abuse of her mother at the hands of her father during most of her childhood. Jane does not have clear memories about the abuse. Jane experienced additional trauma when she was sexually abused by her step-brother between the ages of 6-9 years. Growing up, Jane felt anxious and depressed, and remembers experiencing feelings that she wished she would not wake up in the morning. These feelings became stronger in her late adolescence after she had started to drink and use marijuana daily. Jane dropped out of high school and moved in with her boyfriend who introduced her to heroin. Her boyfriend does not work and introduced her to heroin and prostituition to pay for their addictions. Lately Jane is fighting with her boyfriend more often, which at times becomes physical. She has also started to shoplift to make ends meet. Jane walks into an addiction outpatient clinic looking for services to address her substance use.

Jane's GAIN-SS (CAMH Modified)

To be filled out by the interviewer

Client Name: a. Jane (First name) b. __ (M.I.) c. _____ (Last name)

Date: |__|__| / |__|__| / 20 |__|__| (MM/DD/YYYY)

GAIN Short Screener (GAIN-SS)

Version [GVER]: GAIN-SS ver. 3.0 CAMH

The following questions are about common psychological, behavioural, and personal problems. These problems are considered **significant** when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0
IDScr 1. **When was the last time** that you had **significant** problems with…					
a. feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	(4)	3	2	1	0
b. sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?	(4)	3	2	1	0
c. feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?	(4)	3	2	1	0
d. becoming very distressed and upset when something reminded you of the past?	(4)	3	2	1	0
e. thinking about ending your life or committing suicide?	4	3	2	(1)	0
f. seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts?	4	3	2	1	(0)
EDScr 2. **When was the last time** that you did the following things **two or more times**?					
a. Lied or conned to get things you wanted or to avoid having to do something	(4)	3	2	1	0
b. Had a hard time paying attention at school, work, or home.	4	3	2	(1)	0
c. Had a hard time listening to instructions at school, work, or home.	4	3	2	1	(0)
d. Had a hard time waiting for your turn.	4	3	2	1	(0)
e. Were a bully or threatened other people.	4	3	2	1	(0)
f. Started physical fights with other people	4	3	2	1	(0)
g. Tried to win back your gambling losses by going back another day.	4	3	2	1	(0)
SDScr 3. **When was the last time** that…					
a. you used alcohol or other drugs weekly or more often?	(4)	3	2	1	0
b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (e.g., feeling sick)?	(4)	3	2	1	0
c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	4	3	2	(1)	0
d. your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home, or social events?	4	(3)	2	1	0
e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or avoid withdrawal problems?	4	(3)	2	1	0

(Continued) After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

CVScr 4. **When was the last time** that you…

a.	had a disagreement in which you pushed, grabbed, or shoved someone?	4	3	2	1	(0)
b.	took something from a store without paying for it?	(4)	3	2	1	0
c.	sold, distributed, or helped to make illegal drugs?	4	3	2	1	(0)
d.	drove a vehicle while under the influence of alcohol or illegal drugs?	4	3	2	1	(0)
e.	purposely damaged or destroyed property that did not belong to you?	4	3	2	1	(0)

Additional questions (CAMH modified)

After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

AQ5. **When was the last time** you had **significant** problems with… **(not related to alcohol/drug use)**

a.	missing meals or throwing up much of what you did eat to control your weight?	4	3	2	1	(0)
b.	eating binges or times when you ate a very large amount of food within a short period of time and then felt guilty?	4	3	2	1	(0)
c.	being disturbed by memories or dreams of distressing things from the past that you did, saw, or had happen to you?	(4)	3	2	1	0
d.	thinking or feeling that people are watching you, following you, or out to get you?	4	3	2	1	(0)
e.	videogame playing or internet use that caused you to give up, reduce, or have problems with important activities or people of work, school, home or social events?	4	3	2	1	(0)
f.	gambling that caused you to give up, reduce, or have problems with important activities or people at work, school, home, or social events?	4	3	2	1	(0)

Score Jane's GAIN-SS (CAMH Modified):

GAIN-SS Domains and total:

IDScr (items 1a-1f)
EDScr (items 2a-2g)
SDScr (items 3a-3e)
CVScr (items 4a-4e)
TDScr (items 1a-4e)

CAMH-Modified items:

a (Problematic eating)
b (Problematic eating)
c (Traumatic stress)
d (Disordered thinking)
e (Video game and internet use)
f (Gambling)

Given the scenario and the GAIN-SS (CAMH Modified) scores, what would you do next?

Answer key for Jane

GAIN-SS (CAMH Modified) Domains and total:

Scoring					
Screener	**Items**	**Past month (4)**	**Past 90 days (4, 3)**	**Past year (4, 3, 2)**	**Ever (4, 3, 2, 1)**
IDScr	1a – 1f	4	4	4	5
EDScr	2a – 2g	1	1	1	2
SDScr	3a – 3e	2	4	4	5
CVScr	4a – 4e	1	1	1	1
TDScr	1a – 4e	8	10	10	13
Supplemental questions	AQ5a-f	1	1	1	1

Given the scenario and the GAIN-SS (CAMH Modified) scores, what would you do next?

The screen indicates that Jane is in physical danger from her boyfriend. You address the immediate safety risk by talking to Jane about how she will ensure she is able to stay safe.

You then decide to proceed with an addiction assessment to determine current use levels and potential withdrawal concerns.

The GAIN-SS and information from Jane shows a need for follow-up in the areas of past and current trauma (possibly the source of the depression and anxiety scores). You decide to consult with a mental health colleague and address these issues in a future visit with Jane.

Jill

Jill is brought into an addictions clinic by her parents who are angry that she has been sneaking out to go to parties where she drinks. The parents want her put into residential treatment as they are also worried she is using drugs.

Jill's GAIN-SS (CAMH Modified)

To be filled out by the interviewer

Client Name: a. Jill (First name) b. __ (M.I.) c. _____ (Last name)

Date: |__|__| / |__|__| / 20 |__|__| (MM/DD/YYYY)

GAIN Short Screener (GAIN-SS)

Version [GVER]: GAIN-SS ver. 3.0 CAMH

The following questions are about common psychological, behavioural, and personal problems. These problems are considered **significant** when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0
IDScr 1. **When was the last time** that you had **significant** problems with…					
a. feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	4	3	2	1	(0)
b. sleep trouble, such as bad dreams, sleeping restlessly, or falling asleep during the day?	4	3	2	1	(0)
c. feeling very anxious, nervous, tense, scared, panicked, or like something bad was going to happen?	4	3	2	1	(0)
d. becoming very distressed and upset when something reminded you of the past?	4	3	2	(1)	0
e. thinking about ending your life or committing suicide?	4	3	2	1	(0)
f. seeing or hearing things that no one else could see or hear or feeling that someone else could read or control your thoughts?	4	3	2	1	(0)
EDScr 2. **When was the last time** that you did the following things **two or more times**?					
a. Lied or conned to get things you wanted or to avoid having to do something	(4)	3	2	1	0
b. Had a hard time paying attention at school, work, or home.	4	3	2	(1)	0
c. Had a hard time listening to instructions at school, work, or home.	4	3	2	(1)	0
d. Had a hard time waiting for your turn.	4	3	2	(1)	0
e. Were a bully or threatened other people.	4	3	2	1	(0)
f. Started physical fights with other people	4	3	2	1	(0)
g. Tried to win back your gambling losses by going back another day.	4	3	2	1	(0)
SDScr 3. **When was the last time** that…					
a. you used alcohol or other drugs weekly or more often?	4	3	2	1	(0)
b. you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs (e.g., feeling sick)?	4	3	2	1	(0)
c. you kept using alcohol or other drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	4	3	2	1	(0)
d. your use of alcohol or other drugs caused you to give up or reduce your involvement in activities at work, school, home, or social events?	4	3	2	1	(0)
e. you had withdrawal problems from alcohol or other drugs like shaky hands, throwing up, having trouble sitting still or sleeping, or you used any alcohol or other drugs to stop being sick or avoid withdrawal problems?	4	3	2	1	(0)

(Continued) After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

CVScr 4. **When was the last time** that you…

a. had a disagreement in which you pushed, grabbed, or shoved someone? 4 3 2 1 (0)
b. took something from a store without paying for it? 4 3 2 1 (0)
c. sold, distributed, or helped to make illegal drugs? 4 3 2 1 (0)
d. drove a vehicle while under the influence of alcohol or illegal drugs? 4 3 2 1 (0)
e. purposely damaged or destroyed property that did not belong to you? 4 3 2 1 (0)

Additional questions (CAMH modified)

After each of the following questions, please tell us the last time, if ever, you had the problem by answering whether it was in the past month, 2 to 3 months ago, 4 to 12 months ago, 1 or more years ago, or never.	Past month	2 to 3 months ago	4 to 12 months ago	1+ years ago	Never
	4	3	2	1	0

AQ5. **When was the last time** you had **significant** problems with… **(not related to alcohol/drug use)**

a. missing meals or throwing up much of what you did eat to control your weight? 4 3 2 1 (0)
b. eating binges or times when you ate a very large amount of food within a short period of time and then felt guilty? 4 3 2 1 (0)
c. being disturbed by memories or dreams of distressing things from the past that you did, saw, or had happen to you? 4 3 2 1 (0)
d. thinking or feeling that people are watching you, following you, or out to get you? 4 3 2 1 (0)
e. videogame playing or internet use that caused you to give up, reduce, or have problems with important activities or people of work, school, home or social events? 4 3 2 1 (0)
f. gambling that caused you to give up, reduce, or have problems with important activities or people at work, school, home, or social events? 4 3 2 1 (0)

Score Jill's GAIN-SS (CAMH Modified):

GAIN-SS Domains and total:

IDScr (items 1a-1f)
EDScr (items 2a-2g)
SDScr (items 3a-3e)
CVScr (items 4a-4e)
TDScr (items 1a-4e)

CAMH-Modified items:

a (Problematic eating)
b (Problematic eating)
c (Traumatic stress)
d (Disordered thinking)
e (Video game and internet use)
f (Gambling)

Given the scenario and the GAIN-SS (CAMH Modified) scores, what would you do next?

Answer key for Jill

GAIN-SS Domains and total:

Scoring					
Screener	**Items**	**Past month (4)**	**Past 90 days (4, 3)**	**Past year (4, 3, 2)**	**Ever (4, 3, 2, 1)**
IDScr	1a – 1f	0	0	0	1
EDScr	2a – 2g	1	1	1	4
SDScr	3a – 3e	0	0	0	0
CVScr	4a – 4e	0	0	0	0
TDScr	1a – 4e	1	1	1	5
Supplemental questions	AQ5a-f	0	0	0	0

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Given the scenario and the GAIN-SS (CAMH Modified) scores, what would you do next?

After gathering the stories from the perspective of both Jill and her parents and reviewing the GAIN-SS scores, you determine that Jill does not have any problematic substance use issues. You discuss various ways of improving relations with her parents. You refer both Jill and the parents to an information workshop and offer assistance to help them resolve the parent-adolescent conflict.

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