MASTERING THE DIAGNOSIS OF SUDs

DSM-5-TR AND EVIDENCE-BASED ASSESSMENT TOOLS

NPRNworld

MASTERING THE DIAGNOSIS OF SUDS:

DSM-5-TR AND EVIDENCE-BASED ASSESSMENT TOOLS

ANCC Accredited NCPD Hours: 1 hrs

Target Audience: RN/APRN

NEEDS ASSESSMENT

Despite progress in public awareness and clinical treatment of substance use disorders (SUDs), diagnostic inconsistencies persist across healthcare settings due to a lack of unified frameworks and standardised assessment practices. Many clinicians are not fully trained in applying the **DSM-5-TR diagnostic criteria**, grading severity, or differentiating between substance-induced symptoms and co-occurring psychiatric conditions. This contributes to misdiagnosis, treatment delays, and inadequate care planning, especially in complex or high-risk patients.

At the same time, validated **screening tools** like AUDIT, CRAFFT, DAST-10, and TAPS remain underutilised in busy clinical environments, despite their proven effectiveness in early identification and risk stratification. The **integration of screening into SBIRT (Screening, Brief Intervention, and Referral to Treatment)** workflows remains inconsistent, limiting clinicians' ability to proactively engage at-risk populations.

To improve outcomes, clinicians must be equipped with both the **diagnostic precision** of DSM-5-TR and the **practical application** of evidence-based screening strategies, especially when differentiating between **substance-induced mental disorders** and **dual diagnoses**.

OBJECTIVES

By the end of this module, participants will be able to:

- **Apply** the DSM-5-TR diagnostic criteria to accurately identify and grade substance use disorders (mild, moderate, severe).
- **Utilise** validated screening tools (e.g., AUDIT, CRAFFT, TAPS, DAST-10) to

detect and assess substance use across the lifespan.

- **Differentiate** between substance-induced psychiatric symptoms and co-occurring mental health disorders to support appropriate treatment planning.
- **Integrate** screening and diagnostic findings into the SBIRT model to guide intervention, referral, and ongoing care.
- **Document** assessment findings effectively to support medical necessity, treatment decisions, and insurance reimbursement.

GOAL

To enhance clinicians' ability to accurately diagnose and assess substance use disorders (SUDs) using DSM-5-TR criteria and validated screening tools, while effectively distinguishing co-occurring psychiatric conditions and integrating findings into person-centred treatment plans.

INTRODUCTION

Accurate and timely diagnosis is the cornerstone of effective care for individuals with substance use disorders (SUDs). Misclassification or delayed identification not only impedes treatment but can also exacerbate comorbid psychiatric symptoms, increase healthcare utilisation, and prolong the cycle of addiction. To mitigate these risks, clinicians must be proficient in applying standardised diagnostic frameworks that reflect the complexity and continuum of substance use.

The **DSM-5-TR** provides a robust, dimensional framework for diagnosing SUDs, integrating symptom domains such as impaired control, social impairment, risky use, and pharmacologic criteria. This model replaces outdated dichotomies like "abuse" versus "dependence" with a single, severity-graded diagnosis that better aligns with contemporary clinical practice and individualised treatment planning.

Equally essential is the strategic use of **validated screening tools**, such as the **AUDIT**, **CRAFFT**, **TAPS**, and **DAST-10**, which support early identification, risk stratification, and engagement across all age groups. When implemented within the **SBIRT (Screening, Brief Intervention, and Referral to Treatment)** framework, these tools enable proactive, nonjudgmental conversations about substance use, facilitating early intervention and referral to appropriate levels of care.

Another critical area addressed in this module is the accurate **differentiation between substance-induced psychiatric symptoms and co-occurring mental health disorders**. With nearly **1 in 5 individuals** affected by both SUDs and psychiatric conditions, distinguishing between these diagnoses is essential for developing integrated, person-centred care plans. Failure to do so may result

in either undertreatment of psychiatric symptoms or misattribution of substance-related behaviours, leading to poor outcomes and increased relapse risk.

This module empowers clinicians with the diagnostic clarity, clinical judgment, and evidence-based tools needed to confidently evaluate substance use in both routine and complex clinical scenarios. By mastering this framework, providers can enhance patient outcomes, reduce stigma, and contribute to a more accurate and compassionate model of addiction care.

DIAGNOSIS OF SUBSTANCE USE DISORDERS (SUDS): DSM-5-TR FRAMEWORK

The **Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR)** provides a comprehensive and unified framework for diagnosing **substance use disorders (SUDs)**. This edition merges the previously distinct categories of "substance abuse" and "substance dependence" into a single, dimensional diagnosis based on severity.

Core Definition

Substance Use Disorder is defined as a **problematic pattern of substance use** leading to clinically significant **impairment or distress**, as manifested by **two or more** of the following **11 criteria** within 12 months.

DSM-5-TR CRITERIA FOR SUBSTANCE USE DISORDER

1. Impaired Control

- **Substance taken in larger amounts** or over a longer period than intended.
- **Persistent desire** or unsuccessful efforts to cut down or control use.
- A **great deal of time** spent in activities to obtain, use, or recover from the substance.
- **Craving**, or a strong desire or urge to use the substance.

2. Social Impairment

- **Failure to fulfil major obligations** at work, school, or home.
- **Continued use** despite persistent or recurrent social or interpersonal problems.
- **Important social, occupational, or recreational activities** are given up or reduced.

3. Risky Use

- **Recurrent use in physically hazardous situations** (e.g., driving under the influence).
- **Continued use** despite physical or psychological problems likely caused or worsened by the substance.

4. Pharmacological Criteria

- **Tolerance**:

Either a need for markedly increased amounts or a markedly diminished effect with the same amount.

- **Withdrawal**:
  Characteristic withdrawal symptoms, or the substance is taken to avoid or relieve withdrawal.

Note: In patients using opioids **solely under appropriate medical supervision**, tolerance and withdrawal **do not count** toward an SUD diagnosis.

Severity Specifiers

The severity of SUD is based on the number of criteria met:

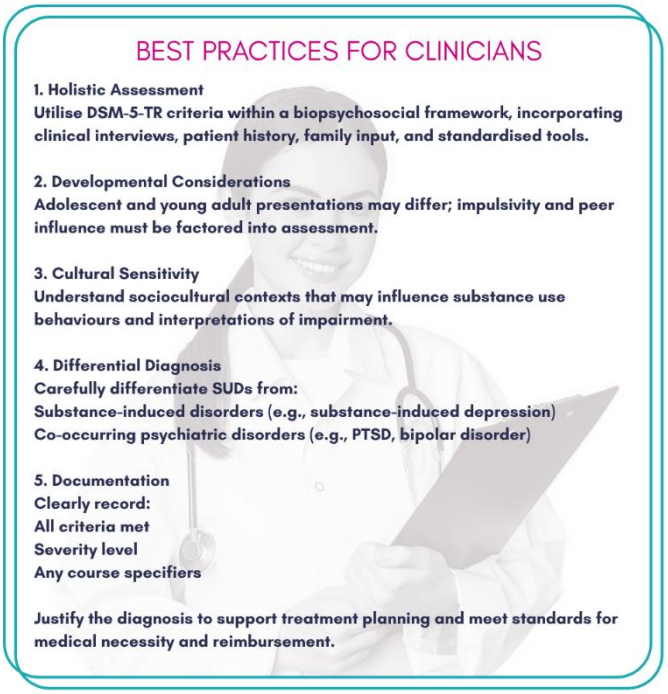
- **Mild**: 2–3 criteria
- **Moderate**: 4–5 criteria
- **Severe**: ≥6 criteria

Course Specifiers

- **Early Remission**: No criteria met (except craving) for at least 3 months but less than 12 months.
- **Sustained Remission**: No criteria met (except craving) for 12 months or longer.
- **Maintenance Therapy**: Patient is on medication-assisted treatment (e.g., methadone, buprenorphine).
- **Controlled Environment**: The patient is in a supervised setting where access to substances is strictly restricted.

Changes from DSM-IV to DSM-5-TR

- **Unified Diagnosis**: Merges "abuse" and "dependence" into a single disorder with severity levels.
- **New Criterion Added**: Craving.
- **Removed Criterion**: Legal problems (due to cultural variability and limited diagnostic value).



SCREENING AND ASSESSMENT FOR SUBSTANCE USE DISORDERS (SUDS)

Early identification of individuals at risk for or currently experiencing substance use disorders (SUDs) is essential for effective intervention and treatment. The **use of validated, structured screening and assessment tools** facilitates timely diagnosis, guides clinical

decision-making, and improves patient outcomes.

PURPOSE OF SCREENING

Screening tools are designed to:

- **Identify risky or problematic substance use** before it progresses to a full SUD.
- **Support brief interventions** that motivate behaviour change.
- **Determine the need for further diagnostic evaluation** or referral to specialised care.

Screening is appropriate in **primary care, emergency departments, schools, mental health settings, and community programs**, and can be **self-administered or clinician-administered**.

Screening and Assessment Tools Chart

Screening tools

ALCOHOL
DRUGS
ADULT
ADOLESCENTS
SELF-ADMINISTERED
CLINICIAN-ADMINISTERED

TOOL	SUBSTANCE TYPE		PATIENT AGE		TOOL ADMINISTERATION	
Screening to Brief Intervention (S2BI)	X	X		X	X	X
Brief Screener for Alcohol, Tobacco, and Other Drugs (BSTAD)	X	X		X	X	X
Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS)	X	X	X		X	X
Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide (NIAAA)	X			X		X
Opioid Risk Tool - OUD (ORT-OUD) Chart		X	X		X	

Assessment Resources

ALCOHOL
DRUGS
ADULT
ADOLESCENTS
SELF-ADMINISTERED
CLINICIAN-ADMINISTERED

TOOL	SUBSTANCE TYPE		PATIENT AGE		TOOL ADMINISTERATION	
Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS)	X	X	X		X	X
CRAFFT	X	X		X	X	X
Drug Abuse Screen Test (DAST-10)*		X	X		X	X
Drug Abuse Screen Test (DAST-20: Adolescent version) *		X		X	X	X
NIDA Drug Use Screening Tool (NMASSIST)	X	X	X			X
Alcohol Screening and Brief Intervention for Youth: A Practitioner's Guide (NIAAA)	X			X		X

PROFESSIONAL STANDARDS ON VALIDATED SCREENING TOOLS FOR SUBSTANCE USE DISORDERS (SUDS)

Effective screening for substance use disorders (SUDs) is a cornerstone of early identification, prevention, and intervention. A professional approach to SUD screening is grounded in the following key principles:

1. Universality

Screening should be a **routine component of all clinical encounters**, regardless of a patient's presenting symptoms, background, or perceived risk level. This **universal approach**:

- Normalises substance use discussions in healthcare.
- Helps reduce stigma and shame often associated with SUDs.
- Increases the likelihood of identifying early or hidden cases.
- Promotes equity by ensuring all populations, including adolescents, older

adults, and underserved groups, receive equal access to screening.

2. Evidence-Based Practice

Only screening tools that are **scientifically validated** should be used. These tools must demonstrate:

- **Reliability** – Consistent performance across populations and settings.
- **Validity** – Accuracy in identifying problematic use, risk levels, or diagnostic criteria for SUDs.

Validated tools include:

- TAPS (Tobacco, Alcohol, Prescription medication, and other Substance use)
- CRAFFT (for adolescents)
- S2BI and BSTAD (for youth)
- DAST-10 and ORT-OUD (for adults)

These instruments have been endorsed by national authorities such as **NIDA, SAMHSA**, and the **American Academy of Paediatrics**.

3. Efficiency and Brevity

Given the time constraints in clinical environments, screening tools must be:

- **Concise** (typically 1–10 items)
- **Rapid to administer** (under 5 minutes)
- **Capable of flagging risk** without the need for lengthy diagnostic interviews

Brief screeners such as the **S2BI**, **CRAFFT**, and **TAPS-1** are especially useful in fast-paced settings like primary care, emergency rooms, and school health clinics.

4. Patient-Centred and Non-Judgmental Approach

The success of any screening process depends on the **manner in which it is delivered**. Best practices include:

- **Respectful and empathetic tone**
- Assurance of **confidentiality**
- Use of **open-ended, non-confrontational language**
- Encouragement of **honest disclosure** by creating a safe space

This approach not only enhances the accuracy of responses but also builds rapport and facilitates trust, which are essential for any follow-up intervention.

5. Integration into Clinical Workflow

To be sustainable, SUD screening must be **embedded into routine care pathways**. This involves:

- Incorporating tools into **electronic health records (EHRs)**
- Training clinicians in **Screening, Brief Intervention, and Referral to Treatment (SBIRT)**
- Aligning screening with **preventive care protocols** (e.g., annual check-ups, behavioural health assessments)

- Creating systems for **follow-up, referral**, and **documentation**

When integrated effectively, screening enhances the continuity of care and supports **long-term health outcomes**.

Validated screening tools are more than checklists; they are **clinical instruments** designed to support early detection, reduce harm, and improve health outcomes. By adhering to professional standards of universality, scientific rigour, efficiency, empathy, and integration, healthcare professionals can significantly enhance their role in combating the public health crisis of substance use disorders.

VALIDATED SCREENING TOOLS FOR SUBSTANCE USE DISORDERS (SUDS): A PROFESSIONAL STANDPOINT

Substance Use Disorders (SUDs) represent a significant public health concern, affecting individuals across all demographics. Timely identification through **validated screening tools** is a critical first step in prevention, early intervention, and treatment. The integration of these tools into a **Screening, Brief Intervention, and Referral to Treatment (SBIRT)** framework enhances the clinical response and supports improved patient outcomes.

VALIDATED SCREENING TOOLS FOR ALCOHOL USE DISORDERS (AUDS)

AUDIT – Alcohol Use Disorders Identification Test

Description:

A 10-item questionnaire was developed by the World Health Organisation (WHO) to identify patterns of hazardous alcohol consumption, alcohol dependence symptoms, and associated alcohol-related consequences within the past 12 months.

Strengths:

- Internationally validated across diverse populations and care settings
- High sensitivity and specificity across the spectrum of alcohol misuse from risky use to probable dependence
- Captures three key domains: consumption, dependence, and alcohol-related harm

Cut-off Score:

- **≥ 8** typically indicates hazardous or harmful alcohol use
- Higher scores correlate with increasing severity and may suggest probable alcohol dependence

Professional Application:

- Recommended as a **comprehensive alcohol screening tool** in primary care, emergency departments, psychiatric settings, and behavioural health clinics

- Facilitates structured follow-up interventions based on severity level
- Can guide clinical decisions on brief interventions, referrals, or diagnostic assessment

AUDIT-C – Alcohol Use Disorders Identification Test: Consumption

Description:

A streamlined, 3-item version of the AUDIT focusing exclusively on **frequency, quantity**, and **binge drinking** behaviour.

Strengths:

- Rapid, effective tool for **universal screening** in busy clinical environments
- Strong predictive validity for detecting hazardous drinking
- Can be integrated easily into electronic health records (EHRs) and routine patient intake workflows

Cut-off Scores for Positive Screen:

- **≥ 3** for **women**
- **≥ 4** for **men**
- **≥ 3** for **adults aged 65+**

Professional Application:

- **Ideal first-line screener** in general medical and outpatient settings
- A positive result prompts either:
  - Administration of the **full AUDIT**
  - A **brief intervention** using motivational interviewing techniques
- Enables **early identification** of at-risk drinkers before progression to dependency

VALIDATED SCREENING TOOLS FOR DRUG USE (EXCLUDING NICOTINE)

DAST-10 – Drug Abuse Screening Test (10-item Version)

Description:

A 10-item **self-report questionnaire** was designed to assess the consequences and severity of non-medical drug use over the **past 12 months**. It excludes alcohol and tobacco use.

Strengths:

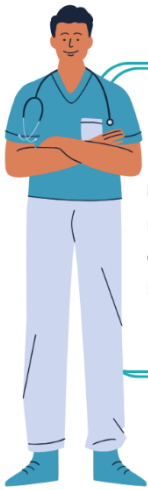
- **Well-validated** across adult populations in medical, psychiatric, and community settings
- Measures both the presence and **severity** of drug-related issues
- Easy to administer and score in outpatient or behavioural health settings

Cut-off Score Interpretation:

- **0** = No problems reported
- **1–2** = Low level; monitor and reassess
- **3–5** = Moderate level; further evaluation or brief intervention recommended
- **6–8** = Substantial level; may warrant referral to treatment
- **9–10** = Severe level; strong indication for specialized treatment referral

Professional Application:

- Ideal for **follow-up** after a positive screen (e.g., from the SIDS or general intake)
- Useful in **behavioural health clinics**, addiction programs, or integrated care teams
- Supports clinical decision-making regarding **treatment intensity and referral needs**



CLINICAL INTEGRATION TIP

Use SIDS for universal, quick screening. If the response is positive, administer the DAST-10 to assess severity and determine whether brief intervention or treatment referral is needed.

SIDS – Single-Item Drug Screen

Description:

A rapid single-question screening tool: *"How many times in the past year have you used an illegal drug or used a prescription medication for non-medical reasons?"*

Strengths:

- **Extremely brief**—takes seconds to administer
- High **sensitivity** for detecting drug use disorders
- Strongly recommended for **initial screening** in primary care or emergency settings

Professional Application:

- **First-line screener** in **time-constrained environments**
- A **"yes" response** indicates possible problematic drug use and warrants further evaluation with a validated tool (e.g., **DAST-10**)
- Normalises discussion of substance use while preserving efficiency

VALIDATED SCREENING TOOL FOR ADOLESCENTS (AGES 12–21)

CRAFFT Screening Tool

Description:

The **CRAFFT** is a **6-item, mnemonic-based screening tool** developed specifically for adolescents to assess **high-risk behaviours** associated with alcohol and drug use. It is designed to be developmentally appropriate and easily administered in medical, school, and behavioural health settings.

Mnemonic Items:

C – Car: Have you ever ridden in a car driven by someone (including yourself) who was high or had been using alcohol or drugs?
R – Relax: Do you ever use alcohol or drugs to relax, feel better about yourself, or fit in?
A – Alone: Do you ever use alcohol or drugs while you are alone?
F – Forget: Do you ever forget things you did while using alcohol or drugs?
F – Family/Friends: Do your family or friends ever tell you that you should cut down on your drinking or drug use?
T – Trouble: Have you ever gotten into trouble while you were using alcohol or drugs?

Strengths:

- **Validated** in adolescent populations across primary care and behavioural health settings
- Uses **age-appropriate, non-judgmental language** to encourage honest disclosure
- Demonstrates **strong sensitivity and specificity** for identifying problematic substance use in youth
- **Endorsed by the American Academy of Paediatrics (AAP)**

Cut-off Score Interpretation:

- **0–1 "yes" responses**: Low risk; provide prevention messaging and continue routine screening
- **Score ≥ 2**: **Positive screen** indicating elevated risk for substance use disorder; warrants further assessment, brief intervention, and/or referral to speciality service

Professional Application:

- Ideal for use in **paediatric primary care, school health programs, adolescent clinics**, and juvenile justice settings
- Should be administered **confidentially** with clear communication about privacy, particularly in the presence of caregivers
- Can be used as part of a broader **SBIRT (Screening, Brief Intervention, Referral to Treatment)** framework tailored to youth

COMPREHENSIVE SCREENING TOOL FOR ALL SUBSTANCES

TAPS Tool

(Tobacco, Alcohol, Prescription Medications, and Other Substances)

Description:

The **TAPS Tool** is a **two-part, validated screening and brief assessment instrument** designed to detect **problematic use of tobacco, alcohol, illicit drugs, and prescription medications** within primary care and integrated behavioural health settings.

- **Part 1: Universal Screening**
  - Assesses **past 12-month use** of a broad range of substances, including nicotine, alcohol, cannabis, cocaine, stimulants, opioids, sedatives, hallucinogens, and other drugs.
  - Designed for **rapid administration** and can be self- or clinician-administered.

- **Part 2: Substance-Specific Risk Assessment**
  - Administered only if **any use** is reported in Part 1
  - Evaluates the **frequency of use and associated risk behaviours** over the past 3 months.
  - Provides a **risk score (0–4)** for each substance category, indicating the level of intervention needed.

Strengths:

- **Covers all major substance categories,** alcohol, drugs, and tobacco in one integrated tool
- **Validated** in diverse adult populations and **endorsed by NIDA** for primary care use
- **A flexible format** can be used in-person, electronically, or via a self-administered tablet or form
- Helps clinicians **differentiate between occasional, risky, and high-severity use**, enabling appropriate next steps
- Useful for **both screening and brief assessment**, minimising the need for multiple tools

Risk Stratification & Interpretation:

- **Score 0:** No reported use → Continue routine screening
- **Score 1:** Low-risk use → Offer brief education and prevention
- **Score 2:** Moderate-risk use → Provide brief intervention using motivational interviewing
- **Score 3–4:** High-risk or probable SUD → Recommend full diagnostic evaluation and **Referral to Treatment**

Professional Application:

- **Ideal in integrated care environments**, such as **Federally Qualified Health Centres (FQHCs)**, **behavioural health clinics**, and **primary care practices**
- Easily incorporated into **SBIRT workflows**
- Facilitates **risk-targeted interventions,** no need to rely on separate tools for each substance
- Supports **billing under behavioural health integration codes** when used as part of comprehensive care

THE SBIRT FRAMEWORK FOR COMPREHENSIVE IDENTIFICATION AND ASSESSMENT

While individual tools are crucial, integrating them into the SBIRT model elevates the professional standard of care for SUD identification.

1. Screening (S): The First Layer

- **Goal:** To quickly and universally identify individuals across the spectrum of

substance use, from no use to at-risk use, to those with a full-blown SUD.

- **Methodology:** Administering the validated tools mentioned above (e.g., AUDIT-C, SIDS) to all patients as part of routine intake.
- **Professional Best Practice:**
  - **Universal, Routine, and Confidential:** Ensure that screening is conducted consistently for all patients, in a private setting, emphasising confidentiality.
  - **Normalising Language:** Introduce screening as a routine health practice, similar to screening for blood pressure or diabetes, to reduce stigma. For example: "As part of our commitment to your overall health, we ask all our patients a few questions about their alcohol and drug use."
  - **Train All Staff:** Ensure all relevant clinical staff (nurses, medical assistants, physicians) are adequately trained in administering screens and understanding their implications.

2. Brief Intervention (BI): The Second Layer

- **Goal:** For individuals who screen positive for at-risk or moderate substance use, the BI aims to increase their awareness, insight, and motivation to change their substance use behaviours.
- **Methodology:** A short, structured conversation (5-15 minutes) utilising motivational interviewing principles (e.g., expressing empathy, developing discrepancy, rolling with resistance, supporting self-efficacy).
- **Professional Best Practice:**
  - **Feedback and Information:** Provide objective, non-judgmental feedback on screening results and discuss the health risks associated with their current pattern of use.
  - **Explore Readiness to Change:** Use open-ended questions to assess the patient's readiness to make changes and elicit their reasons for change.
  - **Collaborative Goal Setting:** Work collaboratively with the patient to set realistic goals, which may include reducing use or abstaining, rather than dictating.
  - **Provide Options and Resources:** Offer practical strategies for change and refer to relevant resources (e.g., educational materials, self-help groups).

3. Referral to Treatment (RT): The Third Layer

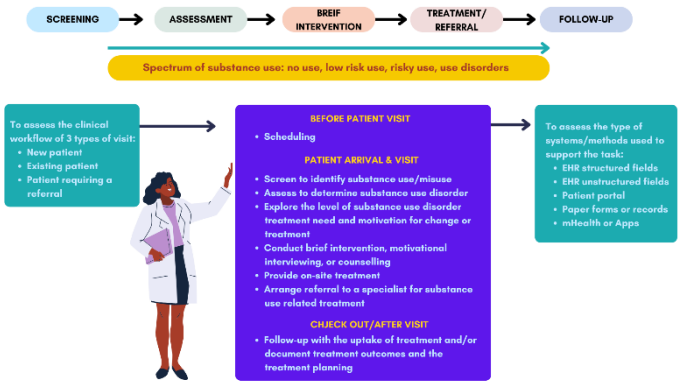
- **Goal:** For individuals identified with moderate-to-severe SUD, or those who require specialised care beyond the scope of a brief intervention, RT ensures a seamless

transition to appropriate speciality treatment.

- **Methodology:** Facilitating linkage to evidence-based treatment services, including medication-assisted treatment (MAT) for OUD and AUD, outpatient counselling, intensive outpatient programs, or residential care.
- **Professional Best Practice:**
  - **Warm Handoffs:** Whenever possible, facilitate a "warm handoff" by directly connecting the patient with a treatment provider or referral specialist rather than just providing a list of phone numbers.
  - **Address Barriers:** Proactively discuss and help overcome common barriers to treatment (e.g., stigma, transportation, cost, childcare).
  - **Follow-Up:** Follow up with the patient to ensure they successfully connected with the referred services.
  - **Knowledge of Local Resources:** Maintain an updated list of local, evidence-based SUD treatment providers and community resources.

By consistently applying these validated screening tools within the structured and patient-centred SBIRT framework, healthcare professionals can significantly enhance their capacity to proactively identify individuals at risk for or experiencing SUDs, leading to earlier intervention, improved health outcomes, and a reduction in the public health burden of these pervasive conditions.

THE CLINICAL WORKFLOW OF SUBSTANCE USE SCREENING, BRIEF INTERVENTION, AND REFERRAL TO TREATMENT.



The consistent and systematic use of validated screening tools, ideally within an SBIRT framework, is an ethical and evidence-based responsibility for healthcare professionals. These tools are not diagnostic in themselves but serve as crucial initial filters to identify individuals who require further assessment, brief intervention, or specialised treatment. By embracing universal screening, clinicians play a vital role in the early detection and prevention of SUDs, ultimately improving patient outcomes and reducing the significant public health burden associated with these conditions.

DISTINGUISHING SUBSTANCE-INDUCED DISORDERS FROM CO-

OCCURRING PSYCHIATRIC CONDITIONS

Accurately differentiating between **substance-induced psychiatric symptoms** and **co-occurring mental health disorders** is essential for establishing a correct diagnosis and delivering effective, individualised treatment. Although both can present with similar clinical features such as mood instability, anxiety, or psychosis, their **underlying causes**, **clinical course**, and **treatment strategies** are fundamentally different.

1. Substance-Induced Mental Disorders

Definition:

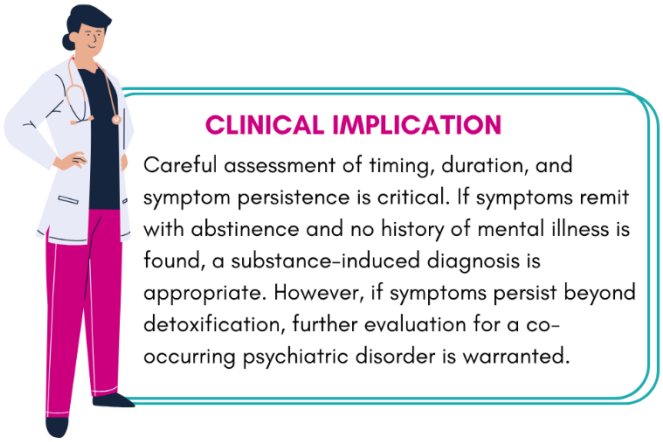
Substance-induced mental disorders are psychiatric symptoms that arise **directly from the effects of substance intoxication or withdrawal** and are not indicative of a primary, independent mental illness.

Common Presentations Include:

- **Substance-induced psychosis** (e.g., hallucinations or delusions during stimulant intoxication)
- **Substance-induced depression or anxiety** (e.g., low mood or panic during alcohol withdrawal)
- **Mood disturbances** such as **irritability, agitation, or emotional lability**

Clinical Characteristics:

FEATURE	DESCRIPTION
Temporal Relationship	Symptoms emerge during active use of the substance or shortly after withdrawal.
Resolution with Abstinence	Symptoms typically resolve or significantly improve after the substance is cleared from the body, usually within days to weeks.
Absence of Prior History	The individual has no prior diagnosis or evidence of a psychiatric condition before substance use. Symptoms occur only during periods of intoxication or withdrawal.



2. Co-Occurring Psychiatric Conditions (Dual Diagnosis)

Definition:

Co-occurring psychiatric conditions refer to **mental health disorders that exist independently of substance use**, although substance use may **worsen the psychiatric symptoms** or serve as a form of self-

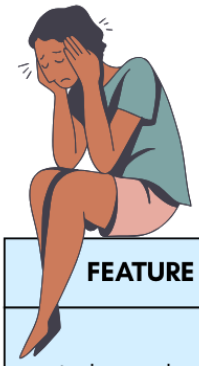
medication. This is also commonly referred to as **dual diagnosis** or **comorbidity**.

Common Examples Include:

- **Major Depressive Disorder (MDD)**
- **Generalised Anxiety Disorder (GAD)**
- **Bipolar Disorder**
- **Schizophrenia**

These psychiatric conditions may be present **before**, **during**, or **after** the development of a substance use disorder (SUD), and they often **require long-term management** even after sobriety is achieved.

Clinical Characteristics:



FEATURE	DESCRIPTION
Independent Existence	The psychiatric symptoms are not solely caused by substance use and are present even during abstinence.
Chronicity or Pre-Existence	The mental health condition predates substance use, or it persists long after cessation of substances.
Complex Interplay	A bidirectional relationship often exists: psychiatric illness can increase vulnerability to SUD, and substance use can intensify psychiatric symptoms.

CLINICAL IMPLICATION

Patients with co-occurring disorders require an integrated treatment approach, where both the psychiatric condition and the substance use disorder are treated simultaneously. Failing to address both components leads to higher relapse rates, poorer functional outcomes, and increased healthcare utilisation.

3. Clinical Importance of Differentiation

Aspect	Substance use induced disorder	Co-Occurring Psychiatric Condition
Primary Intervention	Detoxification and abstinence; supportive care	Integrated treatment for both SUD and psychiatric conditions
Medication Use	Often short-term, focused on withdrawal symptoms	Often long-term, targeted at managing chronic psychiatric illness
Prognosis	Symptoms usually remit with sobriety	Symptoms often persist regardless of substance use status
Treatment Team	May involve addiction medicine alone	Requires collaborative, multidisciplinary care

TREATMENT IMPLICATIONS

Properly distinguishing between **substance-induced disorders** and **co-occurring psychiatric conditions** is essential, as each requires a different clinical approach.

Misclassification can lead to under-treatment, unnecessary pharmacologic intervention, or increased risk of relapse.

A. Substance-Induced Disorders

Treatment Approach:

- **Primary Focus:**
  Achieving **detoxification** and **abstinence** from the offending substance.
- **Pharmacologic Support:**
  Short-term use of medications (e.g., **benzodiazepines for withdrawal anxiety**, **antipsychotics for intoxication-related psychosis**) may be indicated.
- **Prognosis:**
  Psychiatric symptoms typically **resolve or significantly improve** once the substance is eliminated and acute withdrawal has passed.

Key Goals:

- Stabilise the patient through supportive care during withdrawal
- Monitor symptom resolution over **days to weeks**
- Reassess psychiatric status post-detox to determine need for ongoing intervention

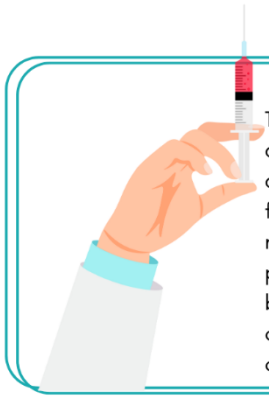
B. Co-Occurring Psychiatric Conditions (Dual Diagnosis)

Treatment Approach:

- **Integrated Care Model:**
  Simultaneous treatment of both the **psychiatric condition** and the **substance use disorder (SUD)** is considered the **gold standard**.
- **Pharmacotherapy:**
  Long-term medication management (e.g., **SSRIs for depression**, **mood stabilisers for bipolar disorder**, **antipsychotics for schizophrenia**) as clinically indicated.
- **Psychotherapy & Behavioural Interventions:**
  - **Cognitive Behavioural Therapy (CBT)**
  - **Dialectical Behaviour Therapy (DBT)**
  - **Motivational Interviewing**
  - **Relapse prevention planning**
- **Addiction Services:**
  Integration of **MAT (e.g., buprenorphine, methadone)**, **12-step support**, and **recovery coaching**.

Key Goals:

- Treat **both conditions concurrently** to address the complex, bidirectional relationship
- Reduce **relapse risk** and improve **functional and psychosocial outcomes**
- Promote **long-term recovery** and psychiatric stability



CLINICAL INSIGHT

Treating only one condition (e.g., addressing the SUD without managing depression) often leads to treatment failure or recurrence of symptoms. A multidisciplinary approach combining psychiatry, addiction medicine, behavioural health, and primary care is often required to achieve sustainable outcomes.

CONCLUSION

A thorough understanding of the diagnostic criteria, screening strategies, and clinical differentiation processes related to substance use disorders (SUDs) is essential for safe, effective, and evidence-based patient care. By applying the **DSM-5-TR diagnostic framework**, clinicians can accurately identify and classify SUDs by symptom domain and severity level, thereby guiding appropriate treatment planning.

The integration of **validated screening tools** such as AUDIT, CRAFFT, TAPS, and DAST-10 further enhances the ability to detect and evaluate substance use across diverse age groups and care settings. These tools support early identification, risk stratification, and tailored intervention.

Equally important is the ability to **differentiate between substance-induced mental health symptoms and independently co-occurring psychiatric disorders**. This distinction informs the clinical approach and ensures that patients receive the right level of care whether it involves short-term stabilisation, long-term psychiatric treatment, or integrated dual-diagnosis management.

Together, these competencies equip clinicians to deliver comprehensive, person-centred care to individuals affected by substance use, supporting accurate diagnosis, improved outcomes, and recovery-oriented practice across the continuum of care.

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