DAST Guide

Using the Drug (Ab)use Screening Test

Dr. Harvey Skinner

Dahdaleh Institute
for Global Health Research,
York University

Toronto, Canada

camh
mental health is health

DAST Guide: Using the Drug (Ab)use Screening Test

For information about alternative formats or other publications, or to place an order, please contact CAMH Publications:

Toll-free: 1 800 661-1111

Toronto: 416 595-6059

Email: publications@camh.ca

Online store: http://store.camh.ca

www.camh.ca

This guide was produced by CAMH Education.

01-2025/PZ074

Contents

Development of the DAST

About the developer of the DAST

Dr. Harvey Skinner has dedicated his life to improving health and well-being worldwide. He is Professor Emeritus of Psychology and Global Health at York University in Toronto, Senior Fellow at the Dahdaleh Institute for Global Health Research and founding Dean of York's Faculty of Health (2006–2016). Before that, he spent 30 years at the Addiction Research Foundation (now the Centre for Addiction and Mental Health [CAMH]), and then moved to the University of Toronto, where he concluded his time as Chair of Public Health Sciences (now the Dalla Lana School of Public Health). Ranked among the top two per cent of scientists worldwide by Stanford University, Dr. Skinner is recognized for developing practical, widely used tools such as the Drug Abuse Screening Test (DAST).

Currently, he and his partner, Susan Harris, co-lead the Wellness Impact Lab at the Dahdaleh Institute, focusing on innovative solutions that support health, wellness and climate resilience. Dr. Skinner is an enthusiastic daily practitioner of mindfulness meditation and qi gong, and he teaches qi gong (tai chi) online to share the benefits of holistic well-being. His passion is "healing ourselves, healing others, healing our planet."

About the publisher of the DAST

The Centre for Addiction and Mental Health (CAMH) is Canada's largest mental health and addiction teaching hospital and a world-leading research centre in this field. CAMH combines clinical care, research, education, policy development and health promotion to help transform the lives of people affected by mental illness and addiction. CAMH is fully affiliated with the University of Toronto and is a Pan American Health Organization / World Health Organization Collaborating Centre.

Introduction to the DAST

For more than four decades, the **Drug Abuse Screening Test (DAST)** has been a cornerstone instrument for identifying, evaluating and monitoring drug-related problems. The DAST was designed to be a brief self-report measure, easy to administer and score, and capable of detecting a range of drug use issues.

Since its introduction, the DAST has garnered global recognition. It exists in two main formats—**DAST-10** for quick screening and **DAST-20** for more comprehensive assessments and research—and has been translated into 19 languages to date, with additional cultural adaptations under way. Health care providers, social service agencies and researchers in many countries rely on the DAST for tasks ranging from population screening to clinical evaluations.

> *"When I developed the DAST in the early 1980s, I never imagined it would become a global standard. It is inspiring to see it help so many people, advance research and remain a topic of interest for colleagues and students worldwide."*
> — Dr. Harvey Skinner

Although its name has remained the same for historical continuity, the DAST is evolving to reflect growing awareness of stigma in the substance use field. Following the U.S. National Institute on Drug Abuse (NIDA)[1] "Words Matter" guidelines developed in 2021, revised versions (**DAST-10-R** and **DAST-20-R**) replace the term "abuse" with "misuse" and "drug use." Similarly, the full title of the DAST has been changed to the **Drug (Ab)use Screening Test** to deemphasize the term "abuse" while retaining the familiar acronym. The preference is to refer to the instrument simply as the DAST. These changes aim to reduce stigmatizing language while maintaining the instrument's psychometric strengths.

This updated guide describes the developmental history of the DAST, explains why drug assessment remains critical, offers detailed guidance on administering and interpreting the DAST (including the revised forms), and outlines future directions for ongoing research, technological innovations and emergent trends in the substance use landscape.

The guide also provides contact information for people seeking permission to reprint the DAST or use it in research studies, and for investigators who are interested in collaborating on calibration and validation studies of the revised DAST versions.

1 Reflecting its own language guidelines, NIDA is proposing to change its name to the National Institute on Drugs and Addiction.

History, development and widespread use

Early foundations (1982–1990)

The DAST came into being as a 28-item prototype devised by Dr. Harvey Skinner with the goal of rapidly screening for drug-related issues. Published in *Addictive Behaviors* in 1982, this original version, the **DAST-28**, underwent initial testing among clinical and community populations. It quickly demonstrated high internal consistency (with Cronbach's alpha estimates frequently exceeding .90) and excellent concurrent validity when compared with clinical diagnoses, self-reported frequencies of drug use and known psychosocial risk factors.

From these early experiences, Dr. Skinner recognized that different contexts called for different levels of detail. This insight led to the development of two shorter versions: the **DAST-10**, a succinct 10-item measure optimized for quick screening, and the **DAST-20**, a more in-depth 20-item version intended for research and comprehensive assessment. Early validation work showed that both shortened forms retained robust correlations with the 28-item prototype, making them pragmatic yet psychometrically sound.

Expansion and systematic recognition (1990–2005)

During the 1990s and early 2000s, the DAST underwent a surge in popularity. Clinicians in primary care, substance use treatment centres, mental health hospitals and forensic settings began using it to detect drug use problems that might otherwise go unnoticed. At the same time, more researchers started conducting cross-cultural validations, creating multiple translations—among them Spanish, French, Chinese and Arabic—to ensure the DAST would be accessible in diverse linguistic contexts.

A turning point came when systematic reviews began to compile and analyze findings across various DAST studies. In particular, Yudko et al. (2007) reviewed the psychometric data from studies up to 2005, concluding that the DAST showed moderate to high internal consistency reliability, strong concurrent validity (as evidenced by significant correlations with other substance use measures) and robust diagnostic validity (sensitivity and specificity) in classifying individuals with known drug problems. This systematic review underscored the DAST's value as an evidence-based tool suitable for public health, clinical and research applications.

Current landscape and further developments (2005–2024)

Over the last two decades, the DAST has been recommended by agencies such as NIDA for routine screening. It has also been integrated into large-scale epidemiological surveys, electronic health record systems and national guidelines for substance use screening protocols. The DAST's acceptance continues to grow internationally, with an ever-increasing list of language versions—19 at present—and with more countries adapting it for local use.

At the same time, the legal and social status of certain substances, especially cannabis, has changed dramatically in many regions. In Canada, for instance, the legalization of non-medical cannabis in 2018 created fresh questions about what constitutes illegal or problematic use. Moreover, the renaissance of psychedelic-assisted therapies—where substances such as psilocybin, LSD and MDMA are being researched for mental health benefits—has further expanded the contexts in which the DAST and its language adaptations might be employed.

> *"The DAST is a unique combination of being scientifically and clinically rigorous while also being readily understandable by people around the globe. That is the reason this evidence-based Canadian innovation has been a cornerstone for advancing substance use screening, assessment and research."*
>
> — Dr. Sanjeev Sockalingam, Senior Vice President, Education, and Chief Medical Officer, CAMH

Recognizing the role of stigma as a barrier to care, Dr. Skinner recently developed the **DAST-R** forms (**DAST-10-R** and **DAST-20-R**), which replace drug "abuse" with "use" or "misuse." Research is under way to confirm that these modifications preserve the original tool's measurement properties and clinical utility while improving respondents' comfort in disclosing sensitive information.

Why assess drug use?

Substance use disorders are a global public health concern that in recent years has reached crisis-level death rates related to opioid overdose. Furthermore, the rising prevalence of opioid misuse, methamphetamine use and non-medical use of prescription drugs, coupled with persistently high rates of alcohol and illicit drug use, significantly burdens health care systems. Reliable and valid screening is therefore essential, not only to identify hidden or emerging issues early, but also to coordinate appropriate, effective responses.

A quantitative screening tool offers insights that can guide interventions. For individuals with milder issues, a brief intervention or outpatient program might suffice. By contrast, higher scores can highlight the need for more intensive treatments, such as partial hospitalization or residential rehabilitation. In community settings, aggregated DAST data can inform policy decisions and help allocate resources for prevention or treatment efforts. Early identification also increases the likelihood of engaging individuals in treatment at a stage when it may be easier to achieve positive outcomes.

DAST versions and revisions

DAST-10

For contexts that demand quick screening, the **DAST-10** offers a streamlined alternative while retaining a strong correlation (around .98) with the 20-item version. The brevity of the DAST-10 makes it ideal for high-volume settings such as community health centres, emergency departments, correctional systems and primary care clinics. Despite having only 10 items, this version demonstrates an alpha coefficient near .92 in various populations, reflecting robust internal consistency reliability.

A wide range of stakeholders, including national task forces, recommend the DAST-10 because it can identify potential drug-related problems without placing a heavy time burden on staff or respondents. This feature has made it especially useful as a first step or "triage" measure in more complex screening procedures such as Screening, Brief Intervention and Referral to Treatment ([SBIRT]; Babor et al., 2007).

DAST-20

The **DAST-20** is a comprehensive tool designed to capture a wider range of possible drug use consequences. With 20 items, it offers broader coverage of different dimensions, including withdrawal symptoms, interactions with family, work problems and physical health concerns. Studies consistently report high internal consistency reliability for the DAST-20 (Cronbach's alpha around .95), which lends confidence to its use in clinical research, program evaluations and detailed individual assessments.

Because of its comprehensive scope, the DAST-20 is commonly used in specialized treatment settings (e.g., outpatient programs for substance use disorders, residential rehabilitation) and in research studies that need granular data on the complexity of drug-related issues. Clinicians and researchers often pair it with other measures (e.g., depression, anxiety or PTSD scales) to gain a multi-faceted understanding of the individual's clinical profile.

DAST-R (DAST-10-R and DAST-20-R)

In an effort to align with evolving perspectives on stigma, Dr. Skinner and his colleagues developed revised forms that follow guidance from NIDA's "Words Matter" recommendations. These **DAST-R** versions replace references to drug "abuse" with "use" or "misuse," reflecting the understanding that language has the power to influence an individual's willingness to disclose sensitive information and pursue help.

Initial feasibility tests have been promising. For example, a study by Crowley (2023) in an Arizona community health clinic found that clinicians were more comfortable administering the revised forms, and respondents reported lower levels of perceived judgment. Although further research is required to solidify the DAST-R's psychometric equivalence to the originals, preliminary analysis indicates that scoring patterns remain very similar. The DAST-R is currently in the research-only phase, with calibration efforts under way to confirm that professionals can use it interchangeably with the original DAST forms.

> *"Reducing structural stigma in substance use disorder treatment is essential for ensuring equitable access to care. The DAST-10-R offers patients and health care providers a non-stigmatizing instrument for the rapid evaluation of substance use disorders."*
>
> — Dr. Lisa Crowley, Psychiatric Nurse Practitioner, Behavioral Health Solutions, Denver, Colorado

Administration guidelines

General principles for administering the DAST

Administering the DAST—whether in its 10-item or 20-item form—requires sensitivity and adherence to standardized approaches. The test should be overseen by qualified professionals (health, mental health, social services, education or research) who understand test administration standards (e.g., confidentiality) for substance use and its risks. While the DAST's items are transparent enough for self-administration, professionals must be prepared to clarify definitions, encourage honest responses and remain mindful of potential underreporting or overreporting.

The recommended time frame for screening is typically the past 12 months. This gives respondents a clear reference period for recalling their drug use. For longitudinal tracking, such as during the course of treatment and follow-up, shorter periods (e.g., "in the past three months") might be used instead, as long as instructions are unambiguously modified to reflect the new time frame.

Given its reliance on self-disclosure, the DAST is best administered in a setting that ensures privacy and, if possible, confidentiality. If individuals believe that their responses could lead to negative consequences (e.g., legal repercussions, job loss), they might be less forthcoming. Professionals should always introduce the DAST by explaining its purpose, emphasizing that the intent is to identify any concerns so that they can be addressed effectively, not to punish or stigmatize the respondent.

Self-report vs. interview formats

Self-report questionnaires administered in person or online allow individuals to complete the DAST privately, often yielding more candid answers. This approach can be more efficient when working with large groups or conducting surveys. However, if respondents have literacy or language barriers, or if the instructions are unclear, respondents might misunderstand certain items. In such cases, interviewer-administered formats can be advantageous: the professional can clarify item content and wording, building rapport in real time. However, interviewer administration also comes with the risk that individuals may respond more defensively if they sense any implied judgment. Training interviewers to remain neutral, empathetic and nonjudgmental is crucial.

Instructions to the respondent

When introducing the DAST to respondents, it is important to define key terms clearly. Specifically, "drug use" typically refers to illicit, non-prescribed substances, and "misuse" refers to taking prescription medications more frequently or in greater amounts than prescribed. Because the DAST excludes alcohol, respondents must be reminded not to consider their drinking habits in their answers. Tools such as the Alcohol Use Disorders Identification Test (AUDIT) can be used for that purpose.

Professionals should also explain that the goal of the DAST is to understand how drug use or misuse may be affecting the respondent's life. Providing assurance that the answers will be kept confidential (within legal and ethical bounds) can help respondents feel more comfortable. Emphasizing the importance of honest responses for accurate identification of potential problems can lessen defensiveness and social desirability biases.

Specific populations

- **Adolescents and young adults:** Although the DAST-10 and DAST-20 are generally validated in adult populations, specialized versions such as the DAST-A exist for adolescents (Martino et al., 2000). For older teens close to adulthood, the standard DAST may still be suitable, but professionals might need to adapt the language to reflect issues relevant to youth, including peer influence, school attendance or family contexts.
- **Older adults:** Polypharmacy and the potential misuse of prescription medications (e.g., opioids, benzodiazepines) call for added caution. Older adults might also have cognitive impairments that affect recall, so interview formats may be preferable.
- **Cultural adaptations:** With 19 language versions in circulation to date, the DAST has shown considerable adaptability. Researchers using newly translated culturally adapted versions should follow recommended translation–back translation processes, pilot testing and psychometric validation to ensure that reliability and validity are maintained. See instructions in the appendix on page 9.
- **Co-occurring disorders:** For respondents with psychiatric comorbidities, it may be prudent to complement the DAST with additional tools or clinical interviews to fully capture the intersection of mental health symptoms and substance use.

Scoring and interpretation

Scoring the DAST

The DAST scoring scheme is straightforward, regardless of version.

For the **DAST-10**, items #1, #2 and #4 to #10 are each worth 1 point if the answer is "Yes." Item #3 ("Are you always able to stop using drugs when you want to?") scores 1 point for "No." This scoring leads to a total range of 0 to 10 (0 = no reported drug problems, 10 = more severe or multiple problems).

For the **DAST-20**, items #1 to #3 and #6 to #20 are each worth 1 point if the answer is "Yes." Items #4 ("Can you get through the week without using drugs?") and #5 ("Are you always able to stop using drugs when you want to?") each score 1 point for "No." Total scores range from 0 to 20.

The same scoring logic applies to the revised R-versions, whose only revision was to replace references to "abuse" with less stigmatizing language.

Severity level	DAST-10 score	DAST-20 score	Recommended action (ASAM level)
None (no problems evident)	0	0	Preventative measures; continue monitoring
Low (possible occasional use or misuse)	1–2	1–5	Outpatient therapy or brief counselling; long-term remission monitoring; medically managed outpatient (Level 1)
Intermediate (likely DSM[a] substance use disorder)	3–5	6–10	Outpatient: intensive outpatient; high-intensity outpatient; medically managed intensive outpatient (Level 2)
Substantial	6–8	11–15	Outpatient or residential: clinically managed low-intensity or high-intensity residential; medically managed residential (Level 3)
Severe	9–10	16–20	Medically managed inpatient (Level 4)

a DSM = *Diagnostic and Statistical Manual of Mental Disorders*

Interpretive guidelines

Scores generally correspond to increasing levels of severity and recommended interventions, as outlined in the *ASAM Criteria* (American Society of Addiction Medicine, 2023).

While the levels described in the table above provide useful benchmarks, no single cutoff is a substitute for professional judgment. Clinicians should interpret scores in light of demographic and contextual factors, including frequency and duration of drug use, presence of physical or psychiatric comorbidities, family and social situations, and any acute safety concerns.

Integrating DAST scores with other data

Because self-reports can be influenced by intentional or unintentional biases, integrating the DAST with additional assessments can be invaluable. Structured or semi-structured clinical interviews such as the Structured Clinical Interview for DSM (SCID) or the Mini International Neuropsychiatric Interview (MINI) can provide diagnostic confirmation. Laboratory-based urine or hair toxicology screens may corroborate the type and level of substances used, and psychosocial measures such as the PHQ-9 for depression or the PCL-5 for trauma symptoms can reveal co-occurring disorders that might complicate treatment.

Advantages and limitations

Advantages of the DAST

A primary strength of the DAST is its brevity. Even the 20-item version usually takes only five to seven minutes to complete, making it suitable for busy health care settings or community screenings. The DAST-10 and DAST-20 also provide a quantitative index, allowing professionals and researchers to distinguish mild or occasional problems from more entrenched misuse. Because the items are clear and direct, the DAST enhances consistency: key areas related to drug use are assessed uniformly, which is especially useful in large-scale studies or multi-site programs.

Furthermore, the DAST can serve as a monitoring tool over time. Repeated assessments can document improvements or detect relapse, allowing care providers to track treatment outcomes and refine interventions. The DAST's demonstrated cross-cultural applicability—including validated translations, normative data and high reliability/validity in multiple countries—underscores its adaptability for global health initiatives and for culturally diverse populations within a single country.

Limitations of the DAST

Because the DAST questions are transparent, respondents might underreport if they fear social or legal repercussions, or they might overreport if they are motivated by secondary gains (e.g., access to treatment covered by insurance). Additionally, cutoff scores are guidelines rather than definitive thresholds, and high scores should be contextualized by clinical and psychosocial data. The DAST also does not assess alcohol use (separate measures such as the AUDIT are required for that domain), nor does it differentiate types of drugs in extensive detail (although revised instructions do clarify "use" vs. "misuse").

Finally, while updated instructions can account for changes in the legality or social acceptability of certain substances, some respondents might still misunderstand whether certain forms of cannabis or psychedelics count as "use" or "misuse." For this reason, professionals administering the DAST must take care to clarify definitions and reinforce that legal status does not necessarily rule out misuse (e.g., driving a vehicle while under the influence of cannabis).

Recent research and future directions

Research highlights

Over the last 15 years, multiple systematic reviews—especially those by Yudko et al. (2007) and Johnson et al. (2024)—have reinforced the DAST's moderate to high reliability, diagnostic validity and clinical utility. The DAST has also been used as a benchmark for validating newer instruments, underscoring its status as a gold standard in drug screening.

International studies of DAST translations continue to be published, verifying that the tool is valid in diverse cultural contexts, whether in psychiatric emergency departments, general hospitals, corrections populations or primary care settings. Currently, there are 19 language versions of the DAST: English, French, Spanish, Chinese (Mandarin), Urdu, Japanese, Korean, Arabic, Persian (Farsi), Turkish, Filipino, Tagalog and Surigaonon (Philippines), Portuguese, Finnish, Swedish, Icelandic, Sinhala (Sri Lanka) and Maltese. Thirteen studies have been published on these adaptations, supporting the DAST's reliability, validity and utility in diverse international contexts (see Skinner et al., 2024). Of note is a recent translation into the Sinhala language by Nawaratne and Vidanapathirana (2024), which provides an excellent example of a study using comprehensive adaptation processes and measurement (psychometric) analyses. This process is described in the appendix on page 9.

DAST-R research initiatives

Preliminary feasibility data by Crowley (2023) for the DAST-R (stigma-reduced version) indicate that clinicians are receptive to changing terminology and that respondents may be more comfortable with items focusing on drug "use" or "misuse." Ongoing calibration studies are comparing DAST-R scores with their original counterparts. Other work is investigating whether the new wording reduces denial or social desirability bias. The introduction of the DAST-R into SBIRT protocols in multiple community clinics will likely shed light on its real-world effectiveness, exploring whether simpler, person-centred language boosts engagement for respondents who need further intervention.

Directions for the next 40 years

While the DAST is poised to remain essential in substance use screening and assessment, changes in how drugs are used and perceived necessitate monitoring and adaptation.

- **Shifts in drug policy and trends:** Legal cannabis markets and decriminalized psychedelics raise new issues around what qualifies as problematic use. The re-emergence of psychedelics as mental health treatment tools presents unique challenges in distinguishing between beneficial therapeutic use and misuse or diversion.
- **Prescription drug misuse:** As stimulants, opioids and sedatives continue to be widely prescribed. There is an ongoing need to monitor and possibly refine the DAST instructions or items to reflect the realities of misuse among individuals with legitimate prescriptions.
- **Technological integration:** The future will see the DAST deployed more often through digital platforms, with the potential for AI-driven analytics to identify risk profiles and offer personalized feedback based on real-time data. Telehealth services, wearable health trackers and smartphone apps could also incorporate the DAST for screening and monitoring purposes.
- **Expanded cross-cultural and demographic adaptations:** It is vital to keep refining the DAST for different subpopulations. This includes translations into more languages, adaptations for older adults (accounting for chronic pain, prescriptions, etc.), further youth-friendly modifications and local normative data on the DAST for aiding interpretation of test scores.
- **Respectful language:** As NIDA and other health care organizations emphasize non-stigmatizing language, it is likely that future enhancements of the DAST-R will incorporate feedback from people with lived experience, ensuring that its language remains respectful and supportive.
- **Research on psychometrics and implementation:** Continuous psychometric research will be crucial to confirm whether the DAST and DAST-R versions remain valid indicators of problematic drug use. Large-scale implementation studies will also examine how effectively the DAST-R leads to better clinical outcomes and fosters earlier interventions in community settings.

Practical tips for using the DAST

Implementing the DAST in real-world settings requires thoughtful planning. Although brief in structure, the DAST must be administered, scored and interpreted within the appropriate professional and ethical frameworks.

1. **Prepare the setting.** Provide a private, respectful environment. This might be a quiet office or a well-designed online platform, ensuring that the respondent's confidentiality is protected. Clear communication about how data will be used and protected can enhance trust.

2. **Explain the purpose of the DAST.** Frame the DAST as a collaborative tool that helps both the professional and the respondent understand any drug-related issues or concerns. If respondents perceive the test as purely evaluative or punitive, they might be less transparent in their answers.
3. **Use nonjudgmental language.** Whether you are administering the revised DAST-R or the original version, always use person-centred, respectful language. Sensitivity and empathy can greatly reduce barriers to honest disclosure.
4. **Consider combining the DAST with other measures.** In many contexts, the DAST is part of a larger battery of screening tools. Pairing it with tests for alcohol misuse (e.g., the AUDIT) or mental health screening (e.g., PHQ-9 for depression) offers a more holistic view of the person's situation.
5. **Provide immediate feedback and referral.** Whenever possible, provide results promptly in a constructive manner. A single screening measure cannot diagnose a substance use disorder, but it can identify risk levels. Explaining what the score range implies and offering referral options—such as brief interventions, counselling or specialized treatment—can facilitate timely intervention.
6. **Conduct follow-up assessments.** In clinical or research contexts, repeating the DAST at set intervals can highlight changes, whether they be treatment progress or indications of relapse. This follow-up information can be essential for adjusting treatment plans or measuring program outcomes.

Permissions, collaboration and version availability

DAST-10 and DAST-20

The DAST-10 and DAST-20 are published by CAMH. For information and permission requests to use these instruments in for-profit or not-for-profit contexts, contact:

- Sandra Booth (CAMH):
  publications@camh.ca
  Toronto tel.: 416 595-6059
  Toll-free: 1 800 661-1111

For information and permission requests to use these instruments in research studies or for training purposes, contact:

- Dr. Harvey Skinner (York University):
  hskinner@yorku.ca

DAST-10-R and DAST-20-R

Currently, the revised DAST-10-R and DAST-20-R are offered for *research use only*, pending calibration and validation studies. If you are a researcher interested in contributing to the calibration studies or exploring the psychometric properties of the revised forms, please contact Dr. Skinner.

Conclusion

> *"Each time someone contacts me to translate the DAST or asks how to use it in their community, I am reminded that this tool thrives because of our shared commitment to preventing and reducing substance use harms. It is deeply rewarding to see that."*
>
> — Dr. Harvey Skinner

The DAST has endured for over 40 years as a potent screening measure that provides a succinct yet informative glimpse into individuals' drug use patterns and their associated consequences. Its brevity, reliability and evidence-based nature have made it a mainstay in various settings—from primary care clinics to correctional facilities to expansive epidemiological surveys.

As drug trends evolve and societal views continue to shift, especially regarding substances such as cannabis and psychedelics, updated administration instructions and non-stigmatizing language are increasingly important. The revised DAST-R forms demonstrate the test developers' commitment to maintaining screening and clinical utility while ensuring respectful engagement with respondents. Notably, the DAST is not merely a snapshot of current use but a potential conversation starter: combined with other data sources, it guides professionals in making more nuanced decisions about patient care, resource allocation and policy.

> *"The DAST allows us, as clinicians and researchers, to get a quick yet rich snapshot of a person's issues with substances. I have always used the DAST in my research and clinical work, and will continue to do so using the updated version. I am excited for the language of the DAST-R and agree that it will contribute to reducing stigma in people who present for substance use treatment."*
>
> — Dr. Matthew Keough, Associate Professor of Psychology, York University, Toronto

Looking forward to the next 40 years, the DAST stands ready to integrate with emerging technologies and be adapted to diverse cultures and subpopulations. Its foundational reliability/validity and simplicity continue to serve as a model for future screening instruments. Ultimately, the DAST's value lies not only in its concise administration mechanism but also in its capacity to initiate meaningful, empathetic dialogues about substance use—dialogues that can drive early identification, determine the appropriate level of intervention, support recovery and improve quality of life for countless people worldwide.

References

This reference list includes only sources cited in the guide. For a comprehensive list of references, see the review articles by Skinner et al. (2024) and Johnson et al. (2024).

American Society of Addiction Medicine (ASAM). (2023). *ASAM Criteria: Treatment Criteria for Addictive, Substance-related, and Co-occurring Conditions. Volume 1. Adults* (4th ed.). Center City, MN: Hazelden Publishing.

Babor, T.F., McRee, B.G., Kassebaum, P.A., Grimaldi, P.L., Ahmed, K. & Bray, J. (2007). Screening, Brief Intervention, and Referral to Treatment (SBIRT): Toward a public health approach to the management of substance abuse. *Substance Abuse, 28*(3), 7–30. https://doi.org/10.1300/J465v28n03_03

Crowley, L. (2023). *Removing Structural Stigma Barriers in Substance Use Disorders: DAST-10-R Introduction and Feasibility of Use*. [Doctoral dissertation, University of Arizona]. UA Campus Repository. https://repository.arizona.edu/handle/10150/669818

Johnson, E., Barstack, S., Xu, Y., Wise, H., Erford, B.T., Chang, C. & Delmonico, D. (2024). Psychometric synthesis of the Drug Abuse Screening Test (DAST) versions. *Measurement and Evaluation in Counseling and Development*, 1–4. https://doi.org/10.1080/07481756.2024.2399199

Martino, S., Grilo, C.M. & Fehon, D.C. (2000). Development of the drug abuse screening test for adolescents (Dast-a). *Addictive Behaviors, 25*(1), 57–70. https://doi.org/10.1016/S0306-4603(99)00030-1

National Institute on Drug Abuse (NIDA). (2021). Words matter – Terms to use and avoid when talking about addiction. https://nida.nih.gov/nidamed-medical-health-professionals/health-professions-education/words-matter-terms-to-use-avoid-when-talking-about-addiction

National Institute on Drug Abuse (NIDA). (2024). National Institute on Drugs and Addiction: Congressional Justification FY 2024. https://nida.nih.gov/sites/default/files/nida_fy_2024_cj_chapter.pdf

Nawaratne, S.D. & Vidanapathirana, J. (2024). Psychometric properties of the modified Drug Abuse Screening Test Sinhala version (DAST-SI): Evaluation of reliability and validity in Sri Lanka. *BMC Public Health, 24,* 1773. https://doi.org/10.1186/s12889-024-19288-x

Skinner, H., Samadi, S., Khan, S.B. & Crowley, L. (2024). The Drug Abuse Screening Test (DAST): First 40 years and future developments. *Canadian Journal of Addiction, 15*(4), 6–13.

Skinner, H.A. (1982). The Drug Abuse Screening Test. *Addictive Behaviors, 7,* 363–371.

Sousa, V.D. & Rojjanasrirat, W. (2011). Translation, adaptation and validation of instruments or scales for use in cross-cultural health care research: A clear and user-friendly guideline. *Journal of Evaluation in Clinical Practice, 17*(2), 268–274. https://doi.org/10.1111/j.1365-2753.2010.01434.x

Yudko, E., Lozhkina, O. & Fouts, A. (2007). A comprehensive review of the psychometric properties of the DAST. *Journal of Substance Abuse Treatment, 32*(2), 189–198.

Appendix

Six-step guide for language and cultural adaptation of the DAST

1. **Review and adapt content.** Examine each DAST item carefully to ensure local and cultural relevance. Adapt wording as needed in collaboration with the instrument's authors when possible.
2. **Translate instructions and items.** Perform a forward translation from English into the target language, ensuring that technical terms and idiomatic expressions match local usage.
3. **Back-translate.** Convert the newly translated version back to English. Compare it to the original and reconcile discrepancies, refining the translated version as needed.
4. **Conduct qualitative pilot testing.** Use a small sample of the target population to assess comprehension, clarity and cultural appropriateness. Encourage respondents to verbalize their thought process for each item, and adjust wording based on their feedback.
5. **Perform a quantitative psychometric evaluation.** Administer the adapted DAST to a suitable sample (e.g., 100+ respondents). Calculate internal consistency (Cronbach's alpha), item-total correlations and, if feasible, test–retest reliability. Assess concurrent validity against gold-standard measures or clinical interviews.
6. **Develop local interpretation guidelines.** Based on normative data or observed score distributions, establish recommended cutoff points (e.g., for level of care) that reflect local contexts. Provide instructions on how to integrate these results into screening or decision making about treatment.

For a thorough discussion of cross-cultural adaptation, see Sousa & Rojjanasrirat (2011), who outline a clear and user-friendly model for translating and validating instruments.