Department of
Mental Health &
Substance Abuse Services

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Substance Use Best Practice Tool Guide

SCREENING TOOLS

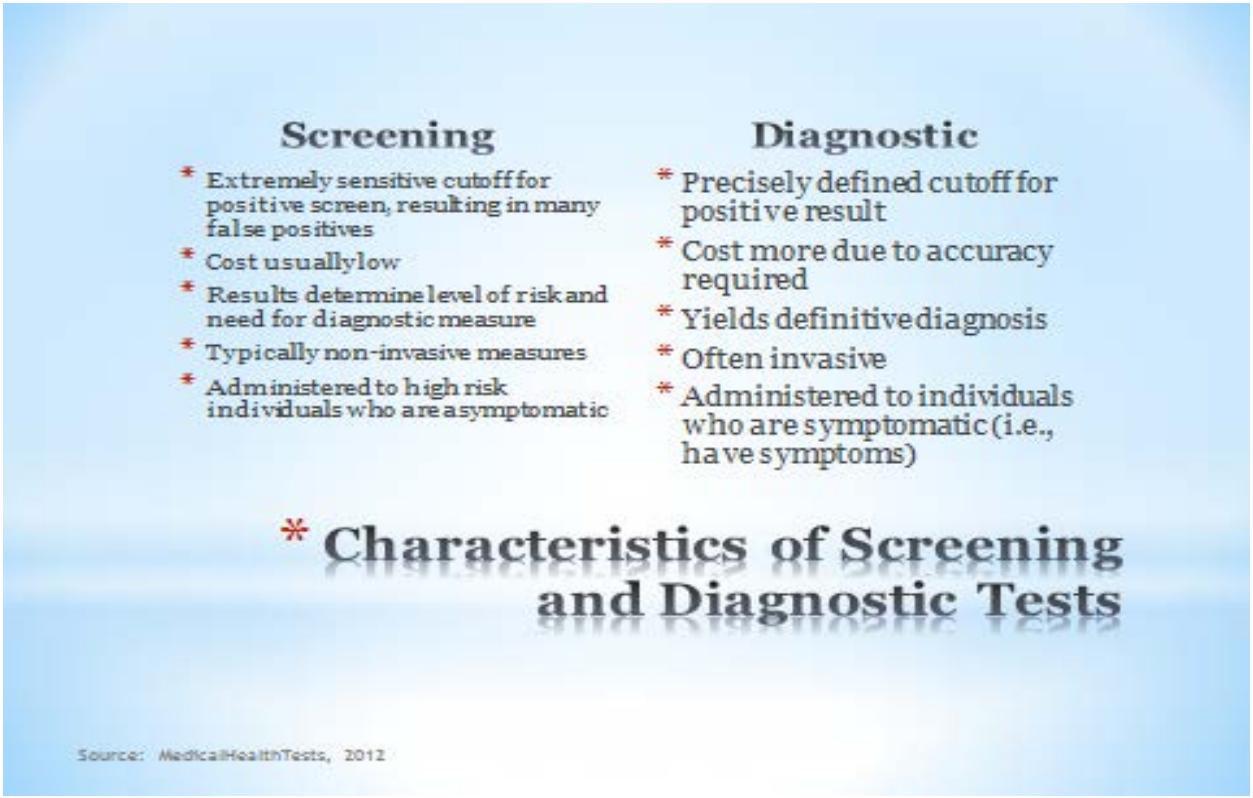
Division of Clinical Leadership in Collaboration with the
Division of Substance Abuse Services

Screening Tools

Screening

Despite the high numbers of individuals with substance use problems, too many go untreated. For many, the disorders are simply not diagnosed. Therefore, screening in primary care offices and other health care settings have been recommended to allow for earlier identification of disorders which can lead to treatment (SAMHSA-HRSA, n.d.). Moreover, the United States Preventive Services Task Force (USPSTF) has recommended that clinicians screen all adults at least 18 years of age for alcohol misuse and, for individuals engaged in hazardous or risky drinking, provide brief behavioral counseling interventions to reduce alcohol misuse, e.g. Misuse involving alcohol is defined as consuming more than the recommended daily, weekly, or per-occasion amounts of alcohol that increase risks for health consequences (USPSTF, 2013).

Screening tests help identify persons who are asymptotic (without symptoms) but may be at risk for developing a condition or disease. Typically they are used with individuals who are considered to be at high risk. Results from the screening help guide the medical professional in determining whether or not additional tests are needed to confirm his or her hypotheses. For instance a positive screen indicates the possibility that the person may have the condition or disease. A diagnostic test would then be used to confirm screening results (Medical Health Tests, 2012).



Two concepts that are very relevant to the value of a test are ***sensitivity*** and ***specificity***. Sensitivity refers to the test's ability to correctly identify individuals with the disease, disorder, or condition. A

test that correctly identifies all patients with the disease has 100% sensitivity. A test with 70 % sensitivity detects 70 percent of individuals with the disease, the true positives, but is unable to detect the 30 percent that actually has the disease (the false negatives). Thus, the test says those 30 percent do not have the disease, though they do. The denominator is equivalent to all of the individuals that have the disease. The numerator involves all the people the test says has the disease. In short, sensitive tests have very few false negatives (Attia, 2003; Lalkhen & McCluskey, 2008). High sensitivity is very important if the test will be used to identify a serious yet treatable disease (Lalkhen & McCluskey, 2008).

Specificity, on the other hand, refers to a test's ability to correctly identify individuals that do not have the disease, condition, or disorder. When specificity is 100%, all individuals without the disease have been correctly identified by the test. A test with 70% specificity correctly reports 70 percent of individuals without the disease as test negative (true negatives) but 30 percent of individuals without the condition is incorrectly identified by the test. The denominator is representative of all the people who do not have the condition. The numerator consists of all the people the test says do not have the disease. Hence, a specific test has very few false positives (Attia, 2003; Lalkhen & McCluskey, 2008).

In general, high sensitivity correlates with low specificity, and vice versa (Lalkhen & McCluskey, 2008). Moreover, screening tests should be suitable. They must demonstrate adequate sensitivity and specificity, minimal discomfort when administered, be safe to use, have a reasonable cost, and be easy to administer and acceptable to the test taker and clinician (New York State Department of Health, 1999).

Screening offers a quick way to identify service recipients who need further assessment or treatment for substance use disorders. Look for tools that are brief, particularly for the population of interest, when considering screening instruments. In fact, having a tool that asks just a few simple questions or observations that raises a high index of suspicion should be extremely helpful (Croton, 2007).

How to Choose a Screening Tool.

The American Public Health Association (2008) recommends consideration of the following issues in selecting/using a tool for screening purposes:

- What are the key characteristics of the target population, e.g., ethnic/racial background, age, rural or inner city location?
- Do you need the questionnaire in languages other than English? If so, which ones?
- What kind of time do you have for administering and scoring the tool?
- Do you want to use a tool that the service recipient can complete on his or her own or that must be administered by a staff person?

There are a plethora of screening tools, many of which are in the public domain. Considering the above issues in tool selection should be very useful to the clinician.

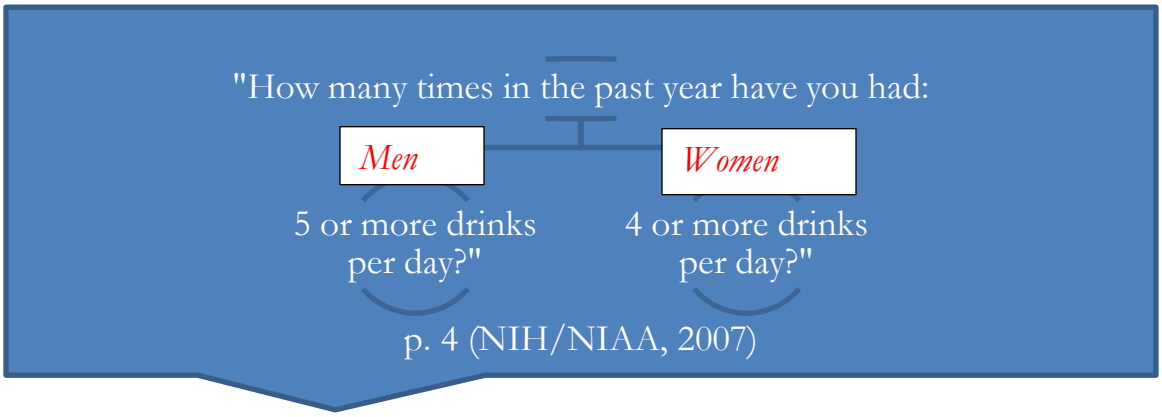
Single Question Screens.

Screening is a highly recommended strategy in the prevention and reduction of substance use and/or abuse. It allows clinicians the opportunity to counsel individuals and, when so indicated, to refer them to appropriate treatment (Smith, Schmidt, Allensworth-Davies, & Saitz, 2010). A primary tool in preventive health care in the United States, screening identifies individuals who are likely to have a disorder, as determined by their answers to certain key questions (NIAAA, 2005).

Time is limited during primary care office visits so practice guidelines in primary care currently recommend use of a single screening question for the detection of unhealthy alcohol use (Smith et al., 2010). This screen starts with the pre-screen question:

"Do you sometimes drink beer, wine, or other alcoholic beverages?" p. 4 (NIH/NIAA, 2007)

If the above prescreen is positive, it is recommended that the following single question about heavy drinking be asked:



The source guide for the aforementioned questions help medical and mental health professionals think about clinical indications for screening as well as setting up a simple process for incorporating this screening (NIH/NIAAA, 2007).

Because of the success of single-questions screeners for alcohol use, a similar technique for drug use screening should be highly considered. The following question was tested (Smith et al., 2010):

> "How many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons? " p. 1156 (Smith et al., 2010)

The question was asked by a trained interviewer. Sometimes the interviewer was asked to clarify the meaning of "nonmedical reasons". A response of at least "1" was indicative of positive drug use. Questions about drug-related problems followed up this single question. Results demonstrated that the single question screener was specific and sensitive for the detection of drug use and drug use disorders for primary care patients. This means that the single-question screen provided information comparable to longer instruments (Smith et al., 2010).

Conjoint screens have been proposed for use in general medical settings as well. The TICS, a two-item conjoint screen that asks a single question about drug use and a single question about alcohol use, has also been validated. However, as it true of most conjoint tests, it targets drug disorders, not drug use (Smith et al., 2010).

In general, single screening questions (SSQs) have been recommended in the evaluation of unhealthy drug and alcohol use. In fact, research has found SSQs effective in identifying substance dependence as well as, and in some cases better than, longer screening tools. They have been observed to be useful in screening and preliminary assessment (Saitz, Cheng, Allensworth-Davies, Winter, & Smith, 2014).

Single screening questions (SSQs) have been recommended in the evaluation of unhealthy drug and alcohol use (Saitz, Cheng, Allensworth-Davies, Winter, & Smith, 2014).

Screening Tools and Resources

National Institute on Drug Abuse (NIDA) Drug Screening Tool.

Below is the National Institute on Drug Abuse's (NIDA's) single question quick screen for use by clinician's in general medical settings. The screen is based on the aforementioned single-question screen by Smith et al. (2010).

NIDA Drug Screening Tool

• Quick Screen

Clinician's Screening Tool for Drug Use in General Medical Settings

In the past year, how often have you used the following?

Alcohol (For men, 5 or more drinks a day. For women, 4 or more drinks a day)

● Never ● Once or Twice ● Monthly ● Weekly ● Daily or Almost Daily

Tobacco Products

● Never ● Once or Twice ● Monthly ● Weekly ● Daily or Almost Daily

Prescription Drugs for Non-Medical Reasons

● Never ● Once or Twice ● Monthly ● Weekly ● Daily or Almost Daily

Illegal Drugs

● Never ● Once or Twice ● Monthly ● Weekly ● Daily or Almost Daily

An online version of the screening tool can be found at http://www.drugabuse.gov/nmassist/. An Application Programming Interface (API) for this tool is also available for developers of Electronic Health Record (EHR) systems. Developer code as well as documentation can be found at www.drugabuse.gov/developer.

Screening for Drug Use in General Medical Settings: Resource Guide.

NIDA developed a *Resource Guide* with screening tools and procedures to be used by clinicians serving adults in general medical settings. It will assist them in conducting screening, brief intervention, and/or treatments referral for persons who may have or be at risk of developing a substance use disorder. This way, clinicians can intervene early and likely enhance medical care through increase awareness of the impact of substance use on the individual's overall health. The guide can be downloaded at no cost from http://www.integration.samhsa.gov/clinical-practice/sbirt/nida_screening_for_drug_use.pdf. The document is in the public domain so its contents can be reproduced (NIDA, n.d.).

The resource guide, part of NIDA's Physicians' Outreach Initiative, contains education and information to help medical professionals be successful as the first line of defense against substance abuse and addiction. Also included is a scoring guide for the screening tool as well as sample scripts for use with patients. The tool will help clinicians in the identification of risky substance use in their adult patients. The guide, serves as an aid in providing patient feedback and arranging for specialty care, where necessary, using the five A's of intervention. The five A's comprise the following:

- Step 1: **A**sk – Screening is first and involves asking at least one question related to substance use.
- Step 2: **A**dvise – Here the medical professional provides strong, direct personal advice to the patient, to make a change if clinically indicated.
- Step 3: **A**ssess – Determine the extent to which a patient is willing to change his or her behavior after receiving the clinician's advice.
- Step 4: **A**ssist – The clinician helps the patient make a change if he or she appears to be ready.
- Step 5: **A**rrange – The medical professional refers the patient for further assessment and treatment, if so indicated, and sets up follow-up appointments (NIDA, n.d.).

Substance Use Risk Profile-Pregnancy Scale.

This tool consists of only three questions that ask about lifetime marijuana use, alcohol use prior to pregnancy, and whether the individual ever felt a need to cut down. Scoring is simple as well. The simplicities of this tool are particularly useful because they allow busy clinicians the opportunity to screen for a variety of substances within a very brief time frame. Moreover, it can be re-administered on multiple occasions with minimal burden to the clinician or the individual. The fact that there is a high risk of relapse during the postpartum period for women with a history of chronic substance use makes the availability of such a tool following delivery very useful (Yonkers, Gotman, Kershaw, Forray, Howell, & Rounsaville, 2010).

1. Have you ever smoked marijuana?
2. In the month before you knew you were pregnant, how many beers, how much wine, or how much liquor did you drink?
3. Have you ever felt that you needed to cut down on your drug or alcohol use? (Lowry, 2010).

Individuals answering "no" to all three questions are deemed to be at low risk of a positive screen for substance use. One "yes" response places a person at moderate risk while responding "yes" to at least two of the three questions places individuals at high risk of having a positive screen for illicit substance or alcohol use. This tool has high sensitivity and acceptable specificity (Lowry, 2010).

CAGE and CAGE-AID.

The CAGE is a substance abuse screener that is quite familiar to clinicians. It is one of the oldest and most popular screening instruments for alcohol abuse around. The CAGE is very brief, consisting of only of four (4) questions for which a single positive response suggests a problem with alcohol. The questions tend to inquire about problems associated with drinking instead of the amount of alcohol consumed. The instrument was likely developed that way because many persons that consume alcohol deny any problems with alcohol. Two "Yes" responses indicate problems with alcohol.

Some researchers argue that the CAGE has limited utility, being most accurate for white males and less valid identifying alcohol abuse in the elderly, white women, and African and Mexican Americans (Buddy, 2010). Further, the CAGE focuses on lifetime use rather than current alcohol consumption.

The fact that the CAGE only dealt with alcohol problems led to the development of the CAGE-AID (CAGE – Adapted to Include Drugs). This tool presents with four (4) questions but this time the questions cover drugs in addition to alcohol conjointly. As with the CAGE, each positive response for the CAGE-AID counts one (1) point. At least one (1) point identifies a positive screen. Both screens are included in these guidelines and available online from https://www.mhn.com/static/pdfs/CAGE-AID.pdf.

CAGE

C
- Has anyone ever felt you should **C**ut down on your drinking?

A
- Have people **A**nnoyed you by criticizing your drinking?

G
- Have you ever felt **G**uilty about your drinking?

E
- Have you ever had a drink first thing in the morning (**E**ye-opener) to steady your nerves or to get rid of a hangover?

The maximum number of points that can be achieved is seven (7) because the first two items count as two points each. The remaining questions count for one point each. A question either receives the maximum score or the minimum score. For Question 1, a response of "3" or higher value yields the maximum score of two for that question. The other four questions receive the maximum score for each "Yes" response and the minimum score for each "No" response.

NOTE: The CAGE is in the public domain.

CAGE-AID

CAGE Adapted to Include Drugs (CAGE-AID)

Patient Name: _____ **Date:** _____

Please circle "Yes" or "No" for each question.

Have you felt you ought to cut down on your drinking or drug use?... Yes … No

Have people annoyed you by criticizing your drinking or drug use?... Yes … No

Have you felt bad or guilty about your drinking or drug use? … Yes … No

Have you every had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)? … Yes … No

NOTE: The CAGE-AID is in the public domain.

CRAFFT.

The CRAFFT is a brief screening tool for adolescent substance abuse recommended by the American Academy of Pediatrics' Committee on Substance Abuse (CeASAR, n.d.). Designed for use with youth ages 11-21 years of age, the screener consists of three preliminary questions, followed by six easy-to-remember items (MDPH/BSAS, 2009).

Title of the screener is a mnemonic acronym of the issues addressed by the six questions. Letters in the title represent the keyword in each of the six questions: *C* = Car; *R* = Relax; *A* = Alone; *F* = Forget; *F* = Family/Friends; and *T* = Trouble. Youth should respond "YES" or "NO". At least two "YES" responses to the six questions signal a significant problem (CeASAR, n.d.). Mental health and/or health professionals should administer the screening test.

A copy of the CRAFFT is available below and also accessible online from the Center for Adolescent Substance Abuse Research (CeASAR) at http://www.ceasar.org/CRAFFT/pdf/CRAFFT_English.pdf. The online version contains scoring instructions as well as information about scoring relevance to the DSM-IV. No reference to the DSM-5 was available at the time of this writing. Card versions of the CRAFFT are available for request from http://www.ceasar.org/about/CRAFFT%20Card%20Request%20Form.pdf. Currently 13 PDF language versions of the CRAFFT are available at http://ceasar.org/CRAFFT/screenCRAFFT.php. Among the language versions are Chinese, Creole, French, Hebrew, Japanese, Khmer, Laotian, Russian, Portuguese, Spanish, Turkish, Vietnamese, and of course English. A self-administered version, to be administered by the teen, can be accessed from http://www.ceasar.org/CRAFFT/pdf/CRAFFT_SA_English.pdf.

CRAFFT Screening Interview

It is suggested that the clinician start with**: "I'm going to ask you a few questions that I ask all my patients. Please be honest."** (Then ask the following opening questions.)

Part A

- **During the PAST 12 MONTHS, did you:**
    - **1**. Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.) YES NO
    - **2**. Smoke any marijuana or hashish? YES NO
    - **3**. Use anything else to get high? ("anything else" includes over the counter and prescription drugs, illegal drugs, and things that you sniff or "huff") YES NO

If the adolescent answers "**YES**" to any of the opening questions, ***administer all six questions in Part B below***. If the adolescent answers "**NO**" to any of the opening questions, ***administer only the first of the six questions in Part B below***.

Part B

	Yes	No
1. **C** - Have you ever ridden in a **CAR** driven by someone (including yourself) who was "high" or had been using alcohol or drugs?	___	___
2. **R** - Do you ever use alcohol or drugs to **RELAX**, feel better about yourself, or fit in?	___	___
3. **A** - Do you ever use alcohol/drugs while you are by yourself, **ALONE**?	___	___
4. **F** - Do you ever **FORGET** things you did while using alcohol or drugs?	___	___
5. **F** - Do your **FAMILY** or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?	___	___
6. **T** - Have you ever gotten into **TROUBLE** while you were using alcohol or drugs?	___	___

CRAFFT cards can be requested from http://www.ceasar.org/about/CRAFFT%20Card%20Request%20Form.pdf. For more information, visit http://www.ceasar.org/CRAFFT/index.php.

Self Administration and Scoring of the CRAFFT.

A self-administered version of the CRAFFT is available at **http://www.ceasar.org/CRAFFT/pdf/CRAFFT_SA_English.pdf**. Both the screener (on the previous page) and the self-administered version should be scored using the same criteria. ***It should be noted that Part A items and responses determine which Part B items should be administered.***

Responses to Part B items are used as the primary screening results. Scoring follows the pattern below:

- ***Each "YES" response should receive a score of 1.***
- ***Two or more "YES" responses are indicative of a positive screen and suggest the probability of a significant problem involving substances.***

Any score of at least 2 indicates a need for additional assessment.

Alcohol Use Disorders Identification Test (AUDIT).

The Alcohol Use Disorders identification Test (AUDIT) was designed to be used to identify individuals with harmful and hazardous patterns of alcohol consumption. Developed by the World Health Organization (WHO) as a simple method of screening for excessive drinking and to assist in brief assessment, it provides a framework for intervention to help risky drinkers cease or at least reduce their alcohol consumption, thereby avoiding the harmful consequences of their drinking. It was designed to be used by health care professionals, but with suitable instructions, the AUDIT can be self-administered or used by non-health care professionals (World Health Organization, 2001). It is currently one of the assessment tools that can be used during SBIRT screening through the Tennessee model.

Alcohol Use Disorders Identification Test (AUDIT)				
Please circle the answer that is correct for you.				
1. How often do you have a drink containing alcohol?				
Never	Monthly or less	Two to four times a month	Two to three times per week	Four or more times per week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?				
1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3. How often do you have six or more drinks on one occasion?				
Never	Less than monthly	Monthly	Two to three times per week	Four or more times per week
4. How often during the last year have you found that you were not able to stop drinking once you had started?				
Never	Less than monthly	Monthly	Two to three times per week	Four or more times per week

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?				
Never	Less than monthly	Monthly	Two to three times per week	Four or more times per week
7. How often during the last year have you had a feeling of guilt or remorse after drinking?				
Never	Less than monthly	Monthly	Two to three times per week	Four or more times per week
8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?				
Never	Less than monthly	Monthly	Two to three times per week	Four or more times per week
9. Have you or someone else been injured as a result of your drinking?				
No	Yes, but not in the last year		Yes, during the last year	
10. Has a relative or friend, or a doctor or other health worker, been concerned about your drinking or suggested you cut down?				
No	Yes, but not in the last year		Yes, during the last year	
The Alcohol Use Disorders Identification Test (AUDIT) can detect alcohol problems experienced in the last year. A score of 8+ on the AUDIT generally indicates harmful or hazardous drinking. Questions 1–8 are scored 0, 1, 2, 3, or 4 points. Questions 9 and 10 are scored 0, 2, or 4 only.				

Source: NIAAA, 2005.

Administration of the 10-question AUDIT requires approximately two to five minutes. It is the most widely studied for detecting alcohol misuse in primary care settings (USPSTF, 2013).

Drug Abuse Screening Test (DAST)-10.

For the DAST-10, drug abuse captures any nonmedical use of drugs or the use of prescribed or over-the counter drugs in excess of the directions. The various classes of drugs may include cannabis (marijuana, hashish), hallucinogens (e.g., LSD), cocaine, stimulants (e.g., speed), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, or narcotics (e.g., heroin). The questions were not designed to include alcoholic beverages (Addiction Research Foundation, 1982).

Drug Abuse Screening Test, DAST-10

Using drugs can affect your health as well as some medications you make take. Please answer the questions below.

Which recreational drugs have you used in the past year?

☐Methamphetamines (speed, crystal)
☐Cannabis (marijuana, pot, hashish)
☐Inhalants (glue, aerosol, paint thinner)
☐Tranquilizers (valium)
☐Cocaine
☐Hallucinogens (LSD, mushrooms)
☐Narcotics (heroin, oxycodone, methadone, etc.)
☐Other _____

	0	1
1. Have you used drugs other than those required for medical reasons?	No	Yes
2. Do you abuse more than one drug at a time?	No	Yes
3. Are you unable to stop using drugs when you want to?	No	Yes
4. Have you ever had blackouts or flashbacks as a result of drug use?	No	Yes
5. Do you ever feel bad or guilty about your drug use?	No	Yes
6. Does your spouse (or parents) ever complain about your involvement with drugs?	No	Yes
7. Have you neglected your family because of your use of drugs?	No	Yes
8. Have you engaged in illegal activities in order to obtain drugs?	No	Yes
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	No	Yes
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)?	No	Yes

Scoring of the DAST-10.

Score Interpretation			
Score Quadrant	**Score**	**Degree of Problems Related to Drug Abuse**	**Suggested Action**
I	0	No problems reported	None at this time
II	1-2	Low level	Monitor, re-assess at a later date
III	3-5	Moderate level	Further investigation
IV	6+	Substantial/severe level	Address problem immediately

Source: Addiction Research Foundation, 1982; Clinical Tools Inc., 2014

Administration and scoring of the 10-question DAST takes approximately three minutes. The tool can be used by primary care physicians (PCPs) to assess for potential substance use disorders in all new patients (Clinical Tools Inc., 2014). The DAST-10 is further one of the screens that might be used in SBIRT-TN.

T-ACE.

Determining a woman's prenatal alcohol consumption can be difficult but clearly identifying women who are drinking during pregnancy is extremely important. However, popular screening instruments may not identify harmful drinking by pregnant women (NIAAA, 2005).

The T-ACE was developed expressly to identify alcohol consumption by women during pregnancy. Based on the CAGE, the instrument has been tested across a variety of obstetric practices and proven to be an efficient and valuable tool for identifying a range of alcohol use, including current prenatal alcohol consumption, pre-pregnancy risk drinking (i.e., more than two drinks per drinking day), and lifetime alcohol diagnoses per the DSM (NIAAA, 2005). Some studies have observed the T-ACE as more effective than other measurements in identifying pregnant women at risk for problem drinking (NIH/NIAAA, 2000).

T-ACE

T (*Tolerance*) How many drinks does it take to make you feel high?

A Have people *annoyed* you by criticizing your drinking?

C Have you ever felt you ought to *cut down* on your drinking?

E (*Eye opener*) Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

A score of at least 2 is considered positive. Reporting tolerance (the T question) counts 2 points. Affirmative answers to questions A, C, or E count 1 point each (NIH/NIAAA, 2000; NIAAA, 2005).

UNCOPE.

UNCOPE

The **UNCOPE** can be used to screen for other drugs in addition to alcohol. Comprised of six (6) questions, it provides a quick and simple way of identifying risk for abuse and dependence on alcohol and other drugs. Developed by Dr. Norman Hoffmann and his colleagues, the UNCOPE has been used in the Comprehensive Assessment and Treatment Outcomes Research (CATOR), the largest independent evaluation of chemical dependency in the United States. Since then, items representing "U" and "P" have revised wording. While either version of the six questions can be used without cost for oral administration in any psychosocial, clinical, or medical interview (Campbell, Hoffmann, Hoffmann, & Gillaspy, 2005), Hoffman tends to use revised "U" and "P" items (Hoffman, n.d.). UNCOPE items are displayed below.

U "In the past year, have you ever drank or **used** drugs more than you meant to?"

OR

"Have you spent more time drinking or using than you intended to?" (revised wording)

N "Have you ever **neglected** some of your usual responsibilities because of using alcohol or drugs?"

C "Have you felt you wanted or needed to **cut down** on your drinking or drug use in the last year?"

O "Has anyone **objected** to your drinking or drug use?" (Alternate wording: "Has your family, a friend, or anyone else ever told you they **objected** to your alcohol or drug use?"

P "Have you ever found yourself **preoccupied** with wanting to use alcohol or drugs?"

OR

"Have you found yourself thinking a lot about drinking or using?" (revised wording)

E "Have you ever used alcohol or drugs to relieve **emotional discomfort**, such as sadness, anger, or boredom?"

Scoring of the UNCOPE.

Questions should be answered "Yes" or "No." Two or more positive responses indicate possible abuse or dependence and the need for further assessment. "Yes" responses qualify as positive responses.

Suggestions for UNCOPE interpretation and feedback to respondent.

The following scores and recommendations should be based on the highest score or algorithm met. This is only a draft to suggest a model and is not intended to represent the scoring or recommendation criteria to be adopted. Those wishing to provide feedback on the UNCOPE-Plus findings are advised to collect data to validate the appropriateness of the interpretation and feedback based on the population for which the screening is intended.

Scoring.

Alcohol use scale (Items 1-3)

1. Level of use modest (Items 2 + 3 = 0)

2. Use may exceed recommended level
For males: ((Item 1 = 4 AND Item 2 > 1) OR (Item 1 >1 AND Item 2 > 2))

3. Potentially hazardous use ((Item 1 > 0 AND Item 2 > 2) OR (Item 3 > 1))

4. Potentially harmful level of use (Total of Items 1-3 = 10+) OR (Item 1 > 1 AND Item 2 = 4)) Drug use scale (Item 4)

Diagnostic indications (UNCOPE):

1. No problem indicated (UNCOPE score < 3)
2. Some risk for substance abuse/misuse (UNCOPE score >2)
3. Indications of substance abuse (Items 5 & 7 both positive and total UNCOPE score = 3+)
4. Indications of possible substance dependence (Items 6 & 8 both positive and UNCOPE score = 3+)
5. Strong indication of substance dependence (Items 5-8 all positive and UNCOPE score = 4+)

Advice. (Partial feedback statements bolded)

Drinking seems to be within normal limits (Alcohol use scale = 1 and UNCOPE score <3)

Drug use although not frequent may be a source of legal or other problems (Item 4 = 2; UNCOPE score < 3)

Comment that drug use seems frequent and should be reduced (Item 4 > 2)

Advised to reduce alcohol use (Alcohol use > 1 and either Item 2 > 1 or Item 3 >1 AND UNCOPE score <3) (For females, Item 2 > 0 may be used as this could indicate possible intoxication)

Strongly advise to try reducing alcohol use (Alcohol use score > 2)

Suggest possible need for counseling for alcohol if unable to reduce alcohol use (Alcohol use scale > 2 and UNCOPE score > 2); **possible need for counseling for drugs if unable to reduce drug use** (and/or Drug use [Item 4] > 2 and UNCOPE score > 2) **Suggest help to reduce both alcohol and drug use if both previous conditions are met** (i.e., Alcohol use scale > 2 and drug use [Item 4] > 2 and UNCOPE score > 2)

Suggest an evaluation ((Alcohol use > 2 and/or Drug use > 2) and UNCOPE score > 3)

Suggest need for assessment at a treatment provider
((Alcohol use scale > 3 and/or Drug use [Item 4] >3) and UNCOPE score > 4)

NOTE: Developer Norman G. Hoffman, PhD, says both versions of the UNCOPE are in the public domain and can be accessed online.

UNCOPE Plus.

The UNCOPE Plus is designed to get at frequency and quantity information similar to the DAST and AUDIT (Hoffman, 2012). Developed by Norman G. Hoffmann, PhD, this form may be used for any appropriate noncommercial clinical applications without prior approvals.

UNCOPE Plus

1. How often do you have a drink containing alcohol?
   (0) Never
   (1) Monthly or less
   (2) 2 to 4 times a month
   (3) 2 to 3 times a week
   (4) 4 or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   (0) 1 or 2
   (1) 3 or 4
   (2) 5 or 6
   (3) 7, 8, or 9
   (4) 10 or more

3. How often do you have five or more drinks on one occasion?

   (0) Never
   (1) Less than monthly
   (2) Monthly
   (3) Weekly
   (4) Daily or almost daily

4. How often do you use marijuana, any other drug, or prescription medication to get high?

   (0) Never
   (1) Monthly or less
   (2) 2 to 4 times a month
   (3) 2 to 3 times a week
   (4) 4 or more times a week

5. Have you spent more time drinking or using drugs than you intended to?
   (0) No
   (1) Yes

6. Have you ever neglected some of your usual responsibilities because of drinking or using drugs?
   (0) No
   (1) Yes

7. Have you felt you wanted or needed to cut down on your drinking or drug use in the last year?
   (0) No
   (1) Yes

8. Has anyone objected to your drinking or drug use?
   (0) No
   (1) Yes

9. Have you found yourself thinking a lot about drinking or using drugs?
   (0) No
   (1) Yes

10. Have you ever used alcohol or drugs to relieve emotional discomfort, such as sadness, anger, or boredom?
    (0) No
    (1) Yes

NOTE: Developer Norman G. Hoffman, PhD, says both versions of the UNCOPE are in the public domain and can be accessed online.

Clinical Opiate Withdrawal Scale (COWS).

The Clinical Opiate Withdrawal Scale (COWS) is a common method of assessing opiate withdrawal levels in individuals who are being monitored for medication-assisted treatment for opioid dependence, as well as for persons in residential treatment settings. The instrument can be used in other types of health care settings where service recipients may experience withdrawal from opioid use. COWS is a clinician-administered scale that contains 11 items. It provides a way of recording scores for various symptoms of opiate withdrawal using a scale from 0 to 4 or 5, depending on the item. The numbers for each item are summed to determine the level of opiate withdrawal. The score should be used to assist the clinician in determining the next course of action for treatment (Opiate.com, n.d.).

A total score of 48 can be obtained on the scale. Scores between 5-12 place the individual in mild opiate withdrawal. Scores between 13-24 signal moderate opiate withdrawal and scores of 25-36 are indicative of moderately severe opiate withdrawal. A score greater than 36 is the worse level and signals severe withdrawal from opiates. The experienced medical team will know where the individual is having difficulty and what treatment should look like given that person's score and other factors (Opiate.com, n.d.).

COWS is in the public domain. , with a quality PDF version available at www.ncbi.nlm.nih.gov/books/NBK143183/bin/annex10-fm3.pdf.

Clinician's Screening Tool for Drug Use in General Medical Settings.

The National Institute on Drug Abuse (NIDA) has a wealth of screening tools for substance abuse that are available at no cost to clinicians. Some of the tools are paper documents that can be downloaded. However, the Clinician's Screening Tool for Drug Use in General Medical Settings is an online instrument. It guides clinicians through a series of questions to identify risky substance use in adult service recipients. There are also accompanying resources to assist in providing feedback and arranging for specialty care, where appropriate, using the five A's of intervention. This online tool is available at http://www.drugabuse.gov/nmassist/?q=nida_questionnaire. Clinicians can read more information about the tool at the site, including instructions and tool development/validation data (NIDA Drug Screening Tool, n.d.).

Michigan Alcohol Screening Test (MAST).

MAST

The Michigan Alcohol Screening Test (MAST) is one of the most accurate alcohol screening tests available, effective in identifying dependent drinkers with up to 98 percent accuracy. Questions focus on problems over the patient's/client's lifetime rather than current problems.

1. Do you feel you are a normal drinker? ☐ YES ☐ NO
("normal" is defined as drinking as much or less than most other people)

2. Have you ever awakened the morning after drinking the night before and found that you could not remember a part of the evening? ☐ YES ☐ NO

3. Does any near relative or close friend ever worry or complain about your drinking?
☐ YES ☐ NO

4. Can you stop drinking without difficulty after one or two drinks? ☐ YES ☐ NO

5. Do you ever feel guilty about your drinking? ☐ YES ☐ NO

6. Have you ever attended a meeting of Alcoholics Anonymous (AA)? ☐ YES ☐ NO

7. Have you ever gotten into physical fights when drinking? ☐ YES ☐ NO

8. Has drinking ever created problems between you and a near relative or close friend?
☐ YES ☐ NO

9. Has any family member or close friend gone to anyone for help about your drinking?
☐ YES ☐ NO

10. Have you ever lost friends because of your drinking? ☐ YES ☐ NO

11. Have you ever gotten into trouble at work because of drinking?
☐ YES ☐ NO

12. Have you ever lost a job because of drinking? ☐ YES ☐ NO

13. Have you ever neglected your obligations, family, or work for two or more days in a row because you were drinking? ☐ YES ☐ NO

14. Do you drink before noon fairly often? ☐ YES ☐ NO

15. Have you ever been told you have liver trouble, such as cirrhosis? ☐ YES ☐ NO

MAST *(continued)*

16. After heavy drinking, have you ever had delirium tremens (DTs), severe shaking, visual or auditory (hearing) hallucinations? □ YES □ NO

17. Have you ever gone to anyone for help about your drinking? □ YES □ NO

18. Have you ever been hospitalized because of drinking? □ YES □ NO

19. Has your drinking ever resulted in your being hospitalized in a psychiatric ward? □ YES□ NO

20. Have you ever gone to any doctor, social worker, clergyman, or mental health clinic for help with any emotional problem in which drinking was part of the problem? □ YES □ NO

21. Have you been arrested more than once for driving under the influence of alcohol?
□ YES □ NO

22. Have you ever been arrested, or detained by an official for a few hours, because of other behavior while drinking?
□ YES □ NO

Scoring

Answered "NO" to Questions 1 or 4: 1 point each

Answered "YES" to Questions 2, 3, 5-22: 1 point each

Total score = 6 or more: Indicative of hazardous drinking or alcohol dependence; further evaluation by a healthcare professional is recommended.

Source: BuddyT. Verywell.com.

FAST Alcohol Screening Test (FAST).

FAST

The FAST is specially designed to make a fast assessment of patients/clients for hazardous drinking in busy settings. It focuses on hazardous drinking within the last 12 months. Most patients/clients only have to answer the first question.

FAST Test

1. How often do you have eight or more drinks on one occasion?

__ Never __ Less Than Monthly __ Monthly __ Weekly __ Daily or Almost Daily

2. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

__ Never __ Less Than Monthly __ Monthly __ Weekly __ Daily or Almost Daily

3. How often during the last year have you failed to do what was normally expected of you because of your drinking?

__ Never __ Less Than Monthly __ Monthly __ Weekly __ Daily or Almost Daily

4. Has a relative or friend, a doctor or other health worker been concerned about your drinking or suggested you cut down?

__ No __ Yes, but not in the last year. __ Yes in the last year.

Scoring

Questions 1, 2 and 3: Never -- 0 points; Less than monthly -- 1 point; Monthly -- 2 points; Weekly -- 3 points; Daily or almost daily -- 4 points
Question 4: No -- 0 points; Yes, but not in the last year -- 2 points; Yes, in the last year -- 4 points

Analyzing Results

- As a general rule, higher scores are better. Maximum score = 16.
- A total score of 3 indicates hazardous drinking.
- Answer "never" on the Question 1 means person is not a hazardous drinker and remaining questions are not necessary.
- Answer "weekly" or "daily or almost daily" on Question 1 means person is considered a hazardous drinker and you can skip the remaining questions.
- Answer "monthly" or "less than monthly" on Question 1 means the other three questions need to be asked to complete the screening for hazardous drinking.

IHR 5P's Behavioral Risk Screening Tool

Patient/Client Name _____ DOB _____

Is patient/client pregnant? ☐ YES ☐ NO Gestational Age _____ Date _____

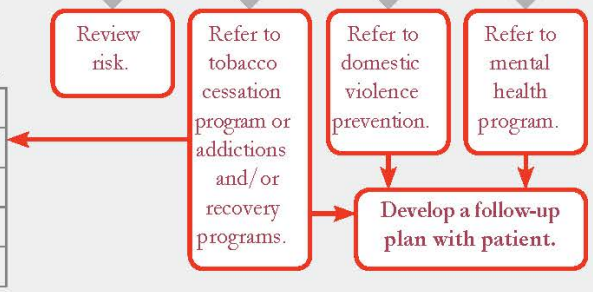
Provider's Name _____ Screener's Name _____

Women and their children's health can be affected by emotional problems, alcohol, tobacco, other drug use and violence. Women and their children's health are also affected when these same problems are present in people who are close to them. **Alcohol includes beer, wine, wine coolers, liquor and spirits**. Tobacco products include cigarettes, cigars, snuff and chewing tobacco.

1. Did any of your parents have a problem with alcohol or other drug use?	**PARENTS**	☐ YES						☐ NO
2. Do any of your friends have a problem with alcohol or other drug use?	**PEERS**	☐ YES						☐ NO
3. Does your partner have a problem with alcohol or other drug use?	**PARTNER**		☐ YES					☐ NO
4. In the past, have you had difficulties in your life due to alcohol or other drugs, including prescription medications?	**PAST**		☐ YES					☐ NO
5. Check YES if she agrees with any of these statements. – In the past month, have you drunk any alcohol or used other drugs? – How many days per month do you drink? ____ – How many drinks on any given day? ____ – How often did you have 4 or more drinks per day in the last month? ____	**PRESENT**		☐ YES					☐ NO
6. Have you smoked any cigarettes or used any tobacco products in the past three months?	**TOBACCO**		☐ YES					☐ NO
7. Over the last few weeks, has worry, anxiety, depression, or sadness made it difficult for you to do your work, get along with other people, or take care of things at home?	**EMOTIONAL HEALTH**					☐ YES		☐ NO
8. Are you currently or have you ever been in a relationship where you were physically hurt, choked, threatened, controlled or made to feel afraid?	**VIOLENCE**			☐ YES				☐ NO

FOR PROVIDER USE

Brief Intervention/Brief Treatment	**Y**	**N**	**NA**
Did you **State** your medical concern?	☐	☐	☐
Did you **Advise** to abstain or reduce use?	☐	☐	☐
Did you **Check** patient's reaction?	☐	☐	☐
Did you **Refer** for further assessment?	☐	☐	☐
Did you **Provide** written information?	☐	☐	☐



Moderate drinking for non-pregnant women is one drink per day. Women who are pregnant or planning to become pregnant should not use alcohol, tobacco, illicit drugs or prescription medication other than as prescribed.

Developed by the Institute for Health and Recovery (IHR), Massachusetts, February, 2007. Adapted by the Southern Oregon Perinatal Task Force in partnership with AllCare Health Plan, Oregon, May 2013. Adapted by TDMHSAS, June 2016.

Structured Clinical Interview for DSM-5 (SCID-5).

The Structured Clinical Interview for DSM-5 (SCID-5) is a great assessment instrument for identifying substance use disorder (SUD), as well as other DSM-5 psychiatric disorders. As a structured clinical interview, the instrument covers a broad range of illnesses, most of which the patient/client probably may not have. Questions on the SCID range from asking about family and medical history to illnesses and current complaints. Moreover, the questions get very detailed and specific and inquire about the nature, severity and duration of symptoms. Thus, the SCID can assist in determining if a patient/client has more than one illness. The questions are standardized which ensures that each person will be interviewed in the same way. Depending on the severity and type of symptoms, the SCID can take anywhere from 15 minutes to several hours to complete. The clinician's version can be purchased from American Psychiatric Publishing, Inc. (APPI).

MDCalc Links to Online Screening/Assessment Tools.

MDCalc is an online resource that includes, among other items, links to screening/assessments instruments, some of which are designed to measure and drug and/or alcohol use. For each tool, data can be entered directly into the instrument online. Summary and/or total scores are generated with comments. Users should read the disclaimer about use of any calculations or interpretative information, which can be found at http://www.mdcalc.com/disclaimer/. Information on how to use the online instruments, next steps, how the instruments were validated, and the calculator's developer are available on each link's site. Please contact MDCalc if you have questions about the content or how you plan to use the instruments in your work. A "Contact MDCalc" link is found on the lower right of each Web page.

For the purposes of this tool guide, links are shown below for the Alcohol Use Disorders Identification Test—Consumption (AUDIT-C), CAGE questions for alcohol use, Clinical Institute Withdrawal Assessment of Alcohol Scale, Revised (CIWA-Ar), and the Clinical Opiate Withdrawal Scale (COWS).

1. AUDIT-C for Alcohol Use

http://www.mdcalc.com/audit-c-for-alcohol-use/

✓ The AUDIT-C is a three-item alcohol screen based on the 10-question AUDIT instrument. It was designed to help identify individuals who are hazardous drinkers or have active AUDs.

2. CAGE Questions for Alcohol Use

http://www.mdcalc.com/cage-questions-for-alcohol-use/

✓ This four-item instrument was designed to screen for alcohol use problems. It can be administered in less than a minute by clinicians. It is appropriate for use with individuals > 16 years of age.

3. CIWA-Ar for Alcohol Withdrawal

http://www.mdcalc.com/ciwa-ar-for-alcohol-withdrawal/

✓ The added value of this instrument is its ability to prevent the over or under-treating of patients in alcohol withdrawal with benzodiazepines. The treatment protocol is considered in conjunction with the CIWA-Ar score.

4. COWS for Opiate Withdrawal

http://www.mdcalc.com/cows-score-for-opiate-withdrawal/

✓ Besides being a useful tool during buprenorphine induction, it can also be used to assess acute opiate withdrawal during an opiate detoxification program, e.g.

Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES), Version 8.

The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES), Version 8, measures readiness to change, with items specifically focused on problem drinkers or drug users. Items can be used to provide feedback to patients/clients about their scores as a starting point for discussion. Re-administrations can be used to assess the impact of interventions on problem recognition, ambivalence, and progress in making changes (SAMHSA/CSAT, 1999). This is an experimental instrument that yields three factorially-derived scale scores: Recognition (Re), Ambivalence (Am), and Taking Steps (Ts). The instrument is in the public domain and may be used without special permission.

Answers should be recorded directly on the questionnaire form. Numbers circled by the respondent for each item are transferred to the SOCRATES Scoring Form for scoring. The sum of each column yields the three scale scores. Data entry screens and scoring routines are available.

Source Citation: Miller, W. R., & Tonigan, J. S. (1996). Assessing drinkers' motivation for change: The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES). *Psychology of Addictive Behaviors, 10*, 81-89.

Personal Drinking Questionnaire (SOCRATES 8A)

INSTRUCTIONS: Please read the following statements carefully. Each one describes a way that you might (or might not) feel *about your drinking*. For each statement, circle one number from 1 to 5, to indicate how much you agree or disagree with it *right now*. Please circle one and only one number for every statement.

	NO! Strongly Disagree	**No** Disagree	**?** Undecided or Unsure	**Yes** Agree	**YES!** Strongly Agree
1. I really want to make changes in my drinking.	1	2	3	4	5
2. Sometimes I wonder if I am an	1	2	3	4	5
3. If I don't change my drinking soon, my problems are going to get worse.	1	2	3	4	5
4. I have already started making some changes in my drinking.	1	2	3	4	5
5. I was drinking too much at one time, but I've managed to change my drinking.	1	2	3	4	5
6. Sometimes I wonder if my drinking is hurting other people.	1	2	3	4	5
7. I am a problem drinker.	1	2	3	4	5
8. I'm not just thinking about changing my drinking, I'm already doing something about it.	1	2	3	4	5
9. I have already changed my drinking, and I am looking for ways to keep from slipping back to my old pattern.	1	2	3	4	5
10. I have serious problems with drinking.	1	2	3	4	5

e

	NO! Strongly Disagree	**No** Disagree	**?** Undecided or Unsure	**Yes** Agree	**YES!** Strongly Agree
11. Sometimes I wonder if I am in control of my drinking.	**1**	**2**	**3**	**4**	**5**
12. My drinking is causing a lot of harm.	**1**	**2**	**3**	**4**	**5**
13. I am actively doing things now to cut down or stop drinking.	**1**	**2**	**3**	**4**	**5**
14. I want help to keep from going back to the drinking problems that I had before.	**1**	**2**	**3**	**4**	**5**
15. I know that I have a drinking problem.	**1**	**2**	**3**	**4**	**5**
16. There are times when I wonder if I drink too much.	**1**	**2**	**3**	**4**	**5**
17. I am an alcoholic.	**1**	**2**	**3**	**4**	**5**
18. I am working hard to change my	**1**	**2**	**3**	**4**	**5**
19. I have made some changes in my drinking, and I want some help to keep from going back to the way I used to drink.	**1**	**2**	**3**	**4**	**5**

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Personal Drug Use Questionnaire (SOCRATES 8D)

INSTRUCTIONS: Please read the following statements carefully. Each one describes a way that you might (or might not) feel *about your drug use*. For each statement, circle one number from 1 to 5, to indicate how much you agree or disagree with it *right now*. Please circle one and only one number for every statement.

	NO! Strongly Disagree	**No** Disagree	**?** Undecided or Unsure	**Yes** Agree	**YES!** Strongly Agree
1. I really want to make changes in my use of drugs.	**1**	**2**	**3**	**4**	**5**
2. Sometimes I wonder if I am an addict.	**1**	**2**	**3**	**4**	**5**
3. If I don't change my drug use soon, my problems are going to get worse.	**1**	**2**	**3**	**4**	**5**
4. I have already started making some changes in my use of drugs.	**1**	**2**	**3**	**4**	**5**
5. I was using drugs too much at one time, but I've managed to change that.	**1**	**2**	**3**	**4**	**5**
6. Sometimes I wonder if my drug use is hurting other people.	**1**	**2**	**3**	**4**	**5**
7. I have a drug problem.	**1**	**2**	**3**	**4**	**5**
8. I'm not just thinking about changing my drug use, I'm already doing something about it.	**1**	**2**	**3**	**4**	**5**
9. I have already changed my drug use, and I am looking for ways to keep from slipping back to my old pattern.	**1**	**2**	**3**	**4**	**5**
10. I have serious problems with drugs.	**1**	**2**	**3**	**4**	**5**

e

	NO! Strongly Disagree	**No** Disagree	**?** Undecided or Unsure	**Yes** Agree	**YES!** Strongly Agree
11. Sometimes I wonder if I am in control of my drug use.	**1**	**2**	**3**	**4**	**5**
12. My drug use is causing a lot of harm.	**1**	**2**	**3**	**4**	**5**
13. I am actively doing things now to cut down or stop my use of drugs.	**1**	**2**	**3**	**4**	**5**
14. I want help to keep from going back to the drug problems that I had before.	**1**	**2**	**3**	**4**	**5**
15. I know that I have a drug problem.	**1**	**2**	**3**	**4**	**5**
16. There are times when I wonder if I use drugs too much.	**1**	**2**	**3**	**4**	**5**
17. I am a drug addict.	**1**	**2**	**3**	**4**	**5**
18. I am working hard to change my drug	**1**	**2**	**3**	**4**	**5**
19. I have made some changes in my drug use, and I want some help to keep from going back to the way I used before.	**1**	**2**	**3**	**4**	**5**

SOCRATES Scoring Form - 19-Item Versions 8.0

Transfer the client's answers from questionnaire (see note below):

	Recognition	Ambivalence	Taking Steps
	1 _____	2 _____	
	3 _____		4 _____
			5 _____
		6 _____	
	7 _____		8 _____
			9 _____
	10 _____	11 _____	
	12 _____		13 _____
			14 _____
	15 _____	16 _____	
	17 _____		18 _____
			19 _____
TOTALS	**Re_____**	**Am_____**	**Ts_____**
Possible Range:	**7-35**	**4-20**	**8-40**

SOCRATES Profile Sheet (19-Item Version 8A)

INSTRUCTIONS: From the SOCRATES Scoring Form (19-Item Version) transfer the total scale scores into the empty boxes at the bottom of the Profile Sheet. Then for each scale, CIRCLE the same value above it to determine the decile range.

DECILE SCORES	Recognition	Ambivalence	Taking Steps
90 Very High		19-20	39-40
80		18	37-38
70 High	35	17	36
60	34	16	34-35
50 Medium	32-33	15	33
40	31	14	31-32
30 Low	29-30	12-13	30
20	27-28	9-11	26-29
10 Very Low	7-26	4-8	8 - 25
RAW SCORES (from Scoring Sheet)	Re=	Am=	Ts=

These interpretive ranges are based on a sample of 1,726 adult men and women presenting for treatment of alcohol problems through Project MATCH. Note that individual scores are therefore being ranked as low, medium, or high *relative to people already presenting for alcohol treatment*.

Guidelines for Interpretation of SOCRATES-8 Scores

Using the SOCRATES Profile Sheet, circle the client's raw score within each of the three scale columns. This provides information as to whether the client's scores are low, average, or high *relative to people already seeking treatment for alcohol problems.* The following are provided as general guidelines for interpretation of scores, but it is wise in an individual case also to examine individual item responses for additional information.

RECOGNITION

- ✓ **HIGH scorers directly acknowledge that they are having problems related to their drinking, tending to express a desire for change and to perceive that harm will continue if they do not change.**

- ✓ **LOW scorers deny that alcohol is causing them serious problems, reject diagnostic labels such as "problem drinker" and "alcoholic," and do not express a desire for change.**

AMBIVALENCE

- ✓ **HIGH scorers say that they sometimes *wonder* if they are in control of their drinking, are drinking too much, are hurting other people, and/or are alcoholic. Thus a high score reflects ambivalence or uncertainty. A high score here reflects some openness to reflection, as might be particularly expected in the contemplation stage of change.**

- ✓ **LOW scorers say that they *do not wonder* whether they drink too much, are in control, are hurting others, or are alcoholic. Note that a person may score low on ambivalence *either* because they "know" their drinking is causing problems (high Recognition), *or* because they "know" that they do not have drinking problems (low Recognition). Thus a low Ambivalence score should be interpreted in relation to the Recognition score.**

TAKING STEPS

- ✓ **HIGH scorers report that they are already doing things to make a positive change in their drinking, and may have experienced some success in this regard. Change is underway, and they may want help to persist or to prevent backsliding. A high score on this scale has been found to be predictive of successful change.**

- ✓ **LOW scorers report that they are not currently doing things to change their drinking, and have not made such changes recently.**

AC-OK Screen for Co-Occurring Disorders.

The AC-OK Screen for Co-Occurring Disorders is a rapid-response screen to identify the co-existing disorders of substance use, mental health and trauma related mental health issues of adolescents.

AC-OK-COD Adolescent Screen

Gender: _____Age: _____Last grade completed

***Read as*: "During the past year have you":**

1.	**Felt really sad, lonely, hopeless; stopped enjoying things, wanted to eat more or less, had problems sleeping, or doing what you need to at home or at school?**	**Yes**	**No**
2.	**Heard voices or seen things that others don't hear or see?**	**Yes**	**No**
3.	**Drink alcohol or used other drugs more than you meant to?**	**Yes**	**No**
4.	**Burned or cut yourself?**	**Yes**	**No**
5.	**Have you experienced a very bad thing happen (a traumatic event) where you continue to feel scared, worried, or nervous or even had nightmares that bothered you after it was all over?**	**Yes**	**No**
6.	**Tried to stop drinking alcohol or using other drugs, but couldn't?**	**Yes**	**No**
7.	**Been prescribed medication for your feelings?**	**Yes**	**No**
8.	**Got in trouble with the law, school, or parents, or lost friends because of your drinking alcohol or using other drugs, and continued to use?**	**Yes**	**No**
9.	**Drink alcohol or used other drugs to change the way you feel?**	**Yes**	**No**
10.	**Had thoughts about hurting yourself or wanting to die?**	**Yes**	**No**
11.	**Tried to kill yourself?**	**Yes**	**No**
12.	**Have you ever been afraid of your parent, caretaker or a family member?**	**Yes**	**No**
13.	**Have you ever been hit, slapped, kicked, touched in a bad way, cursed at, yelled at or threatened by someone?**	**Yes**	**No**
14	**Changed your friends or planned your free time to include drinking alcohol or using other drugs?**	**Yes**	**No**
15.	**Needed to drink more alcohol or use more drugs to get the same buzz or high as when you first started using?**	**Yes**	**No**

Instructions: OK Adolescent Screen

"I'm glad you called (or came in); let's see how I can help. In your own words, what is going on, OR can you tell me a little about why you called (or came in) today?"

"In order to find the best services for you, I'd like to ask you a few short yes or no questions to see if there is anything we may have missed. There are no right or wrong answers and these questions may or may not apply to your situation. Is this okay with you?"

Scoring: Remember, one (1) "Yes" answer on any of the three (3) domains (Substance Abuse, Mental Health, and Trauma) indicates that an additional assessment(s) is needed in that domain.

Substance Abuse:	**3□ , 6 □, 8 □ , 9□ , 14□ , 15 □**
Mental Health:	**1 □ , 2□ , 4 □ , 7 □ , 10□ , 11 □ ,**
Trauma	**5□ , 12□ , 13□**

<u>Reading Level of Screen</u>:

Flesch Reading ease: .76

Flesch—Kincaid Grade Level: 6

Trauma Screening Questionnaire (TSQ).

The TSQ is a 10-item symptom screen designed for use with survivors of all types of traumatic stress. It is based on items from the PTSD Symptom Scale - Self Report (PSS-SR; Foa et al., 1993) and has five arousal items and five re-experiencing items. Respondents are asked to endorse those items that they have experienced at least twice in the past week. A positive screen occurs when there is an endorsement of at least six items. The authors recommend that screening be conducted three to four weeks following the trauma to allow for normal recovery processes to take place. This questionnaire is not in the public domain (VA, 2016).

PTSD Checklist (PCL).

The PTSD Checklist (PCL) is used to explore whether an individual my meet criteria for **post-traumatic stress disorder**. Sometimes people think they are experiencing PTSD, but in reality they are not. In other cases, people deny having PTSD, but have a lot of symptoms that define the disorder. A problem with PTSD is that it doesn't go away by itself. People can avoid the PTSD-triggers, but the pain is still there. And when people get to the point they can't avoid the triggers, they may experience a lot of pain. It only takes about three minutes to complete the PCL. There is a military version as well as a civilian version of the PCL. The military version is more specific to PTSD caused by military experiences and the civilian version applies generally to any traumatic event (Barends Psychology Practice, n.d.).

Scoring the PCL

- Add up all items from each of the 17 items for a total severity score (range = 17-85).
- A score of 17-29 shows little to no severity.
- A score of 28-29 is indicative of some PTSD symptoms.
- Scores of 30–44 are Moderate to Moderately High in severity of PTSD symptoms.
- Scores of 45-85 reflect High Severity of PTSD symptoms (Choices Counseling, n.d.).

The checklist is in the public domain so it is permissible for personal or group use (Choices Counseling, n.d.).

PTSD Checklist (PCL)

If an event listed on the Life Events Checklist happened to you or you witnessed it, please complete the items below. If more than one event happened, please choose the one that is most troublesome to you now.

The event you experienced was _____ on _____.
(EVENT) (DATE)

Instructions: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, then circle one of the numbers to the right to indicate how much you have been bothered by the problem in the past month.

BOTHERED BY	NOT AT ALL	A LITTLE BIT	MODERATELY	QUITE A BIT	EXTREMELY
1. Repeated disturbing memories, thoughts, or images of the stressful experience?	1	2	3	4	5
2. Repeated, disturbing dreams of the stressful experience?	1	2	3	4	5
3. Suddenly acting or feeling as if the stressful experience were happening again (as if you were reliving it)?	1	2	3	4	5
4. Feeling very upset when something reminded you of the stressful experience?	1	2	3	4	5
5. Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of the stressful experience?	1	2	3	4	5
6. Avoiding thinking about or talking about the stressful experience or avoiding having feelings related to it?	1	2	3	4	5
7. Avoiding activities or situations because they remind you of the stressful experience?	1	2	3	4	5
8. Trouble remembering important parts of the stressful experience?	1	2	3	4	5
9. Loss of interest in activities that you used to enjoy?	1	2	3	4	5
10. Feeling distant or cut off from other people?	1	2	3	4	5
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?	1	2	3	4	5
12. Feeling as if your future will somehow be cut short?	1	2	3	4	5
13. Trouble falling or staying asleep?	1	2	3	4	5
14. Feeling irritable or having angry outbursts?	1	2	3	4	5
15. Having difficulty concentrating?	1	2	3	4	5
16. Being "super alert" or watchful or on guard?	1	2	3	4	5
17. Feeling jumpy or easily startled?	1	2	3	4	5

Columbia-Suicide Severity Rating Scale (C-SSRS).

The Columbia-Suicide Severity Rating Scale (C-SSRS), Screener version, contains from three to six questions for use by individuals where frequent monitoring of suicidal ideation/behaviors is required. This version includes all information necessary to make a decision about next steps (the 1 to 5 questions about severity of suicidal ideation (thoughts of suicide) and one question on the full range of suicidal behaviors. The C-SSRS Screen version is most often used with the **Recent** timeframe of one month for ideation and three months for behavior or as a **Since Last Visit** measurement.

C-SSRS SCREENER WITH TRIAGE POINTS*

I. SUICIDE IDEATION DEFINITIONS AND PROMPTS:	**Past Month**	
Ask questions that are in bolded and underlined	**Yes**	**NO**
Ask Questions 1 and 2		
1) Wish to be Dead: Person endorses thoughts about a wish to be dead or not alive anymore, or wish to fall asleep and not wake up? ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) Suicidal Thoughts: General non-specific thoughts of wanting to end one's life/commit suicide, "*I've thought about killing myself" without general thoughts of ways to kill oneself/ associated methods, intent, or plan.*" ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6		
3) Suicidal Thoughts with Method (without Specific Plan or Intent to Act): Person endorses thoughts of suicide and has thought of a least one method during the assessment period. This is different than a specific plan with time, place or method details worked out. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*" ***Have you been thinking about how you might do this?***		
4) Suicidal Intent (without Specific Plan): Active suicidal thoughts of killing oneself and patient reports having some intent to act on such thoughts, as oppose to "*I have the thoughts but I definitely will not do anything about them.*" ***Have you had these thoughts and had some intention of acting on them?***		
5) Suicide Intent with Specific Plan: Thoughts of killing oneself with details of plan fully or partially worked out and person has some intent to carry it out. ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		

C-SSRS SCREENER WITH TRIAGE POINTS*

I. SUICIDE IDEATION DEFINITIONS AND PROMPTS:	Past Month	
Ask questions that are in bolded and underlined	**Yes**	**NO**
6) Suicide Behavior Question: ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***How long ago did you do any of these?*** ☐ Over a year ago? ☐Between three months and a year ago? ☐Within the last three months?		

II. Triage Protocol for C-SSRS Screening
(Items 1 to-5 linked to last item answered YES)

Item 1 – Mental Health Referral at discharge
Item 2 – Mental Health Referral at discharge
Item 3 – Care Team Consult (Psychiatric Nurse) and Possible Patient Safety Monitor/ Procedures
Item 4 – Psychiatric Consultation and Patient Safety Monitor/ Procedures
Item 5 – Psychiatric Consultation and Patient Safety Monitor/ Procedures

Item 6 – If over a year ago, Mental Health Referral at discharge
If between 1 week and 1 year ago- Care Team Consult (Psychiatric Nurse)
and Patient Safety Monitor
If one week ago or less- Psychiatric Consultation and Patient Safety Monitor

Disposition:
☐ Mental Health Referral at discharge
☐ Care Team Consult (Psychiatric Nurse) and Possible Patient Safety Monitor/Procedures
☐ Psychiatric Consultation and Patient Safety Monitor/ Procedures

III. Training

The Columbia University Medical Center, Center for Suicide Risk Assessment, C-SSRS Web site contains links to a variety of trainings in different languages. There is no cost associated with training. Training videos can be downloaded for use by individuals and/or groups. The full C-SSRS video is 45 minutes and the training video for the screener version is 18 minutes in duration (CUMC/CSRA/C-CCRS, n.d.).

*Used with permission.

Addiction Severity Index (ASI) – 5th edition*.

The Addiction Severity Index (ASI) was developed in 1980 by A. Thomas McLellan, Ph.D., and colleagues at the University of Pennsylvania's Center for the Studies of Addiction.. (McLellan also founded and served as chairman of the board of the Treatment Research Institute.) Over the years, the ASI has become one of the most widely utilized addiction assessment instruments in the field (Mäkelä, 2004; Wikipedia, n.d.). It allows clinicians to identify and address client needs, along with potential challenges or barriers, to their goals of significantly reducing or abstaining from drug use.(Cohen, Collins, Jr., Young, McChargue, Leffingwell, & Cook, 2009). The tool has been translated into a number of languages, with a European version developed in the early 1990s (Mäkelä, 2004). It is in the public domain (NIAAA, n.d.).

ASI administration takes 45-60 minutes for a trained interviewer. Another 10-20 minutes is required for scoring (Mäkelä, 2004). The tool explicitly reminds both clinicians and clients that the ASI is an interview and not a test. As a semistructured interview, the ASI screens for impairments and problems that commonly accompany substance use and dependence. Included are interpersonal difficulties with friends, family, and co-workers; medical conditions such as , sexually transmitted diseases, hepatitis B and C, HIV/AIDS, alcoholic liver disease, pneumonia, acute myocardial infarction, and metabolic and endocrine complications; and legal troubles. It covers seven potential problem areas: medical status, employment and support, drug use, alcohol use, legal status, family/social status, and psychiatric status. These areas of focus allow the interview to gather a comprehensive picture of how substance use may be affecting the different areas. Hence, the ASI focuses on the big picture of addiction, taking into consideration that substance use is often rooted in several different areas, like biology, environment, or psychology (Samet, Waxman, Hatzenbuehler, & Hasin, 2007).

*There is a 6th edition. However, the writer was unable to locate this version for inclusion in this document.

Addiction Severity Index - 5th Edition

Clinical/Training Version

A. Thomas McLellan, Ph.D.
Deni Carise, Ph.D.
Thomas H. Coyne, MSW
T. Ron Jackson, MSW

Remember: This is an interview, not a test

≈Item numbers circled are to be asked at follow-up.≈
≈Items with an asterisk * are cumulative and should be rephrased at

INTRODUCING THE ASI: Introduce and explain the seven potential problem areas: Medical, Employment/Support Status, Alcohol, Drug, Legal, Family/Social, and Psychiatric. All clients receive this same standard interview. All information gathered is confidential; explain what that means in your facility; who has access to the information and the process for the release of information.
There are two time periods we will discuss:

1. The past 30 days
2. Lifetime

Patient Rating Scale: Patient input is important. For each area, I will ask you to use this scale to let me know how bothered you have been by any problems in each section. I will also ask you how important treatment is for you for the area being discussed.
The scale is:
0 - Not at all
1 - Slightly
2 - Moderately
3 - Considerably
4 - Extremely

Inform the client that he/she has the right to refuse to answer any question. If the client is uncomfortable or feels it is too personal or painful to give an answer, instruct the client not to answer. Explain the benefits and advantages of answering as many questions as possible in terms of developing a comprehensive and effective treatment plan to help them.

Please try not give inaccurate information!

INTERVIEWER INSTRUCTIONS:

1. Leave no blanks.
2. Make plenty of Comments (if another person reads this ASI, they should have a relatively complete picture of the client's perceptions of his/her problems).
3. -9 = Question not answered.
   -8 = Question not applicable.
4. Terminate interview if client misrepresents two or more sections.
5. When noting comments, please write the question number.

HALF TIME RULE: If a question asks the number of months, round up periods of 14 days or more to 1 month. Round up 6 months or more to 1 year.

CONFIDENCE RATINGS:
⇒ Last two items in each section.
⇒ Do not over-interpret.
⇒ Denial does not warrant misrepresentation.
⇒ Misrepresentation = overt contradiction in information.

Probe, cross-check and make plenty of comments!

HOLLINGSHEAD CATEGORIES:

1. Higher execs, major professionals, owners of large businesses.
2. Business managers if medium sized businesses, lesser professions, i.e., nurses, opticians, pharmacists, social workers, teachers.
3. Administrative personnel, managers, minor professionals, owners/ proprietors of small businesses, i.e., bakery, car dealership, engraving business, plumbing business, florist, decorator, actor, reporter, travel agent.
4. Clerical and sales, technicians, small businesses (bank teller, bookkeeper, clerk, draftsperson, timekeeper, secretary).
5. Skilled manual - usually having had training (baker, barber, brakeperson, chef, electrician, fireman, machinist, mechanic, paperhanger, painter, repairperson, tailor, welder, police, plumber).
6. Semi-skilled (hospital aide, painter, bartender, bus driver, cutter, cook, drill press, garage guard, checker, waiter, spot welder, machine operator).
7. Unskilled (attendant, janitor, construction helper, unspecified labor, porter, including unemployed).

LIST OF COMMONLY USED DRUGS:

Alcohol:	Beer, wine, liquor
Methadone:	Dolophine, LAAM
Opiates:	Pain killers = Morphine, Diluaudid, Demerol, Percocet, Darvon, Talwin, Codeine, Tylenol 2,3,4, Robitussin, Fentanyl
Barbiturates:	Nembutal, Seconal, Tuinol, Amytal, Pentobarbital, Secobarbital, Phenobarbital, Fiorinol
Sed/Hyp/Tranq:	Benzodiazepines = Valium, Librium, Ativan, Serax Tranxene, Xanax, Miltown, Other = ChloralHydrate (Noctex), Quaaludes Dalmane, Halcion
Cocaine:	Cocaine Crystal, Free-Base Cocaine or "Crack," and "Rock Cocaine"
Amphetamines:	Monster, Crank, Benzedrine, Dexedrine, Ritalin, Preludin, Methamphetamine, Speed, Ice, Crystal
Cannabis:	Marijuana, Hashish
Hallucinogens:	LSD (Acid), Mescaline, Mushrooms (Psilocybin), Peyote, Green, PCP (Phencyclidine), Angel Dust, Ecstacy
Inhalants:	Nitrous Oxide, Amyl Nitrate (Whippits, Poppers), Glue, Solvents, Gasoline, Toluene, Etc.

Just note if these are used: Antidepressants,
Ulcer Meds = Zantac, Tagamet
Asthma Meds = Ventoline Inhaler, Theodur
Other Meds = Antipsychotics, Lithium

ALCOHOL/DRUG USE INSTRUCTIONS:

The following questions refer to two time periods: the past 30 days and lifetime. Lifetime refers to the time prior to the last 30 days.

⇒ 30 day questions only require the number of days used.
⇒ Lifetime use is asked to determine extended periods of use.
⇒ Regular use = 3+ times per week, binges, or problematic irregular use in which normal activities are compromised.
⇒ Alcohol to intoxication does not necessarily mean "drunk", use the words "to feel or felt the effects", "got a buzz", "high", etc. instead of intoxication. As a rule of thumb, 3+ drinks in one sitting, or 5+ drinks in one day defines "intoxication".
⇒ How to ask these questions:
→ "How many days in the past 30 have you used....?"
→ "How many years in your life have you regularly used....?"

Addiction Severity Index - 5th Edition
Clinical/Training Version

Agency Name: _____ **Site Name:** _____

ID #: _ _ _ _ _ _ **Date:** _ _ / _ _ / _ _ _ _

GENERAL INFORMATION

G1. **ID Number** _____

G4. **Date of Admission** _ _ /_ _ /_ _ _ _
mm/dd/yyyy

G5. **Date of Interview** _ _ /_ _ /_ _ _ _
mm/dd/yyyy

G6. **Time Begun** _ _ : _ _
Use 24 hr clock; code hours:minutes

G7. **Time Ended** _ _ : _ _
Use 24 hr clock; code hours:minutes HRS MINS

G8. **Class** _
1 - Intake 2 - Follow-up

G9. **Contact Code** _
1 - In person 2 - Telephone *(Intake ASI must be in person)*

G10. **Gender** _
1 - Male 2 - Female

G99. **Treatment Episode Number** _ _

G11. **Interviewer Code Number** _ _ _

G12. **Special** _
1 - Patient terminated
2 - Patient refused
3 - Patient unable to respond

G14. **How long have you lived at your current address?** _ _ / _ _
YRS MOS

G15. **Is this residence owned by you or your family?** _
0 - No 1 - Yes

G16. **Date of birth** _ _ /_ _ /_ _ _ _
mm/dd/yyyy

G17 **Of what race do you consider yourself?** _
1 - White (not Hisp)
2 - Black (not Hisp)
3 - American Indian
4 - Alaskan Native
5 - Asian/Pacific
6 - Hispanic-Mexican
7 - Hispanic-Puerto Rican
8 - Hispanic-Cuban
9 - Unknown

G18. **Do you have a religious preference?** _
1 - Protestant
2 - Catholic
3 - Jewish
4 - Islamic
5 - Other
6 - None

G19. **Have you been in a controlled environment in the past 30 days?** _
1 - No
2 - Jail/prison
3 - Alcohol or drug tx
4 - Medical tx
5 - Psychiatric tx
6 - Other
*A place, **theoretically**, without access to drugs/alcohol.*

G20. **How many days?** _ _
If G19 is No, code -8.
Refers to total number of days detained in the past 30 days.

GENERAL INFORMATION COMMENTS
(Include the question number with your notes)

MEDICAL STATUS

M1. * **How many times in your life have you been hospitalized for medical problems?** ___

Include O.D.'s and D.T.'s. Exclude detox, alcohol/drug, psychiatric treatment and childbirth (if no complications). Enter the number of ***overnight*** *hospitalizations for medical problems.*

M2. **How long ago was your last hospitalization for a physical problem?** ___ ___ / ___ ___ (YRS / MOS)

If no hospitalizations in Question M1, then code -8 / -8.

M3. **Do you have any chronic medical problems which continue to interfere with your life?** ___

0 - No 1 - Yes

If Yes, specify in comments.

A chronic medical condition is a serious physical condition that requires regular care (i.e., medication, dietary restriction) preventing full advantage of their abilities.

M4. **Are you taking any prescribed medication on a regular basis for a physical problem?** ___

0 - No 1 - Yes

If Yes, specify in comments.

Medication prescribed by a MD for medical conditions; ***not psychiatric medicines****. Include medicines prescribed whether or not the patient is currently taking them. The intent is to verify chronic medical problems.*

M5. **Do you receive a pension for a physical disability?** ___

0 - No 1 - Yes

If Yes, specify in comments.

Include Workers' compensation, exclude psychiatric disability.

M6. **How many days have you experienced medical problems in the past 30 days?** ___ ___

Include flu, colds, etc. Include serious ailments related to drugs/alcohol, which would continue even if the patient were abstinent (e.g., cirrhosis of liver, abscesses from needles, etc.).

For Questions M7 & M8, ask patient to use the Patient Rating Scale

M7. **How troubled or bothered have you been by these medical problems in the past 30 days?** ___

Restrict response to problem days in Question M6.

M8. **How important to you now is treatment for these medical problems?** ___

If client is currently receiving medical treatment, refer to the need for ***additional*** *medical treatment by the patient.*

INTERVIEWER SEVERITY RATING

M9. **How would you rate the patient's need for medical treatment?** ___

Refers to the patient's need for ***additional*** *medical treatment.*

CONFIDENCE RATINGS

Is the above information significantly distorted by:

M10. **Patient's misrepresentation?** ___

0 - No 1 - Yes

M11. **Patient's inability to understand?** ___

0 - No 1 - Yes

MEDICAL COMMENTS

(Include the question number with your notes)

EMPLOYMENT/SUPPORT STATUS

E1. * **Education completed** — __ __ / __ __ (YRS / MOS)
GED = 12 years, note in comments.
Include formal education only.

E2. * **Training or technical education completed** — __ __ (MOS)
Formal, organized training only. For military training, only include training that can be used in civilian life (i.e., electronics, computers).

E3. **Do you have a profession, trade, or skill?** — __
0 - No 1 - Yes
Employable, transferable skill acquired through training.
If Yes, specify: _____

E4. **Do you have a valid driver's license?** — __
0 - No 1 - Yes
Valid license; not suspended/revoked.

E5. **Do you have an automobile available for use?** — __
0 - No 1 - Yes
*If answer to E4 is No, then E5 **must** be No.*
Does not require ownership, only requires availability on a regular basis.

E6. **How long was your longest full-time job?** — __ __ / __ __ (YRS / MOS)
Full-time = 35+ hours weekly; does not necessarily mean most recent job.

E7. * **Usual (or last) occupation** — __
Specify _____
Use Hollingshead Categories Reference Sheet

E8. **Does someone contribute to your support in any way?** — __
0 - No 1 - Yes
Is patient receiving any regular support (i.e., cash, food, housing) from family/ friend. Include spouse's contribution; exclude support by an institution.

E9. **Does this support constitute the majority of your support?** — __
0 - No 1 - Yes
If E8 is No, then E9 is -8.

E10. **Usual employment pattern, past 3 years?** — __
1 - Full time (35+ hours)
2 - Part time (regular hours)
3 - Part time (irregular hours)
4 - Student
5 - Military service
6 - Retired/disability
7 - Unemployed
8 - In controlled environment
Answer should represent the majority of the last 3 years, not just the most recent selection. If there are equal times for more than one category, select that which best represents the current situation.

E11. **How many days were you paid for working in the past 30 days?** — __ __
Include "under-the-table" work, paid sick days and vacation.

EMPLOYMENT/SUPPORT COMMENTS
(Include the question number with your notes)

EMPLOYMENT/SUPPORT STATUS (cont)

For questions E12-E17:
How much money did you receive from the following sources in the past 30 days?

E12. Employment $___ ___,___ ___ ___
Net or "take home" pay, include any "under the table" money.

E13. Unemployment compensation $___ ___,___ ___ ___

E14. Welfare $___ ___,___ ___ ___
Include food stamps, transportation money provided by an agency to go to and from treatment.

E15. Pension, benefits or social security $___ ___,___ ___ ___
Include disability, pensions, retirement, veteran's benefits, SSI & workers' compensation.

E16. Mate, family or friends $___ ___,___ ___ ___
*Money for personal expenses (i.e., clothing); include unreliable sources of income. Record **cash** payments only, include windfalls (unexpected), money from loans, legal gambling, inheritance, tax returns, etc.*

E17. Illegal $___ ___,___ ___ ___
***Cash** obtained from drug dealing, stealing, fencing stolen goods, illegal gambling, prostitution, etc. **Do not** attempt to convert drugs exchanged to a dollar value.*

E18. How many people depend on you for the majority of their food, shelter, etc.? ___ ___
Must be regularly depending on patient; do include alimony/child support, do not include the patient or self-supporting spouse, etc.

E19. How many days have you experienced employment problems in the past 30? ___ ___
Include inability to find work, if they are actively looking for work, or problems with present job in which that job is jeopardized.

For Questions E20 & E21, ask patient to use the Patient Rating Scale

E20. How troubled or bothered have you been by these employment problems in the past 30 days? ___
If the patient has been incarcerated or detained during the past 30 days, they cannot have employment problems. In that case, code -8.

E21. How important to you now is counseling for these employment problems? ___
Stress help in finding or preparing a job, not giving them a job.

INTERVIEWER SEVERITY RATING

E22. How would you rate the patient's need for employment counseling? ___

CONFIDENCE RATINGS

Is the above information significantly distorted by:

E23. Client's misrepresentation? ___
0 - No 1 - Yes

E24. Client's inability to understand? ___
0 - No 1 - Yes

EMPLOYMENT/SUPPORT COMMENTS
(Include the question number with your notes)

ALCOHOL/DRUGS

Route of Administration Types:
1 - Oral 2 - Nasal 3 - Smoking 4 - Non-IV injection 5 - IV

Note the usual or most recent route. For more than one route, choose the most severe. The routes are listed from least severe to most severe.

		A. Past 30 Days	B. Lifetime (Years)	C. Route of Admin
D1.	Alcohol (any use at all)	__ __	__ __	
D2.	Alcohol (to intoxication)	__ __	__ __	
D3.	Heroin	__ __	__ __	__
D4.	Methadone	__ __	__ __	__
D5.	Other Opiates/Analgesics	__ __	__ __	__
D6.	Barbiturates	__ __	__ __	__
D7.	Other Sedatives/Hypnotics/ Tranquilizers	__ __	__ __	__
D8.	Cocaine	__ __	__ __	__
D9.	Amphetamines	__ __	__ __	__
D10.	Cannabis	__ __	__ __	__
D11.	Hallucinogens	__ __	__ __	__
D12.	Inhalants	__ __	__ __	__
D13.	More than one substance per day *Including alcohol*	__ __	__ __	

D14. According to the interviewer, which substance is/are the major problem? __ __

Interviewer should determine the major drug or drugs of abuse.
Code the number next to the drug in questions D1-D12, or:
00 = no problem
15 = alcohol & one or more drugs
16 = more than one drugs but no alcohol.
Ask patient when not clear.

D15. How long was your last period of voluntary abstinence from this major substance? __ __ MOS

*Last attempt of at least one month, not necessarily the longest. Periods of hospitalization/incarceration **do not count**. Periods of antabuse, methadone, or naltrexone use during abstinence **do count**.*
00 = never abstinent

D16. How many months ago did this abstinence end? __ __ MOS

If D15 = 0, then D16 = -8, 00 = Still abstinent

ALCOHOL/DRUGS COMMENTS

(Include the question number with your notes)

ALCOHOL/DRUGS (cont)

D17.* **How many times have you had Alcohol D.T.'s?** ___ ___
Delirium Tremems (DTs): *Occur 24-48 hours after last drink, or significant decrease in alcohol intake, shaking, severe disorientation, fever, hallucinations, they usually require medical attention.*

D18.* **How many times have you overdosed on drugs?** ___ ___
Overdoses (OD): *Require requires intervention by someone to recover, not simply sleeping it off, include suicide attempts by OD.*

How many times in your life have you been treated for:

D19.* **Alcohol abuse?** ___ ___

D20.* **Drug abuse?** ___ ___

Include detoxification, halfway houses, in/outpatient counseling, and AA or NA (if 3+ meetings within one month period).

How many of these were detox only?

D21.* **Alcohol?** ___ ___
If D19 = 0, then D21 = -8

D22.* **Drugs?** ___ ___
If D20 = 0, then D22 = -8

How much money would you say you spent during the past 30 days on:

D23. **Alcohol?** $___ ___,___ ___ ___

D24. **Drugs?** $___ ___,___ ___ ___

*Only count actual **money** spent. What is the financial burden caused by drugs/alcohol?*

D25. **How many days have you been treated in an outpatient setting for alcohol or drugs in the past 30 days?** ___ ___
Include AA/NA

How many days in the past 30 have you experienced:

D26. **Alcohol problems?** ___ ___

D27. **Drug problems?** ___ ___

Include craving, withdrawal symptoms, disturbing effects of use, or wanting to stop and being unable to.

For Questions D28 - D31, ask patient to use the Patient Rating Scale

How troubled or bothered have you been in the past 30 days by these:

D28. **Alcohol problems** ___

D29. **Drug problems** ___

How important to you now is treatment for these:

D30. **Alcohol problems** ___

D31. **Drug problems** ___

INTERVIEWER SEVERITY RATING

How would you rate the patient's need for treatment for:

D32. **Alcohol problems** ___

D33. **Drug problems** ___

CONFIDENCE RATINGS

Is the above information significantly distorted by:

D34. **Client's misrepresentation?** ___
0 - No 1 - Yes

D35. **Client's inability to understand?** ___
0 - No 1 - Yes

ALCOHOL/DRUG COMMENTS
(Include the question number with your notes)

LEGAL STATUS

L1. **Was this admission prompted or suggested by the criminal justice system?** ___
0 - No 1 - Yes
Judge, probation/parole officer, etc.

L2. **Are you on probation or parole?** ___
0 - No 1 - Yes
Note duration and level in comments.

How many times in your life have you been arrested and charged with the following?

L3.*	Shoplifting/Vandalism	___ ___
L4.*	Parole/Probation Violations	___ ___
L5.*	Drug Charges	___ ___
L6.*	Forgery	___ ___
L7.*	Weapons Offense	___ ___
L8.*	Burglary/Larceny/Breaking & Entering	___ ___
L9.*	Robbery	___ ___
L10.*	Assault	___ ___
L11.*	Arson	___ ___
L12.*	Rape	___ ___
L13.*	Homicide/Manslaughter	___ ___
L14.*	Prostitution	___ ___
L15.*	Contempt of Court	___ ___
L16.*	Other: _____	___ ___

Include total number of counts, not just convictions.
Do not include juvenile (pre-age 18) crimes, unless they were tried as an adult.
Include formal charges only.

L17.* **How many of these charges resulted in convictions?** ___ ___
If L3-16 = 00, then Question L17 = -8.
Do not include misdemeanor offenses from questions L18-20 below.
Convictions include fines, probation, incarcerations, suspended sentences, guilty please, and plea bargaining.

How many times in your life have you been charged with the following:

L18.*	Disorderly conduct, vagrancy, public intoxication	___ ___
L19.*	Driving while intoxicated	___ ___
L20.*	Major driving violations *Moving violations: speeding, reckless driving, no license, etc.*	___ ___

L21.* **How many months were you incarcerated in your life?** ___ ___ MOS
If incarcerated 2 weeks or more, round this up to 1 month.
List total number of months incarcerated.

L22. **How long was your last incarceration?** ___ ___ MOS
Of 2 weeks or more. Code -8 if never incarcerated.

L23. **What was it for?** ___ ___
Use codes 03–16, 18–20
If multiple charges, code most severe.Code -8 if never incarcerated.

L24. **Are you presently awaiting charges, trial, or sentence?** ___
0 - No 1 - Yes

L25. **What for?** ___ ___
Refers to Question L24. Use the number of the type of crime committed: 03-16 and 18-20. If multiple charges, code most severe.

LEGAL COMMENTS
(Include the question number with your notes)

LEGAL STATUS (cont)

L26. **How many days in the past 30 were you detained or incarcerated?** ___ ___
Include being arrested and released on the same day.

L27. **How many days in the past 30 have you engaged in illegal activities for profit?** ___ ___
Exclude simple drug possession. Include drug dealing, prostitution, selling stolen goods, etc. May be cross-checked with E17 under Employment section.

For Questions L28 & L29, ask patient to use the Patient Rating Scale

L28. **How serious do you feel your present legal problems are?** ___
Exclude civil problems.

L29. **How important to you now is counseling or referral for these legal problems?** ___
*Patient is rating a need for **additional** referral to legal counsel for defense against criminal charges.*

INTERVIEWER SEVERITY RATING

L30. **How would you rate the patient's need for legal services or counseling?** ___

CONFIDENCE RATINGS

Is the above information significantly distorted by:

L31. **Client's misrepresentation?** ___
0 - No 1 - Yes

L32. **Client's inability to understand?** ___
0 - No 1 - Yes

LEGAL COMMENTS
(Include the question number with your notes)

FAMILY HISTORY

Have any of your blood-related relatives had what you would call a significant drinking, drug use or psychiatric problem? Specifically, was there a problem that did or should have led to treatment?

0 - Clearly NO for all relatives in the category

1 - Clearly YES for any relative within category

-9 - Uncertain or don't know

-8 - Never was a relative

In cases where there is more than one person for a category, record the occurrence of problems for *any* in that group. Accept the patient's judgment on these questions.

Mother's Side	Alc	Drug	Psych
H1. Grandmother	___	___	___
H2. Grandfather	___	___	___
H3. Mother	___	___	___
H4. Aunt	___	___	___
H5. Uncle	___	___	___

Father's Side	Alc	Drug	Psych
H6. Grandmother	___	___	___
H7. Grandfather	___	___	___
H8. Father	___	___	___
H9. Aunt	___	___	___
H10. Uncle	___	___	___

Siblings	Alc	Drug	Psych
H11. Brother	___	___	___
H12. Sister	___	___	___

FAMILY HISTORY COMMENTS

(Include the question number with your notes)

FAMILY/SOCIAL RELATIONSHIPS

F1. **Marital Status** ___

1 - Married
2 - Remarried
3 - Widowed
4 - Separated
5 - Divorced
6 - Never married

Common-law marriage = 1. Specify in comments.

F2. **How long have you been in this marital status?** ___ ___ / ___ ___ (YRS / MOS)
Refers to F1. If never married, then since age 18.

F3. **Are you satisfied with this situation?** ___
0 - No 1 - Indifferent 2 - Yes
Satisfied=client generally liking the situation.
Refers to F1 and F2.

F4. * **Usual living arrangements (past 3 years)** ___

1 - With sexual partner & children
2 - With sexual partner alone
3 - With children alone
4 - With parents
5 - With family
6 - With friends
7 - Alone
8 - Controlled environment
9 - No stable arrangement

Choose arrangements most representative of the past 3 years. If there is an even split in time between these arrangements, choose the most recent arrangement.

F5. **How long have you lived in these arrangements?** ___ ___ / ___ ___ (YRS / MOS)
If with parents or family, since age 18.
Code years and months living in arrangements from F4.

F6. **Are you satisfied with these arrangements?** ___
0 - No 1 - Indifferent 2 - Yes

Do you live with anyone who:

F7. **Has a current alcohol problem?** 0 - No 1 - Yes ___

F8. **Uses non-prescribed drugs?** 0 - No 1 - Yes ___
Or abuses prescribed drugs

F9. **With whom do you spend most of your free time?** ___
1 - Family 2 - Friends 3 - Alone
If a girlfriend/boyfriend is considered as family by patient, then they must refer to them as family throughout this section, not a friend.

F10 **Are you satisfied with spending your free time this way?** ___
0 - No 1 - Indifferent 2 - Yes
A satisfied response must indicate that the person generally likes the situation.
Refers to F9.

F11. **How many close friends do you have?** ___
*Stress that you mean **close**.*
Exclude family members.
These are "reciprocal" relationships or mutually supportive relationships.

Would you say you have had a close reciprocal relationship with any of the following people:

F12. **Mother** ___
F13. **Father** ___
F14. **Brothers/Sisters** ___
F15. **Sexual Partner/Spouse** ___
F16. **Children** ___
F17. **Friends** ___

0 - Clearly NO for all in class
1 - Clearly YES for any in class
-9 - Uncertain or "I don't know"
-8 - Never was a relative

By reciprocal, you mean "that you would do anything you could to help them out and vice versa."

FAMILY/SOCIAL COMMENTS
(Include the question number with your notes)

FAMILY/SOCIAL RELATIONSHIPS (cont)

Have you had significant periods in which you have experienced serious problems getting along with:

0 - No 1 - Yes

		Past 30 Days	In Your Life
F18.	Mother	___	___
F19.	Father	___	___
F20.	Brothers/Sisters	___	___
F21.	Sexual Partner/Spouse	___	___
F22.	Children	___	___
F23.	Other significant family *Specify:* _____	___	___
F24.	Close Friends	___	___
F25.	Neighbors	___	___
F26.	Co-Workers	___	___

"Serious problems" mean those that endangered the relationship.
A "problem" requires contact of some sort, either by telephone or in person.
If no contact, code -8.

Has anyone ever abused you?

0 - No 1 - Yes

		Past 30 Days	In Your Life
F27.	Emotionally? *Make you feel bad through harsh words*	___	___
F28.	Physically? *Caused you physical harm*	___	___
F29.	Sexually? *Force sexual advances/acts*	___	___

How many days in the past 30 have you had serious conflicts:

F30.	With your family?	___ ___
F31.	With other people? *(excluding family)*	___ ___

For Questions F32 - F35, ask patient to use the Patient Rating Scale

How troubled or bothered have you been in the past 30 days by:

F32.	Family problems	___
F33.	Social problems	___

How important to you now is treatment or counseling for these:

F34.	Family problems *Patient is rating his/her need for counseling for family problems, not whether they would be willing to attend.*	___
F35.	Social problems *Include patient's need to seek treatment for such social problems as loneliness, inability to socialize, and dissatisfaction with friends. Patient rating should refer to dissatisfaction, conflicts, or other serious problems.*	___

INTERVIEWER SEVERITY RATING

F36.	How would you rate the patient's need for family and/or social counseling?	___

CONFIDENCE RATINGS

Is the above information significantly distorted by:

F37.	Client's misrepresentation? 0 - No 1 - Yes	___
F38.	Client's inability to understand? 0 - No 1 - Yes	___

FAMILY/SOCIAL COMMENTS
(Include the question number with your notes)

PSYCHIATRIC STATUS

How many times have you been treated for any psychological or emotional problems:

P1.* **In a hospital or inpatient setting?** ___ ___

P2.* **Outpatient/private patient?** ___ ___

Do not include substance abuse, employment, or family counseling. Treatment episode = a series of more or less continuous visits or treatment days, not the number of visits or treatment days.
Enter diagnosis in comments if known.

P3. **Do you receive a pension for a psychiatric disability?**
0 - No 1 - Yes ___

Have you had a significant period of time (that was not a direct result of drug/alcohol use) in which you have:

	0 - No 1 - Yes	Past 30 Days	In Your Life
P4.	**Experienced serious depression** Sadness, hopelessness, loss of interest, difficulty with daily functioning	___	___
P5.	**Experienced serious anxiety or tension** Uptight, unreasonably worried, inability to feel relaxed	___	___
P6.	**Experienced hallucinations** Saw things/heard voices that others didn't see/hear	___	___
P7.	**Experienced trouble understanding, concentrating or remembering**	___	___
P8.	**Experienced trouble controlling violent behavior including episodes or rage or violence** *Patient can be under the influence of alcohol/drugs.*	___	___
P9.	**Experienced serious thoughts of suicide** *Patient seriously considered a plan for taking his/her life.* *Patient can be under the influence of alcohol/drugs.*	___	___
P10	**Attempted suicide** *Include actual suicidal gestures or attempts. Patient can be under the influence of alcohol / drugs.*	___	___
P11	**Been prescribed medication for any psychological or emotional problems** *Prescribed for the patient by a physician. Record "Yes" if a medication was prescribed even if the patient is not taking it.*	___	___

P12. **How many days in the past 30 have you experienced these psychological or emotional problems?** ___ ___
Refers to problems noted in Questions P4-P10.

For Questions P13 & P14, ask the patient to use the Patient Rating Scale

P13. **How much have you been troubled or bothered by these psychological or emotional problems in the past 30 days?** ___
Patient should be rating the problem days from Question P12.

P14. **How important to you now is treatment for these psychological problems?** ___

PSYCHIATRIC STATUS COMMENTS
(Include the question number with your notes)

PSYCHIATRIC STATUS (cont)

The following items are to be completed by the interviewer:

At the time of the interview, the patient was: 0 - No 1 - Yes

P15. Obviously depressed/withdrawn ___

P16. Obviously hostile ___

P17. Obviously anxious/nervous ___

P18. Having trouble with reality testing, thought disorders, paranoid thinking ___

P19. Having trouble comprehending, concentrating, remembering ___

P20. Having suicidal thoughts ___

INTERVIEWER SEVERITY RATING

P21. How would you rate the patient's need for psychiatric/ psychological treatment? ___

CONFIDENCE RATINGS

Is the above information significantly distorted by:

P22. Client's misrepresentation? 0 - No 1 - Yes ___

P23. Client's inability to understand? 0 - No 1 - Yes ___

PSYCHIATRIC STATUS COMMENTS

(Include the question number with your notes)

Problems	SEVERITY PROFILE									
	0	1	2	3	4	5	6	7	8	9
MEDICAL										
EMPL/SUP										
ALCOHOL										
DRUG										
LEGAL										
FAM/SOC										
PSYCH										

Opioid Risk Tool (ORT).

Some experts say that risks for opioid abuse should be considered before any prescription for opioids is written. The Opioid Risk Tool (ORT) is one tool designed to help clinicians take into account a patient's risk of opioid abuse. ORT can also be downloaded from https://www.drugabuse.gov/sites/default/files/files/OpioidRiskTool.pdf.

OPIOID RISK TOOL

Mark each box that applies	Female	Male
Family history of substance abuse		
Alcohol	1	3
Illegal drugs	2	3
Rx drugs	4	4
Personal history of substance abuse		
Alcohol	3	3
Illegal drugs	4	4
Rx drugs	5	5
Age between 16—45 years	1	1
History of preadolescent sexual abuse	3	0
Psychological disease		
ADD, OCD, bipolar, schizophrenia	2	2
Depression	1	1
Scoring totals		

Total Score	**Risk Category**
Low Risk	0 – 3
Moderate Risk	4 – 7
High Risk	> 8

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Drinking Agreement: Handout.

Drinking Agreement

Date: _____

I, _____, agree to the following drinking limit:

- Number of drinks per week: _____
- Number of drinks per occasion: _____

Signature: _____

It is never a good idea to drink and drive OR to drink during pregnancy.

Adapted from American Public Health Association SBI Manual, 2008.

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