CSAC 890 Advanced Addiction Treatment

26 Addiction Screening & Assessment Instruments

This resource is intended to help you identify instruments used for screening and assessment of substance use and substance use disorders.

Substance abuse assessment tools

Alcohol abuse

The Alcohol Use Disorders Identification Test *(AUDIT)*

Brief Michigan Alcoholism Screening Test *(BMAST)*

CAGE Questionnaire

Michigan Alcoholism Screening Test *(MAST)*

TWEAK

Clinical Institute Withdrawal Assessment *(CIWA-Ar)*

Short Michigan Alcoholism Screening Test (*SMAST*)

C.A.S.T

Paddington Alcohol Test (*PAT*)

Severity of Alcohol Dependency Questionnaire (*SADQ*)

Assessment for Alcohol and Other Drug Abuse

- Addiction Severity Index (*ASI*)
- Objective Opiate Withdrawal Scale (*OOWS*)
- Structured Clinical Interview for DSM-IV Disorders (*SCID*)
- Stages of Change Readiness and Treatment Eagerness Scale (*SOCRATES*)
- Subjective Opiate Withdrawal Scale (*SOWS*)
- University of Rhode Island Change Assessment (*URICA*)
- NIDA drug use screening tool
- CRAFFT
- Drug Abuse Screening Tool (*DAST*)

- Substance Abuse/Chemical Dependency Assessment (*SACHEM*)
- Substance Abuse Life Circumstance Evaluation (*SALCE*)

Assessments for Adolescents

Several tests are designed specifically to diagnose alcohol problems in adolescents. They include:

Adolescent Alcohol Involvement Scale (*AAIS*)
Adolescent Obsessive-Compulsive Drinking Scale (*A-OCDS*)
Alcohol Expectancy Questionnaire - Adolescent Form
Comprehensive Adolescent Severity Inventory (*CASI*)
Customary Drinking and Drug Use Record (*CDDR*)
Personal Experience Screening Questionnaire (*PESQ*)
Problem Recognition Questionnaire (*PRQ*)
Teen Addiction Severity Index (*T-ASI*)

26 Addiction Screening & Assessment Instruments

1. **The Alcohol Use Disorders Identification Test** (**AUDIT**) is a simple ten-question test developed by the WHO to determine if a person's alcohol consumption may be harmful. The test was designed to be used internationally, and was validated in a study using patients from six countries.

- Questions 1–3 deal with alcohol consumption, 4–6 relate to alcohol dependence and 7–10 consider alcohol- related problems. A score of 8 or more in men (7 in women) indicates a strong likelihood of hazardous or harmful alcohol consumption. A score of 20 or more is suggestive of alcohol dependence (although some authors quote scores of more than 13 in women and 15 in men as indicating likely dependence).
- The **AUDIT alcohol consumption questions (AUDIT-C)** is a 3-question screening test for problem drinking which can be used in a doctor's office.
- **Administered by:** Patient interview or Self-Report.
    - It is recommended that the AUDIT be administered as part of a general health interview, medical history, or lifestyle questionnaire. Administration requires approximately 2 minutes, and training is recommended for administration.
    - The WHO also has developed a screening tool called the Clinical Screening Instrument, which is meant to be used as an adjunct to the AUDIT. The WHO recommends utilizing this instrument as a follow-up to the AUDIT if a clinician suspects that a patient may not be providing accurate answers to the AUDIT. Its use is also recommended in situations in which it may not be appropriate to administer the AUDIT, such as when a patient is clearly intoxicated.
- **Intended settings:** Primary care, emergency rooms, psychiatric clinics, courts, jails, prisons, armed forces, industries, colleges and universities

- **Scoring and Interpretation:** Scoring is done by hand and requires approximately 1 minute.
  - Add up the total points for all questions (maximum score = 40). The test consists of 3 subscales designed to address 3 domains: amount and frequency of drinking, alcohol dependence, and consequences of alcohol use. The first 3 questions relate to quantity and frequency, the following three to dependence, and the last four to harmful or abusive use.

  - Questions 1 through 8 = 0, 1, 2, 3, or 4 points.

  Questions 9 and 10 are scored as 0, 2, or 4.
  - A score of 8 or more on the AUDIT generally indicates harmful or hazardous drinking. Moreover, a score of 8 is considered a sensitive cutoff for identifying patients with possible problems in a general population (Babor et al. 2001). However, Bradley et al. (1998) suggested considering a cutoff point lower than 7 for women in order to maximize sensitivity.
- **Format:** This is a 10-item screening questionnaire. It is used internationally with 3 questions on the amount and frequency of drinking, 3 questions on alcohol dependence, and 4 on problems caused by alcohol.
- ***Purpose:*** To identify persons whose alcohol consumption has become hazardous or harmful to their health.
- ***Groups with whom this instrument has been used:*** Adults, particularly primary care, emergency room, surgery, and psychiatric patients; DWI offenders; offenders in court, jail, and prison; enlisted men in the armed forces; workers receiving help from employee assistance programs and in industrial settings.
- ***Administration time****:* Two minutes and *Scoring time:* One minute
- The AUDIT is administered by a health professional or paraprofessional. Training is required for administration. A detailed user's manual and a videotape training module explain proper administration

- Advantages:
  - Shown to perform well in detecting subjects with formal alcohol disorders and hazardous alcohol intake and useful for early detection (Piccinelli et al. 1997).
  - Sensitive to detecting current problems, not just past alcohol issues (Isaacson et al. 1994).
  - Shown effective across a variety of subpopulations, including primary care patients, emergency room cases, drug users, university students, unemployed and persons of low socio-economic status (Babor et al. 2001

  Limitations:
  - Lengthy Administration Time
  - More difficult to score than the shorter tests.

2. The CAGE Test

- One of the oldest and most popular screening tools for alcohol abuse is the CAGE test, which is a short, four-question test that diagnoses alcohol problems over a lifetime.
- **C** - Have you ever felt you should **cut down** on your drinking?
- **A**- Have people **annoyed** you by criticizing your drinking?
- **G** - Have you ever felt bad or **guilty** about your drinking?
- **E - Eye opener**: Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?
- Because denial usually accompanies alcohol abuse problems, **the CAGE test, like most alcohol screening tests, asks questions about problems associated with drinking rather than the amount of alcohol consumed**. Two "yes" answers to the CAGE test indicates problems with alcohol.
- The disadvantage of the CAGE test is that it is most accurate for white, middle-aged men and not very accurate for identifying alcohol abuse in older people, white women, and African and Mexican Americans.

http://alcoholism.about.com/od/tests/a/tests.htm

- By far the most important question in the CAGE questionnaire is the use of a drink as an Eye Opener, so much so that some clinicians use a "yes" to this question alone as a positive to the questionnaire; this is due to the fact that the use of an alcoholic drink as an Eye Opener connotes dependence since the patient is going through possible withdrawal in the morning, hence the need for a drink as an Eye Opener
- It is not valid for diagnosis of other substance use disorders, although somewhat modified versions of the CAGE questionnaire are frequently implemented for such a purpose.

- ***Format:*** Very brief, relatively non confrontational questionnaire for detection of alcoholism, usually directed "have you ever" but may be focused to delineate past or present use.
- ***Purpose:*** Used to detect alcoholism.
- ***Clinical value:*** The CAGE Questionnaire is a very useful bedside, clinical desk instrument and has become the **favorite** of many family practice and general internists and among nurses.
- ***Groups with whom this instrument has been used****:* Adults and adolescents (over 16 years old)
- *Norms:* Yes
- *Administration time:* Less than 1 minute
- *Scoring time:* Instantaneous
- *Computer scoring?* No
- *Administrator training and qualifications:* No training required for administration; it is easy to learn, easy to remember, and easy to replicate.

3. CAGE-AID

- **Purpose:** The CAGE-AID (Adapted to Include Drugs) is a version of the CAGE alcohol screening questionnaire, adapted to include drug use. It assesses likelihood and severity of alcohol and drug abuse.
- **Target population:** Adults and adolescents
- **Evidence:**
  - Easy to administer, with good sensitivity and specificity (Leonardson et al. 2005).
  - More sensitive than original CAGE questionnaire for substance abuse (Brown & Rounds 1995)
  - Less biased in term of education, income, and sex then the original CAGE questionnaire (Brown & Rounds 1995).

  Test Features
- **Estimated time:** brief, approximately 1 minute to administer and score
- **Length:** 4 items
- **Administered by:** Patient Interview or Self-Report
- **Intended settings:** Primary care
- **Scoring and Interpretation:** Of the 4 items, one or more positive responses (a "yes" answer) is considered a positive screen, and substance use should be further addressed with the patient.

4. The Paddington alcohol test (PAT) was first published in the *Journal of Accident and Emergency Medicine* in 1996.

- The Paddington Alcohol Test was also designed to be given to patients being treated for falls and accidents in the emergency room. The test contains only three questions and is easy to score. The disadvantage to the PAT test is that it asks direct questions about how much alcohol the patient consumes, which patients tend to minimize or deny.
- It concords well with the Alcohol Use Disorders Identification (AUDIT) questionnaire but is administered in a fifth of the time. In one study, it took an average of 73 seconds to administer the AUDIT questionnaire but only 20 seconds for the PAT.

- When 40–70% of the patients in an accident and emergency department (AED) are there because of alcohol-related issues, it is useful for the staff of the AED to determine which of them are hazardous drinkers so that they can treat the underlying cause and offer brief advice which may reduce the health impact of alcohol for that patient. In accident and emergency departments it is also important to triage incoming patients as quickly as possible, to reduce staff size and cost.

5. The SAAST Test

- The Self-Administered Alcoholism Screening Test (SAAST) is a 35-question test which asks questions about the patient's loss of control, job performance, drinking consequences, and family history of alcoholism.

- One **major advantage of the SAAST test is that there is a version of the test that can be filled out by someone who knows the patient, such as their spouse.**

- The **disadvantage of the SAAST test is that it is not accurate with older people, white women, and**
  African and Mexican Americans, research has indicated.

6. The FAST Test

- The FAST test is a four-question quiz which was designed specifically for patients being treated in urgent care or emergency room situations.

- The test is quick and easy to score, but research shows it only detects 90 percent of alcohol problems that are detected using the AUDIT test.

7. Five-Shot Questionnaire

- This is another popular short test that contains five multiple-choice questions. It is composed of two questions from the AUDIT test and three questions from the CAGE test. The Five-Shot test is designed to be a shorter form of the AUDIT Questionnaire.

8. The RAPS4 Test

- The Rapid Alcohol Problems Screen (RAPS) asks questions similar as the CAGE test, but from a different perspective. One "yes" answer on the RAPS4 test indicates a possible alcohol abuse problem and the results have shown to be very accurate across gender and ethnic groups.

9. The T-ACE Test

- The T-ACE test is also only four questions, including three found on the CAGE test, but it has proved to be more accurate in diagnosing alcohol problems in both men and women.

  - ❖**T** - Does it **take** more than three drinks to make you feel high?
  - ❖**A** - Have you ever been **annoyed** by people's criticism of your drinking?
  - ❖**C** - Are you trying to **cut down** on drinking?
  - ❖**E** - Have you ever used alcohol as an **eye opener** in the morning?

- Again, "yes" answers to two of these four questions is an indication of possible alcohol abuse or dependence.

10. Michigan Alcoholism Screening Test (MAST)

- One of the oldest and widely used measures for assessing alcohol abuse, the MAST is a questionnaire designed to provide a rapid and effective screening for lifetime alcohol-related problems and alcoholism. The MAST has been productively used in a variety of settings with varied populations.
- Developed in 1971, the Michigan Alcohol Screening Test (MAST) is one of the oldest and most accurate alcohol screening tests available, effective in identifying dependent drinkers with up to 98

percent accuracy. It contains 22 yes-or-no questions with six positive responses indicating a drinking problem. The disadvantage to the MAST test is its length and time required to score in a busy medical office. One advantage of this test is that it also effectively diagnoses adolescents.

- Questions on the MAST test relate to the patient's self-appraisal of social, vocational, and family problems frequently associated with heavy drinking. The test was developed to screen for alcohol problems in the general population.
- A brief version called BMAST is now in place. Purpose: Used to screen for alcoholism with a variety of

populations. It is used on

adults.

- The BMAST can save clinicians time when integrated with instruments used to screen for other behavioral health problems (Pokorny et al. 1972). Format: Ten-item questionnaire; interview or paper-and-pencil
- Administration time: Five minutes
- Scoring time: Two to 3 minutes

11. TWEAK

- The TWEAK alcohol screening test is a short, five-question test which was originally designed to screen pregnant women for harmful drinking habits.

- The test is made up of three questions which appear on the CAGE test, plus two additional questions -- one about
  the person's tolerance to alcohol and another about blackouts.
- The name of the test is an acronym for **Tolerance, Worried, Eye-opener, Amnesia, and K/Cut down** (with a poetic license use of "K" instead of "C" for cutting down on alcohol consumption).
- ***Purpose:*** Screens for heavy drinking and alcohol dependence in the past year in male and female samples of the
  general household population and hospital clinic outpatients (Chan et al.1993).

- **Clinical utility:** The TWEAK provides a quick and easy method of targeting outpatients and inpatients in need of more thorough assessments of their alcohol use patterns and problems to determine whether treatment is needed. The TWEAK has also been used to screen for peri conceptional risk drinking among obstetric outpatients (Russell et al. 1994), which may improve pregnancy outcome among high-risk drinkers.
- **Groups with whom this instrument has been used:** Adults
- **Format:** Five items; pencil and paper self-administered, administered by interview, or computer self-administered.
- Administration time: Less than 2 minutes
- Scoring time: Approximately 1 minute
- Administrator training and qualifications: No training required

12. Clinical Institute Withdrawal Assessment (CIWA-Ar)

- *Format:* A 10-item scale for clinical quantification of the severity of the alcohol withdrawal syndrome.
- *Purpose:* tracks severity of withdrawal; measures severity of alcohol withdrawal.
- *Clinical utility:* Aid to adjustment of care related to withdrawal severity
- *Groups with whom this instrument has been used:* Adults
- *Administration time:* Two minutes
- *Scoring time:* Four to 5 minutes
- *Administrator training and qualifications:* Training is required; the CIWA-Ar can be administered by nurses, doctors, research associates, and detoxification unit workers.

13. Severity of Alcohol Dependency Questionnaire (SADQ)

- SADQ is a 20 item clinical screening tool designed to measure the presence and level of alcohol dependence.
- It is divided into five sections:
    1. Physical withdrawal symptoms,
    2. Affective withdrawal symptoms,
    3. Craving and relief drinking,

4. Typical daily consumption
5. and Reinstatement of dependence after a period of abstinence.

- Each item is scored on a 4-point scale, giving a possible range of 0 to 60. A score of over 30 indicates severe alcohol dependence.

14. Addiction Severity Index (ASI)

- was developed in 1980 by A. Thomas Mclellan. It is a semi-structured interview for substance abuse that was designed to gather valuable information about areas of a client's life that may contribute to their substance-abuse problems.
- The ASI was the first standardized assessment tool of its kind to measure the multiple dimensions of substance abuse.
- It is one of the **commonly used addiction assessment tool by state agencies and treatment providers**. It is simple to use and cost effective. Clinicians, researchers, and trained technicians worldwide Use it.
- It has been translated into 18 languages & different versions i.e, Teen Addiction Severity Index (T-ADI) and the Addiction Severity Index North Dokota State adaptation for use with Native-Americans (ASI_ND/NAV), have been developed. Both are modified versions of the original ASI, and take into account age appropriateness and cultural sensitivities.

- **How the ASI works**; It focuses on the *big picture*. It takes into consideration that addiction to drugs or alcohol

can result from life events that precede, occur at the same time as, or result from substance abuse problems. Rather than focusing on the client's substance abuse, the ASI highlights seven potential problem areas.

- **It covers medical status, employment and support, drug use, alcohol use, legal status, family/social status, and psychiatric status.** This broad overview helps to determine the client's level of stability. It has also proven useful for understanding life events that contribute to alcohol and drug dependency.
- The Addiction Severity Index is a 1 hour face-to-face interview that takes place when a client is admitted for treatment. **The ASI interviewer collects data in two parts: lifetime severity ratings and 30 day composite scores.**
- ASI Severity Ratings-Severity ratings are based on the following 10 point scale (0-9):

  * **0-1** No real problem, treatment not indicated
  * **2-3** Slight problem, treatment probably not necessary
  * **4-5** Moderate problem, some treatment indicated
  * **6-7** Considerable problem, treatment necessary
  * **8-9** Extreme problem, treatment absolutely necessary

- The severity ratings scale allows for the interviewer to determine the seriousness of a client's problem. The higher the score is, the greater the need for treatment in each area or immediate intervention. The ASI scores can be used to profile a client's problem areas and then plan an effective course of treatment.

- The Objective Opiate Withdrawal Scale (OOWS) provides an objective measure of the severity of opiate withdrawal symptoms. This tool may be used as part of initial assessment, for ongoing monitoring to assess their response to medication. The OOWS is frequently used when monitoring withdrawal using Buprenorphine.
- **Scoring:**
- Encourage the patient to score down the columns placing a score from 0 – 1 (symptom present or absent) for each item. Add the total score for possible range from 0 – 13.15. SOWS

- The Subjective Opiate Withdrawal Scale provides patients with an opportunity to be involved in their care, and in assessing the severity of their withdrawal symptoms. Self-report measures can assist in reducing the patients anxiety about their care, and their concerns about being appropriately medicated.

- **Scoring:**
- Encourage the patient to score down the columns placing a score from 0-4 for each item. Add the total score for possible range from 0 – 64.

16. Structured Clinical Interview for DSM-IV Disorders (SCID)

- This is a diagnostic interview designed for use by mental health professionals. It assesses thirty-three of the more commonly occurring psychiatric disorders described in the fourth edition of the Diagnostic and statistical manual (DSM-IV) of the American Psychiatric Association (1994). Among these are Mood disorders (including Major depressive disorder), psychotic disorders (including Schizophrenia), Anxiety disorders (including Panic disorder) and the substance-use disorders.
- The SCID is a semi-structured interview that allows the experienced clinician to tailor questions to fit the patient's understanding; to ask additional questions that clarify ambiguities; to challenge inconsistencies; and to make clinical judgments about the seriousness of symptoms.
- The main uses of the SCID are for diagnostic evaluation, research, and the training of mental-health professionals.

- *Purpose:* Obtains Axis I and II diagnoses using the DSM-IV diagnostic criteria for enabling the interviewer to either rule out or to establish a diagnosis of “drug abuse” or “drug dependence” and/or “alcohol abuse” or “alcohol dependence.”
- *Clinical utility:* A psychiatric interview
- *Groups with whom this instrument has been used:* Psychiatric, medical, or community-based normal adults.
- *Norms:* No
- *Format:* A psychiatric interview form in which diagnosis can be made by the examiner asking a series of approximately 10 questions of a client.
- *Administration time:* Administration of Axis I and Axis II batteries may require more than 2 hours each for patients with multiple diagnoses. The Psychoactive Substance Use Disorders module may be administered by itself in 30 to 60 minutes.
- *Scoring time:* Approximately 10 minutes
- *Computer scoring?* No. Diagnosis can be made by the examiner after the interview.
- *Administrator training and qualifications:* Designed for use by a trained clinical evaluator at the master's or doctoral level, although in research settings it has been used by bachelor's level technicians with extensive training.

- **17. The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES)** was developed in 1996 by William R. Miller and J. Scott Tonigan.
- It is meant to measure a substance abusers current state of readiness for change. SOCRARTES is a 19 item self-report that breaks down readiness for change into 3 main scales: Recognition, Ambivalence, and Taking Steps. The items are scored on a 5-point system and then summed according to one of the 3 scales. The questionnaire takes approximately 3 minutes to complete and there is no training required to administer it.
- SOCRARTES is used by clinicians to identify a client's readiness or willingness to change. It indicates where the client is on the continuum between *not prepared to change* and *already changing*. Clients in the pre-contemplation stage are more likely to deny that they have a problem. Conversely, clients in the preparation and action stages are more likely to admit that they have a drinking problem. Determining where a client is on the scale provides valuable information for treatment planning. It also promotes a discussion to perceived barriers of change.

(Ref: http://alcoholrehab.com/drug-addiction-treatment/readiness-to-change-socrates/)

Description:

- The SOCRATES is a 19-item experimental instrument designed to assess readiness for change in alcohol abusers. The instrument yields three factorially-derived scale scores: **Recognition (Re), Ambivalence (Am), and Taking Steps (Ts).** The SOCRATES differs from URICA, also a stages of change measure, in that the SOCRATES poses questions specifically about alcohol or other drug use, whereas URICA asks about the client's "problem" and change in a more general manner. Version 8 is reduced nineteen item scale based on factor analyses with prior versions.
- In clinical settings, the SOCRATES can assist with obtaining information necessary for treatment planning (client motivation for change is an important predictor of treatment compliance and eventual outcome). The SOCRATES is useful in research because it has been found to be an important predictor of long-term alcohol treatment outcome. Work continues in the area of client-treatment matching strategies as well as identifying baseline correlates of client readiness to change.
- The SOCRATES is available in pencil-and-paper self-administered format and can be administered in approximately 3 minutes.

Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES)

- *Purpose:* Designed to assess client motivation to change drinking- or drug-related behavior. Consists of five scales: precontemplation, contemplation, determination, action, and maintenance. Separate versions are available for alcohol and illicit drug use.
- *Clinical utility:* The SOCRATES can assist clinicians with necessary information about client motivation for change, an important predictor of treatment compliance and outcome, and aid in treatment planning.

- *Groups with whom this instrument has been used:* Adults
- *Norms:* N/A
- *Format:* Forty items; paper-and-pencil
- *Administration time:* Five minutes
- *Computer scoring?* No
- *Administrator training and qualifications:* No training required.

18. The *University of Rhode Island Change Assessment Scale,* or URICA, is a self report measure that is used to assess an individual's readiness to change when entering addiction treatment.

- An individual's level of motivation for change and the information they reveal in the URICA can be used to guide treatment options.

19. NIDA drug use screening tool

- The NIDA Drug Use Screening Tool is an interactive web tool that offers a single question Quick Screen to identify patients with recent substance use. NIDA Modified ASSIST: For at-risk patients
- For patients that have been found to be at risk using the Quick Screen, continue with the NIDA Modified ASSIST (NM **ASSIST**). Based on the World Health Organizations's Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST), the NM**ASSIST** guides clinicians through a short series of screening questions and, based on the patient's responses, generates a substance involvement score that suggests the

level of intervention needed.

- The NIDA Quick Screen and NIDA-modified ASSIST are appropriate for patients age 18 or older. You may deliver it as an interview and record patient responses, or read the questions aloud and have the patient fill out responses on a written questionnaire. It is recommended that the person administering the screening review the sample script to introduce the screening process. The script offers helpful language for introducing what can be a sensitive topic for patients.

20. CRAFFT Screening Test is a short, self-administered behavioural health screening tool developed to screen adolescents for high risk alcohol and other drug use disorders simultaneously. It is considered an effective screening tool intended to assess whether further assessment is warranted.

- The CRAFFT performs a similar function to the CAGE questionnaire, which is used for screening alcohol disorders in adults, but which has poor psychometric properties for teens and adolescents.
- The published questionnaire is currently available in three languages: English, Spanish and Portuguese. The questionnaire comprises two parts. **Part A** asks whether during the past 12 months the respondent:
  - Drank any alcohol (more than a few sips)
  - Smoked any marijuana or hashish
  - Used anything else to get "high".
- If the answer is "no" to all three questions, the respondent is directed to the first question only of part B. If the answer is "yes" to any of the above three questions, the respondent is directed to all six questions in part B. Of the six questions in **Part B**, two or more ‘‘yes’’ answers suggest a significant problem and need for additional assessment. The questions are
  - **C** Have you ever ridden in a **CAR** driven by someone (including yourself) who was ‘‘high’’ or had been

using alcohol or other drugs?

- **R** Do you ever use alcohol or other drugs to **RELAX**, feel better about yourself, or fit in?
- **A** Do you ever use alcohol or other drugs while you are **ALONE**?
- **F** Do you ever **FORGET** things you did while using alcohol or other drugs?
- **F** Do your family or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?
- **T** Have you ever gotten into **TROUBLE** while you were using alcohol or other drugs?

21. The Severity of Alcohol Dependence Questionnaire (SADQ or SAD-Q) is a 20 item clinical screening tool designed to measure the presence and level of alcohol dependence.

It is divided into five sections:

- Physical withdrawal symptoms
- Affective withdrawal symptoms
- Craving and relief drinking
- Typical daily consumption
- Reinstatement of dependence after a period of abstinence.

- Each item is scored on a 4-point scale, giving a possible range of 0 to 60. A score of over 30 indicates severe alcohol dependence.
- Some local clinical guidelines use the SADQ to predict the levels of medication needed during alcohol detoxification·

22. Opiod Risk Tool

- Length/Time: 5 items, less than 1 minute to administer and score
- Developed by: Webster & Webster, 2005
- Target Population: Adults
- Intended Settings: Primary care
- Assesses: Risk of aberrant behaviors when patients are prescribed opioids for chronic pain
- Administered by: Self-Report

- **Evidence**
- Provides excellent discrimination between high risk and low risk patients (Passik, et al, 2008), Exhibited a high degree of sensitivity and specificity for determining which individuals are at risk for opioid abuse (Webster & Webster, 2005), Patients categorized as high-risk on the ORT have an increased likelihood of future abusive drug-related behavior (Chou et al., 2009).
- **Indications:** Screens for risk of deviant behaviors associated with substance abuse in pain patients, Preferable to SOAPP in low-risk populations (Passik, et al, 2008)
- **Advantages**: Brief, simple scoring tool that is validated in pain populations (Passik, et al, 2008), Validated for both male and female patients (Webster & Webster, 2005).
- **Limitations**
- One question on the ORT is limited by the patient's knowledge of family history of substance abuse (Passik, et al, 2008), Not validated in non-pain populations.

23. The Drug Abuse Screening Test (DAST) was developed in 1982 and is still an excellent screening tool. It is a 28-item self-report scale that consists of items that parallel those of the Michigan Alcoholism Screening Test (MAST).

- The DAST has “exhibited valid psychometric properties” and has been found to be “a sensitive screening instrument for the abuse of drugs other than alcohol.
- The Drug Abuse Screening Test (DAST-10) is a 10-item brief screening tool that can be administered by a clinician or self-administered. Each question requires a yes or no response, and the tool can be completed in less than 8 minutes. **This tool assesses drug use, not including alcohol or tobacco use, in the past 12 months.**
- **Purpose:** The Drug Abuse Screening Test (DAST) assesses problems and consequences related to drug (including prescription) misuse. Primary care physicians can use this tool to assess for potential substance abuse in all new patients (NIDA 2005).
- **Target population:** Adults and adolescents
- **Evidence:**
  - Very high internal consistency and reliability on full version (Skinner 1982)
  - Validated for use on adolescent populations (Martino et al. 2000)
  - Effective for diagnosis of lifetime alcohol abuse or dependence (Bohn et al. 1991)

Test Features

- **Estimated time:** About 10 minutes to administer and score
- **Length:** 10 items (Also available in 28 item format)
- **Administered by:** Self-Report
- **Intended settings:** Primary care, psychiatric clinics, inpatient
- **Scoring and Interpretation:** Each positive response receives 1 point. Six or more positive responses indicate a need for the physician to address the problem immediately.
  1 - 2 points = monitor patient and reassess later
  3 - 5 points = investigate substance use further
  6 - 8 points = address the problem immediately

24. Substance Abuse Life Circumstance Evaluation (SALCE)

- The SALCE model approaches assessment of an individual's substance use/abuse by examining a broad range of behavior. This model simulates the techniques and procedures that would be employed in the personal interview process. It focuses on, and examines, patterns of respondent answers rather than relying primarily upon answers to individual questions in formulating the SALCE evaluation.
- The goal of this examination is to arrive at the most appropriate intervention to bring about the required behavior change. The written evaluation consists of 98 questions. Most questions require a "yes" or "no" answer. The report provides:

- Analysis and verification of truthfulness of answers provided
- Analysis of your current stressors that may trigger alcohol or drug abuse
- Analysis of your level of alcohol and/or drug use

- The SALCE report presents assessment information that can be used in a broad range of decision-making situations.
  The SALCE report includes specific identifiers for making quick decisions for referral to treatment or education, as
  well as providing detailed information useful in conducting personal interviews. The SALCE instrument is easy to
  administer and provides accurate information in a matter of minutes.

- The SALCE report addresses and includes the following assessment issues:

- Test Taking Attitude	-Driving Record
- Life Circumstance Evaluation	-Demographics
- Drinking Evaluation Category	-Important Symptoms
- Alcohol Addiction Evaluation	-Summary score
- Drug Use Evaluation	-Recommended Interventions

POSSIBLE AREAS OF CONCERN

- 2 alcohol/drug-related arrests
- 1 accident(s)
- 9 driving points

- 1 felony arrests(s)
- drink to relax
- family/friends have complained about my drinking
- i feel guilty about my drinking
- drinking has caused problems with family/friends
- spouse or children have been in counseling
- my spouse/friend threatened to leave because of my drinking
- neglected obligations because of drinking
- lost job because of drinking
- drug use issues
- i have tried social drugs in the past 2 years
- i have abused social or prescription drugs
- my family/friends have complained about my drug use

25. COWS

- The Clinical Opiate Withdrawal Scale (COWS) is an 11-item scale designed to be administered by a clinician (Pen and Paper). This tool can be used in both inpatient and outpatient settings to reproducibly rate common signs and symptoms of opiate withdrawal and monitor these symptoms over time.
- The summed score for the complete scale can be used to help clinicians determine the stage or severity of opiate withdrawal and assess the level of physical dependence on opioids. With increasing use of opioids for treatment of pain and the availability of sublingual buprenorphine in the United States for treatment of opioid dependence, clinical assessment of opiate withdrawal intensity has received renewed interest.
- Practitioners sometimes express concern about the objectivity of the items in the COWS; however, the symptoms of opioid withdrawal have been likened to a severe influenza infection (e.g., nausea, vomiting, sweating, joint aches, agitation, tremor), and patients should not exceed the lowest score in most categories without exhibiting some observable sign or symptom of withdrawal.

26. Substance Abuse Subtle Screening Inventory

- The SASSI is a brief self-report, easily administered psychological screening measure that is available in separate versions for adults and adolescents. The Adult SASSI-3 helps identify individuals who have a high probability of having a substance dependence disorder with an overall empirically tested accuracy of 93 percent. The Adolescent SASSI-A2 is designed to identify individuals who have a high probability of having a substance use disorder, including both substance abuse and substance dependence, with its decision rules yielding an overall accuracy of 94 percent. The SASSI includes both face valid and subtle items that have no apparent relationship to substance use. **The subtle items are included to identify some individuals with alcohol and**

other drug problems who are unwilling or unable to acknowledge substance misuse or symptoms associated with it. Support materials for the SASSI include User's Guides containing easy-to-understand instructions for administering, scoring, interpretation, and Manuals providing comprehensive information on development, reliability, and validity.