SUBSTANCE MISUSE FACT SHEETS

CATEGORY III – ASSESSMENT AND SCREENING TOOLS

1.0 Introduction
Assessment is the most important aspect of identifying substance use, misuse and dependence in patients, it includes:
- History taking to ask questions about all aspects of substance use and the impact this has on the individual
- Recording and making observations of the individual
- Using screening tools
- Undertaking biological testing for confirmation of substance use

2.0 Context
In 2014/15 around 1 in 12 (8.2%) adults (16-59) had taken an illicit drug which equates to around 2.8 million people. Cannabis was the most commonly used drug, with 6.7% of adults aged 16 to 59 using it in 2014/15 (Home Office, 2015). Around 10.8 million adults drink alcohol at levels that increase the risk of harm to their health, 1.6 million adults show some sign of alcohol dependence and alcohol is the third biggest risk factor for illness and death (PHE 2016). There are about 10 million adults who smoke cigarettes in Great Britain and every year, over 100,000 smokers in the UK die from smoking related causes. Smoking accounts for over one-third of respiratory deaths, over one-quarter of cancer deaths, and about one-seventh of cardiovascular disease deaths (ASH, 2015). In England in 2013-14 there were 7,104 admissions to hospital with a primary diagnosis of a drug-related mental health and behavioural disorder and 13,917 admissions with a primary diagnosis of poisoning by illicit drugs. (Health and Social Care Information Centre, 2014).

Since substance use is associated with a myriad of medical conditions i.e. cancer, cardiovascular, respiratory, hepatic, infectious, neurological, psychiatric, every patient should be assessed with regard to substance use.

3.0 The purpose of screening and assessment
When patients present to services, the reasons for presenting may be either directly or indirectly related to substance use.

Screening and assessment are not the same: screening is an initial, simple enquiry about indicators of health problems the results of which may lead to further assessment. Often, screening takes place when the individual first presents to services, and can sometimes be referred to as triage.

Screening generally includes:
- A brief assessment of presenting problems
- Identification of any immediate risks (including urgent psychiatric concerns, safeguarding children and young people or safeguarding vulnerable adults)
- Use of appropriate screening tools
- Blood tests and testing for biological markers, such as
  - Urinalysis
  - Saliva
  - Hair tests
  - Fingernail clippings
  - Blood tests

The purpose of assessment is to determine the level of impact substance use is having on the individual’s health both physical and mental and also on their wider social network and functioning. Assessment is an in-depth, comprehensive, ongoing and sometimes protracted process, which includes the use of detailed history taking, instruments, and biological tests regularly so to formulate the case and monitor progress.

3.1 Classification
The following tables provide the overarching framework for the definition and classification of dependent (addictive) and non-dependent use. There are two classifications: the International Classification of Diseases (ICD) and the Diagnostic and Statistical Manual of Mental Disorders (DSM).

The ICD classify diseases and other health problems recorded on many types of health and vital records including death certificates and health records, and these records also provide the basis for the compilation of national mortality and morbidity statistics by WHO Member States. DSM (now edition 5) is the classification and diagnostic tool for psychiatric disorders.

The use of these diagnostic tools assist in understanding to what degree a patient is using a particular substance
and provides a guide to the severity and extent of the problems associated with substance use. This will inform what diagnosis or diagnoses can be made and which in turn will inform the treatment package.

Criteria for Substance Use Disorder (DSM-V) and Harmful Use and Dependence (ICD10)

There are currently two systems of classification used to diagnose conditions associated with substance use:

1. DSM V: Diagnostic and Statistical Manual of the American Psychiatric Association (American Psychiatric Association, 2013). In DSM V “dependence” and “abuse” diagnoses are combined them into “substance use disorder” which has been expanded to include gambling disorder.

2. ICD 10: International Classification of Diseases (WHO, 1994) and this this is currently being revised for version 11.

<table>
<thead>
<tr>
<th>DSM V</th>
<th>ICD 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>The presence of at least 2 of these symptoms indicates Substance Use Disorder (SUD). The severity of the SUD is defined as:</td>
<td>Harmful use: A pattern of psychoactive substance use that is causing damage to health; the damage may be to physical or mental health</td>
</tr>
<tr>
<td><strong>Mild</strong>: the presence of 2 to 3 symptoms</td>
<td>Dependence: Diagnosis of a dependence should be made if three or more of the following have been experienced or exhibited at some time during the last year</td>
</tr>
<tr>
<td><strong>Moderate</strong>: the presence of 4 to 5 symptoms</td>
<td>A strong desire or sense of compulsion to take the substance</td>
</tr>
<tr>
<td><strong>Severe</strong>: the presence of 6 or more symptoms</td>
<td>Difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use</td>
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<tr>
<td>The substance is often taken in larger amounts or over longer period than was intended</td>
<td>A great deal of time is spent in activities necessary to obtain substances, use substances, or recover from their effects</td>
</tr>
<tr>
<td>There is a persistent desire or unsuccessful efforts to cut down or control substance use</td>
<td>Physiological withdrawal state when substance use has ceased or been reduced, as evidenced by either of the following: the characteristic withdrawal syndrome for the substance of use of the same (or closely related) substance with the intention of relieving or avoiding withdrawal symptoms</td>
</tr>
<tr>
<td>A great deal of time is spent in activities necessary to obtain substances, use substances, or recover from their effects</td>
<td>Craving, or a strong desire or urge to use a substance(s)</td>
</tr>
<tr>
<td><strong>This is new to DSM V</strong></td>
<td>Evidence of tolerance, such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses</td>
</tr>
<tr>
<td>Recurrent substance use resulting in a failure to fulfil major role obligations at work, school or home</td>
<td>Progressive neglect of alternative pleasures or interests because of psychoactive substance use and increased amount of time necessary to obtain or take the substance or to recover from its effects</td>
</tr>
<tr>
<td>Continued substance use despite having persistent recurrent social or interpersonal problems caused or exacerbated by the effects of the substance</td>
<td>Persisting with substance use despite clear evidence of overly harmful consequences (physical or mental)</td>
</tr>
<tr>
<td>Important social, occupational, or recreational activities are given up or reduced because of substance use</td>
<td></td>
</tr>
<tr>
<td>Recurrent substance use in situations in which it is physically hazardous</td>
<td></td>
</tr>
<tr>
<td>Substance use is continued despite knowledge of having had a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance</td>
<td></td>
</tr>
<tr>
<td><strong>Tolerance as defined by either of the following:</strong></td>
<td></td>
</tr>
<tr>
<td>a) A need for markedly increased amount of substance to achieve intoxication or desired effect or markedly diminished effect</td>
<td></td>
</tr>
<tr>
<td>b) A markedly diminished effect with continued use of the same amount of substance</td>
<td></td>
</tr>
<tr>
<td><strong>Withdrawal, as manifested by either of the following:</strong></td>
<td></td>
</tr>
<tr>
<td>a) The characteristic withdrawal syndrome for substance use</td>
<td></td>
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<tr>
<td>b) A substance is taken to relieve or avoid withdrawal symptoms</td>
<td></td>
</tr>
</tbody>
</table>
3.2 Comprehensive history taking

This section is the protocol for history taking as part of assessment

The key principle underlying an assessment is to determine the nature and extent of substance use and the interaction of use and psychological and physical symptomatology. Every patient should be assessed for substance use. It is important to emphasise that the style of questioning, i.e. that it should be non-judgmental, non-confrontational, and should be seen as part of engagement – the start - of the treatment process. It is important if feasible to build a relationship with the patient prior to administering assessment tools too rapidly. Much depends on the context of the initial consultation or meeting. Avoidance of stereotyping is central to this process.

The assessment process will include

- Initial screening (presenting problem, current substance use, risk assessment including mental state and any safeguarding issues, confidentiality and consent)
- Comprehensive history as outlined below
- Physical and mental state examination
- Biological testing
- Use of appropriate tools to monitor pattern of substance use, estimation of problems associated with substance use and assessment of dependence and degree of dependence

The table below highlights the schedule of areas to be covered in a comprehensive assessment.

### Comprehensive protocol for history taking

<table>
<thead>
<tr>
<th>Area of questioning</th>
<th>Questions to ask</th>
</tr>
</thead>
</table>
| **Substance use**    | - Age of initiation: first tried each substance  
                       - Age of onset of weekend use  
                       - Age of onset of weekly use  
                       - Age of onset of daily use  
                       - Pattern of use during each day i.e. quantity/weight, frequency  
                       - Route of use e.g. oral, smoking, snorting, intramuscular, intravenous, subcutaneous (“skin popping”)  
                       - Age of onset of specific withdrawal symptoms and dependence syndrome features (see classification above)  
                       - Current use over previous day, week, month  
                       - Number of days of abstinence (reasons for this)  
                       - Current cost of use  
                       - Maximum use ever  
                       - How substance use is funded  
                       - Source of substances  
                       - Periods of abstinence  
                       - Triggers to relapse  
                       - Preferred substance(s) and reasons  
                       - If injecting, current injection sites, previous injection sites, any problems with these.  |
| **Treatment episodes** | - Dates, length of contact with service  
                          - Type of services, and what was provided/types of interventions  
                          - The outcome of each contact, what was achieved, did patient view it as successful or otherwise  
                          - What was the reason to discontinue with the service  
                          - Triggers to relapse, reasons to make contact with the service again  |
| **Family history**    | - Parents, siblings, grandparents, aunts, uncles, wife, husband, partner, children  
                          - History of substance use within the family members mentioned and any related problems  
                          - History of psychiatric problems e.g. suicide, self-harm, depression, anxiety, psychotic illness  
                          - History of physical health problems  
                          - Separation, divorce, death  
                          - Family relationships, conflict, support  
                          - Occupational history  
                          - Whether childhood spent with biological parents or others  
                          - Friends and other support networks  |
### Area of questioning

<table>
<thead>
<tr>
<th>Living arrangements</th>
<th>Questions to ask</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Current living arrangements – e.g. home, hostel, care home</td>
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<tr>
<td>• With spouse, partner, family, friends, alone</td>
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</tr>
<tr>
<td>• Cared for/carer</td>
<td></td>
</tr>
<tr>
<td>• Permanent, temporary</td>
<td></td>
</tr>
<tr>
<td>• Social network</td>
<td></td>
</tr>
<tr>
<td>• Future plans</td>
<td></td>
</tr>
<tr>
<td>• Housing support needs</td>
<td></td>
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<tr>
<td>• Benefits</td>
<td></td>
</tr>
<tr>
<td>• Any concerns of vulnerability? Such as victim of a pimp or drug dealer, domestic violence</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Life style issues</th>
<th>Questions to ask</th>
</tr>
</thead>
<tbody>
<tr>
<td>• General physical state</td>
<td></td>
</tr>
<tr>
<td>• Sleep, diet, weight</td>
<td></td>
</tr>
<tr>
<td>• Injecting practices including risk to others</td>
<td></td>
</tr>
<tr>
<td>• Wound management</td>
<td></td>
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<tr>
<td>• Oral health</td>
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<tr>
<td>• Vaccination history</td>
<td></td>
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<tr>
<td>• History of breast, cervical cancer screening</td>
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<tr>
<td>• Sexual health issues</td>
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<tr>
<td>• Other health issues</td>
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<table>
<thead>
<tr>
<th>Medical history</th>
<th>Questions to ask</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Past history – chronic conditions</td>
<td></td>
</tr>
<tr>
<td>• Current diagnosis, medications, treatment</td>
<td></td>
</tr>
<tr>
<td>• Episodes of acute or chronic illnesses: respiratory, infective, HIV, tuberculosis, cardiovascular, hepatitis, injury, accidents, surgery, overdose, disability – and whether any of these are related to substance use</td>
<td></td>
</tr>
<tr>
<td>• Any screening for blood borne viruses (hepatitis B, C and HIV), dates and outcomes</td>
<td></td>
</tr>
<tr>
<td>• Admission to hospital, dates, problems, treatment, length of admission and outcome</td>
<td></td>
</tr>
<tr>
<td>• Current GP, care, condition(s), treatments</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychiatric history</th>
<th>Questions to ask</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Past history</td>
<td></td>
</tr>
<tr>
<td>• Current signs and symptoms</td>
<td></td>
</tr>
<tr>
<td>• Risk assessment</td>
<td></td>
</tr>
<tr>
<td>• Current diagnosis, medication</td>
<td></td>
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<tr>
<td>• Assessment by GP for “minor” complaints such as anxiety, depression</td>
<td></td>
</tr>
<tr>
<td>• Treatment by GP with psychoactive drugs</td>
<td></td>
</tr>
<tr>
<td>• Referral to specialist psychiatric services for assessment and treatment, dates, reasons, diagnosis, outcome</td>
<td></td>
</tr>
<tr>
<td>• Any mental health act assessments</td>
<td></td>
</tr>
<tr>
<td>• History of self-harm and family history of self-harm and suicide</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Personal history</th>
<th>Questions to ask</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Developmental milestones, occupational, sexual, marital, relationships, maturity</td>
<td></td>
</tr>
<tr>
<td>• Pregnancy/infertility/trying to conceive</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Educational History</th>
<th>Questions to ask</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Age started and left school</td>
<td></td>
</tr>
<tr>
<td>• Any truancy or difficulties at school e.g. bullying, abuse</td>
<td></td>
</tr>
<tr>
<td>• School achievements and aspirations</td>
<td></td>
</tr>
<tr>
<td>• Apprenticeships</td>
<td></td>
</tr>
<tr>
<td>• University or other higher education</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Criminal history</th>
<th>Questions to ask</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Involvement in criminal activities, both related and non-related to substance use</td>
<td></td>
</tr>
<tr>
<td>• Age in first contact with the criminal justice system and reasons</td>
<td></td>
</tr>
<tr>
<td>• Cautions, charges, convictions</td>
<td></td>
</tr>
</tbody>
</table>
3.3 Obtaining information from others
In addition to taking a full assessment, it is useful to obtain information for others to assist in building up an accurate picture and to also clarify any ambiguity. This may include some of the following:
- Family members and friends
- Colleagues
- Carers
- Other professionals e.g. GPs, other specialists, social workers, probation officers, pharmacists
- In the case of young people (school, college, tutors)
This may particularly important in relation to patients who are unconscious, have a memory loss, or where English is not the first language. Also special consideration needs to be given for older people, who may not be able to recall information or who are not able to provide an accurate account.

3.4 Physical examination and recording
A physical examination should be conducted to assess medical illnesses. This will include a wide range of medical conditions including medical emergencies, neurological deficits, infectious diseases, states of withdrawal and intoxication, and cardio-respiratory disorders to mention a few. It is useful to record on a diagram the location of observations of the impact of substance use on the patient, such as track marks from injecting, or abscesses, scars from previous abscesses. This enables identification of the impact that substance use has on all systems and all parts of the body, including location of track marks, abscesses, or other injection sites.

3.5 Mental health examination
It is important to distinguish between substance-induced and substance related psychiatric disorders. The key elements of the mental state examination should include:
- Attitude to the interview
- Appearance and behaviour
- Speech
- Mood
- Thought processes including suicidal ideas, plans and intentions
3.6 Investigations and tests

Substances can be tested in blood, urine, hair, saliva and breath. Blood tests are a better detector of recent use, since they measure the actual presence of substance in the system. Because they are invasive and difficult to administer, blood tests are used less frequently. They are typically used in investigations of accidents, injuries or incidents where they can give a useful indication of whether the subject was actually under the influence of substances.

<table>
<thead>
<tr>
<th>Substance type</th>
<th>Detection period in urine drug screening (maximum range)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cocaine</td>
<td>12-72 hours</td>
</tr>
<tr>
<td>Amphetamines</td>
<td>2-4 days</td>
</tr>
<tr>
<td>Heroin</td>
<td>2-4 days</td>
</tr>
<tr>
<td>Codeine</td>
<td>2-4 days</td>
</tr>
<tr>
<td>Cannabis (casual use)</td>
<td>2-4 days</td>
</tr>
<tr>
<td>Cannabis (chronic use)</td>
<td>30 days</td>
</tr>
<tr>
<td>Diazepam</td>
<td>30 days</td>
</tr>
</tbody>
</table>

A number of blood tests are used for detection of the effects of alcohol:

- **Gamma Glutamyl Transferase (GGT)**: Often elevated before liver damage has occurred due to alcohol induced enzyme induction. At higher readings damage more likely
- **Alanine Transaminase (ALT)**: When raised it is more suggestive of hepatocellular injury
- **Aspartate Transaminase (AST)**: AST:ALT ratio of more than 2 in the presence of liver disease suggests alcohol related liver damage
- **Alkaline Phosphatase**: Raised in hepatitis with biliary duct obstruction
- **Bilirubin**: Individuals may be jaundiced if elevated
- **Albumin**: Low albumin can reflect acute hepatitis or cirrhosis
- **Triglycerides**: Raised in early stages of fatty liver infiltration before hepatitis develops
- **Uric acid**: Metabolism of alcohol results in acidosis, a build up of urates and possibly gout
- **Amylase**: Raised in pancreatitis
- **Mean Cell Volume (MCV)**: If raised check B12 and folate levels, which may also be deficient due to alcohol misuse
- **Platelet count**: Low count may reflect bone marrow toxicity
- **Haemoglobin**: Anaemia may be due to poor nutrition, vitamin deficiencies or bleeding from ulcers
- **White Blood Count**: Reduced in bone marrow toxicity and raised in infection, hepatitis and pancreatitis

To perform a drug test on someone’s urine, a sample has to be collected in an examination cup, (often in a controlled environment). For immediate results, the test is performed with a dip stick, but for most sophisticated results, the urine is sent out to a testing facility for immunoassay or gas chromatography and the results are given after a week or two.

Hair tests do not measure current use, but rather non-psychoactive residues that remain in the hair for months afterwards. These residues are absorbed internally and do not appear in the hair until 7-10 days after first use. These are not commonly used in the UK except for research purposes. Saliva testing is also used in the detection of substances in specialist drug clinics. They detect secretions from inside the oral tissues that cannot be washed out with mouthwash.

Breathalyser: it is not always possible to detect alcohol use on the breath, and therefore it is useful to invite the patient to blow into a breathalyser (alcometer) as an effective way of measuring blood alcohol levels.

Urine tests are widely used for assessment of drugs in the system. A positive result is not a sign of dependence, but an indication that the drug has been taken. It is important to note that it is not uncommon for a patient to provide a fake specimen knowing what the result will be, for example if someone wants to ensure there is a negative test due to being in an accident where their substance use may be demonstrated. Where the patient is drug seeking and looking for drugs to be prescribed, they will want to provide a positive test result. These may be provided by others (a fake test). Dip stick tests are a useful way to check substance use in urine as part of overall assessment, but this result alone should not be relied upon.
There are a range of tools available for the screening of drug and alcohol use (see table). Assessment tools are often used to help guide and structure dialogue between professional and patient. When used in the assessment of substance misusers, they commonly collect information on the:
- Changing pattern of substance use (tobacco, alcohol, drugs)
- Problems associated with substance use especially risk behaviour
- Dependence and degree of dependence
- Health, social and economic circumstances

### 4.1 Screening tools

There are a range of screening tools designed to assist in detection of an alcohol or drug problem, a selection of these can be found in the table below.

<table>
<thead>
<tr>
<th>Tool</th>
<th>Description of tool</th>
<th>Link</th>
</tr>
</thead>
<tbody>
<tr>
<td>The <strong>AUDIT</strong> (Alcohol Use Disorders Identification Test)</td>
<td>Detects hazardous and harmful drinking 10 items in 3 sub groups 2 minutes to complete</td>
<td><a href="http://www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/?parent=4444&amp;child=4896">http://www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/?parent=4444&amp;child=4896</a></td>
</tr>
<tr>
<td><strong>AUDIT C</strong></td>
<td>Brief Screens for alcohol use Assess level of risk of drinking patterns 3 questions</td>
<td><a href="http://www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/?parent=4444&amp;child=4896">http://www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/?parent=4444&amp;child=4896</a></td>
</tr>
<tr>
<td><strong>FAST</strong> (Fast Alcoholic Screening Test)</td>
<td>Screening for alcohol use Relevant to screening in A&amp;E 4 questions, can be self administered or completed by a staff member Takes about 30 seconds to complete</td>
<td><a href="http://www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/?parent=4444&amp;child=4570">http://www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/?parent=4444&amp;child=4570</a></td>
</tr>
<tr>
<td><strong>DAST 10</strong></td>
<td>Screening for drug use Shorter version 10 items To identify problems associated with drug use in adults, and takes 5-10 minutes</td>
<td><a href="http://www.psychcongress.com/saudras-corner/scales-screeners/suds/drug.use.questionnaire-dast-10">http://www.psychcongress.com/saudras-corner/scales-screeners/suds/drug.use.questionnaire-dast-10</a></td>
</tr>
<tr>
<td><strong>PAT</strong> (Paddington Alcohol Test)</td>
<td>Evolved over 15 years as a clinical tool to facilitate emergency doctors and nurses giving brief advice. Detect alcohol use</td>
<td><a href="http://www.alcohollearningcentre.org.uk/Topics/Browse/Hospital/EmergencyMedicine/">www.alcohollearningcentre.org.uk/Topics/Browse/Hospital/EmergencyMedicine/</a></td>
</tr>
<tr>
<td><strong>FIVE SHOT</strong></td>
<td>Questionnaire on heavy drinking</td>
<td><a href="http://www.alcoholism.about.com/od/test/a/fiveshot.htm">http://www.alcoholism.about.com/od/test/a/fiveshot.htm</a></td>
</tr>
<tr>
<td><strong>CRAFFT</strong></td>
<td>Screens adolescents for high risk alcohol and other drug use disorders This is a short, self-administered behavioural health screening tool developed specifically for young people</td>
<td><a href="http://www.ceasar-boston.org/Clinicians/crafft.php">http://www.ceasar-boston.org/Clinicians/crafft.php</a></td>
</tr>
<tr>
<td><strong>CAGE</strong></td>
<td>The CAGE is a brief 4-item screen for alcohol use, and can be undertaken on 1 minute.</td>
<td><a href="http://patient.info/doctor/cage-questionnaire">http://patient.info/doctor/cage-questionnaire</a> <a href="http://www.partnersagainstpain.com/printouts/A7012D14.pdf">http://www.partnersagainstpain.com/printouts/A7012D14.pdf</a></td>
</tr>
<tr>
<td><strong>CAGEAID</strong></td>
<td>The CAGEAID (adapted to Include Drugs) has been developed for screening drug use disorders. Can be used in adults, adolescents, inpatients of general medical hospitals and clients with schizophrenia</td>
<td><a href="http://www.sbirtraining.com/node/535">www.sbirtraining.com/node/535</a></td>
</tr>
<tr>
<td><strong>Fagerstrom</strong></td>
<td>Screening for nicotine dependence A six point questionnaire, that takes 2 minutes to compete.</td>
<td><a href="http://ndrXurtin.edu.au/btitp/documents/Fagerstrom_test.pdf">http://ndrXurtin.edu.au/btitp/documents/Fagerstrom_test.pdf</a></td>
</tr>
</tbody>
</table>

See appendix for screening tools
### 4.2 Assessment Tools

There are a wide range of assessment tools used in undertaking a more comprehensive assessment for a range of objectives e.g. severity of dependence, treatment needs and monitoring, some of which are listed below.

<table>
<thead>
<tr>
<th>Tool</th>
<th>Description</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>SADQ (Severity of Alcohol Dependence Questionnaire)</td>
<td>The SADQ is a short, self-administered, 20-item questionnaire designed by the World Health Organisation to measure severity of dependence on alcohol. Self-complete by the patient, takes 5 minutes, it takes 1 minute for a staff member trained in its use to score.</td>
<td><a href="http://www.alcohollearningcentre.org.uk/Topics/Latest/Resource/?cid=4615">http://www.alcohollearningcentre.org.uk/Topics/Latest/Resource/?cid=4615</a></td>
</tr>
<tr>
<td>The Severity of Dependence Scale (SDS)</td>
<td>The Severity of Dependence Scale (SDS) is a 5-item questionnaire that provides a score indicating the severity of dependence on opioids. Each of the five items is scored on a 4-point scale (0-3). Takes less than one minute to complete.</td>
<td><a href="http://www.alcohollearningcentre.org.uk/Topics/Latest/Resource/?cid=4615">www.emcdda.europa.eu/html.cfm/index7343EN.html</a></td>
</tr>
</tbody>
</table>

See appendix for screening tools

### 4.3 Guidance of levels of drinking

Recommendations for drinking have been issued by various bodies including the Department of Health, Royal College of Physicians & NHS.

### 5.0 References and useful resources

- Alcohol and Drug Abuse Institute Library, University of Washington; Substance Use Screening & Assessment Instruments Database  
- ASH (2015) Smoking statistics  
- Boston Children’s Hospital Adolescent Substance Abuse Program – research and resources for SBIRT with adolescents and children.  
  [http://www.teensubstancescreening.org/research/](http://www.teensubstancescreening.org/research/)
- Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, abbreviated as DSM-V  
  [http://www.dsm5.org/Pages/Default.aspx](http://www.dsm5.org/Pages/Default.aspx)
- European Monitoring Centre Drugs and Drug Addiction: The Evaluation Instruments Bank (EIB) online archive of freely available instruments for evaluating drug-related interventions.  
  [http://alcalc.oxfordjournals.org/content/50/2/244.abstract?etoc](http://alcalc.oxfordjournals.org/content/50/2/244.abstract?etoc)
- Appendix 4 Hamid Ghodse Substance Abuse Assessment Questionnaire  
  [Appendix 7 & 8; Opiate Withdrawal; Appendix 9 Attendance Record](http://www.alcohollearningcentre.org.uk/Topics/Latest/Resource/?cid=4615)
- Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, abbreviated as DSM-V  
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- Appendix 4 Hamid Ghodse Substance Abuse Assessment Questionnaire  
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Appendix: Screening tools used in substance use

Screening Tools

There are a range of tools available for the screening of drug and alcohol use. These tools address:

- Pattern of substance use i.e. quantity, frequency and duration
- Assessment of mental, physical and social problems associated with substance use
- Assessment of extent of use, misuse, harmful use and dependence, as well as degree of dependence

AUDIT is a screening instrument of good sensitivity and specificity for detecting hazardous and harmful drinking among people not seeking treatment for alcohol problems. The full AUDIT comprises 10 questions.

### 1.0 The AUDIT (Alcohol Use Disorders Identification Test)

<table>
<thead>
<tr>
<th>AUDIT</th>
<th>Scoring system</th>
<th>Your score</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do you have a drink containing alcohol?</td>
<td>Never Monthly or less</td>
<td>0</td>
</tr>
<tr>
<td>How many units of alcohol do you drink on a typical day when you are drinking?</td>
<td>1-2</td>
<td>1</td>
</tr>
<tr>
<td>How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?</td>
<td>Never Less than monthly</td>
<td>0</td>
</tr>
<tr>
<td>How often during the last year have you found that you were not able to stop drinking once you had started?</td>
<td>Never Less than monthly</td>
<td>0</td>
</tr>
<tr>
<td>How often during the last year have you failed to do what was normally expected from you because of your drinking?</td>
<td>Never Less than monthly</td>
<td>0</td>
</tr>
<tr>
<td>How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?</td>
<td>Never Less than monthly</td>
<td>0</td>
</tr>
<tr>
<td>How often during the last year have you had a feeling of guilt or remorse after drinking?</td>
<td>Never Less than monthly</td>
<td>0</td>
</tr>
<tr>
<td>How often during the last year have you been unable to remember what happened the night before because you had been drinking?</td>
<td>Never Less than monthly</td>
<td>0</td>
</tr>
<tr>
<td>Have you or somebody else been injured as a result of your drinking?</td>
<td>No</td>
<td>0</td>
</tr>
<tr>
<td>Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?</td>
<td>No</td>
<td>0</td>
</tr>
</tbody>
</table>

**Scoring:** 0 – 7 Lower risk, 8 – 15 Increasing risk, 16 – 19 Higher risk, 20+ Possible dependence

### 2.0 AUDIT – C is a shortened version

<table>
<thead>
<tr>
<th>AUDIT</th>
<th>Scoring system</th>
<th>Your score</th>
</tr>
</thead>
<tbody>
<tr>
<td>How often do you have a drink containing alcohol?</td>
<td>Never Monthly or less</td>
<td>0</td>
</tr>
<tr>
<td>How many units of alcohol do you drink on a typical day when you are drinking?</td>
<td>1-2</td>
<td>1</td>
</tr>
<tr>
<td>How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?</td>
<td>Never Less than monthly</td>
<td>0</td>
</tr>
</tbody>
</table>

**Scoring:** A total of 5+ indicates increasing or higher risk drinking. An overall total score of 5 or above is AUDIT-C positive.
### 3.0 FAST

FAST is a rapid and efficient screening tool for detecting alcohol misuse in the A&E setting. The FAST Alcohol Screening Test is a 4-item initial screening test taken from AUDIT. It was developed for busy clinical settings as a two-stage initial screening test that is quick to administer since >50% of patients are identified by using just the first question. This version also provides the remaining questions from AUDIT to be administered to those who are FAST positive in order to obtain a full AUDIT score.

The Fast Alcohol Screening Test (FAST) is a simpler test that you can use to check whether your drinking has reached hazardous levels. FAST consists of four questions, listed below. The number after each answer is that answer’s score.

1. **How often do you drink eight or more units (men) or six or more units (women) on one occasion?**
   - never (if this is your answer you can stop the test)
   - less than monthly (1)
   - monthly (2)
   - weekly (3)
   - daily or almost daily (4)

2. **How often during the last year have you been unable to remember what happened the night before because you had been drinking?**
   - never (0)
   - less than monthly (1)
   - monthly (2)
   - weekly (3)
   - daily or almost daily (4)

3. **How often during the past year have you failed to do what was normally expected of you because you had been drinking?**
   - never (0)
   - less than monthly (1)
   - monthly (2)
   - weekly (3)
   - daily or almost daily (4)

4. **In the last year has a relative or friend, or a doctor or other health worker been concerned about your drinking or suggested that you cut down?**
   - no (0)
   - yes, on one occasion (1)
   - yes, on more than one occasion (2)

A FAST score of three or more indicates that you’re drinking at a hazardous level.

### 4.0 The Drug Abuse Screening Test (DAST)

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.

**Instruction for use:** The following questions concern information about your involvement with drugs. Drug abuse refers to (1) the use of prescribed or “over-the-counter” drugs in excess of the directions, and (2) any non-medical use of drugs. Consider the past year (12 months) and carefully read each statement. Then decide whether your answer is YES or NO and check the appropriate space. Please be sure to answer every question.

1. Have you used drugs other than those required for medical reasons? Yes No
2. Have you abused prescription drugs? Yes No
3. Do you abuse more than one drug at a time? Yes No
4. Can you get through the week without using drugs (other than those required for medical reasons)? Yes No
5. Are you always able to stop using drugs when you want to? Yes No
6. Do you abuse drugs on a continuous basis? Yes No
7. Do you try to limit your drug use to certain situations? Yes no
8. Have you had “blackouts” or “flashbacks” as a result of drug use? Yes No
9. Do you ever feel bad about your drug abuse? Yes No
10. Does your spouse (or parents) ever complain about your involvement with drugs? Yes No
11. Do your friends or relatives know or suspect you abuse drugs? Yes No
12. Has drug abuse ever created problems between you and your spouse? Yes No
13. Has any family member ever sought help for problems related to your drug use? Yes No
14. Have you ever lost friends because of your use of drugs? Yes No
15. Have you ever neglected your family or missed work because of your use of drugs? Yes No
16. Have you ever been in trouble at work because of drug abuse? Yes No
17. Have you ever lost a job because of drug abuse? Yes No
18. Have you gotten into fights when under the influence of drugs? Yes No
19. Have you ever been arrested because of unusual behaviour while under the influence of drugs? Yes No
20. Have you ever been arrested for driving while under the influence of drugs? Yes No
21. Have you engaged in illegal activities in order to obtain drug? Yes No
22. Have you ever been arrested for possession of illegal drugs? Yes No
23. Have you ever experienced withdrawal symptoms as a result of heavy drug intake? Yes No
24. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)? Yes No
25. Have you ever gone to anyone for help for a drug problem? Yes No
26. Have you ever been in a hospital for medical problems related to your drug use? Yes No
27. Have you ever been involved in a treatment program specifically related to drug use? Yes No
28. Have you been treated as an outpatient for problems related to drug abuse? Yes No

**Scoring and interpretation:** A score of “1” is given for each YES response, except for items 4, 5, and 7, for which a NO response is given a score of “1.” Based on data from a heterogeneous psychiatric patient population, cut-off scores of 6 through 11 are considered to be optimal for screening for substance use disorders. Using a cut-off score of 6 has been found to provide excellent sensitivity for identifying patients with substance use disorders as well as satisfactory specificity (i.e., identification of patients who do not have a substance use disorder). Over 12 is definitely a substance abuse problem. In a heterogeneous psychiatric patient population, most items have been shown to correlate at least moderately well with the total scale scores. The items that correlate poorly with the total scale scores appear to be items 4, 7, 16, 20, and 22.
5.0 DAST 10
This is a summarised version of the full 28 item screening tool “Drug abuse” refers to (1) the use of prescribed or over the counter drugs in excess of the directions, and (2) any nonmedical use of drugs.
The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium diazepam), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcoholic beverages.

6.0 PADDINGTON ALCOHOL TEST 2011

‘make the connection’

 PATIENT IDENTIFICATION STICKER:
 NAME
 D.O.B.

A. PAT for TOP 10 presentations – circle as necessary
B. Clinical Signs of alcohol use
C. Blood Alcohol Concentration: refer direct from resusc. room if BAC>80mgs/100ml BAC = …………... mgs/100ml

1. FALL (incl. trip) 2. COLLAPSE (incl. fit) 3. HEAD INJURY 4. ASSAULT
5. ACCIDENT 6. UNWELL 7. GASTRO-INTESTINAL 8. CARDIAC (i. Chest pain)
9. PSYCHIATRIC (incl. DSH & OD) please state 10. REPEAT ATTENDER Other (please state)

EARLY IDENTIFICATION TO REDUCE RE-ATTENDANCE
Only proceed after dealing with patient’s ‘agenda,’ i.e. patient’s reason for attendance.

“We routinely ask all patients having …(above presentation)…about their alcohol use.”

1 How often do you drink alcohol?

Never
Less than weekly
… times per week
Every day
May be dependent. Consider thiamine (?) Nutrition) & chlordiazepoxide (?) CIWA.

(continue to next question)

2 What is the most you will drink in any one day?

Use the following guide to estimate total daily units. (Standard pub units in brackets; home measures often three times the amount!)

Beer /lager / cider
Pints (2) Cans (1.5)
Litre bottles (4.5)
Strong beer /lager / cider
Pints (5) Cans (4)
Litre bottles (10)
Wine
Glasses (1.5) 75ml bottles (9)
Alcopops
Fortified Wine (Sherry, Port, Martini)
Glasses (1)
75ml bottles (12)
330ml bottles (1.5)
Spirits (Gin, Vodka, Whisky etc)
Singles (1)
75ml bottles (30)

(continue to Q3 for all)

3 Do you feel your attendance at A&E is related to alcohol?

YES (PAT +ve) NO

If PAT +ve give feedback e.g. “Can we advise that your drinking is harming your health”. “It is recommended that you do not regularly drink more than 4 units/day for men or 3 units/day for women”.

We would like to offer you further advice. Would you be willing to see our alcohol health worker? (Remember direct referral if BAC>80mgs/100ml)

YES NO

If “YES” to Q5 give ANS appointment card and leaflet and make appointment in diary @ 9am to 10am. Other appointment times available, please speak to ANS or ask patient to contact (phone number on app. card). Give alcohol advice leaflet (“Units and You”) to all PAT+ve patients, especially if they decline AHW appointment.

Please note here if patient admitted to ward …………………………………………

Referrer’s Signature Name Stamp Date:

ANS OUTCOME:
### A. History

**PAT(2009)** is a clinical and therapeutic tool to ‘make the connection’ between ED attendance and drinking.

Any ED doctor or nurse can follow PAT to give **Brief Advice (BA)** taking less than two minutes for most patients.

**BA** is followed by the offer of a **Brief Intervention (BI)** from the Alcohol Nurse Specialist (ANS).

**BI** is a specialist session lasting more than 20 minutes.

This reduces the likelihood of re-attendance at the ED.

**PAT**

Gain the patient’s confidence: Deal with the patient’s reason for attending first, so they are in a receptive frame of mind for receiving Brief Advice.

Then apply PAT for **THE TOP 10 presentations** or when signs of alcohol use.

**PAT** takes less than a minute for most patients who drink.

**ROUTINE**

**Q1** ‘We **routinely** ask all patients having (this presentation) if they drink alcohol - do you drink?’

If No: PAT-ve, discontinue (providing clinician agrees with the answer).

**QUANTITY**

**Q2:** “What is the most you will drink in any one day?”

1 Unit (UK) = 10ml alcohol = 8gms alcohol

Units = % ABV x volume (in litres)

% ABV is “% of alcohol by volume” as indicated on bottle or can.

**FREQUENCY**

**Q3:** “How often do you drink?” Daily drinking may indicate dependence.

Any heavy drinking risks adverse consequences and A&E re-attendance.

NB Hazardous drinkers should be given leaflet “Units & You”.

**MAKE THE CONNECTION**

Everyone who says yes to Q1 should be asked **Q4:**

“Do you feel your current attendance at A&E is related to alcohol?”

If yes, then you have successfully started **Brief Advice (BA)** by the patient associating their drinking with resulting hospital attendance.

---

### B. Clinical Signs

**B. Clinical Signs of acute alcohol use: ‘SAFE  Moves: ABCD’**

<table>
<thead>
<tr>
<th>Smell</th>
<th>of alcohol.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech</td>
<td>varying volume &amp; pace; slurring &amp; jumbled.</td>
</tr>
<tr>
<td>Affect</td>
<td>variable judgement &amp; inappropriate behaviour; euphoria/depression; decreased co-operation; emotional.</td>
</tr>
<tr>
<td>Eyes</td>
<td>red conjunctiva, nystagmus*, ophthalmoplegia*.</td>
</tr>
<tr>
<td>Moves</td>
<td>fine motor control*, incoordination <em>(acute cerebellar syndrome)</em>; gross motor control <em>(walking)</em>, <em>(truncal ataxia – chronic)</em>.</td>
</tr>
<tr>
<td>Airway</td>
<td>snoring with obstruction. Inhalation of vomit - ? Mallory-Weiss</td>
</tr>
<tr>
<td>Breathing</td>
<td>slow/shallow, hypoxia with CO2 retention - ? air entry</td>
</tr>
<tr>
<td>Circulation</td>
<td>tachycardia, irregularity. Hypotension; vasodilatation with heat loss.</td>
</tr>
<tr>
<td>Disability</td>
<td>Urinary retention or incontinence; but ? dehydration.</td>
</tr>
</tbody>
</table>


---

### C. Resusc. Room

**Resusc. Room:** request Blood Alcohol Concentration, **BAC** - same grey bottle as for glucose - for all 5 presentations of:-

1. Collapse
2. Self-harm
3. Trauma
4. Gastro-intestinal/Abdominal
5. Chest pain

If **BAC + i.e. >10mgs/100ml**: apply PAT when out of Resusc. Or direct referral to ANS’s if >80mgs


For further information about the Paddington Alcohol Test (PAT), ‘SAFE Moves’ or BAC contact:

- Prof. Robin Touquet FCEM - robin.touquet@imperial.nhs.uk
- or Adrian Brown RMN – ade.brown@nhs.net or Win Keane RMN – win.keane@nhs.net
### 7.0 FIVE-SHOT QUESTIONNAIRE

1. How often do you have a drink containing alcohol:
   - (0.0) Never
   - (0.5) Monthly or less
   - (1.0) Two to four times a month
   - (1.5) Two to three times a week
   - (2.0) Four or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?
   - (0.0) 1 or 2
   - (0.5) 3 or 4
   - (1.0) 5 or 6
   - (1.5) 7 to 9
   - (2.0) 10 or more

### Scoring

Score of 2.5 or greater indicates possible alcohol misuse and the need for further investigation

*Maximum Score = 7.*

(Seppa et al, 198).

---

### 8.0 MAST THE MICHIGAN ALCOHOL SCREENING TEST (MAST)

The original MAST was a 25-item questionnaire. Later, the MAST was downsized to a 22-item questionnaire that not unlike the original instrument, was designed to provide a quick and accurate screening tool for identifying alcohol-related problems and alcoholism.

The MAST has been productively used in a number of diverse settings with various populations.

The following represents the 22 questions that make up the MAST.

Please answer YES or NO to the following questions:

1. Do you feel you are a normal drinker? ("normal" - drink as much or less than most other people)
   - YES or NO

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

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

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

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

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

7. Have you ever gotten into physical fights when drinking?
   - YES or NO
8. Has drinking ever created problems between you and a near relative or close friend?
   YES or NO

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

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

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

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

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

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

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

16. After heavy drinking have you ever had delirium tremens (D.T.’s), severe shaking, visual or auditory (hearing) hallucinations?
    YES or NO

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

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

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

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

22. Have you ever been arrested, even for a few hours because of other behavior while drinking?
    (If Yes, how many times ________ )
    YES or NO

---

**SCORING**

Please score one point if you answered the following:

1. No
2. Yes
3. Yes
4. No
5. Yes
6. Yes

7 through 22: Yes

Add up the scores and compare to the following score card:

<table>
<thead>
<tr>
<th>Score Range</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 2</td>
<td>No apparent problem</td>
</tr>
<tr>
<td>3 - 5</td>
<td>Early or middle problem drinker</td>
</tr>
<tr>
<td>6 or more</td>
<td>Problem drinker</td>
</tr>
</tbody>
</table>

---

**Short Michigan Alcoholism Screening Test – Geriatric Version**


YES (1) NO (0)

1. When talking with others, do you ever underestimate how much you actually drink?
2. After a few drinks, have you sometimes not eaten or been able to skip a meal because you didn’t feel hungry?
3. Does having a few drinks help decrease your shakiness or tremors?
4. Does alcohol sometimes make it hard for you to remember parts of the day or night?
5. Do you usually take a drink to relax or calm your nerves?
6. Do you drink to take your mind off your problems?
7. Have you ever increased your drinking after experiencing a loss in your life?
8. Has a doctor or nurse ever said they were worried or concerned about your drinking?
9. Have you ever made rules to manage your drinking?
10. When you feel lonely, does having a drink help?

TOTAL S-MAST-G SCORE (0-10) ______

Scoring: 2 or more “yes” responses indicative of alcohol problem.
9.0 CRAFFT
Screening using the CRAFFT begins by asking the adolescent to “Please answer these next questions honestly”; telling him/her “Your answers will be kept confidential”; and then asking three opening questions.

If the adolescent answers “No” to all three opening questions, the provider only needs to ask the adolescent the first question - the CAR question. If the adolescent answers “Yes” to any one or more of the three opening questions, the provider asks all six CRAFFT questions.

CRAFFT is a mnemonic acronym of first letters of key words in the six screening questions. The questions should be asked exactly as written.

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 gotten into TROUBLE while you were using alcohol or drugs?

The CRAFFT or CAGE-AID should be preceded by these two questions:
1. Do you drink alcohol?
2. Have you ever experimented with drugs?

If the patient has experimented with drugs, ask the CAGE-AID questions. If the patient only drinks alcohol, then ask the CRAFFT questions.

CAGE-AID Questions
1. In the last three months, have you felt you should cut down or stop drinking or using drugs?
   Yes
   No
2. In the last three months, has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs?
   Yes
   No
3. In the last three months, have you felt guilty or bad about how much you drink or use drugs?
   Yes
   No
4. In the last three months, have you been waking up wanting to have an alcoholic drink or use drugs?
   Yes
   No

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Scoring
Of the 4 items, a "yes" answer to one item indicates a possible substance use disorder and a need for further testing.

Reference
11.0 Karl Fagerstrom Nicotine Tolerance Questionnaire
For each statement, circle the most appropriate number that best describes you.
Total Point(s): _______
1. How many cigarettes do you smoke per day?
   a) 10 or less
   b) 11 – 20
   c) 21 – 30
   d) 31 or more
2. How soon after you wake up do you smoke your first cigarette?
   a) 0 – 5 min
   b) 30 min
   c) 31 – 60 min
   d) After 60 min
3. Do you find it difficult to refrain from smoking in places where smoking is not allowed (e.g. hospitals, government offices, cinemas, libraries etc)?

4. Do you smoke more during the first hours after waking than during the rest of the day?
   a) Yes
   b) No
5. Which cigarette would you be the most unwilling to give up?
   a) First in the morning
   b) Any of the others
6. Do you smoke even when you are very ill?
   a) Yes
   b) No

TOTAL SCORE ______

LEVEL OF DEPENDENCE
<table>
<thead>
<tr>
<th>Points</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 – 3</td>
<td>Low</td>
</tr>
<tr>
<td>4 – 6</td>
<td>Medium</td>
</tr>
<tr>
<td>7 – 10</td>
<td>High</td>
</tr>
</tbody>
</table>

A score of 31 or higher indicates ‘severe alcohol dependence’.
A score of 16 -30 indicates ‘moderate dependence’
A score of below 16 usually indicates only a mild physical dependence.
A chlordiazepoxide detoxification regime is usually indicated for someone who scores 16 or over.

12.0 Opiate Treatment Index (OTI)
The OTI consists of six independent outcome domains. The domains chosen to reflect the dimensions of treatment outcome were: Drug Use, HIV Risk-taking Behaviour, Social Functioning, Criminality, Health Status, and Psychological Adjustment.

13.0 SADQ (Severity of Alcohol Dependence Questionnaire)
The SADQ questions cover the following aspects of dependence syndrome:
- physical withdrawal symptoms
- affective withdrawal symptoms
- relief drinking
- frequency of alcohol consumption
- speed of onset of withdrawal symptoms.

Scoring:
Answers to each questions are rated on a four point scale:
Almost never = 0
Sometimes = 1
Often = 2
Nearly always = 3

14.0 The Severity of Dependence Scale (SDS)
The Severity of Dependence Scale (SDS) is a 5-item questionnaire that provides a score indicating the severity of dependence on opioids. Each of the five items is scored on a 4-point scale (0-3). It takes less than one minute to complete.

15.0 Assessment of levels of drinking
Recommended levels of drinking:

<table>
<thead>
<tr>
<th>Department of Health</th>
<th>The Royal College of Physicians (RCP)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Men</strong></td>
<td>should not regularly drink more than 3-4 units of alcohol a day</td>
</tr>
<tr>
<td><strong>Women</strong></td>
<td>women should not regularly drink more than 2-3 units a day</td>
</tr>
</tbody>
</table>
Note: ‘Regularly’ means drinking every day or most days of the week. If you do drink more heavily than this on any day, allow 48 alcohol-free hours afterwards to let your body recover.

RCP also state that it is recommended to have 2-3 alcohol-free days a week to allow the liver time to recover after drinking anything but the smallest amount of alcohol.

A quote from the RCP “in addition to quantity, safe alcohol limits must also take into account frequency. There is an increased risk of liver disease for those who drink daily or near daily compared with those who drink periodically or intermittently.”

The House of Commons Science and Technology Committee advise that people should have at least two alcohol-free days a week.

It is useful to assess the level of drinking based on unit of alcohol to enable advice about reducing harmful effects of alcohol.

<table>
<thead>
<tr>
<th>NHS – your drinking and you</th>
<th>Men</th>
<th>Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drinking within the lower-risk guidelines</td>
<td>no more than 3–4 units a day on a regular basis</td>
<td>no more than 2–3 units a day on a regular basis</td>
</tr>
<tr>
<td>Drinking above the lower-risk guidelines, putting your health at increasing risk</td>
<td>more than 3–4 units a day on a regular basis</td>
<td>more than 2–3 units a day on a regular basis</td>
</tr>
<tr>
<td>Drinking in a way that puts your health at even higher risk</td>
<td>more than 50 units per week (or more than 8 units per day) on a regular basis</td>
<td>more than 35 units per week (or more than 6 units per day) on a regular basis</td>
</tr>
</tbody>
</table>

**Drinking above the lower-risk guidelines**

For men, drinking more than 3–4 units a day on a regular basis puts your health at increasing risk.

For women, drinking more than 2–3 units a day on a regular basis puts your health at increasing risk.

**Drinking above the higher-risk guidelines**

For men, drinking on a regular basis more than 8 units a day or more than 50 units a week puts your health at higher risk.

For women, drinking on a regular basis more than 6 units a day or more than 35 units a week puts your health at higher risk.

March 2016