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**

LEARNING OUTCOMES

Medical students will understand the following:

1. How to undertake an assessment for substance use.
2. The range of tools available to screen and assess drug and alcohol use.
3. What tests and investigations that are useful for diagnostic purposes.
4. To make a diagnosis of substance dependence (addiction).

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.

	DSM V	ICD 10
	The presence of at least 2 of these symptoms indicates Substance Use Disorder (SUD). The severity of the SUD is defined as: **Mild:** the presence of 2 to 3 symptoms **Moderate:** the presence of 4 to 5 symptoms **Severe:** the presence of 6 or more symptoms	Harmful use: A pattern of psychoactive substance use that is causing damage to health; the damage may be to physical or mental health 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
1	The substance is often taken in larger amounts or over longer period than was intended	A strong desire or sense of compulsion to take the substance
2	There is a persistent desire or unsuccessful efforts to cut down or control substance use	Difficulties in controlling substance-taking behaviour in terms of its onset, termination, or levels of use
3	A great deal of time is spent in activities necessary to obtain substances, use substances, or recover from their effects	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
4	Craving, or a strong desire or urge to use a substance(s) **This is new to DSM V**	Evidence of tolerance, such that increased doses of the psychoactive substance are required in order to achieve effects originally produced by lower doses
5	Recurrent substance use resulting in a failure to fulfil major role obligations at work, school or home	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
6	Continued substance use despite having persistent recurrent social or interpersonal problems caused or exacerbated by the effects of the substance	Persisting with substance use despite clear evidence of overly harmful consequences (physical or mental)
7	Important social, occupational, or recreational activities are given up or reduced because of substance use	
8	Recurrent substance use in situations in which it is physically hazardous	
9	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	
10	**Tolerance as defined by either of the following:** **a)** A need for markedly increased amount of substance to achieve intoxication or desired effect or markedly diminished effect **b)** A markedly diminished effect with continued use of the same amount of substance	
11	**Withdrawal, as manifested by either of the following:** **a)** The characteristic withdrawal syndrome for substance use **b)** A substance is taken to relieve or avoid withdrawal symptoms	

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

Area of questioning	Questions to ask
Substance use Ask the same questions for each substance in turn • Alcohol • Amphetamines • Benzodiazepines • Cannabis • Cocaine • Ecstasy • Heroin and other opiates • "Legal Highs" • Methadone • Nicotine • Over the counter medication • Prescribed medication • Solvents • Any other drugs bought over the internet	• 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	Questions to ask
Living arrangements	• Current living arrangements – e.g. home, hostel, care home • With spouse, partner, family, friends, alone • Cared for/carer • Permanent, temporary • Social network • Future plans • Housing support needs • Benefits • Any concerns of vulnerability? Such as victim of a pimp or drug dealer, domestic violence
Life style issues	• General physical state • Sleep, diet , weight • Injecting practices including risk to others • Wound management • Oral health • Vaccination history • History of breast, cervical cancer screening • Sexual health issues • Other health issues
Medical history	• Past history – chronic conditions • Current diagnosis, medications, treatment • 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 • Any screening for blood borne viruses (hepatitis B, C and HIV), dates and outcomes • Admission to hospital, dates, problems, treatment, length of admission and outcome • Current GP, care, condition(s), treatments
Psychiatric history	• Past history • Current signs and symptoms • Risk assessment • Current diagnosis, medication • Assessment by GP for "minor" complaints such as anxiety, depression • Treatment by GP with psychoactive drugs • Referral to specialist psychiatric services for assessment and treatment, dates, reasons, diagnosis, outcome • Any mental health act assessments • History of self-harm and family history of self-harm and suicide
Personal history	• Developmental milestones, occupational, sexual, marital, relationships, maturity • Pregnancy/infertility/trying to conceive
Educational History	• Age started and left school • Any truancy or difficulties at school e.g. bullying, abuse • School achievements and aspirations • Apprenticeships • University or other higher education
Criminal history	• Involvement in criminal activities, both related and non-related to substance use • Age in first contact with the criminal justice system and reasons • Cautions, charges, convictions

Area of questioning	Questions to ask
	• Types of activity, shoplifting, theft, prostitution • Imprisonment at any time in Young offenders institution or prison • Any current issues
Vocational and social function	• Employment, training or education after school – past and current • Types of work • Ongoing activities and plans • Skills • Retirement • Volunteering • Leisure/hobbies
Social background	• Ethnicity and cultural background • Religious and spiritual beliefs
Financial status	• Any current problems that may require support from an adviser such as debts, benefits issues,
Biological measures	• Biochemistry: alcohol levels, drug screens • Virology
Contact with other services (current and previous)	• Child protection history • Child abuse/neglect • Vulnerable adult • Other social services involvement
Risk factors	• Social isolation • Recent losses • History of harm to self and others
Further information	• Carers, family, friends • Other service provider
Perspective of patient	• Perception of problems • Motivation for change – strengths, barriers, support

(Source: adapted from: Crome and Ghodse, 2007)

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

- Delusions
- Perceptual disturbances
- Cognition
- Judgement and capacity to consent to treatment
- Insight

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.

Substance type	Detection period in urine drug screening (maximum range)
Cocaine	12-72 hours
Amphetamines	2-4 days
Heroin	2-4 days
Codeine	2-4 days
Cannabis (casual use)	2-4 days
Cannabis (chronic use)	30 days
Diazepam	30 days

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.

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

4.0 Tools

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.

Tool	Description of tool	Link
The AUDIT (Alcohol Use Disorders Identification Test)	Detects hazardous and harmful drinking 10 items in 3 sub groups 2 minutes to complete	http://www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/?parent=4444&child=4896
AUDIT C	Brief Screens for alcohol use Assesses level of risk of drinking patterns 3 questions	http://www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/?parent=4444&child=4898
FAST (Fast Alcoholic Screening Test)	Screening for alcohol use Relevant to screening in A&E 4 questions, can be self administered or completed by a staff member Takes about 30 seconds to complete	http://www.alcohollearningcentre.org.uk/Topics/Browse/BriefAdvice/?parent=4444&child=4570
DAST (Drug Abuse Screening Test)	Screening for drug use Long version is a 28 item tool To identify problems associated with drug use	http://www.drtepp.com/pdf/substance_abuse.pdf
DAST 10	Screening for drug use Shorter version 10 items To identify problems associated with drug use in adults, and takes 5-10 minutes	http://www.psychcongress.com/saundras-corner/scales-screeners/suds/drug.use.questionnaire-dast-10
PAT (Paddington Alcohol Test)	Evolved over 15 years as a clinical tool to facilitate emergency doctors and nurses giving brief advice. Detect alcohol use	www.alcohollearning.centre.org.uk/Topics/Browse/Hospital/EmergencyMedicine/?
FIVE SHOT	Questionnaire on heavy drinking	http://www.alcoholism.about.com/od/test/a/fiveshot.htm
MAST **S-MAST-G** Geriatric Version	Screening for alcohol with a shorter one specifically designed to be used when screening older people	http://sbirt.vermont.gov/screening-forms/older-adult-alcohol-screening-instrument/
CRAFFT	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	http://www.ceasar-boston.org/Clinicians/crafft.php
CAGE	The CAGE is a brief 4-item screen for alcohol use, and can be undertaken on 1 minute.	http://patient.info/doctor/cage-questionnaire http://www.partnersagainstpain.com/printouts/A7012DA4.pdf
CAGEAID	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	www.sbirttraining.com/node/535
Fagerstrom	Screening for nicotine dependence A six point questionnaire, that takes 2 minutes to compete.	http://ndrXurtin.edu.au/btitp/documents/Fagerstrom_test.pdf

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.

Opiate treatment Index (OTI)	Reflects all aspects of treatment including drug use, HIV risk-taking behaviour, social functioning, criminality, health status and psychological adjustment. Most suitable for use in specialist substance misuse services	http://ndarc.med.unsw.edu.au/resources/opiate-treatment-index-oti-manual
SADQ (Severity of Alcohol Dependence Questionnaire)	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.	http://www.alcohollearningcentre.org.uk/Topics/Latest/Resource/?cid=4615
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). Takes less than one minute to complete.	www.emcdda.europa.eu/html.cfm/index7343EN.html

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
http://lib.adai.washington.edu/instruments/
ASH (2015) Smoking statistics
http://www.ash.org.uk/files/documents/ASH_93.pdf
Boston Children's Hospital Adolescent Substance Abuse Program – research and resources for SBIRT with adolescents and children.
http://www.teensubstancescreening.org/research/
Crome I and Ghodse A.H (2007) Drug Misuse on medical patients, in Handbook of Liaison Psychiatry, eds. Geoffrey Lloyd and Elspeth Guthrie, Cambridge University Press
Darke, S., Ward, J., Hall, W., Heather, N. & Wodak, A. (1991). The Opiate Treatment Index (OTI) Researcher's Manual. National Drug and Alcohol Research Centre Technical Report Number 11. Sydney: National Drug and Alcohol Research Centre
Diagnostic and Statistical Manual of Mental Disorders Fifth Edition, abbreviated as DSM-V
http://www.dsm5.org/Pages/Default.aspx
http://www.dsm5.org/Documents/Substance%20Use%20Disorder%20Fact%20Sheet.pdf

European Monitoring Centre Drugs and Drug Addiction: The Evaluation Instruments Bank (EIB) online archive of freely available instruments for evaluating drug-related interventions. http://www.emcdda.europa.eu/eib
Foxcroft D, R. et al (2015) Accuracy of Alcohol Use Disorders Identification Test for Detecting Problem Drinking in 18–35 Year-Olds in England: Method Comparison Study Alcohol& Alcoholism. 50: 244-250
http://alcalc.oxfordjournals.org/content/50/2/244.abstract?etoc

Gavin DR; Ross HE; Skinner HA. (1989) 'Diagnostic validity of the Drug Abuse Screening Test in the assessment of DSM-III drug disorders', *British Journal of Addiction 84(3): 301-307*
Ghodse H (2010). Ghodes's Drugs and Addictive Behaviour; a guide to treatment. 4thed ,Cambridge University Press. Chapter 6 Assessment; Appendix 4 Hamid Ghodse Substance Abuse Assessment Questionnaire Appendix 7 & 8; Opiate Withdrawal; Appendix 9 Attendance Record

Health and Social Care Information Centre ((2014)Drug Misuse statistics,England 2014
http://www.hscic.gov.uk/catalogue/PUB15943
Home Office (2015) Drug Misuse: Findings from the 2014/15 Crime Survey for England
and Wales
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/462885/drug-misuse-1415.pdf
ICD 10 The International Classification of Diseases (ICD
http://www.who.int/classifications/icd/en/

Public Health England (2016) Health matters: harmful drinking and alcohol dependence https://www.gov.uk/government/publications/health-matters-harmful-drinking-and-alcohol-dependence/health-matters-harmful-drinking-and-alcohol-dependence

Royal College of General Practitioners (2013): Certificate in the management of drug abuse: a free e-learning course, which takes three hours to complete aimed at all healthcare professionals. The free drugs eLearning module covers:
- evidence-based management of substance misuse
- risks associated with poly drug use
- screening and assessment in primary care
- prescribing treatments opioid users
- social context
- older drug users.

Skinner, H.A (1982) *Drug Abuse Screening Test (DAST),* Addiction Research Foundation.

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)

AUDIT	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
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?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last [illegible]	

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

2.0 AUDIT – C is a shortened version

AUDIT	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
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?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

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 substance use disorders). Using a cut off score of <11 somewhat reduces the sensitivity for identifying patients with substance use disorders, but more accurately identifies the patients who do not have a substance use disorders. 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 nonmendical 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), hallucionogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions do not include alcoholic beverages.

Interpretation of Score

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	None at this time
1-2	Low level	Monitor, re-assess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

(Source: Addiction Research Foundation (1982)

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. fits)* **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	PAT ends
Less than weekly	
____ times per week	Advise against daily drinking.
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? (UK alcohol units)

If more than twice daily limits **(8 units/day for men, 6 units/day for women)** PAT +ve

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)**		750ml bottles **(9)**		**Alcopops**		
Fortified Wine (Sherry, Port, Martini)	Glasses **(1)**		750ml bottles **(12)**		330ml bottles **(1.5)**		
Spirits (Gin, Vodka, Whisky etc)	Singles **(1)**		750ml 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 **B. Clinical Signs** **C. Blood Alcohol Concentration**

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 **a**lcohol **b**y **v**olume' 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 of acute alcohol use: 'SAFE Moves: ABCD'

'**S**'mell	of alcohol.
'**S**'peech:	varying volume & pace; slurring & jumbled.
'**A**'ffect:	variable judgement & inappropriate behaviour; euphoria/depression; decreased co-operation; emotional.
'**F**'ace:	sweating/flushed (*cushingoid – chronic*), ? injury.
'**E**'yes:	red conjunctiva, nystagmus*, ophthalmoplegia*
'**Moves**':	fine motor control*, incoordination (acute cerebellar syndrome)*. gross motor control (walking)*, (*truncal ataxia – chronic*)*.
Airway:	snoring with obstruction. Inhalation of vomit - ? Mallory-Weiss
Breathing:	slow/shallow, hypoxia with CO2 retention - ? air entry
Circulation:	tachycardia, irregularity. Hypotension; vasodilatation with heat loss. Collapse. Urinary retention or incontinence; but ? dehydration.
Disability:	variable alertness*, confusion*, hallucinations*, sleepiness. ? GCS.

*** Signs of possible Wernicke's - give thiamine iv. In UK: 'Pabrinex', BNF '54', 2007 onwards.**
For monitoring withdrawal use 'CIWA' (Clinical Institute Withdrawal Assessment)

C. 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

Ref. Touquet R & Brown A. PAT(2009) – Revisions to the PAT. *Alcohol & Alcoholism* 2009;44(3):284-6.

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 of 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

3. Have people annoyed you by criticising your drinking?

(0.0) No
(1.0) Yes

4. Have you ever felt bad or guilty about your drinking?

(0.0) No
(1.0) Yes

5. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hang-over?

(0.0) No
(1.0) Yes

Scoring
Score of 2.5 or greater indicates possible alcohol misuse and the need for further investigation
Maximum Score = 7.

(Seppa et al, 1`8).

the past 12 months… Circle			
1.	Have you used drugs other than those required for medical reasons?	Yes	No
2.	Do you abuse more than one drug at a time?	Yes	No
3.	Are you unable to stop abusing drugs when you want to?	Yes	No
4.	Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5.	Do you ever feel bad or guilty about your drug use?	Yes	No
6.	Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7.	Have you neglected your family because of your use of drugs?	Yes	No
8.	Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9.	Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10.	Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)?	Yes	No
Scoring: Score 1 point for each question answered "Yes," except for question 3 for which a "No" receives 1 point.		**Score:**	

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:

0 - 2	No apparent problem
3 - 5	Early or middle problem drinker
6 or more	Problem drinker

Short Michigan Alcoholism Screening Test – Geriatric Version

(S-MAST- G) © The Regents of the University of Michigan, 1991.

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.

C - Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?

R - Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?

A - Do you ever use alcohol/drugs while you are by yourself, ALONE?

F - Do you ever FORGET things you did while using alcohol or drugs?

F - Do your family or FRIENDS ever tell you that you should cut down on your drinking or drug use?

T - Have you gotten into TROUBLE while you were using alcohol or drugs?

10.0 CAGE ASSESSMENT (Brief version)

C Have you ever tried to **C**ut back on your use?

A Have you ever been **A**nnoyed/**A**ngered when questioned about your use?

G Have you ever felt **G**uilt about your use?

E Have you ever had an **E**ye-opener to get started in the morning?

The Cage Assessment is a quick questionnaire to help determine if an alcohol assessment is needed. If you answer yes to two or more of these questions, then an assessment is advised.

CAGE-AID Questionnaire

CAGE-AID (Adapted to Include Drugs) is a version of the CAGE alcohol screening questionnaire, adapted to include drug use. This four item screening tool takes approximately 1 minute to administer and score. The target population for the CAGE-AID is both adults and adolescents and can be administered by patient interview or self-report in a primary care setting.

Evidence

- Easy to administer, with good sensitivity and specificity (Leonardson, et al, 2005).
- More sensitive than original CAGE questionnaire for diagnosis of substance use disorder (Brown & Rounds, 1995)
- Less biased in term of education, income, and sex then the original CAGE questionnaire(Brown & Rounds, 1995).

Indications

- Intended as a brief clinical screening during primary care visits

Advantages

- The CAGE-AID is well suited for use in a primary care facility.+
- Quick and easy to administer
- Easily incorporated into a medical history protocol or intake procedure

Limitations

- Screening for alcohol and drug usage conjointly rather than separately

The CAGE 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 CAGE 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

Brown RL, Leonard T, Saunders LA, Papasouliotis O. The prevalence and detection of substance use disorder among inpatients ages 18 to 49: an opportunity for prevention. Preventive Medicine. 1998;27:101-110.

11.0 Karl Fagerstrom Nicotine Tolerance Questionnaire

For each statement, circle the most appropriate number that best describes you.

Total Point(s):_____

Point(s)

1. How many cigarettes do you smoke per day?
   a) 10 or less
   b) 11 – 20
   0
   1
   c) 21 – 30
   2
   d) 31 or more
   3
2. How soon after you wake up do you smoke your first cigarette?
   a) 0 – 5 min
   b) 30 min
   c) 31 – 60 min
   3
   2
   1
   d) After 60 min
   0
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)?
   a) Yes
   1
   b) No
   0
4. Do you smoke more during the first hours after waking than during the rest of the day?
   a) Yes
   1
   b) No
   0
5. Which cigarette would you be the most unwilling to give up?
   a) First in the morning
   1
   b) Any of the others
   0
6. Do you smoke even when you are very ill?
   a) Yes
   1
   b) No
   0

TOTAL SCORE _____

LEVEL OF DEPENDENCE	
0 – 3	points Low
4 – 6	points Medium
7 – 10	points High

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.

http://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/TR.011.pdf

Source: Darke, S et al (1991).

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

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.

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:

	Department of Health	The Royal College of Physicians (RCP)
Men	should not regularly drink more than 3-4 units of alcohol a day	no more than 21 units per week
Women	women should not regularly drink more than 2-3 units a day	no more than 14 units per week

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.

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

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