Appendix G:

Screening and Assessment Instruments

Addiction Severity Index (ASI)

Purpose: The ASI is most useful as a general intake screening tool. It effectively assesses a client's status in several areas, and the composite score measures how a client's need for treatment changes over time.

Clinical utility: The ASI has been used extensively for treatment planning and outcome evaluation. Outcome evaluation packages for individual programs or for treatment systems are available.

Groups with whom this instrument has been used: Designed for adults of both sexes who are not intoxicated (drugs or alcohol) when interviewed. Also available in Spanish.

Format: Structured interview

Administration time: 50 minutes to 1 hour

Scoring time: 5 minutes for severity rating

Computer scoring? Yes

Administrator training and qualifications: A self-training packet is available as well as onsite training by experienced trainers.

Fee for use: No cost; minimal charges for photocopying and mailing may apply.

Available from:

A. Thomas McLellan, Ph.D.
Building 7
PVAMC
University Avenue
Philadelphia, PA 19104
Phone: (800) 238-2433

Alcohol Use Disorders Identification Test (AUDIT)

Purpose: The purpose of the AUDIT is to identify persons whose alcohol consumption has become hazardous or harmful to their health.

Clinical utility: The AUDIT screening procedure is linked to a decision process that includes brief intervention with heavy drinkers or referral to specialized treatment for patients who show evidence of more serious alcohol involvement.

Groups with whom this instrument has been used: Adults, particularly primary care, emergency room, surgery, and psychiatric patients; DWI offenders; criminals in court, jail, and prison; enlisted men in the armed forces; and workers in employee assistance programs and industrial settings.

Format: A 10-item screening questionnaire with 3 questions on the amount and frequency of drinking, 3 questions on alcohol dependence, and 4 on problems caused by alcohol.

Administration time: 2 minutes

Scoring time: 1 minute

Computer scoring? No

Administrator training and qualifications: The AUDIT is administered by a health professional or paraprofessional. Training is required for administration. A detailed user's manual and a videotape training module explain proper administration, procedures, scoring, interpretation, and clinical management.

Fee for use: No

Available from: Can be downloaded from Project Cork Web site: www.projectcork.org

Beck Depression Inventory–II (BDI–II)

Purpose: Used to screen for the presence and rate the severity of depression symptoms.

Clinical utility: The BDI–II consists of 21 items to assess the intensity of depression. The BDI-II can be used to assess the intensity of a client's depression, and it can also be used as a screening device to determine whether there is any current indication of the need for a referral for further evaluation. Each item is a list of four statements arranged in increasing severity about a particular symptom of depression. These new items bring the BDI–II into alignment with *Diagnostic and Statistical Manual for Mental Disorders, 4th edition* (DSM-IV) criteria.

Items on the new scale replace items that dealt with symptoms of weight loss, changes in body image, and somatic preoccupation. Another item on the original BDI that tapped work difficulty was revised to examine loss of energy. Also, sleep loss and appetite loss items were revised to assess both increases and decreases in sleep and appetite.

Groups with whom this instrument has been used: All clients age 13 through 80 who can read and understand the instructions, and clients who cannot read (requires reading the statements to them).

Format: Paper-and-pencil self-administered test.

Administration time: 5 minutes, either self-administered or administered verbally by a trained administrator.

Scoring time: N/A

Computer scoring? No. Any staff member can perform the simple scoring.

Administrator training and qualifications: Doctoral-level training or masters-level training with supervision by a doctoral-level clinician are required to interpret test results.

Fee for use: $66 for manual and package of 25 record forms.

Available from: The Psychological Corporation
19500 Bulderve
San Antonio, TX 78259
Phone: (800) 872-1726
www.psychcorp.com

CAGE Questionnaire

Purpose: The purpose of the CAGE Questionnaire is to detect alcoholism.

Clinical utility: The CAGE Questionnaire is a very useful bedside, clinical desk instrument and has become the favorite of many family practice and general internists—also very popular in nursing.

Groups with whom this instrument has been used: Adults and adolescents (over 16 years)

Format: Very brief, relatively nonconfrontational questionnaire for detection of alcoholism, usually directed "have you ever" but may be focused to delineate past or present.

Administration time: Less than 1 minute

Scoring time: Instantaneous

Computer scoring? No

Administrator training and qualifications: No training required for administration; it is easy to learn, easy to remember, and easy to replicate.

Fee for use: No

Available from: May be downloaded from the Project Cork Web site: www.projectcork.org

Circumstances, Motivation, and Readiness Scales (CMR Scales)

Purpose: The instrument is designed to predict retention in treatment and is applicable to both residential and outpatient treatment modalities.

Clinical utility: The instrument consists of four derived scales measuring external pressure to enter treatment, external pressure to leave treatment, motivation to change, and readiness for treatment. Items were developed from focus groups of recovering staff and clients and retain much of the original language. Clients entering substance abuse treatment perceive the items as relevant to their experience.

Groups with whom this instrument has been used: Adults

Format: 18 items at approximately a third-grade reading level. Responses to the items consist of a 5-point Likert scale on which the individual rates each item on a scale from Strongly Disagree to Strongly Agree. Versions are also available in Spanish and Norwegian.

Administration time: 5 to 10 minutes

Scoring time: Can be easily scored by reversing negatively worded items and summing the item values.

Computer scoring? No

Administrator training and qualifications: Self-administered; no training required for administration.

Fee for use: No

Available from: George De Leon, Ph.D., or Gerald Melnick, Ph.D.
National Development and Research Institutes, Inc.
71 West 23rd Street
8th Floor
New York, NY 1001
Phone: (212) 845-4400
Fax: (917) 438-0894
E-mail: gerry.melnick@ndri.org
www.ndri.org

Clinical Institute Withdrawal Assessment (CIWA-Ar)

Purpose: Converts DSM-III-R items into scores to track severity of withdrawal; measures severity of alcohol withdrawal.

Clinical utility: Aid to adjustment of care related to withdrawal severity.

Groups with whom this instrument has been used: Adults

Format: A 10-item scale for clinical quantification of the severity of the alcohol withdrawal syndrome.

Administration time: 2 minutes

Scoring time: 4 to 5 minutes

Computer scoring? No

Administrator training and qualifications: Training is required and the CIWA is administered by nurses, doctors, and research associates/detoxification unit workers.

Fee for use: No

Available from: Dr. E.M. Sellers
Ventana Clinical Research Corporation
340 College Street
Suite 400
Toronto, Canada
M5T 3A9
Phone: (416) 963-9338
Fax: (416) 963-9732
www.ventana-crc.com

Drug Abuse Screening Test (DAST)

Purpose: The purpose of the DAST is (1) to provide a brief, simple, practical, but valid method for identifying individuals who are abusing psychoactive drugs; and (2) to yield a quantitative index score of the degree of problems related to drug use and misuse.

Clinical utility: Screening and case finding; level of treatment and treatment/goal planning.

Groups with whom this instrument has been used: Individuals with at least a sixth-grade reading level.

Format: A 20-item instrument that may be given in either a self-report or a structured interview format; a "yes" or "no" response is requested from each of 20 questions.

Administration time: 5 minutes

Scoring time: N/A

Computer scoring? No. The DAST is planned to yield only one total or summary score ranging from 0 to 20, which is computed by summing all items that are endorsed in the direction of increased drug problems.

Administrator training and qualifications: For a qualified drug counselor, only a careful reading and adherence to the instructions in the "DAST Guidelines for Administration and Scoring," which is provided, is required. No other training is required.

Fee for use: The DAST form and scoring key are available either without cost or at nominal cost.

Available from:
Centre for Addiction and Mental Health
Marketing and Sales Services
33 Russell Street
Toronto, Ontario, Canada M5S 2S1
Phone: (800) 661-1111 (Continental North America)
International and Toronto area: (416) 595-6059

Global Appraisal of Individual Needs (GAIN)

Purpose: The GAIN was developed to implement an integrated biopsychosocial model of treatment assessment, planning, and outcome monitoring that can be used for evaluation, clinical practice, and administrative purposes.

Clinical utility: The GAIN embeds questions for documenting substance use disorder, attention deficit/hyperactivity disorder, oppositional defiant disorder, conduct disorder, and pathological gambling; dimensional patient placement criteria for intoxication/withdrawal, health distress, mental distress, and environment distress to guide movement among and between levels of care; treatment planning; reporting requirements related to the State client data system; and measures of a core set of clinical status and service utilization outcomes used in the Drug Outcome Monitoring Study.

Groups with whom this instrument has been used: Adults and adolescents

Format: The content of the GAIN is divided into eight areas: background and treatment arrangements, substance use, physical health, risk behaviors, mental health, environment, legal, and vocational. In each area, the questions check for major problem areas and the recency of any problems.

Administration time: 15 to 30 minutes

Scoring time: 20 minutes

Computer scoring? No

Administrator training and qualifications: N/A

Fee for use: The GAIN and its products are tools that are proprietary products owned by Chestnut Health Systems either exclusively or jointly and protected under U.S. copyright laws. The current work is in beta test form, but can be used for evaluation and research under a non-exclusive, non-transferable, limited license at the cost of $1 plus any materials/assistance requested.

Available from:
The Lighthouse Institute
Chestnut Health Systems
720 West Chestnut
Bloomington, IL 61701
Phone: (309) 827-6026
www.chestnut.org/li/gain/

Level of Care Utilization System (LOCUS)

Purpose: To assess immediate service needs (e.g., for clients in crisis); to plan resource needs over time, as in assessing service requirements for defined populations; to monitor changes in status or placement at different points in time.

Clinical utility: LOCUS is divided into three sections. The first section defines six evaluation parameters or dimensions: (1) risk of harm; (2) functional status; (3) medical, addictive, and psychiatric co-morbidity; (4) recovery environment; (5) treatment and recovery history; and (6) engagement. A five-point scale is constructed for each dimension and the criteria for assigning a given rating or

score in that dimension are elaborated. In dimension IV, two subscales are defined, while all other dimensions contain only one scale.

Groups with whom this instrument has been used: Adults

Format: A document that is divided into three sections.

Administration time: 15 to 30 minutes

Scoring time: 20 minutes

Computer scoring? No

Administrator training and qualifications: N/A

Fee for use: No

Available from: American Association of Community Psychiatrists
www.wpic.pitt.edu/aacp/find.html

Michigan Alcoholism Screening Test (MAST)

Purpose: Used to screen for alcoholism with a variety of populations.

Clinical utility: A 25-item questionnaire designed to provide a rapid and effective screen for lifetime alcohol-related problems and alcoholism.

Groups with whom this instrument has been used: Adults

Format: Consists of 25 questions

Administration time: 10 minutes

Scoring time: 5 minutes

Computer scoring? No

Administrator training and qualifications: No training required.

Fee for use: Fee for a copy but no fee for use.

Available from: Melvin L. Selzer, M.D.
6967 Paseo Laredo
La Jolla, CA 92037-6425

M.I.N.I. Plus

Purpose: Assists in the assessment and tracking of patients with greater efficiency and accuracy.

Clinical utility: The M.I.N.I. is not designed or intended to be used in place of a full medical and psychiatric evaluation by a qualified licensed physician-psychiatrist. It is intended only as a tool to facilitate accurate data collection and processing of symptoms elicited by trained personnel.

Groups with whom this instrument has been used: Adults

Format: An abbreviated psychiatric structured interview that takes approximately 15 to 20 minutes to administer. It uses decision tree logic to assess the major adult Axis I disorders in DSM-IV and ICD-10. It elicits all the symptoms listed in the symptom criteria for DSM-IV and ICD-10 for 15 major Axis I diagnostic categories, one Axis II disorder, and for suicidality. Its diagnostic algorithms are consistent with DSM-IV and ICD-10 diagnostic algorithms.

Administration time: 15 to 20 minutes

Scoring time: N/A

Computer scoring? A computerized version of the M.I.N.I. is available in six languages in the MINI Outcomes program.

Administrator training and qualifications: The M.I.N.I. was designed to be used by trained interviewers who do not have training in psychiatry or psychology.

Fee for use: The M.I.N.I. is made available at no charge on the Internet, mainly for researchers and clinicians who may make single copies of the M.I.N.I. for their own use. When the M.I.N.I. is used in a research study or published paper, appropriate credit should

be given for its use. The proper citation is provided on the last page of the M.I.N.I.

Available from: Medical Outcome Systems, Inc.
medical-outcomes.com

Psychiatric Research Interview for Substance and Mental Disorders (PRISM)

Purpose: The instrument was designed to maximize reliability and validity in community samples, alcohol, drug, and co-occurring disorder treatment samples.

Clinical utility: Although primarily designed as a research instrument, the PRISM provides systematic coverage of alcohol- and drug-related experiences and symptoms that may be useful in identifying areas of focus for treatment. Additionally, the unusually high reliability of the depression diagnoses in individuals with heavy drinking may provide a better basis for treatment decisions than less consistent methods for assessing major depression and dysthymia.

Groups with whom this instrument has been used: Adults

Format: The PRISM is a semistructured clinician-administered interview that measures DSM-III, DSM-III-R, and DSM-IV diagnoses (current and past) of alcohol, drug, and psychiatric disorders and continuous measures of severity, organic, etiology, treatment, and functional impairment.

Administration time: 1 to 3 hours

Scoring time: Immediately

Computer scoring? Yes

Administrator training and qualifications: Interviewer should have at least a master's degree in a clinical field and some clinical experience. Training is required for administration. Training for the administrator involves a self-study manual, ratings of videotapes of interviews, and small group sessions with an experienced trainer.

Fee for use: No

Available from: Dr. Deborah Hasin
New York State
Psychiatric Institute
Box 123 722
West 168th Street
New York, NY 10032
Phone: (212) 960-5518
Cost/source of computerized scoring: Call Dr. Hasin for current information.

Readiness to Change Questionnaire

Purpose: Designed to assist the clinician in determining the stage of readiness for change among problem drinkers or people with alcohol use disorders.

Clinical utility: Assesses drinker's readiness to change drinking behaviors; may be useful in assignment to different types of treatment.

Groups with whom this instrument has been used: Adults and adolescents

Format: A brief 12-item questionnaire consisting of three subscales.

Administration time: 2 to 3 minutes

Scoring time: 1 to 2 minutes

Computer scoring? No

Administrator training and qualifications: No training is required.

Fee for use: No

Available from: Center for Alcohol and Drug Studies
Plummer Court, Carliol Place
Newcastle upon Tyne
NE1 6UR
UNITED KINGDOM
Phone: 44(0)191219 5648
Fax: 44(0)191219 5649

Recovery Attitude and Treatment Evaluator (RAATE)

Purpose: Designed to assist in placing patients into the appropriate level of care at admission, in making continued stay or transfer decisions during treatment (utilization review), and documenting appropriateness of discharge.

Clinical utility: The RAATE provides objective documentation to assist in making appropriate treatment placement decisions; it strengthens individualized care and facilitates more individualized treatment planning; it measures treatment process; and it assesses the need for continuing care and discharge readiness.

Groups with whom this instrument has been used: Adults

Format: A 35-item structured interview

Administration time: 20 to 30 minutes

Scoring time: Less than 5 minutes

Computer scoring? No

Administrator training and qualifications: Training is required for administration. The RAATE is administered by trained chemical dependency professional (RAATE-CE) or patient (RAATE-QI).

Fee for use: Yes. The RAATE manual is available for $35.00 and the scoring templates are $8.75.

Available from: Evince Clinical Assessments
P.O. Box 17305
Smithfield, RI 02917
Phone: (401) 231-2993
Toll-free in USA:
(800)-755-6299
www.evinceassessment.com

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

Purpose: Obtains Axis I and II diagnoses using the DSM-IV diagnostic criteria for enabling the interviewer to either rule out or establish a diagnosis of "drug abuse" or "drug dependence" and/or "alcohol abuse" or "alcohol dependence."

Clinical utility: A psychiatric interview.

Groups with whom this instrument has been used: Psychiatric, medical, or community-based normal adults.

Format: A psychiatric interview form in which diagnosis can be made by the examiner asking a series of approximately 10 questions of a client.

Administration time: Administration of Axis I and Axis II batteries may require more than 2 hours each for patients with multiple diagnoses. The Psychoactive Substance Use Disorders module may be administered by itself in 30 to 60 minutes.

Scoring time: Approximately 10 minutes

Computer scoring? No. Diagnosis can be made by the examiner asking a series of questions of a client.

Administrator training and qualifications: Designed for use by a trained clinical evaluator at the master's or doctoral level, although in research settings it has been used by bachelor's-level technicians with extensive training.

Fee for use: Yes

Available from: American Psychiatric Publishing, Inc.
1400 K Street, N.W.
Washington, DC 20005
www.appi.org

Substance Abuse Treatment Scale (SATS)

Purpose: To assess and monitor the progress that people with severe mental illness make toward recovery from substance use disorder.

Clinical utility: This scale is for assessing a person's stage of substance abuse treatment, not for determining diagnosis.

Groups with whom this instrument has been used: Adults, adolescents (over 16 years)

Format: Very brief, relatively nonconfrontational questionnaire for detection of alcoholism, usually directed by saying "have you ever" but may be focused to delineate past or present.

Administration time: Less than 1 minute

Scoring time: Instantaneous

Computer scoring? No

Administrator training and qualifications: No training required for administration; it is easy to learn, easy to remember, and easy to replicate.

Fee for use: No

Available from: Can be downloaded from the Center for Mental Health Services Web site, www.mentalhealth.org/cmhs/CommunitySupport/research/toolkits/pn6toc.asp

University of Rhode Island Change Assessment (URICA)

Purpose: The URICA operationally defines four theoretical stages of change—precontemplation, contemplation, action, and maintenance—each assessed by eight items.

Clinical utility: Assessment of stages of change/readiness construct can be used as a predictor, treatment matching, and outcome variables.

Groups with whom this instrument has been used: Both inpatient and outpatient adults

Format: The URICA is a 32-item inventory designed to assess an individual's stage of change located along a theorized continuum of change.

Administration time: 5 to 10 minutes to complete

Scoring time: 4 to 5 minutes

Computer scoring? Yes, computer-scannable forms.

Administrator training and qualifications: N/A

Fee for use: No; instrument is in the public domain. Available from author.

Available from: Carlo C. DiClemente
University of Maryland
Psychology Department
1000 Hilltop Circle
Baltimore, MD 21250
Phone: (410) 455-2415

Appendix H: Screening Instruments

This appendix reproduces two screening instruments available for unrestricted use:

- Mental Health Screening Form-III (MHSF-III)
- Simple Screening Instrument for Substance Abuse (SSI-SA)

One of the difficult decisions facing the consensus panel related to the inclusion of specific screening and assessment instruments. The consensus panel decided to include an instrument for the substance abuse field to screen for mental health issues and an instrument for mental health settings to use to screen for substance abuse issues.

Recognizing time, cost, and effort as severe initial barriers to implementing anything new into a treatment service system, the consensus panel selected two screening instruments that can be reproduced for free and have instructions that can also be reproduced for free. Information about other screening instruments and assessment tools is given in appendix G.

There is clear face validity as well as supportive psychometric findings to the two screening instruments in this appendix. Neither the questions nor the formats of the MHSF-III and the SSI-SA are likely to cause difficulty for staff or clients. These two screening techniques require minimal staff training for their use, and their simplicity makes their incorporation into treatment services relatively easy. Both instruments were specifically designed for use within a clinical setting for clients receiving or seeking treatment and for administration and use under the standard conditions found in most substance abuse and/or mental health clinics. The consensus panel cautions against other uses of these instruments, unless the professionals deciding on such use have given full consideration to the limitations of these two specialized screens.

The Mental Health Screening Form-III

With the permission of Project Return Foundation, Inc., the consensus panel has taken the opportunity to present the Mental Health Screening Form-III in its entirety (see also www.projectreturn.org and www.asapnys.org/Resources/mhscreen.pdf).

Guidelines for Using the Mental Health Screening Form-III

The Mental Health Screening Form-III was initially designed as a rough screening device for clients seeking admission to substance abuse treatment programs.

Each MHSF-III question is answered either "yes" or "no." All questions reflect the respondent's entire life history; therefore all questions begin with the phrase "Have you ever…"

The preferred mode of administration is for staff members to read each item to respondents and get their "yes" and "no" responses. Then, after completing all 18 questions (question 6 has two parts), the staff member should inquire about any "yes" response by asking "When did this problem first develop?"; "How long did it last?"; "Did the problem develop before, during, or after you started using substances?"; and, "What was happening in your life at that time?" This information can be written below each item in the space provided. There is additional space for staff member comments at the bottom of the form.

The MHSF-III can also be given directly to clients to complete, providing they have sufficient reading skills. If there is any doubt about someone's reading ability, have the client read the MHSF-III instructions and question number one to the staff member monitoring this process. If the client cannot read and/or comprehend the questions, the questions must be read and/or explained to him or her.

Whether the MHSF-III is read to a client or he reads the questions and responds on his own, the completed MHSF-III should be carefully reviewed by a staff member to determine how best to use the information. It is strongly recommended that a qualified mental health specialist be consulted about any "yes" response to questions 3 through 17. The mental health specialist will determine if a follow-up, face-to-face interview is needed for a diagnosis and/or treatment recommendation.

The MHSF-III features a "Total Score" line to reflect the total number of "yes" responses. The maximum score on the MHSF-III is 18 (question 6 has two parts). This feature will permit programs to do research and program evaluation on the mental health-chemical dependence interface for their clients.[1]

The first four questions on the MHSF-III are not unique to any particular diagnosis; however, questions 5 through 17 reflect symptoms associated with the following diagnoses/diagnostic categories: Q5, Schizophrenia; Q6, Depressive Disorders; Q7, Posttraumatic Stress Disorder; Q8, Phobias; Q9, Intermittent Explosive Disorder; Q10, Delusional Disorder; Q11, Sexual and Gender Identity Disorders; Q12, Eating Disorders (Anorexia, Bulimia); Q13, Manic Episode; Q14, Panic Disorder; Q15, Obsessive-Compulsive Disorder; Q16, Pathological Gambling; and Q17, Learning Disorder and Mental Retardation.

[1]Note: The "Total Score" cannot be used with any individual client. Summing the number of "yes" responses cannot be taken to be indicative of more or less of any "trait" or "dimension." Even the use of a "Total Score" for research and program evaluation purposes requires careful understanding of and attention to the fact that fundamentally each item is an independent and separate screening device/question on its own. That is, every "yes" item is a positive screen suggesting the need for further evaluation, and most items are screens for a particular mental disorder. Anyone using "Total Scores" for an appropriate narrow set of possibilities related to program evaluation and/or research should take care that such use does not create confusion.

The relationship between the diagnoses/diagnostic categories and the above-cited questions was investigated by having four mental health specialists independently select the one MHSF-III question that best matched a list of diagnoses/diagnostic categories. All of the mental health specialists matched the questions and diagnoses/diagnostic categories in the same manner, that is, as noted in the preceding paragraph.

A "yes" response to any of questions 5 through 17 does not, by itself, ensure that a mental health problem exists at this time. A "yes" response raises only the possibility of a current problem, which is why a consult with a mental health specialist is strongly recommended.

Simple Screening Instrument for Substance Abuse

The Simple Screening Instrument for Substance Abuse (SSI-SA) was developed by the consensus panel of TIP 11, *Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases* (Center for Substance Abuse Treatment 1994*c*). The SSI-SA has previously been called the Simple Screening Instrument for Outreach for Alcohol and Other Drug Abuse; the Simple Screening Instrument (SSI); and the Simple Screening Instrument for AOD (SSI-AOD). To avoid confusion, the consensus panel suggests using "SSI-SA" (Simple Screening Instrument for Substance Abuse) when referring to this screening instrument.

As a government-supported document, the SSI-SA is in the public domain, can be used without charge or permission and can be reproduced without limit, including the instructions. It is a 16-item scale, although only 14 items are scored so that scores can range from 0 to 14. These 14 items were selected by the TIP 11 consensus panelists from existing alcohol and drug abuse screening tools. A score of 4 or greater has become the established cut-off point for warranting a referral for a full assessment.

Since its publication in 1994 the SSI-SA has been widely used and its reliability and validity investigated. Peters and colleagues (2004) reported on a national survey of correctional treatment for COD. Reviewing 20 COD treatment programs in correctional settings from 13 States, the SSI-SA was identified as among the most common screening instruments used. Peters et al. (2000) found the SSI-SA to be effective in identifying substance-dependent inmates, and the SSI-SA demonstrated high sensitivity (92.6 percent for alcohol or drug dependence disorder, 87.0 percent for alcohol or drug abuse or dependence disorder) and excellent test-retest reliability (.97). Knight et al. (2000) also found the SSI-SA a reliable substance abuse screening instrument among adolescent medical patients.

Peters and Peyton (1998) evaluated a number of screening instruments for use by drug courts and found the Alcohol Dependence Scale/Addiction Severity Index – Drug Use section combined, the Texas Christian University Drug Dependence Screen (TCUDS), and the SSI-SA "to hold considerable promise for use with participants in drug court programs" (p. 17).

The Urban Institute (Moore and Mears 2003) interviewed practitioners within correction-based drug treatment programs in 13 States selected to include a diversity of regions and sizes. Again, the TCUDS and the SSI-SA were widely used, as was the Michigan Alcohol Screening Test (MAST). The TCUDS was deemed to produce fewer false positives than the SSI-SA. Winters (1995), in a small study of 95 clients from a drug evaluation program, found a sensitivity of 97.0 percent and specificity of 55.2 percent. "Overall classification accuracy or 'hit rate' was 84.2 percent …. [Thus] false classifications occurred in 15.8 percent of the sample, yet the majority of the errors are of the 'false positive' type … which is the preferred type of error for a screening test" (p. 3). For program administrators or clinicians considering the SSI-SA for their own screening purposes, the false–positive rate will produce more referrals than other screening

Mental Health Screening Form-III

Instructions: In this program, we help people with all their problems, not just their addictions. This commitment includes helping people with emotional problems. Our staff is ready to help you to deal with any emotional problems you may have, but we can do this only if we are aware of the problems. Any information you provide to us on this form will be kept in strict confidence. It will not be released to any outside person or agency without your permission. If you do not know how to answer these questions, ask the staff member giving you this form for guidance. Please note, each item refers to your entire life history, not just your current situation, this is why each question begins - "Have you ever …."

1. Have you ever talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem?

   YES NO

2. Have you ever felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems?

   YES NO

3. Have you ever been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem?

   YES NO

4. Have you ever been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons?

   YES NO

5. Have you ever heard voices no one else could hear or seen objects or things which others could not see?

   YES NO

6. (a) Have you ever been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself?

   YES NO

   (b) Did you ever attempt to kill yourself?

   YES NO

7. Have you ever had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed?

   YES NO

8. Have you ever experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help?

   YES NO

9. Have you ever given in to an aggressive urge or impulse, on more than one occasion, that resulted in serious harm to others or led to the destruction of property?

   YES NO

10. Have you ever felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior?

    YES NO

Mental Health Screening Form-III (continued)

11. Have you ever experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner?

YES NO

12. Was there ever a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up?

YES NO

13. Have you ever had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly non-stop, when you moved quickly from one activity to another, when you needed little sleep, and believed you could do almost anything?

YES NO

14. Have you ever had spells or attacks when you suddenly felt anxious, frightened, uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, you felt dizzy or unsteady, as if you would faint?

YES NO

15. Have you ever had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or your social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate.

YES NO

16. Have you ever lost considerable sums of money through gambling or had problems at work, in school, with your family and friends as a result of your gambling?

YES NO

17. Have you ever been told by teachers, guidance counselors, or others that you have a special learning problem?

YES NO

Print client's name: _____ Program to which client will be assigned: _____

Name of admissions counselor: _____ Date: _____

Reviewer's comments:_____

_____

_____

_____

Total Score: _____(each yes = 1 point)

Source: J.F.X. Carroll, Ph.D., and John J. McGinley, Ph.D.; Project Return Foundation, Inc., 2000.

www.asapnys.org/Resources/mhscreen.pdf

instruments, such as the TCUDS, might produce. On the other hand, the SSI-SA is likely to correctly identify a high percentage of cooperative clients and to miss (false negatives) only a few—that is, only a few people who warrant a full evaluation and are likely to have a substance use disorder will be deemed by this screening instrument not to warrant a full assessment. Choosing a screening instrument and designing a screening and assessment treatment process are complex challenges that typically require expert input.

Lastly, the National Health Care for the Homeless Council recently developed general recommendations for the care of homeless patients (Bonin et al. 2004). Within these guidelines are recommendations to consider the SSI-SA to screen for substance use problems (and the MHSF-III to screen for mental disorders).

The following sections are reprinted from TIP 11.

Development of the SSI-SA

Routine screening for substance abuse can be used to initiate the process of assessment by identifying a client's possible problems and determining whether he or she needs a comprehensive assessment. Ideally, a screening instrument for substance abuse should have a high degree of sensitivity: It should be broad in its detection of individuals who have a potential substance abuse problem, regardless of the specific drug or drugs being abused.

The substance abuse screening instrument presented in this section was designed to encompass a broad spectrum of signs and symptoms for substance use disorders. These conditions are characterized by substance use that leads to negative physical, social, and/or emotional consequences and loss of control over one's pattern and amount of consumption of the substance(s) of abuse.

The view of substance abuse problems and disorders presented in this section and reflected in the screening instrument is consistent with that adopted by the World Health Organization and the American Psychiatric Association. Briefly stated, this view holds that substance abuse disorders are biopsychosocial disorders, causing impairment and dysfunction in physical, emotional, and social domains. Certain cognitive and behavioral signs and symptoms are also associated with substance abuse (see the observation checklist at the end of the screening instrument for substance abuse). Although many of these latter signs and symptoms can be the result of various medical, psychiatric, and social problems, individuals with a substance abuse disorder generally exhibit several of them.

The screening instrument for substance abuse was developed by first identifying five primary content domains, which are described in the sections that follow. The screening questions then devised were assigned to one or more of these categories. These screening questions were adapted from existing tools found in the published literature. Because most of these existing tools were designed to screen for alcohol abuse, many items needed to be revised to address other drugs. The sources for the screening items included in the instrument are shown in Figure H-1.

Domains Measured by the Instrument

Substance consumption

A person's consumption pattern—the frequency, length, and amount of use—of substances is an important marker for evaluating whether he or she has a substance abuse problem. Questions 1, 10, and 11 in the substance abuse screening instrument were formulated in order to help delineate an individual's consumption pattern.

Patterns of substance consumption can vary widely among individuals or even for the same individual. Although substance use disorders often consist of frequent, long-term use of substances, addiction problems may also be characterized by periodic binges over shorter periods.

Figure H-1
Sources for Items Included in the Simple Screening Instrument for Substance Abuse

Question No.	Source Instrument
1	Revised Health Screening Survey (RHSS)
2	Michigan Alcohol Screening Test (MAST)
3	CAGE
4	MAST, CAGE
5	History of Trauma Scale, MAST, CAGE
6	MAST, Drug Abuse Screening Test (DAST)
7	MAST, Problem-Oriented Screening Instrument for Teenagers (POSIT)
8	MAST, DAST
9	MAST, DSM-II-R
10	POSIT, DSM-III-R
11	POSIT
12	POSIT
13	MAST, POSIT, CAGE, RHSS, Alcohol Use Disorders Identification Test (AUDIT), Addiction Severity Index (ASI)

Note: References for these sources appear at the end of this section.

Preoccupation and loss of control

The symptoms of preoccupation and loss of control are common in people with substance use disorders. Preoccupation refers to an individual spending inordinate amounts of time concerned with matters pertaining to substance use. Loss of control is a symptom usually typified by loss of control over one's use of substances or over one's behavior while using substances. These symptoms are measured by screening test questions 2, 3, 9, 11, and 12.

The symptom of preoccupation is marked by an individual's tendency to spend a considerable amount of time thinking about, consuming, and recovering from the effects of the substance(s) of abuse. In some cases, the individual's behavior may be noticeably altered by his or her preoccupation with these matters. Such an individual may, for example, lose interest in personal relationships or may become less productive at work as a result of constant preoccupation with obtaining more of the substance of abuse.

Loss of control over substance use is typified by the consumption of more of the substance(s) of abuse than originally intended. Many persons with a substance abuse problem feel that they have no direct, conscious control over how much and how often they use substances. Such an individual may, for example, initially intend to have only one drink but then be unable to keep from drinking more. He or she may find it difficult or impossible to stop drinking once he or she has started. In other instances, a person who originally plans to use a drug for a short period of time may find that he or she is increasingly using it over longer periods than originally intended.

Loss of behavioral control, on the other hand, is typified by loss of inhibitions and by behaviors that are often destructive to oneself or others. In many cases, these behaviors do not occur when the individual is not using substances. A person with a substance use problem may begin taking unnecessary risks and may

act in an impulsive, dangerous manner. Individuals who are intoxicated from substance abuse may, for example, have sex with someone in whom they ordinarily would not have a sexual interest, or they may start an argument or fight.

Adverse consequences

Addiction invariably involves adverse consequences in numerous areas of an individual's life, including physical, psychological, and social domains. In the screening instrument for substance abuse, questions 5–9, 12, and 13 are designed to elicit adverse consequences of substance abuse.

Examples of adverse physical consequences resulting from substance abuse include experiencing blackouts, injury and trauma, or withdrawal symptoms or contracting an infectious disease associated with high-risk sexual behaviors. One of the most serious health threats to people with substance use disorders, particularly those who inject drugs intravenously, is infection with HIV, the causative agent of AIDS.

Adverse psychological consequences arising from substance abuse include depression, anxiety, mood changes, delusions, paranoia, and psychosis. Negative social consequences include involvement in arguments and fights; loss of employment, intimate relationships, and friends; and legal problems such as civil lawsuits or arrests for abuse, possession, or selling of illicit drugs.

As an individual's use continues over time and addiction takes hold, adverse consequences tend to worsen. Thus, people in the very early stages of addiction may have fewer adverse consequences than those in the later stages. Individuals in the early stages of addiction may therefore not make the connection between their substance abuse and the onset of negative consequences. For this reason, some of the items directed at identifying substance-related adverse consequences in the screening instrument attempt to obtain this information without making an overt association with substance abuse.

Problem recognition

Making a mental link between one's use of substances and the problems that result from it—such as difficulties in personal relationships or at work—is an important step in recognizing one's substance abuse problem. Questions 2–4 and 13–16 in the substance abuse screening instrument are problem recognition items. Some of these items ask about past contacts with intervention and treatment services, because both research and clinical experience indicate that a history of such contacts can be a valid indicator of substance abuse problems.

Some individuals who have experienced negative consequences resulting from their substance abuse will report these problems during a screening assessment. Clients who show insight about the relationship between these negative consequences and their use of substances should be encouraged to seek help.

Many, if not most, people who abuse substances, however, do not consciously recognize that they have a problem. Other reasons why a person may not disclose a substance abuse problem include denial, lack of insight, and mistrust of the interviewer. These individuals cannot be expected to respond affirmatively to "transparent" problem recognition items—those in the form of direct questions, such as "Do you have a substance problem?"—during a screening interview. For these individuals, questions must be worded indirectly in order to ascertain whether negative experiences have ensued from the use of substances.

Tolerance and withdrawal

Substance abuse, particularly prolonged abuse, can cause a variety of physiological problems that are related to the development of tolerance and withdrawal. Questions 5 and 10 are aimed at determining whether an individual has experienced any of the signs of tolerance and withdrawal.

Tolerance is defined as the need to use increasing amounts of a substance in order to create the same effect. If tolerance has developed and the individual stops using the substance of abuse, it is common for withdrawal effects to emerge.

Withdrawal from stimulants and related drugs often includes symptoms of depression, agitation, and lethargy; withdrawal from depressants (including alcohol) often includes symptoms of anxiety, agitation, insomnia, and panic attacks; and withdrawal from opioids produces agitation, anxiety, and physical symptoms such as abdominal pain, increased heart rate, and sweating.

Administration of the Simple Screening Instrument

Two versions of the simple screening instrument are presented in this section. They have been designed to be administered in the form of either an interview (Figure H-2, p. 506) or a self-administered test (Figure H-3, p. 509) to individuals who may be at risk of having a substance abuse problem.

Use of the screening instrument should be accompanied by a careful discussion about confidentiality[2] issues. The interviewer should also be clear about the instrument's purpose and should make it understood that the information elicited from the instrument will be used to benefit, not to punish, the individual being screened.

Ideally, the screening test should be administered in its entirety. Situations may arise, however, in which there is inadequate time to administer the entire test. Street outreach community workers, for example, may have very limited time with an individual.

In such situations, a subset of the screening instrument can be administered. The four boldfaced questions—1, 2, 3, and 16—constitute the short form of the screening instrument. These items were selected because they represent the prominent signs and symptoms covered by the full screening instrument. Although this abbreviated version of the instrument will not identify the variety of dimensions tapped by the full instrument and is more prone to error, it may serve as a starting point for the screening process.

Notes on the screening questions

The screening instrument begins with a question about the individual's consumption of substances (question 1). This question is intended to help the interviewer decide whether to continue with the interview—if the response to this first question is no, continued questioning may be unnecessary.

Questions 2–4 are problem recognition items intended to elicit an individual's assessment of whether too much of a substance is being used, whether attempts have been made to stop or control substance use, and whether previous treatment has been sought. Answers to these questions may help the service provider understand how the individual thinks and feels about his or her use of substances. People who later report negative consequences as the result of their substance use but who nevertheless answer "no" to these problem recognition questions may have poor insight about their substance abuse or may be denying the severity of their substance problem.

Questions 5–12 were designed to determine whether an individual has experienced any adverse consequences of substance abuse. These include medical, psychological, social, and legal problems that often are caused by substance abuse and addiction. Some questions are intended to elicit symptoms of aggression

[2]Confidentiality is governed by the Federal "Confidentiality of Alcohol and Drug Abuse Patient Records" regulations (42 C.F.R. Part 2) and the Federal "Standards for Privacy of Individually Identifiable Health Information" (45 C.F.R. Parts 160 and 164).

Figure H-2
Simple Screening Instrument for Substance Abuse Interview Form

Note: **Boldfaced** questions constitute a short version of the screening instrument that can be administered in situations that are not conducive to administering the entire test. Such situations may occur because of time limitations or other conditions.

Introductory statement:

"I'm going to ask you a few questions about your use of alcohol and other drugs during the past 6 months. Your answers will be kept private. Based on your answers to these questions, we may advise you to get a more complete assessment. This would be voluntary—it would be your choice whether to have an additional assessment or not."

During the past 6 months…

1. **Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opioids, uppers, downers, hallucinogens, or inhalants.)** (yes/no)
2. **Have you felt that you use too much alcohol or other drugs?** (yes/no)
3. **Have you tried to cut down or quit drinking or using drugs?** (yes/no)
4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.) (yes/no)
5. Have you had any of the following?
   - Blackouts or other periods of memory loss
   - Injury to your head after drinking or using drugs
   - Convulsions, or delirium tremens ("DTs")
   - Hepatitis or other liver problems
   - Feeling sick, shaky, or depressed when you stopped drinking or using drugs
   - Feeling "coke bugs," or a crawling feeling under the skin, after you stopped using drugs
   - Injury after drinking or using drugs
   - Using needles to shoot drugs
6. Has drinking or other drug use caused problems between you and your family or friends? (yes/no)
7. Has your drinking or other drug use caused problems at school or at work? (yes/no)
8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.) (yes/no)
9. Have you lost your temper or gotten into arguments or fights while drinking or using drugs? (yes/no)
10. Are you needing to drink or use drugs more and more to get the effect you want? (yes/no)
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs? (yes/no)
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone? (yes/no)

Figure H-2 (continued)
Simple Screening Instrument for Substance Abuse Interview Form

13. Do you feel bad or guilty about your drinking or drug use? (yes/no)

    Now I have some questions that are not limited to the past 6 months.

14. Have you ever had a drinking or other drug problem? (yes/no)
15. Have any of your family members ever had a drinking or drug problem? (yes/no)
16. **Do you feel that you have a drinking or drug problem now?** (yes/no)

- Thanks for answering these questions.
- Do you have any questions for me?
- Is there something I can do to help you?

Notes: _____

_____

_____

_____

_____

_____

Observation Checklist

The following signs and symptoms may indicate a substance abuse problem in the individual being screened:

- Needle track marks
- Skin abscesses, cigarette burns, or nicotine stains
- Tremors (shaking and twitching of hands and eyelids)
- Unclear speech: slurred, incoherent, or too rapid
- Unsteady gait: staggering, off balance
- Dilated (enlarged) or constricted (pinpoint) pupils
- Scratching
- Swollen hands or feet
- Smell of alcohol or marijuana on breath
- Drug paraphernalia such as pipes, paper, needles, or roach clips
- "Nodding out" (dozing or falling asleep)
- Agitation
- Inability to focus
- Burns on the inside of the lips (from freebasing cocaine)

(question 9), physical tolerance (question 10), preoccupation (question 11), and loss of control (question 12). Question 13 is designed to tap feelings of guilt, which may indicate that the individual has some awareness or recognition of a substance problem; questions 14 and 16 are intended to measure the respondent's awareness of a past or present problem; and question 15 elicits the individual's family history of substance abuse problems.

Parenthetical words or phrases that accompany some of the screening questions are intended to provide the interviewer with specific examples of what is being looked for or to help the respondent understand the question. For instance, question 1 asks whether an individual has used substances, and the wording in parentheses prompts the administrator to ask about specific substances of abuse.

Scoring and interpretation

A preliminary scoring mechanism for the screening instrument is provided in Figure H-4, p. 511.

Questions 1 and 15 are not scored, because affirmative responses to these questions may provide important background information about the respondent but are too general for use in scoring. The observational items are also not intended to be scored, but the presence of most of these signs and symptoms may indicate a substance abuse problem.

It is expected that people with a substance abuse problem will probably score 4 or more on the screening instrument. A score of less than 4, however, does not necessarily indicate the absence of a substance abuse problem. A low score may reflect a high degree of denial or lack of truthfulness in the subject's responses. The scoring rules have not yet been validated, and thus the substance abuse screening instrument needs to be used in conjunction with other established screening tools when making referrals.

Referral Issues

The substance abuse screening instrument, as a first step in the process of assessment for substance abuse problems, can help service providers determine whether an individual should be referred for a more thorough assessment. When an individual with a potential substance abuse problem is identified through the instrument, the interviewer has the further responsibility of linking the individual to resources for further assessment and treatment.

Agencies and providers using the substance abuse screening instrument should be prepared to make an appropriate referral when the screening identifies a person with a possible substance abuse problem. A phone number written on a piece of paper is not likely to be effective in linking the individual to the appropriate resource for assessment and treatment. Rather, a thorough familiarity with local community resources is needed on the part of the service provider. The referring provider should take a proactive role in learning about the availability of appointments or treatment slots, costs, transportation needs, and the names of contact people at the agencies to which referrals are made.

Because many individuals identified as having possible substance abuse problems receive services from more than one agency, it is essential that one agency assume primary responsibility for the client. The ideal model is a case management system. Through personal contacts, case managers can help patients progress through various programs and systems, cut red tape, and remove barriers to access to services.

Providing effective services for substance abuse requires close cooperation among agencies. Community linkages can help increase the quality of treatment for patients, whereas interagency competition decreases the quality of comprehensive care.

Substance abuse problems should be seen within the larger context of other problems, both current and past, confronted by the individual. Current problems such as instability in housing

Figure H-3

Simple Screening Instrument for Substance Abuse Self-Administered Form

Directions: The questions that follow are about your use of alcohol and other drugs. Your answers will be kept private. Mark the response that best fits for you. Answer the questions in terms of your experiences in the past 6 months.

During the last 6 months…

1. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opioids, uppers, downers, hallucinogens, or inhalants)

   ___Yes ___No

2. Have you felt that you use too much alcohol or other drugs?

   ___Yes ___No

3. Have you tried to cut down or quit drinking or using alcohol or other drugs?

   ___Yes ___No

4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program.)

   ___Yes ___No

5. Have you had any health problems? For example, have you:

   ___Had blackouts or other periods of memory loss?

   ___Injured your head after drinking or using drugs?

   ___Had convulsions, delirium tremens ("DTs")?

   ___Had hepatitis or other liver problems?

   ___Felt sick, shaky, or depressed when you stopped?

   ___Felt "coke bugs" or a crawling feeling under the skin after you stopped using drugs?

   ___Been injured after drinking or using?

   ___Used needles to shoot drugs?

6. Has drinking or other drug use caused problems between you and your family or friends?

   ___Yes ___No

7. Has your drinking or other drug use caused problems at school or at work?

   ___Yes ___No

Figure H-3 (continued)

Simple Screening Instrument for Substance Abuse Self-Administered Form

8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.)

   ___Yes ___No

9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs?

   ___Yes ___No

10. Are you needing to drink or use drugs more and more to get the effect you want?

    ___Yes ___No

11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs?

    ___Yes ___No

12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone?

    ___Yes ___No

13. Do you feel bad or guilty about your drinking or drug use?

    ___Yes ___No

The next questions are about your lifetime experiences.

14. Have you ever had a drinking or other drug problem?

    ___Yes ___No

15. Have any of your family members ever had a drinking or drug problem?

    ___Yes ___No

16. Do you feel that you have a drinking or drug problem now?

    ___Yes ___No

Thanks for filling out this questionnaire.

and employment, homelessness, and hunger often represent immediate needs that are more pressing for the individual than treatment for his or her substance abuse. Past crises, such as incest, rape, and sexual abuse, can also affect how an individual responds to the screening questions.

Some of the items in the screening instrument may trigger emotional distress or a crisis. Reactions may sometimes include anxiety or depression, which may be accompanied by suicidal thoughts and behaviors. Agencies should therefore develop specific protocols to manage such crises. These protocols should include

Figure H-4

Scoring for the Simple Screening Instrument for Substance Abuse

Name/ID No.: _____ Date: _____

Place/Location: _____

Items 1 and 15 are not scored. The following items are scored as 1 (yes) or 0 (no):

___ 2	___ 7	___ 12
___ 3	___ 8	___ 13
___ 4	___ 9	___ 14
___ 5 (any items listed)	___ 10	___ 16
___ 6	___ 11	

Total score: ____ Score range: 0-14

Preliminary interpretation of responses:

Score	Degree of Risk for Substance Abuse
0-1	None to low
2-3	Minimal
>4	Moderate to high: possible need for further assessment

inhouse management and appropriate referrals and followup.

See appendix C, Glossary, for substance abuse screening terms.

Sources for the Substance Screening Questions

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