**Topic 4: Addiction Screening and Assessment Tools Chart**

**Directions:**Compete the following chart. An example has been provided for you in the first row. Include in-text citations in the table as well as a GCU-style reference listing below. A minimum of two to three scholarly references should be included per tool.

| **Addiction Assessment Tool**Include the full name, description of the tool, and what the tool measures (i.e., opioids, process, withdrawal) | **Tool Description**Type of tool (paper, pen, structured, unstructured), how it is administered, how many questions, and general scoring information | **Appropriateness of Use**When/where the tool is appropriate or inappropriate to use, where the tool will most likely be used (i.e., online, in-patient, outpatient, clinic), and what specific population the tool is used for (i.e., adolescents, elderly, pregnant.) |
| --- | --- | --- |
| CAGE QuestionnaireA brief 4 item, widely used questionnaire designed to assess alcohol use. CAGE is acronym for:**C**=Cut down**A**=Annoyed**G**=Guilty**E**=Eye opener | Paper and pen or orally administered Takes less than 1 minute, Yes or No responseTypically administered by health care professional or clinician and is client’s self- report, scored by testerCAGE Questionnaire-4 questions1. Have you ever felt you should **C**ut down on your drinking?
2. Have people **A**nnoyed you by criticizing your drinking?
3. Have you ever felt bad or **G**uilty about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (**E**ye opener)?

Scoring: Item responses on the CAGE are scored as 0 or 1. A higher score is an indication of alcohol problems. A total score of 2 or greater is considered to be clinically significant (Ewing, 1984; NIAAA, 2002) | * Often used in medical settings
* Several adaptations of tool available for use including computerized and self- administered versions.
* Free, in public domain and translated into many languages
* Not used to assess for drugs but adapted CAGE-AID questionnaire can be used for drug use.
* Best use is in adult populations
* Criticism of the CAGE- not gender-sensitive. Women who are problem drinkers less likely to screen positive than men.
* It identifies alcohol-dependent persons, but may not identify binge drinkers.
* CAGE asks about "lifetime" experience rather than current drinking. A person who no longer drinks may screen positive unless the clinician directs the questions to focus on a more current time frame (ADAI, 2016).
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| 1. Drug Abuse Screen Test (DAST-10). It is used for all the adults and older adults for drug abuse screening and magnitude (Yudko et. al., 2007). Drug class does not include alcohol beverages.
 | **Administration:** Requires paper and pencil for marking responses. It takes approximately 5 minutes for administration. **Administrator:** It can be self-administered as well as professional assistance can be intervened. **Scorer**: Scorer is mental health professional, psychologist or counselor **Item details:** It has 10 items with yes/no responses. Yes means 1 and no means 0. Items include (Carey et. al., 2000):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:**  | This tool is appropriate to use while diagnosing mental illness e.g., mental disorder due to substance use. It is appropriate for adults and older adults using drugs for past 12 months (ARF, 1982) |
| 1. CAGE-AID

It is the revision of CAGE in which alcohol use was replaced with “alcohol and drug use.” It was developed by Brown and Rounds in 1995. | **Administration:** Requires paper and pencil for marking responses. It takes approximately 5 minutes for administration. **Administrator:** It can be self-administered as well as professional assistance can be intervened. **Scorer**: Scorer is mental health professional, psychologist or counselor **Item details:** It is a 5 item scale with dichotomous options e.g., yes/no. Items include (Brown & Rounds, 1995):1. Have you ever felt you should **c**ut down on your drinking or drug use?
2. Have people **a**nnoyed you by criticizing your drinking or drug use?
3. Have you ever felt bad or **g**uilty about your drinking or drug use?
4. Have you ever had a drink or used drug as first thing in the morning to steady your nerves or to get rid of a hangover?

**Scoring:** this indicates positive screening either client is willing to undergo “change” or not. Score of 2 or more indicates positivity and willingness of client to eradicate drug use ((Brown & Rounds, 1995) | This tool is applicable to clinical or home setting due to its online availability. It is used for illegal or prescription drug abuse ((Brown & Rounds, 1995; Hinkin et. al., 2001).  |
| 1. AUDIT-C

Developed by W.H.O in 1982 for the screening and identification of people at risk of alcohol problems. Specifically designed for alcohol addiction.  | **Administration:** Requires paper and pencil for marking responses or it can be completed online. It takes approximately 5-8 minutes for completion. **Administrator:** It requires professional assistance for administration. **Scorer**: Scorer is mental health professional, psychologist or counselor **Item details:** it has 10 questions with poly-chotomous format. Some items have 0-4 options whereas some has 0-2-4. Items are as follows (WHO, 1982): **1. How often do you have a drink containing alcohol?**(0) Never (Skip to Questions 9-10)(1) Monthly or less(2) 2 to 4 times a month(3) 2 to 3 times a week(4) 4 or more times a week**2. How many drinks containing alcohol do you have on a typical day when you are drinking?**(0) 1 or 2(1) 3 or 4(2) 5 or 6(3) 7, 8, or 9(4) 10 or more**3. How often do you have six or more drinks on one occasion?**(0) Never(1) Less than monthly(2) Monthly(3) Weekly(4) Daily or almost daily**4. How often during the last year have you found that you were not able to stop drinking once you had started?**(0) Never(1) Less than monthly(2) Monthly(3) Weekly(4) Daily or almost daily**5. How often during the last year have you failed to do what was normally expected from you because of drinking?**(0) Never(1) Less than monthly(2) Monthly(3) Weekly(4) Daily or almost daily **6. How often during the last year have you been unable to remember what happened the night before because you had been drinking?**(0) Never(1) Less than monthly(2) Monthly(3) Weekly(4) Daily or almost daily**7. How often during the last year have you needed an alcoholic drink first thing in the morning to get yourself going after a night of heavy drinking?**(0) Never(1) Less than monthly(2) Monthly(3) Weekly(4) Daily or almost daily**8. How often during the last year have you had a feeling of guilt or remorse after drinking?**(0) Never(1) Less than monthly(2) Monthly(3) Weekly(4) Daily or almost daily**9. Have you or someone else been injured as a result of your drinking?**(0) No(2) Yes, but not in the last year(4) Yes, during the last year**10. Has a relative, friend, doctor, or another health professional expressed concern about your drinking or suggested you cut down?**(0) No(2) Yes, but not in the last year(4) Yes, during the last year **Scoring:** The scores are combined and total score of 8 or above indicate problematic alcohol use requiring instant professional intervention (WHO, 1982) | This test makes 95% correct distinction between alcoholics and non-alcoholics. Its use is found to be best-suited in the primary care settings. It is used in variety of populations and cultures (Fujii et. al., 2016).  |
| 1. Opioid Risk Tool (ORT)

It is a simple 10 item scale which is used for assessing the risk of Opioid dependency before prescribing it for chronic pain management. It was developed in 2005 by Lynn R. Webster.  | **Administration**: It is a paper-pencil assessment tool applied by the General Health practitioner prior to prescribing Opioids for chronic pain management. It takes approximately 8-10 minutes to be completed**Administrator:** mental or physical health professionals may use it. **Scorer:** mental and physical health professionals **Item details:** it has 10 items with varying subjects specified for male and female with different scoring (Webster, 2005):Mark each box that applies**Family history of substance abuse**1. Alcohol: 1-Female 3-Male
2. Illegal drugs: 2-female 3-male
3. Rx drugs: 4-female 4-male

**Personal history of substance abuse**1. Alcohol 3-female 3-male
2. Illegal drugs 4-female 4-male
3. Rx drugs 5-female 5-male

**Age between 16-45 years** 1-female 1-male**History of preadolescent sexual abuse** 3-female 0-male**Psychological disease**1. ADD, OCD, bipolar, schizophrenia 2-female 2-male
2. Depression 1-female 1-male

**Scoring:** A score of 3 or lower indicates low risk for future opioid abuse, a score of 4 to 7 indicates moderate risk for opioid abuse, and a score of 8 or higher indicates a high risk for opioid abuse. | It is used in primary healthcare setting to the individuals with chronic pain requiring opioid drugs for treatment. Its findings have validated its effectiveness among male and female individuals, whereas among non-pain patients, its validity is still inconclusive (Webster, 2005; Averill et. al., 2016) |
| 1. DAST-20

It was developed by Harvey A, Skinner working for Addiction Research Foundation in 1982. It is the extensive version of DAST-10 | **Administration:** Requires paper and pencil for marking responses. It takes approximately 5 minutes for administration. **Administrator:** It can be self-administered as well as professional assistance can be intervened. **Scorer**: Scorer is mental health professional, psychologist or counselor **Item details:** It has 20 items with yes/no responses. Yes means 1 and no means 0. Items include (Skinner, 1982):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? Yes No
5. Are you always able to stop using drugs when you want to? Yes No
6. Have you had "blackouts" or "flashbacks" as a result of drug use? Yes/No
7. Do you ever feel bad or guilty about your drug use? Yes/No
8. Does your spouse (or parents) ever complain about your involvement with drugs? Yes/No
9. Has drug abuse created problems between you and your spouse or your parents? Yes No
10. Have you lost friends because of your use of drugs? Yes No
11. Have you neglected your family because of your use of drugs? Yes No
12. Have you been in trouble at work because of drug abuse? Yes No
13. Have you lost a job because of drug abuse? Yes No
14. Have you gotten into fights when under the influence of drugs? Yes No
15. Have you engaged in illegal activities in order to obtain drugs? Yes No
16. Have you been arrested for possession of illegal drugs? Yes No
17. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs? Yes No
18. Have you had medical problems as a result of your drug use (e. g., memory loss, hepatitis, convulsions, bleeding, etc)? Yes No
19. Have you gone to anyone for help for a drug problem? Yes No
20. Have you been involved in a treatment program specifically related to drug use? Yes no

**Scoring:** scoring takes 1-2 minutes. Scores greater than 16 indicate problematic drug and prescription drug dependence (Skinner, 1982; Gavin et. al., 1989).  | This tool is appropriate to use while diagnosing mental illness e.g., mental disorder due to substance use. It is appropriate for adults and older adults using drugs for past 12 months (ARF, 1982). It is appropriate for grade 6 students to adults where work is replaced by school.  |

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