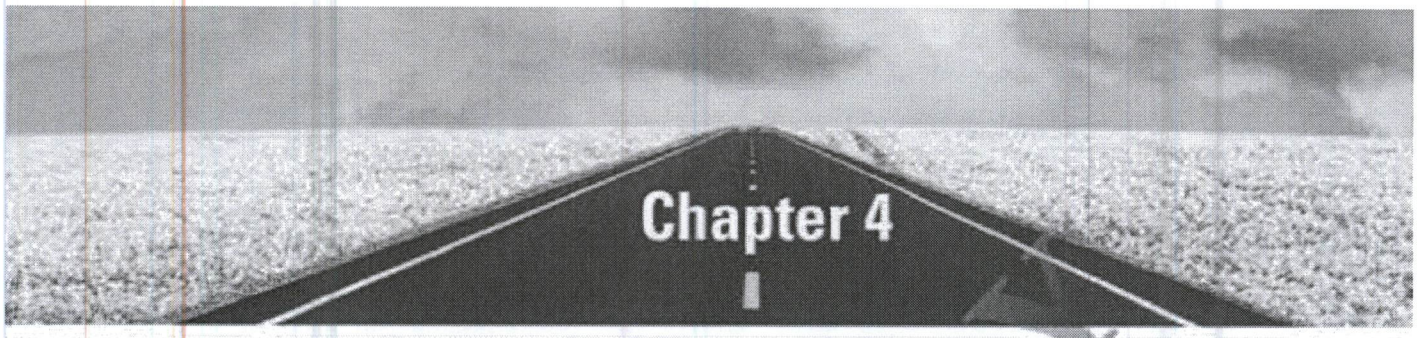

Chapter 4

Screening for Substance-Related Disorders

Sharon J. Davis

Key Terms: screening, assessment, reliability, validity

Key Objectives: After reading this chapter, students will be able to (a) identify the purpose of a screening instrument and (b) implement a reliable and valid SUD screen.

The first step in client assessment is client screening. According to the Substance Abuse and Mental Health Services Administration (SAMHSA), screening is a method of "quickly assessing the severity of substance use" and identifying the appropriate level of treatment (SAMHSA, n.d). Simply put, the purpose of a screen is to determine if substance use problems actually exist (Capuzzi & Stauffer, 2008). When a person seems to be presenting with symptoms of a substance use disorder (SUD), but there is not enough evidence to order a full assessment, a screening instrument can be a quick and cost-effective way to rule out the need for further assessment. In cases where there are drug or alcohol problems, however, the screening process can help counselors to know when to request a comprehensive assessment or whether to provide brief intervention or make a referral to treatment (Capuzzi & Stauffer, 2008). Keep in mind, screening instruments provide only a minimal amount of information about a client. Counselors must always be careful not to confuse a screening with an assessment. An assessment is a comprehensive process which is done by a trained professional to determine a client's diagnosis and treatment plan needs (SAMHSA, 2017). An assessment may include a screening instrument, but a single screening instrument is never enough to be considered an assessment. Typical assessments will include several sources of information on your client. This may include collateral information from previous treatment providers and referral sources, one or more screening instruments, family and significant others, and the client interview. A diagnosis should be based on several sources of information, never just a single test score. This chapter will focus specifically on screening for SUDs.

A typical screening instrument only takes 5–10 minutes to complete. The screening process is efficient and cost-effective, which makes it ideal in sorting out individuals at actual risk for having a SUD from those who do not need services. It would be unrealistic and incredibly time-consuming for comprehensive SUD assessments to be routinely given to the general public. SAMHSA suggests that people with little or no risky behavior and with low screening scores do not need an actual SUD intervention; however, they may still benefit from more universal prevention programs. Individuals with moderate screening scores will likely benefit from a brief intervention program, and comprehensive assessment and SUD treatment should be reserved for those with high screening scores (SAMHSA, 2013).

As a counselor, it will be your responsibility to choose reliable and valid screening instruments to use on your clients. Screening instruments are always short and limited in the information they give you. The best use of a screening instrument is to identify areas where the client may have needs which should then be given a more thorough assessment. Screening instrument responses can serve as a "red flag" that highlights a possible client issue. It would be unethical to apply a diagnosis to a client based only on a screening result.

Prescreening

Sometimes a counselor or other professional may meet a person they suspect might have a drug or alcohol use problem, but there is very little time for screening. This is when a prescreening might be more convenient. Prescreenings are shortened versions of screenings. They may even consist of only one question. There are few validated prescreening instruments, however, so as a counselor you will want to choose wisely. SAMHSA (2013) suggests the AUDIT-C or the NIAAA prescreening tools. The Alcohol Use Disorders Identification Test-Consumption (AUDIT-C) is a validated prescreen which uses the first three questions of the 10-item AUDIT questionnaire. The AUDIT is discussed later on in this chapter.

The National Institute on Alcohol Abuse and Alcoholism (NIAAA) prescreen consists of only one question which varies based on gender. For males ask, "how many times in the past year have you had 5 drinks or more in a day?" For females ask, "how many times in the past year have you had 4 drinks or more in a day?" Five drinks in a day is considered heavy drinking for males, but for females it only takes four drinks. A similar single question can be used to prescreen for illicit drug use. It is "how many times in the past year have you used an illegal drug or used a prescription medication for nonmedical reasons?" If a person can answer never to any of these questions, a screening is probably not necessary.

When to Use a Screening

As a counselor, you will have to decide between prescreenings, screenings, and assessments. Prescreenings are rarely used, but certainly can save the most amount of time. They also provide the least amount of information, however. When in doubt, choose a screening over a prescreening. There are many situations where it would be prudent to do a screening for SUD rather than a full assessment. Screenings are fast to do, but provide limited information about a client. It may be helpful for a counselor to use a screening to identify a client who might have a SUD, but has not had a full SUD assessment. For example, let's say you are providing mental health counseling to a client and you suspect they may have a drug or alcohol problem. Screenings are also useful during crisis interventions involving clients the counselor is unfamiliar with. For example, imagine you have been called to the local emergency room to assess a person who is suicidal, but you suspect they may also have a co-occurring SUD. Screenings are typically very simple to use and require little training; therefore, oftentimes they are conducted by noncounseling professionals.

SBIRT

Since 2003, an initiative known as SBIRT has received a lot of attention. Screenings can be useful across multiple settings. The Screening, Brief Intervention, and Referral to Treatment (SBIRT) initiative has been popular for a number of years. SBIRT is a public health approach designed to provide universal screening and early intervention and treatment services for those with SUDs, as well as prevention of

SUD in communities. SBIRT trains providers across various disciplines to perform drug and alcohol screenings and to provide brief interventions when needed. Brief interventions are time limited (typically one or two sessions) and focus on increasing client insight and awareness regarding substance use. Brief interventions can also be used to increase client motivation and readiness to change. The brief intervention method can be used by providers who are not counselors. SBIRT programs train these providers in how to do a brief intervention. In the case of more severe client needs, the providers are trained in how to make an appropriate referral to SUD treatment.

Providers implementing a SBIRT program screen all of the individuals they come in contact with, regardless of suspicion of SUD. For example, a physician using SBIRT would give all of their patients a substance use screen even when the patient was not presenting with SUD symptoms. SBIRT is meant to provide *universal screening*. SBIRT screening typically only takes 5–10 minutes and you do not have to be a licensed counselor to use these instruments. This is important since physicians usually do not have time to provide patients with a lengthy screening. Any patient with a positive score on a drug or alcohol screen would then be provided with a brief intervention by the healthcare facility. If a brief intervention alone was not adequate in addressing the patient's substance use, then the physician would make a referral to a SUD treatment provider. SBIRT has been used successfully by hospitals, state cooperatives, and colleges (SAMHSA, 2013).

What to Look for in a Screen

A screening instrument needs to be sensitive, specific, reliable, and valid (Capuzzi & Stauffer, 2008). Sensitivity refers to the ability of a screen to accurately provide the counselor with a true positive result. That is, if a person really has a SUD, will the screen detect it? Specificity refers to the ability of a screen to yield a true negative. For example, if a client does not actually have a SUD the screening result will be negative. A good screen can detect those with an actual SUD and rule out those who do not. Both these concepts are related to a screening instrument's reliability and validity.

Reliability is a screen's consistency in results. If a screen is reliable it will give you the same results time after time. As an example, if your client has an alcohol use disorder, a good screening instrument will yield a positive result each time you administer it. Validity refers to the screen's ability to measure what it is designed to measure. For example, a screen that is supposed to detect possible alcohol use disorder should actually measure a possible alcohol use disorder and not some other disorder. As a counselor, it will be your responsibility to use screening instruments that have all of these qualities. A good screening instrument will have this information in its manual or in published research study results. Also, as a counselor you should be aware of the source of the instrument you have chosen. As a general rule, if you find a "screening instrument" on a social media site it is probably not an acceptable choice. Look for reputable sources when selecting screens. For example, both SAMHSA and the National Institute on Drug Abuse (NIDA) are good sources for screening materials available to counselors. In this chapter, I will introduce you to some screening instruments which have been shown to have high reliability and validity.

Examples of Instruments

The NIDA Drug Use Screening Tool

The NIDA Drug Use Screening Tool is a 1- to 7-item questionnaire adapted by the NIDA. It is based on the World Health Organization's (WHO, 2008) screening instrument known as the ASSIST. This questionnaire is available in electronic format and is appropriate for screening of drug and alcohol use in adults. The screening is available for free at https://www.drugabuse.gov/nmassist/.

The GAIN-SS

A highly respectable agency which develops assessment and screening materials is Chestnut Health Systems. Dr. Michael Dennis and the staff at Chestnut Health Systems have developed a series of instruments known as the Global Appraisal of Individual Needs (GAIN). The first of these instruments was created in 1993. They have full assessment instruments (like the GAIN-I) and screening instruments, like the GAIN-SS (or Short Screener). However, Chestnut Health Systems does require a counselor to go through training and certification to use their instruments.

This screen can be used as part of an SBIRT program or by counselors. Training in using the GAIN-SS takes about 60 minutes and more information on becoming trained can be found online at http://gaincc.org/instruments. The GAIN-SS consists of 23 items and takes about 10 minutes to administer. The 23 items are divided into four sections: Internalizing Disorders, Externalizing Disorders, Crime/violence, and Substance Use Disorders. The GAIN-SS has been shown to have good reliability and validity (Dennis, Chan, & Funk, 2006; Dennis, Feeney, Hanes-Stevens, & Bedoya, 2008). Examples of items from each section in GAIN-SS include:

Internalizing Disorder:

Example: When was the last time you had significant problems with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?

Externalizing Disorder:

Example: When was the last time you did the following things two or more times: lied or conned to get things you wanted or to avoid having to do something?

Substance Use Disorder:

When was the last time you spent a lot of time either getting alcohol or other drugs, using alcohol or other drugs, or recovering from the effects of alcohol or other drugs?

Crime/Violence:

When was the last time you had a disagreement in which you pushed, grabbed, or shoved someone?

Each item on the GAIN-SS is answered with responses of never, past month, 2–3 months ago, 4–12 months ago, or 1 year ago. For more information on accessing the GAIN materials, please contact the GAIN Coordinating Center at Chestnut Health Systems (http://gaincc.org/).

The SASSI

The Substance Abuse Subtle Screening Instrument (SASSI) includes both alcohol and drug related questions. It takes 10–15 minutes to complete. This screen consists of two groups of items—subtle items and risk prediction scale items. There are 52 items which are described as "subtle" because they refer to a variety of nondrug and alcohol behaviors related to health, emotional states, social interactions, interests, needs, values, and preferences. The risk prediction scales include 12 alcohol-related items and 14 drug-related items. The risk prediction scale items are also called the "face valid" items because it is obvious that they are measuring drug or alcohol problems.

The SASSI was developed by Glen A. Miller in 1985 and revised in 1999. There is no training required to use it; however, it is a copyrighted instrument which requires a fee for its use. Counselors can find more information about obtaining the SASSI by contacting the SASSI Institute through their website: www.sassi.com. The SASSI has been shown to have good reliability and validity.

CAGE and CAGE-AID

One of the shortest screening tools available is the CAGE. It consists of just four questions. The CAGE was developed by Ewing (1984) and published in the *Journal of the American Medical Association*. This screen is available for counselors to use for free and no training is required. The original CAGE was used to screen for possible alcohol use disorder. For each "yes" response the client gives, one point is given. Any score of 2 or higher indicates problem drinking. Remember, however, a screening instrument cannot be used to yield a diagnosis. The items on the CAGE measure 1) has the client ever felt they need to cut down on their use of alcohol, 2) if they have been annoyed by other people's criticism of their drinking, 3) if they have ever felt guilty because of their use of alcohol, and 4) have they ever drank in the morning to get themselves up and going.

The CAGE-AID was adapted to include drug use. It was developed by Brown and Rounds in 1995. Scoring of the CAGE-AID is the same as for the CAGE, but the questions are slightly different. The CAGE-AID is free for counselors to use and can be found online at https://www.integration.samhsa.gov/clinical-practice/screening-tools#drugs.

AUDIT

Another easy to use screen is the AUDIT. The Alcohol Use Disorders Identification Test (AUDIT), developed in 1982 by the WHO, is a simple way to screen and identify people at risk of alcohol problems. This screen can also be used with no formal training and at no cost. The AUDIT consists of 10 questions and is scored by adding up the corresponding numbers listed by the responses. A score of 8 or more on the AUDIT indicates the client might have an alcohol use disorder. A counselor would want to use any positive AUDIT result to identify clients who need a more thorough assessment.

Alcohol Use Disorders Identification Test (AUDIT)

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

Add up the points associated with answers. A total score of 8 or more indicates harmful drinking behavior.

DAST

The Drug Abuse Screening Test (DAST) was developed by Harvey Skinner in 1982. The DAST consists of 20 questions and is designed to measure possible drug use disorders. It is available in both adult and adolescent versions. The DAST is easy to use and to score. There is also a convenient 10-item version of the DAST. It is recommended by SAMHSA and can be found at https://www.integration.samhsa.gov/clinical-practice/screening-tools#drugs.

ASSIST

The Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) is an 8-item screening instrument developed by the WHO. It was designed to screen for substance use in primary care and medical settings. It is available in several languages and is easy to administer and score. Patients use response cards to answer each question. This makes it especially easy to give. And each patient is given a report card after scoring, so they can understand their results. There is no fee or training required to use this screening; however, it does include a manual for use in primary care which should be followed. The questionnaire instructions, items, response card, and report card examples are as follows.

Alcohol, Smoking, and Substance Involvement Screening Test

INTRODUCTION: I am going to ask you some questions about your experience with alcohol, tobacco products, and other drugs across your lifetime and in the past 3 months. These substances can be smoked, swallowed, snorted, inhaled, injected, or taken in pill form ***(Show Drug & Response Card).***

Reprinted from *ASSIST: The Alcohol, Smoking and Substance Involvement Screening Test: Manual for Use in Primary Care*, World Health Organization, "Appendix A: The Alcohol, Smoking and Substance Involvement Screening Test," Pages 42–52, © World Health Organization 2010. http://www.who.int/substance_abuse/publications/assist/en/. May 1, 2018.

Some of the substances listed may be prescribed by a doctor (like sedatives, pain medications, amphetamines, etc.). For this interview, I will not record medications that are used as prescribed by your doctor. However, if you have taken such drugs for reasons other than prescription, or taken them more frequently or at higher doses than prescribed, please let me know. While I am interested in knowing about your use of various illicit drugs, please be assured that the information on such use will be treated as strictly confidential.

In your life, which of the following substances have you ever used? (*non-medical use only*)	**No**	**Yes**	**In the past three months, how often have you used the substances mentioned (*first drug, second drug, etc.*)?**	**Never**	**Once or Twice**	**Monthly**	**Weekly**	**Daily or Almost Daily**
a. Tobacco products	0	3	a. Tobacco products	0	2	3	4	6
b. Alcoholic beverages	0	3	b. Alcoholic beverages	0	2	3	4	6
c. Marijuana	0	3	c. Marijuana	0	2	3	4	6
d. Cocaine or Crack	0	3	d. Cocaine or Crack	0	2	3	4	6
e. Amphetamines or Stimulants	0	3	e. Amphetamines or Stimulants	0	2	3	4	6
f. Inhalants	0	3	f. Inhalants	0	2	3	4	6
g. Sedatives or Sleeping Pills	0	3	g. Sedatives or Sleeping Pills	0	2	3	4	6
h. Hallucinogens	0	3	h. Hallucinogens	0	2	3	4	6
i. Heroin, Morphine, Pain Medication	0	3	i. Heroin, Morphine, Pain Medication	0	2	3	4	6
j. Other, specify:	0	3	j. Other, specify:	0	2	3	4	6

Probe if all answers are negative: "Not even when you were in school?" If "No" to all items, stop the interview.

If "Yes" to any of these items, ask Question 2 for each substance ever used.

If Never to all items in Question 2, skip to Question 6. If any substance in Question 2 was used in the previous 3 months continue with Questions 3, 4, and 5 for each substance used.

During the past three months, how often have you had a strong desire or urge to use (*first drug, second drug, etc.*)?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily	During the past three months, how often has your use of (*first drug, second drug, etc.*) led to health, social, legal, or financial problems?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products	0	3	4	5	6	a. Tobacco products	0	4	5	6	7
b. Alcoholic beverages	0	3	4	5	6	b. Alcoholic beverages	0	4	5	6	7
c. Marijuana	0	3	4	5	6	c. Marijuana	0	4	5	6	7
d. Cocaine or Crack	0	3	4	5	6	d. Cocaine or Crack	0	4	5	6	7
e. Amphetamines or Stimulants	0	3	4	5	6	e. Amphetamines or Stimulants	0	4	5	6	7
f. Inhalants	0	3	4	5	6	f. Inhalants	0	4	5	6	7
g. Sedatives or Sleeping Pills	0	3	4	5	6	g. Sedatives or Sleeping Pills	0	4	5	6	7
h. Hallucinogens	0	3	4	5	6	h. Hallucinogens	0	4	5	6	7
i. Heroin, Morphine, Pain Medication	0	3	4	5	6	i. Heroin, Morphine, Pain Medication	0	4	5	6	7
j. Other, specify:	0	3	4	5	6	j. Other, specify:	0	4	5	6	7

During the past three months, how often have you failed to do what was normally expected of you because of your use of (*first drug, second drug, etc.*)?	**Never**	**Once or Twice**	**Monthly**	**Weekly**	**Daily or Almost Daily**
a. Tobacco Products					
b. Alcoholic beverages	0	5	6	7	8
c. Marijuana	0	5	6	7	8
d. Cocaine or Crack	0	5	6	7	8
e. Amphetamines or Stimulants	0	5	6	7	8
f. Inhalants	0	5	6	7	8
g. Sedatives or Sleeping Pills	0	5	6	7	8
h. Hallucinogens	0	5	6	7	8
i. Heroin, Morphine, Pain Medication	0	5	6	7	8
j. Other, specify:	0	5	6	7	8

Ask Questions 6 and 7 for all substances ever used (i.e., those endorsed in Question 1).

Has a friend or relative or anyone else ever expressed concern about your use of (*first drug, second drug, etc.*)?	**No, Never**	**Yes, in the past three months**	**Yes, but not in the past three months**	**Have you ever tried and failed to control, cut down or stop using (*first drug, second drug, etc.*)?**	**No, Never**	**Yes, in the past three months**	**Yes, but not in the past three months**
a. Tobacco products	0	6	3	a. Tobacco products	0	6	3
b. Alcoholic beverages	0	6	3	b. Alcoholic beverages	0	6	3
c. Marijuana	0	6	3	c. Marijuana	0	6	3
d. Cocaine or Crack	0	6	3	d. Cocaine or Crack	0	6	3
e. Amphetamines or Stimulants	0	6	3	e. Amphetamines or Stimulants	0	6	3
f. Inhalants	0	6	3	f. Inhalants	0	6	3
g. Sedatives or Sleeping Pills	0	6	3	g. Sedatives or Sleeping Pills	0	6	3
h. Hallucinogens	0	6	3	h. Hallucinogens	0	6	3
i. Heroin, Morphine, Pain Medication	0	6	3	i. Heroin, Morphine, Pain Medication	0	6	3
j. Other, specify:	0	6	3	j. Other, specify:	0	6	3

ASSIST

Response Card

a. **Tobacco products** such as cigarettes, chewing tobacco, cigars, etc.
b. **Alcoholic beverages** such as beer, wine, hard liquor, etc.
c. **Marijuana,** pot, grass, reefer, weed, ganja, hash, chronic, gangster, etc.
d. **Cocaine,** coke, blow, snow, flake, toot, crack, rock, etc.
e. **Amphetamines,** speed, Ritalin, ecstasy, X, diet pills, crystal meth, ice, crank, Dexedrine, etc.
f. **Inhalants,** glue, correction fluid, gasoline, butane, paint thinner, lighter fluid, spray paint, poppers, snappers, Rush, Locker Room, Nitrous Oxide, laughing gas, whippets, etc.
g. **Sedatives or sleeping pills,** Valium, Xanax, Librium, Dalmane, Ativan, Halcion, Miltown, Thorazine, Mellaril, Restoril, Rohypnol, roofies, GHB, Liquid X, Liquid E, Mebaral, Nembutal, Seconal, Fiorinal, Amytal, Phenobarbital, Placidyl, Doriden, downers, etc.
h. **Hallucinogens,** LSD, blotter, acid, mushrooms, PCP, angel dust, THC, wet, illy, ketamine, Special K, vitamin K, 2C-B, etc.
i. **Pain medication, Opioids,** codeine, OxyContin, Darvon, Vicodin, Dilaudid, Demerol, Lomotil, Percodan, Talwin-Nx, heroin, morphine, methadone, etc.
j. **Other drug**: Something not listed here? Please specify: _____

Responses for Questions 2–5

Never: not used in the last 3 months

Once or twice: 1 or 2 times in the last 3 months
Monthly: 1 to 3 times in one month
Weekly: 1 to 4 times per week
Daily or almost daily: 5 to 7 days per week

Responses for Questions 6–8

No, Never

Yes, but not in the past 3 months
Yes, in the past 3 months
ASSIST Patient Feedback Report

Substance	Risk Level			Your Score
	Low	Moderate	High	
Tobacco products such as cigarettes, chewing tobacco, cigars, etc.	0–3	4–26	27+	
Alcoholic beverages such as beer, wine, hard liquor, etc.	0–10	11–26	27+	
Marijuana, pot, grass, reefer, weed, ganja, hash, chronic, etc.	0–3	4–26	27+	
Cocaine, coke, blow, snow, flake, toot, crack, rock, etc.	0–3	4–26	27+	
Amphetamines, speed, Ritalin, ecstasy, X, diet pills, crystal meth, ice, crank, Dexedrine, etc.	0–3	4–26	27+	
Inhalants, glue, correction fluid, gasoline, butane, paint thinner, lighter fluid, spray paint, poppers, snappers, Rush, Locker Room, Nitrous Oxide, laughing gas, whippets, etc.	0–3	4–26	27+	
Sedatives or sleeping pills, Valium, Xanax, Librium, Dalmane, Ativan, Halcion, Miltown, Thorazine, Mellaril, Restoril, Rohypnol, roofies, GHB, Liquid X, Liquid E, Mebaral, Nembutal, Seconal, Fiorinal, Amytal, Phenobarbital, Placidyl, Doriden, downers, etc.	0–3	4–26	27+	
Hallucinogens, LSD, blotter, acid, mushrooms, PCP, angel dust, THC, wet, illy, ketamine, Special K, vitamin K, 2C-B, etc.	0–3	4–26	27+	
Pain medication, Opioids, codeine, OxyContin, Darvon, Vicodin, Dilaudid, Demerol, Lomotil, Percodan, Talwin-Nx, heroin, morphine, methadone, etc.	0–3	4–26	27+	
Other Drugs	0–3	4–26	27+	

What do your scores mean?

Low: You are at low risk of health and other problems from your current pattern of use.
Moderate: You are at risk of health and other problems from your current pattern of substance use.
High: You are at high risk of experiencing severe problems (health, social, financial, legal relationship) as a result of your current pattern of use and are likely to be dependent.

SCORING THE ASSIST

Substance Specific Score.

Sum across questions 2–7 for each drug category separately.
For example, the cannabis use score would be: 2c+3c+4c+5c+6c+7c
Maximum score for tobacco = 31
Maximum score for each of the other drug categories = 39

Substance	Assist Score	Risk Level		
		Low	Moderate	High
a. Tobacco products		0–3	4–26	27+
b. Alcoholic Beverages		0–10	11–26	27+
c. Cannabis		0–3	4–26	27+
d. Cocaine		0–3	4–26	27+
e. Amphetamine type stimulants		0–3	4–26	27+
f. Inhalants		0–3	4–26	27+
g. Sedatives or Sleeping Pills		0–3	4–26	27+
h. Hallucinogens		0–3	4–26	27+
i. Opioids		0–3	4–26	27+
j. Other-specify		0–3	4–26	27+

Low Risk—You are at low risk of health and other problems from your current pattern of use.
Moderate Risk—You are at risk of health and other problems from your current pattern of use.
High Risk—You are at high risk of experiencing severe problems (health, social, financial, legal relationship) as a result of your current pattern of use and are likely to be dependent

Global Continuum of Risk Score.

Sum items (questions 1 – 7) + question 8 for all drug classes together. For example,

(Q1a-Q1j) + (Q2a-Q2j) + (Q3a-Q3j) + (Q4a-Q4j) + (Q5b-Q5j) + (Q6a-Q6j) + (Q7a-Q7j) + Q8.

Maximum score = 414

Most ASSIST-related documents, manuals and supporting materials can be found on the WHO, ASSIST Web Site. (http://www.who.int/substance_abuse/activities/assist/en/).

MAST

The Michigan Alcohol Screening Test (MAST) is a 25-item screening tool for detecting consequences associated with alcohol use. This is the instrument from which the previously discussed DAST was adapted. The MAST was first developed in 1971 by Selzer. Other versions of the MAST have also been developed—the 13-item Short MAST and the MAST-G for geriatric populations. The MAST is a simple, self-scoring test that uses simple "yes" "no" items. You can access the MAST for free at https://www.integration.samhsa.gov/clinical-practice/screening-tools#drugs. Items in the MAST measure a variety of alcohol-related problems, including social, legal, emotional, psychological, and behavioral.

Summary/Conclusion

A good screening instrument can provide a starting place for identifying possible client drug or alcohol problems. Screening requires little training and can be done in a variety of settings, including treatment agencies, schools, healthcare clinics, hospitals, and other community agencies. Paraprofessionals and treatment professionals alike can use screenings to help identify persons who may benefit from brief interventions or referrals for assessment and treatment. A screening instrument is not meant to be a diagnostic tool. Only a trained professional using a comprehensive assessment can ethically diagnose a SUD.

Resources

1. For information on SAMHSA approved screening instruments visit: https://www.integration.samhsa.gov/clinical-practice/screening-tools#drugs
2. For information on the latest statistics and research related to drugs and alcohol, including national trends visit: http://www.drugabuse.gov
3. For information on how to obtain GAIN instruments for screening and assessment visit the Global Appraisal of Individual Needs (GAIN) Coordinating Center at: http://gaincc.org/
4. For information on the SBIRT initiative visit: https://www.samhsa.gov/sbirt

Suggested Activity

Have the class break into pairs. Each pair of students should practice using either the DAST, CAGE-AID, or AUDIT on each other. This can be done "role-play" style where the student acting in the role of the client assumes a fictional identity.

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