Screening, Assessment and Evaluation

alcohol and other drug, smoking and gambling

Matua Raki

National Addiction Workforce Development

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(*alcohol and other drug, smoking and gambling*).
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Matua Raki
The National Addiction Workforce Centre
PO Box 25056, Panama Street, Wellington 6146, New Zealand.

Web **www.matuaraki.org.nz**

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Disclosure

This resource has been prepared by Matua Raki (The National Addiction Workforce Centre) and is based on current knowledge and practice at the time of publication. It is not intended as a comprehensive training manual or a systematic review of screening, assessment and evaluation tools currently used in the addiction treatment sector in New Zealand. Matua Raki will not be liable for any consequences resulting from the use or misuse of any of the material in this publication.

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Acknowledgements

Tēna koutou, warm Pacific greetings and salutations,

It is with great pleasure that Matua Raki is able to meet the demand for a reprint of this popular resource. Again, we wish to acknowledge those practitioners who submitted for consideration the various screening tools and assessment forms that they utilise on a daily basis. We would also like to acknowledge those who have provided comments since this document was released as these have informed some minor changes to this current document. Ian MacEwan (Social Worker and Executive Director of DAPAANZ) was not only the original project leader who facilitated the Matua Raki working group (listed below) but was also a link to the resource prepared by ALAC in 1996. The popularity of this resource is in part due to the group that reviewed various instruments and then held vigorous debate and discussion to decide which tools were to be included. Our appreciation goes to:

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Matua Raki acknowledges the New Zealand Ministry of Health for their support and funding for this project. The valuable groundwork undertaken in 1996 by the Alcohol Advisory Council to produce a similar resource has been greatly appreciated. Lastly we would like to acknowledge those in the health and social service sectors who endeavour to offer welcoming, hopeful and competent service to individuals, families and wh nau. We trust this resource is helps make a difference.

Raine Berry
Director
Matua Raki

April 2012

Contents

Introduction

This resource was compiled by Matua Raki, the National Addiction Workforce Centre, to update the guidelines published in 1996 by the Alcohol Advisory Council (ALAC)[1]. This resource is both broader in scope and more specific than the earlier ALAC publication. The term 'addiction' is utilised as a generic term to be inclusive of alcohol and other drug, tobacco smoking and problem gambling.

A collection of screening instruments, assessment tools and frameworks, this resource is primarily intended to assist experienced and trained practitioners in the course of their work with people who have addiction-related issues. Material in this resource is also useful for those in primary care, health and social services. This resource helps promote a common understanding and operating language with regard to screening, assessment and evaluation activity. This 'standardisation' will also be useful in clarifying expectations of those who ask for or receive screenings and assessments including Courts and the Parole Board.

In New Zealand, as in most of the world, there exists a high prevalence of coexisting addiction and mental health conditions in the population. People with complex multiple health and social issues presenting to addiction and mental health services are the expectation rather than the exception. Recently, considerable emphasis has been placed on responding to coexisting addiction and mental health problems (in both the addiction and the mental health sector) through the coexisting problems (CEP) initiative. Two factors attributed to past failures to address coexisting addiction and mental health problems have been an inability to identify coexisting problems or to respond to multiple complexities in an integrated, recovery-oriented way. This resource presents information on screening and assessment that may help to identify the presence of coexisting conditions. Such timely identification will impact on how practitioners can influence the course, maintenance and resolution of any potential condition.

Because an ever-growing number of screening tools, assessments and evaluation instruments has become available, Matua Raki recognised the need to provide some guidance in order to promote quality, standardisation and consistency. This resource was developed with the contribution of a range of practitioners who sent instruments they used or that were in use by their agencies to the Matua Raki working group convened for this project.

After review and discussion (which included reviewing the literature relating to the psychometrics of the various screenings and assessment frameworks for reliability, validity, sensitivity, specificity and clinical utility), the working group chose for this resource screening and assessment instruments that are in common use in New Zealand. Instruments selected for inclusion were freely available and seen to have high utility value for experienced and competent practitioners. Many are supported by evidence-based literature and/or have been formally validated for New Zealand populations (particularly Māori and Pacific populations). The Matalafi Matrix has been included because it is being used predominantly by Pacific practitioners and reflects a Pacific paradigm. Although considered for inclusion, the Rangi Matrix (Te Ngaru Learning Systems) and a Te Whare Tapa Whā assessment did not make the final cut because they lacked guidelines for use and training.

A number of other screening instruments or assessment frameworks, such as the Simple Screening Instrument for Substance Abuse (SSI-SA), the Mental Health Screening Form-III (MHSF-III), or the Mental State Exam do not appear in this resource, however experienced competent practitioners are encouraged to investigate these further.

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1 The Alcohol Advisory Council. (1996). Guidelines for Alcohol and Drug Assessment: Review of Alcohol and Drug Screening, Diagnostic and Evaluation Instruments. Wellington: ALAC.

Introduction

The information presented in this document is intended neither to replace the proper acquisition of interviewing skills nor to distract workers from pursuing assessment training opportunities. Assessment skills are not genetically transmitted, but are taught, practised under supervision and those using them are always accountable. Accountability is always firstly to the service user, their family or wh nau. Registration boards, such as the Addiction Practitioners' Association Aotearoa New Zealand (DAPAANZ), may well have some minimum standards or expectations with respect to screening and assessment processes. This resource reinforces these expectations of professional practice. Although brief intervention (including motivational interviewing) is outside the scope of this work, it will be touched on briefly as some of the skills and techniques involved are relevant to screening and assessment activity.

A distinction is drawn in this document between the tasks of **screening**, **assessment**, **outcomes** and **evaluation**.

- **Screening** is part of a brief intervention that aims to identify who may have an issue from those who may not.
- **Assessment** formally looks to increase understanding of the nature and extent of any presenting problem as a way to identify potential pathways for change.
- **Outcome** and **Evaluation**, for the purposes of this resource, is intended to mean the use of instruments to assist the practitioners and the client to assess or monitor changing affective and behavioural factors during the treatment process and, usefully, in the maintenance of post-treatment goals.

This document has been structured so that practitioners, whether they are in the addiction, mental health or social service sectors, can readily access relevant sections. Screening tools developed and particularly suitable for use in a variety of healthcare and social service settings (Primary Care) screen for a number of different lifestyle issues including substance use, problem gambling and mental health. Some of these screens are also being used in specialist mental health and addiction settings.

The description of each instrument includes at least one key reference; whether any validation studies have been undertaken with New Zealand populations and outlines the instrument's use (administration and scoring).

Special Considerations

These instruments should be the servants of the practitioner in that they are adjuncts to good practice, and should be subsidiary to the interviewing and analytical skills of the practitioner. Matua Raki urges practitioners to resist using instruments as a checklist or litmus test of the pre-treatment characteristics of individuals. This approach is often unreliable and is a poor predictor of change. Rather, the therapeutic engagement of reflective listening and accurate understanding of the client's experience as well as their social and cultural context appear to be stronger markers for effective assessment and intervention.

An important part of engagement is helping to make the person being interviewed feel welcome and to ensure that the purpose of any screening, assessment or evaluation is clearly stated. It is also important that the questions are understood by those being assessed so that as accurate a response as possible can be given. Practitioners are also reminded that intoxication, coercion and withdrawal states can affect the quality and accuracy of information gathered from a screening or assessment activity. Despite this, it may be the only window of opportunity to engage in any change process.

Ethnocultural considerations

The concept of ethnoculture encompasses both culture and ethnicity. Throughout the process of assessment and evaluation, practitioners are encouraged to be mindful of the social and cultural context of the people they are working with.

Effective engagement, assessment and goal setting may be affected by a person's 'ethnocultural identity'. The way a person might identify themselves and 'see the world' may impact on the ways they might express distress; the way in which they might perceive problems or solutions and/or their communication styles. Practitioners have an important role in ensuring that the people they are working with understand health information well enough to be able to make informed choices or decisions. New Zealanders have poor health literacy – particularly Māori and Pacific peoples[2]. This may well mean assessors giving some thought to how assessment information is interpreted and communicated, putting it into a relevant context as well as considering the content of any message.

Screening

As stated earlier, the purpose of screening is to determine whether a particular problem may or may not be present – it is not an assessment or a diagnosis. Where screening instruments are brief, easy to score and appropriate to the social and cultural context of the community they are being used in, they are ideal for use in primary care settings.

Those working in primary care include social workers, youth workers, Probation Officers as well as GPs and practice nurses and are often referred to as generalists. These workers have an important part to play in identifying and working to curb risky or hazardous behaviour that might progress to become more problematic. Further, people who have a severe problem but who do not see themselves as having a problem and/or who are not presenting at specialist addiction services may present before these generalists.

Routine screening for various conditions is important because it can mean early detection, which may prevent problems escalating. Screening can also help identify issues which the client (or their whānau and family) were not aware of or do not acknowledge as problematic but which impact on their presentation at a service. All these reasons invite further conversation and possible assessment and or intervention. Screening is also an opportunity to provide positive affirmation to those with non-problematic screening outcomes. A positive screen must be followed up with a more detailed assessment of the condition potentially identified.

Regardless of setting, it is important to introduce screening instruments in a non-threatening way. Letting clients know the relevance of the screening instrument to any assessment procedure (including the instrument's purpose); reassuring them of confidentiality and informing them how the information is used and how long it will take, will all help in this respect and improve the quality of responses and therefore the reliability of the results.

After administering any instrument it is important to give individualised feedback about the scores and to invite reflection. At this stage a practitioner may make use of a brief intervention (including motivational enhancement techniques) if appropriate.

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2 'the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions': Ministry of Health. 2010. *Kōrero Mārama: Health Literacy and Māori.* Wellington: Ministry of Health.

Brief Intervention

The evidence strongly suggests that many people do not need a protracted and expensive course of individual or group treatment to benefit. Brief interventions offer the possibility of making the practitioner's attempts to influence potentially harmful behaviour much more cost effective. By identifying these clients (screening) and offering them a brief intervention appropriate to their needs, we can devote more time and energy to those with severe problems and who require a more intensive approach.

Early interventions are generally brief and opportunistic but can be more extended. They are appropriate for clients who have not specifically sought help for particular issues but who are detected as 'being at risk or hazardous'. The goal of a brief intervention for individuals in this group is to reduce risk of harm – this may mean raising the awareness of the person of potential harms or motivating people to consider or maintain change.

Brief interventions can range from one to nine sessions and a session can take from four minutes to an hour. It can be broken down into four parts; the screen, brief intervention; extended brief intervention (also sometimes called brief treatment) and referral. The content and approach of the sessions vary depending on the nature and severity of the problem. In some instances a course of awareness raising and enhancing motivation can be considered a brief treatment. A brief intervention can include:

- giving people feedback,
- advice and information (including giving self-help material),
- assessment of motivation or readiness for change,
- problem solving, goal setting and/or relapse prevention,
- encouraging people to reduce use of substances or gambling – particularly in those not seeking treatment – and negotiating further assessment, treatment, referral or a follow-up session.

Within a more extended brief intervention the components are often summarised by the acronym **FRAMES:**

Feedback,
Responsibility,
Advice,
Menu of strategies,
Empathy, and
Self-efficacy.

Goal setting, follow-up and timing also have been identified as important to the effectiveness of a brief intervention

Assessment

Practitioners may find **assessment** instruments useful as they assist in formalising an understanding about the nature and extent of addiction-related problems. A personal and individualised comprehensive assessment is the best foundation for selection of the most appropriate and effective intervention.

As stated earlier, a screen is not an assessment, nor is an assessment a diagnosis. An assessment gathers information that allows practitioners to better their understanding of the social and cultural context of a person, their strengths and why they are presenting. This includes finding out the

hopeful goals of the person being assessed. From this information, a trained and competent practitioner is able to make an assessment that is a combination of clinical judgement and objective criteria, such as those contained in the Diagnostic and Statistical Manual of Mental Disorders (see DSM-IV-TR in the Appendices) or the International Classification of Diseases (ICD). This assessment will contribute to a formulation from which an appropriate management plan and treatment goals can be developed in consultation with the person being assessed.

The assessment process should be seen as an opportunity to engage and build rapport (including any support people involved) and not as an interrogation. Assessment and reassessment can be considered an intervention in its own right. Asking the appropriate questions can help people make connections between events in their lives and their behaviours and structured feedback of an assessment can contribute to significant change in motivation without the need to provide more intensive interventions.

A brief assessment can be something of a triage process and elicits information about the person (their social and cultural context) and about the type, quantity, and frequency of an individual's substance (or gambling) use and non-use (historical and current) in order to get a sense of patterns of use and associated problems. It should include information about abstinence (historical and current); treatment history; relevant medical history; psychiatric history and any family history of substance misuse (including nicotine); gambling or mental health problems. This information should be enough to identify strengths, any possible 'diagnosis', risks to self or others and potential barriers to service access (including motivation and readiness to change for each identified issue). A suitably trained **and** experienced practitioner could elicit this information in a single interview.

A comprehensive assessment is an interview in greater depth. It not only gathers the same information as a brief assessment but also evaluates a person's own resources and strengths that can be utilised, including family and other close supports. It will seek corroboration of self-report from significant others, assess current mental status and mental health and assess current social circumstances. Ideally, a comprehensive assessment will also include a statement of the person's strengths; a problem list; case formulation; prognosis and a suggested integrated stage-matched management or treatment plan.

A competent assessor will integrate an ethno-cultural perspective throughout the engagement and assessment process. As mentioned earlier, this will mean the assessor is aware of the norms, values and characteristic behaviours that identify the person being assessed as being a member (or not) of a particular ethno-cultural group – this includes spiritual or religious dimensions. A cultural formulation tool can be used as a supplement to a comprehensive assessment to ensure a holistic assessment is provided. For instance in looking at the person's connectedness and social context a competent assessor might watch for acculturation or displacement issues. A competent assessor is aware of different ways people express distress and explain their condition, or of ways in which they want to address the issues for which they are presenting. This is important in terms of 'diagnoses' and making sense of presentation. Effectively integrating information to support a cultural formulation will require the assessor to examine their own communication style, identifying any cultural barriers that could stifle, or enhancers that could foster, engagement with the client, their family or whānau.

This last point is important because a key skill is being client-centred and engaging in a way that increases the client's (and possibly the client's support people including whānau and families) understanding of their situation so that clients can make informed decisions about their choices.

Providing accurate non-judgemental recovery-oriented assessment feedback can help to increase knowledge about the harms and complications associated with substance use or problem gambling as well inspire some hope. Assessment feedback should not be confused with education about the detrimental effects of substance misuse and gambling in general.

Feedback should be a summary of the person's substance use or gambling and related problems as self-reported in the clinical interview. It should be delivered in an empathic (collaborative), non-judgemental and non-threatening manner so that the client (and their whānau and family) can understand what is being said and what options they have to choose from. After feedback, it is important to invite reflection so that the person being assessed is able to develop or negotiate their own treatment goals. Such a process leads to a collaborative atmosphere, which is more likely to engender engagement and change.

A practitioner trained and experienced in working with addiction-related issues could elicit most of this assessment information and give feedback in a single session, but information may be gathered over a number of sessions. The length and format of any assessment report may depend on its purpose.

It is worth emphasising that a working knowledge of standard drink measures and recommended drinking limits is also needed in order to inform an accurate screening and assessment. Many screens utilise the concept of 'standard drinks' to ensure consistency of language and measurement for both practitioners and those being assessed. Such knowledge, plus knowledge of local 'drinking limits', are useful in delivering brief interventions.

It is also important to note that the assessment section in this resource is written primarily for experienced addiction practitioners who have received training in comprehensive assessment. It is acknowledged that this training will have influenced (knowingly or unknowingly) practitioners and services. This being the case what is suggested in this resource should be considered a minimum standard and complexity capable practitioners may well utilise additional tools and techniques such as but not limited to the Mental Status Examination or risk assessment.

Glossary

Addiction: used in this resource as a comprehensive term to cover the range of problems related to misuse of alcohol and other drugs, tobacco and gambling.

Alcohol or other drug-related problems: principally problems caused by intoxication and/or excessive consumption over time.

Client: terms used synonymously include: 'Tangata whaiora', patient, service user and consumer. Client is used in this document to represent the person who is the subject of health care or social service services.

Coexisting problems (CEP): particularly describes the presence of addiction and mental health-related problems in the same person at the same time. A person can have coexisting physical, intellectual or social conditions as well. Other terms used interchangeably include dual diagnosis, co-occurring disorders, coexisting disorders and comorbidity.

Dependence: an impaired control over substance use which has had negative consequences, including behavioural change, subjective psychological impact, or adverse physical implications; may include tolerance, withdrawal and salience.

Domains: category; a group of related behaviours.

False negatives: occur when test scores suggest the absence of problems which are in fact there.

False positives: occur when test scores suggest the presence of problems, which are not in fact there.

Practitioner: the term 'practitioner' is used in this document to capture the range of workers within addiction, social and mental health services. Within the addiction sector, the term 'practitioner' is preferred by many, while within mental health services 'clinician' is often the preferred term.

Prevalence: the number of instances of a given condition, e.g. alcohol dependence, in a given population at a particular time.

Primary Care: settings where the core business of the practitioners is not addiction specific but who may well work with addiction-related problems – the presentation of risky substance misuse or the consequences of someone else's gambling e.g. Probation, primary health organisation (PHO) or a food bank.

Psychometric: the validity and reliability of the measurement or assessment of individual differences in abilities, aptitudes, attitudes, behaviour, intelligence and/ or other attributes.

Reliability: consistency; the extent to which a test or measuring procedure yields the same results on repeated trials.

Self-efficacy: describes a person's belief in their capability to do things or to have influence over things in their life.

Sensitivity: refers to the proportion of people *with* the problem screened for who score positive on the screen.

Specificity: refers to the proportion of people *without* the problem screened for who score negative on the screen.

Validity: the extent to which a test measures accurately what it is intended to measure.

ALCOHOL and OTHER DRUG SCREENS

Alcohol Use Disorders Identification Test AUDIT

Principal Reference

Saunders J, Aasland O, Babor T, De La Fuente J and Grant M. (1993). Development of the Alcohol Use Disorders Identification Test (AUDIT): WHO Collaborative Project on Early Detection of Persons with Harmful Alcohol Consumption-II. *Addiction*, 88: 791–804.

The AUDIT is a ten-item questionnaire developed by a World Health Organisation (WHO) collaborative project to detect hazardous or harmful alcohol consumption use across a wide range of groups. It was first developed in 1993 and continues to be the subject of research and study across different cultures and countries. The AUDIT has the potential to differentiate between people with differing levels of alcohol misuse, i.e. levels of consumption, dependence and related-problems.

▪ Use

The AUDIT is appropriate to use in primary care settings, emergency departments, general hospital settings, employee assistance programmes and with Defence Force personnel. It is used also with people accessing mental health services, drink drivers, offenders and problem gamblers.

The AUDIT may be used by any worker who needs a reliable screening instrument to identify alcohol misuse problems. AUDIT has been widely validated across many cultures and languages but not formally validated for New Zealand populations.

▪ Administration and scoring

The AUDIT is designed as a self-report instrument but it can be administered by a practitioner.

The AUDIT is scored by adding each of the 10 items: A score of 8 or above has been frequently used to indicate the presence of alcohol problems. While studies have found this cut-off point to have adequate sensitivity and specificity for adult men, a lower cut-off point of 4 may be more useful for women and adolescents.

AUDIT scoring and suggested interventions

Alcohol education	**0–7**
Simple advice	**8–15**
Extended advice plus brief counselling and continued monitoring	**16–19**
Referral to specialist for diagnostic evaluation and treatment	**20–40**

Clinical judgment should be exercised in cases where a person's score is not consistent with other evidence, or if the person has a prior history of alcohol dependence. The AUDIT also has some subscales relevant to consumption, dependence and related problems. These are:

Consumption score and intervention: (Add up questions 1 to 3)

A score of 6 or 7 may indicate a risk of alcohol-related harm, even if this is also the total score for the AUDIT (e.g. consumption could be over the recommended weekly intake in the absence of scoring on any other questions). Drinking may also take place in dangerous situations (e.g. driving, fishing/boating).

Scores of 6 to 7 may also indicate potential harm for those groups more susceptible to the effects of alcohol, such as young people, women, the elderly, people with mental health problems and people on medication. Further inquiry may reveal the necessity for harm reduction advice.

Dependence score and intervention: (Add up questions 4 to 6)

A 'dependence' score of 4 or more to questions 4-6 suggests the possibility of alcohol dependence (and therefore the need for more intensive intervention if further assessment confirms dependence).

Alcohol-related problems: score and intervention

Any scoring on questions 7 to 10 warrants further investigation to determine whether the problem is of current concern and requires an intervention.

▪ Training

The AUDIT requires no specific training. However, a lack of training in its use and how to interpret the scores has in the past led to the situation where hazardous alcohol use is often interpreted as dependent use. Therefore, practitioners using the AUDIT should have a good understanding of a standard drink.

A copy of the AUDIT and a practical training manual and guideline is available free of charge at **http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf**

▪ Availability

AUDIT is open source. The interview and self-report versions of AUDIT may be obtained from **www.bpac.org.nz** (keyword: addiction-tools.)

Alcohol Use Disorders Identification Test – Self-Report **AUDIT**

Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest.

Place an **X** in one box that best describes your answer to each question.

Questions	0	1	2	3	4
1 How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
2 How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3 How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	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?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5 How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6 How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7 How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8 How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9 Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10 Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year
TOTAL					

Alcohol Use Disorders Identification Test – C AUDIT-C

Principal Reference

Bush K, Kivlahan D, McDonell M, Fihn S and Bradley K. (1998). The AUDIT alcohol consumption questions (AUDIT-C): an effective brief screening test for problem drinking. Ambulatory Care Quality Improvement Project (ACQUIP). Alcohol Use Disorders Identification Test. *Archives of Internal Medicine*,158 (16):1789 – 1795.

The AUDIT-C is a shorter version of the AUDIT and was developed as a screening instrument to help identify hazardous drinkers or those who have active alcohol use disorders (including alcohol abuse or dependence). The items ask about frequency of drinking, quantity consumed on a typical occasion and frequency of heavy episodic drinking.

▪ Use

It is used in a number of health (including primary healthcare) and social service settings. There are no New Zealand AUDIT-C related validation studies.

▪ Administration and scoring

The AUDIT-C is designed as a self-report instrument. However it has been used via computer and telephone. It can also be administered by a practitioner.

The AUDIT-C differs from the full AUDIT in that it uses only the first three questions in the form of a multiple-choice test (with scoring for each response).

▪ Training

It is similar to the AUDIT in that there is no specific training needed. However practitioners using the AUDIT-C should have a good understanding of a standard drink.

▪ Availability

The AUDIT-C is open source and therefore free to use – with due acknowledgement to the source. The AUDIT-C may be obtained from **www.bpac.org.nz** (keyword: addiction-tools.)

Alcohol Use Disorders Identification Test – C AUDIT-C

Q1: How often did you have a drink containing alcohol in the past year?

Answer	*Points*
Never	0
Monthly or less	1
Two to four times a month	2
Two to three times a week	3
Four or more times a week	4

Q2: How many drinks did you have on a typical day when you were drinking in the past year?

Answer	*Points*
None, I do not drink	0
1 or 2	0
3 or 4	1
5 or 6	2
7 to 9	3
10 or more	4

Q3: How often did you have six or more drinks on one occasion in the past year?

Answer	*Points*
Never	0
Less than monthly	1
Monthly	2
Weekly	3
Daily or almost daily	4

The AUDIT–C is scored on a scale of 0–12 (scores of 0 reflect no alcohol use).

In men, a score of 4 or more is considered positive;
in women, a score of 3 or more is considered positive.

Generally, the higher the AUDIT–C score, the more likely it is that the patient's drinking is affecting his/her health and safety.

Biomarkers for problematic alcohol use

Blood alcohol concentration (BAC) refers to the concentration of alcohol in the blood and is measured in milligrams of alcohol per 100 ml of blood (mg/100ml). Blood alcohol concentrations can be reliably measured using breath alcohol testing equipment, a noninvasive procedure in which the concentration of alcohol in end-expiratory breath is measured. The advantages of using BAC include ease of administration, immediacy of feedback, affordability and portability. BAC, however, cannot distinguish between acute and chronic alcohol use, as BAC detects recent alcohol consumption only. It is also insensitive to binge-drinking patterns and long-term alcohol abuse.

Laboratory tests can detect abnormalities in the body chemistry that may be a result of heavy alcohol consumption. Unfortunately there are no biomarkers which combine high sensitivity with high specificity and ready availability for clinical use. The following biomarkers are useful to note for the purposes of this resource; while others exist, they tend to be used in specialised settings.

Test	Window of assessment	Sensitivity	Specificity	Utility
Breath/blood/urinary alcohol level	Hours	High	High	With clinical correlation can indicate high tolerance and by inference extended high level consumption
AST Aspartase aminotransferase	2 – 3 weeks	Less than GGT	Many sources false positives	Chronic heavy drinking, cheap, widely available
ALT Alanine transaminase	2 – 3 weeks	Less than GGT	Many sources false positives	Chronic heavy drinking, cheap, widely available
AST/ALT	2 – 3 weeks	Similar to either alone	Less false positives	
CDT Carbohydrate deficient transferon	2 – 3 weeks	Similar GGT	Less false positives	Expensive, availability varies, in some regions requires specific funding
GGT Gamma glutamyl transpeptidase	2 – 3 weeks	Moderate	Many sources false positives	Chronic heavy drinking, cheap, widely available
GGT + CDT	2 – 3 weeks	Similar to either alone	Less false positives	
MCV Mean cell volumes of erythocytes	months	Less than GGT	Several conditions cause false positives	Several conditions causing false positives (liver disease, B12 deficiency, folate deficiency, hypothyroidism) are known and can readily be excluded

In most situations the self-report test remains a sensitive and specific measure of alcohol consumption. The exception is when an individual faces reprimand or significant sanction as a result of detection of alcohol use (e.g. drinking driving or work-based drug testing) in which case laboratory tests can be used to confirm use.

Biomarkers (laboratory tests)

Biochemical measures of drug use

Urine analysis

Urine drug testing aims to detect the presence or absence of specific drugs and/or drug metabolites in urine. A toxicologist can roughly determine, using metabolite concentrations, the approximate time, dose and therefore (within reasonable doubt) extent of use. However this latter procedure can be costly and so in most services urinalysis is not used to determine dosage, time of drug administration or the extent of any drug effect.

To differentiate between recent drug use and continued excretion of the drug from previous (heavy and prolonged) use, it is possible to perform a semi-quantitative analysis in which the concentration of the drug in urine is monitored over time. If the person has ceased to use the drug, then the concentration of drug in urine would be expected to decrease each time a urine sample is assayed. Increases or no change in concentration of drug in urine is consistent with continued use.

There are a number of factors that influence whether a urine drug screen is positive or negative. Firstly, the higher the dose, the more likely it is that the drug will be detected. For example, while a dose of 30 mg of codeine might be detected for 1 – 6 hours after use, a 60 mg dose may be detected for 1 – 10 hours. Frequency of use is also an important factor influencing detection. As a general rule, with regular use, most drugs tend to accumulate in the body. The more frequently a drug is consumed the more likely it is that it will be detected in a drug screen. Cannabis can be detected for up to three weeks after cessation of use if it has been used daily basis over an extended period.

(taken from *Review of diagnostic screening instruments for alcohol and other drug use and other psychiatric disorders, 2nd Edition*, Dawe, S., Loxton, N., Hides, L., Kavanagh, D., Mattick, R,; Commonwealth Department of Health and Ageing August 2002).

Maintaining Therapeutic Alliance

Accurate interpretation of urinalysis results requires an understanding of the type of laboratory assay ordered, major and minor drug metabolic pathways, expected drug detection times and potential causes of false-positive and false-negative results. Misinterpretation of results can harm therapeutic alliance or perceptions of wellbeing, especially if it contributes to misdiagnosis or the discontinuation of any medications etc.

Section 4.7 of *The Practice Guidelines for Opioid Substitution Treatment in New Zealand* (Ministry of Health, 2008) makes a number of salient points with regard to monitoring drug use. It is recommended that practitioners using, or investigating, urine drug testing have an understanding of its use and limitations. They should also regularly consult the laboratory toxicologist regarding which test(s) to order and how to interpret results.

The Cannabis Use Disorder Test – Revised CUDIT-R

Principal Reference

Adamson S, Kay-Lambkin F, Baker A, Lewin T, Thornton, Kelly B and Sellman J. (2010). An improved brief measure of cannabis misuse: The Cannabis Use Disorders Identification Test-Revised (CUDIT-R). *Drug and Alcohol Dependence*, 110 (1-2): 137 - 143.

CUDIT-R was developed and validated in New Zealand.

▪ Use

The **CUDIT-R** is an eight-question screen developed in New Zealand and used to assess problematic cannabis use in adolescents and adults. The CUDIT, originally published in 2003, was an adaption of the AUDIT (discussed above). While performing well, some psychometric concerns about individual items were highlighted. A revised CUDIT-R was subsequently developed containing eight items, two each from the domains of consumption, cannabis problems (abuse), dependence, and psychological features.

While the psychometric adequacy of the original CUDIT was confirmed, the CUDIT-R is shorter and has equivalent or superior psychometric properties. High sensitivity (91%) and specificity (90%) have also been achieved.

▪ Scoring and Administration

The CUDIT-R was designed for self-administration and is scored by adding each of the 8 items:

Items 1 to 7 are scored on a 0 – 4 scale and Item 8 is scored 0, 2 and 4.

Scores of 8 or more indicate hazardous cannabis use, whilst scores of 12 or more indicate a possible cannabis use disorder for which further intervention may be required.

▪ Training

There are currently no guidelines or specific training available.

▪ Availability

The CUDIT-R is open source and therefore free to use. It may be obtained from **www.bpac.org.nz** (keyword: addiction-tools.)

The Cannabis Use Disorder Test – Revised CUDIT-R

Have you used any cannabis over the past six months? YES / NO

If YES, please answer the following questions about your cannabis use. Circle the response that is most correct for you in relation to your cannabis use *over the past six months*

1. How often do you use cannabis?

Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
0	1	2	3	4

2. How many hours were you "stoned" on a typical day when you had been using cannabis?

Less than 1	1 or 2	3 or 4	5 or 6	7 or more
0	1	2	3	4

3. How often during the past 6 months did you find that you were not able to stop using cannabis once you had started?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
0	1	2	3	4

4. How often during the past 6 months did you fail to do what was normally expected from you because of using cannabis?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
0	1	2	3	4

5. How often in the past 6 months have you devoted a great deal of your time to getting, using, or recovering from cannabis?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
0	1	2	3	4

6. How often in the past 6 months have you had a problem with your memory or concentration after using cannabis?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
0	1	2	3	4

7. How often do you use cannabis in situations that could be physically hazardous, such as driving, operating machinery, or caring for children:

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
0	1	2	3	4

8. Have you ever thought about cutting down, or stopping, your use of cannabis?

Never	Yes, but not in the past 6 months	Yes, during the past 6 months
0	2	4

This scale is in the public domain and is free to use with appropriate citation:

Adamson SJ, Kay-Lambkin FJ, Baker AL, Lewin TJ, Thornton L, Kelly BJ, and Sellman JD. (2010). An Improved Brief Measure of Cannabis Misuse: The Cannabis Use Disorders Identification Test – Revised (CUDIT-R). *Drug and Alcohol Dependence* 110:137-143.

Situational Confidence Questionnaire SCQ

Principal Reference:
Annis H. (1987). *Situational Confidence Questionnaire (SCQ-39).* Toronto: Addiction Research Foundation.

The SCQ has three versions, containing 100, 39 or eight items. The latter two are shorter and the most commonly used. The eight-item version, Brief SCQ (BSCQ), assesses eight domains (which correspond to the eight subscales of the SCQ). The eight domains are:

- unpleasant emotions,
- physical discomfort,
- pleasant emotions,
- testing personal control,
- urges and temptations,
- social problems at work,
- social tension, and
- positive social situations.

▪ Use

Widely used in research and evaluation, SCQ measures self-efficacy. The SCQ and BSCQ are also used clinically to identify situations in which the client is potentially at greatest risk of relapse. The SCQ has been validated with adults and adolescents – but not with a New Zealand population.

Because the BSCQ is a state of being measure, assessing self-efficacy at the start of and during treatment allows practitioners to evaluate changes in reported self-efficacy as a function of the intervention, i.e. an outcome measure. This is important because self-efficacy at the end of treatment is associated with more positive client outcomes. Thus, a goal of treatment is to help clients have a high level of self-confidence.

The BSCQ has several clinical advantages over the longer versions. It can be administered in a few minutes, is easily interpreted by practitioners and it provides immediate feedback for the client. Additionally, it can be used easily in primary care and other health and social service settings.

▪ Administration and Scoring

The SCQ and BSCQ are not designed for self-administration. The BSCQ first asks people to imagine themselves as they are "*right now*" in each of the eight domains noted above. They are then asked to indicate on a visual analogue scale how confident they are **at the present time** (i.e. right now) that they can resist the urge to drink heavily (the definition of heavy is left up to the person) or to use drugs in each of the situations.

Each of the 8 scale situations consists of a 100-mm line, anchored by 0% ("**not at all confident**") and 100% ("**totally confident**") where clients are asked to place an "**X**" along the line, from **0%** to **100%.**

The intent in using the BSCQ is to identify and highlight a client's three highest risk situations. That is, the three situations where they say they are the least confident of resisting the urge to drink heavily or to use other drugs.

▪ Training

BSCQ questionnaires and guidelines for use can be downloaded from:
www.nova.edu/gsc/online_files.html

▪ Availability

The SCQ is copyrighted and may be obtained by writing to the copyright holder: Marketing Services, Addiction Research Foundation, 33 Russell Street, Toronto, Ontario, Canada M5S 2S1.

The BSCQ is copyrighted and may be obtained by writing to its author:
Linda Sobell at sobell@cps.nova.edu.

MENTAL HEALTH SCREENS

Principal Reference

Andrews G and Slade T. (2001). Interpreting scores on the Kessler Psychological Distress Scale (K10). *Australian and New Zealand Journal of Public Health*, 25 (6): 494 - 497.

▪ Use

The K10 is a self-report questionnaire developed as a simple test of "psychological distress", based on questions about the respondent's level of anxiety and depressive symptoms in the most recent four-week period.

Although originally developed in 'population studies' it is increasingly being used in clinical settings, and is widely used in both primary care and specialist service settings (including addiction treatment services).

▪ Administration and Scoring

The K10 is designed as a self-report instrument but there are also computerised versions. It can also be administrated by a practitioner. It takes approximately three minutes to complete and score. The K10 has 10 items and each item is scored from 1 to 5, from "none of the time" to "all of the time". Total scores range from 10 (no distress) to 50 (severe distress).

People who score **0–15** have one quarter the population risk of meeting criteria for an anxiety or depressive disorder as identified by the CIDI, and a remote chance of reporting a suicidal attempt in their lifetime. They can be told their score is low and that they probably do not need the self-help information.

People who score **16–30** have a one in four chance (three times the population risk) of having a current anxiety or depressive disorder and 1% chance (three times the population risk) of ever having made a suicide attempt. They should be encouraged to use the information and self-help techniques.

People who score **30–50** have a three out of four chance (ten times the population risk) of meeting criteria for an anxiety or depressive disorder and 6% chance (20 times the population risk) of ever having made a suicide attempt. This group makes up about 2% of the population, and strongly encouraged to seek help.

▪ Training

No specific training is required in the use and interpretation of the scores. Guidelines for use and computerised versions are available at: *CRUFAD (Clinical Research Unit for Anxiety and Depression) website:* **www.crufad.org/** and **www.crufad.com/index.php/take-a-free-test#**

The Kessler-10 K-10

Instructions

The following ten questions ask about how you have been feeling in the **last four (4) weeks**. For each question, mark the circle under the option that best describes the amount of time you felt that way.

	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1. In the last four weeks, about how often did you feel tired out for no good reason?					
2. In the last four weeks, about how often did you feel nervous?					
3. In the last four weeks, about how often did you feel so nervous that nothing could calm you down?					
4. In the last four weeks, about how often did you feel hopeless?					
5. In the last four weeks, about how often did you feel restless or fidgety?					
6. In the last four weeks, about how often did you feel so restless you could not sit still?					
7. In the last four weeks, about how often did you feel depressed?					
8. In the last four weeks, about how often did you feel that everything was an effort?					
9. In the last four weeks, about how often did you feel so sad that nothing could cheer you up?					
10. In the last four weeks, about how often did you feel worthless?					

PsyCheck

Principal Reference:

Lee N.K. and Jenner L. (2010). Development of the PsyCheck screening tool: An instrument for detecting common mental health conditions among substance use treatment clients. *Mental Health and Substance Use: Dual Diagnosis*, 3(1): 56-65.

The PsyCheck was developed by Turning Point, Alcohol & Drug Centre, Australia. It has been validated for use with AOD treatment clients. It has not been designed or tested for indigenous or culturally and linguistically diverse clients. The PsyCheck has not been validated with New Zealand populations.

▪ Use

The PsyCheck Screening Tool has been developed as part of a brief intervention package and is designed for routine screening of mental health problems among clients of alcohol and other drug (AOD) treatment services by non-mental health specialists.

PsyCheck has 29 items with three sections that focus on different aspects of mental health experiences:

1 General Mental Health Screen (5 items)

2 Suicide/Self Harm Risk Assessment (4 items)

3 Self-reporting Questionnaire of Symptoms (20 items)

▪ Administration and Scoring

The first two sections of the PsyCheck are administered by the practitioner, the third section can be administered by the practitioner with the client or self-administered by the client.

Sections 1 and 2 collect information regarding clients' history of mental health issues and treatment. Section 3 (the self-report questionnaire) is scored. If any symptoms are identified, the practitioner provides the level of PsyCheck intervention appropriate for their severity and then re-screens after four (4) sessions/weeks. If after the re-screen there is no improvement in the score, referral to a specialist service should be considered.

▪ Availability

The PsyCheck is open source. An interactive CD-Rom orientation package is available on the PsyCheck website **www.psycheck.org.au/** as is a *Screening Tool User's Guide*.

PRIMARY CARE

Alcohol, Smoking & Substance Involvement Screening Test **ASSIST**

Principal Reference

Humeniuk R. (2006). *Validation of the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) and pilot brief intervention: A technical report of phase II findings of the WHO ASSIST* Project. The WHO ASSIST Phase II Study Group. WHO, Geneva.

▪ Use

The ASSIST is an eight-domain questionnaire developed by an international group of substance abuse researchers for the World Health Organisation. It has been developed for use in primary health care settings. Its purpose is to detect problematic psychoactive substance use. ASSIST has not yet been validated with a New Zealand population.

The ASSIST is an interviewer-administered pen and paper questionnaire that screens for all levels of problem or hazardous substance use. It provides information about the substances ever used over a person's lifetime and in the past three months. The ASSIST also elicits information about problems related to substance use, risk of harm (current and future) and possible dependence, as well as injecting drug use.

A risk score is generated for each substance used (substances addressed include: tobacco, alcohol, amphetamine type stimulants, cannabis, cocaine, hallucinogens, inhalants, opioids, sedatives, and other drugs). The risk score helps determine the level of intervention needed e.g. brief intervention, referral.

▪ Administration and Scoring

The ASSIST is an interviewer-administered screening tool which it is estimated takes around 7–10 minutes to administer. The resulting scores are recorded on the ASSIST Feedback Report card and are used to provide feedback to clients about their substance use and associated risks as part of linked Brief Intervention. The linked Brief Intervention adds another 10–15 minutes to the administration time.

▪ Training

Training on how to administer the ASSIST and the linked brief intervention can be obtained through reading the Self-Training Manuals.

▪ Availability

The ASSIST is open source and copies of the screen and guidelines for use in primary care can be obtained from:

www.who.int/substance_abuse/activities/assist_v3_english.pdf
www.who.int/substance_abuse/activities/assist_technicalreport_phase2_final.pdf

Case-finding and Help Assessment Tool — CHAT

Principal Reference

Goodyear-Smith F, Coupe N, Arroll B, Elley C, Sullivan S and McGill A. (2008). Case-finding of lifestyle and mental health problems in primary care: Validation of the 'CHAT'. *British Journal of General Practice*, 58 (546): 26-31.

CHAT has been found to be both valid and acceptable for lifestyle and mental health disorder screening in primary care in New Zealand.

▪ Use

The **CHAT** is a composite screen that was developed in New Zealand to identify a range of addiction and other health or lifestyle problems. It is designed for adults and offered opportunistically in a primary health setting. It assesses for tobacco use, alcohol and other drug misuse, problem gambling, depression, anxiety and stress, abuse, anger problems, inactivity, and eating disorders.

The tool was designed by a team of GPs, university researchers, a psychologist, and a community-based brief-intervention educator of primary healthcare providers. It has been found to be both valid and acceptable for lifestyle and mental health disorder screening in primary care in New Zealand.

▪ Administration and Scoring

The CHAT can be self-administered.

A positive answer to any of the nine items, and any associated issue also raised by the screen, may be followed by either an assessment or longer conversation addressing the issue.

▪ Training

Specific training is not required

▪ Availability

The CHAT is open source and therefore free to use – with due acknowledgement to the source i.e. Goodyear-Smith et al. An online version, the eCHAT, has been developed for use in primary care.

Case-finding and Help Assessment Tool **CHAT**

Questions	Response options	Positive
How many cigarettes do you smoke on an average day (*tick none if you do not smoke*)	None less than 1 a day 1-10 11-20 21-30 31-more	> 10 cigarettes a day
Do you ever feel the need to cut down or stop your smoking?	No / Yes	Yes
Do you want help with your smoking?	No/ Yes, but not today/ Yes	Yes, but not today/ Yes
Do you ever feel the need to cut down on your drinking alcohol? (*tick no if you do not drink alcohol OR do not feel the need to cut down*)	No / Yes	Yes
In the last year, have you ever drunk more alcohol than you meant to?	No / Yes	Yes
Do you want help with your drinking?	No/ Yes, but not today/ Yes	Yes, but not today/ Yes
Do you ever feel the need to cut down on your non-prescription or recreational drug use? (*tick no if you do not use other drugs* **or** *do not feel the need to cut down*)	No / Yes	Yes
In the last year, have you ever used non-prescription or recreational drugs	No/ Yes, but not today/ Yes	Yes, but not today/ Yes
Do you sometimes feel unhappy or worried after a session of gambling? (*tick no if you do not gamble* **or** *do not feel unhappy about gambling)*	No / Yes	Yes
Does gambling sometimes cause you problems?	No / Yes	Yes
Do you want help with your gambling?	No/ Yes, but not today/ Yes	Yes, but not today/ Yes
Over the last 2 weeks, how often have you been bothered by having days/little interest or pleasure in doing things?	Not at all Several days More than half the days Nearly every day	More than half the days Nearly every day
Over the last 2 weeks, how often have you been bothered by days/feeling down, depressed, or hopeless?	Not at all Several days More than half the days Nearly every day	More than half the days Nearly every day

Case-finding and Help Assessment Tool CHAT

Questions	Response options	Positive
Do you want help with this?	No/ Yes, but not today/ Yes	Yes, but not today/ Yes
Over the last 2 weeks have you been worrying a lot about everyday problems?	No / Yes	Yes
Do you want help with your anxiety or worrying?	No/ Yes, but not today/ Yes	Yes, but not today/ Yes
Is there anyone in your life of whom you are afraid or who hurts you in any way?	No / Yes	Yes
Is there anyone in your life who controls you and prevents you doing what you want?	No / Yes	Yes
Do you want help with any abuse or violence that you are experiencing?	No/ Yes, but not today/ Yes	Yes, but not today/ Yes
Is controlling your anger sometimes a problem for you?	No / Yes	Yes
Do you want help with controlling your anger?	No/ Yes, but not today/ Yes	Yes, but not today/ Yes
As a rule, do you do less than 30 minutes of moderate or vigorous exercise (such as walking or a sport) on 5 days of the week?	No / Yes	Yes
Do you want help with getting more exercise?	No/ Yes, but not today/ Yes	Yes, but not today/ Yes

PROBLEM GAMBLING SCREENS

Principal Reference

Sullivan S, McCormick R, Lamont R and Penfold A. (2007). Problem gambling: patients affected by their own or another's gambling may approve of help from GPs. *New Zealand Medical Journal*, 120:1257

▪ Use

Living with another's problem gambling can have a serious effect on a person's health and wellbeing. There are, however, few screens that focus upon those affected by another's behaviour. The **COGS** is a three-question screen developed in New Zealand for use with family or whānau of problem gamblers, whose wellbeing may have been negatively impacted by that other person's gambling. It identifies the specific impacts of another's problem gambling and identifies the readiness of the affected person to receive help and/or sows the seed for future assistance.

It is appropriate to use in primary care settings including food banks, at budget advisory or Citizens' Advisory services, primary health organisations (PHOs) and alcohol and other drug services. The COGS has not been formally validated with New Zealand populations.

▪ Administration and Scoring

The COGS is designed as a self-report instrument, but can be administered by another. A negative on the first question signals that there is no need to continue with the screen. It is also an awareness-raising instrument, as it allows a person affected by another's gambling to indicate what assistance they desire and to sow the seed for addressing that harm.

- A 'yes' to any of the last three responses in question one (i.e. any except the first) is a positive.
- Question two provides an opportunity for the affected person to identify the impact of another's gambling (awareness-raising) with one or more response(s) possible. Question two provides the focus for the initial conversation.
- A response to question three indicates the intervention the person desires by acknowledging the client has control over the next step. Even selecting 'nothing' provides an opportunity for discussion at any future meeting or sows a seed of possible assistance.

▪ Training

No specific training is required.

▪ Availability

The COGS is open source and therefore free to use. Copies of the screen can be obtained from **http://www.acts.co.nz/Art_The_Forgotten_Family.php**

Concerned Others Gambling Screen — COGS

Sometimes **someone else's gambling** can affect the health and wellbeing of others who may be concerned. The gambling behaviour is often hidden and unexpected, while its effects can be confusing, stressful and long-lasting.

To help us identify if this is affecting your own well-being could you answer the questions below to the best of your ability.

1. **Do you think you have ever been affected by** *someone else's* **gambling?**
   No, never (*you need not continue further*)
   - ☐ I don't know for sure if their gambling affected me
   - ☐ Yes, in the past
   - ☐ Yes, that's happening to me now

2. **How would you describe the effect of that person's gambling on you** *now***?**
   (*tick one or more if they apply to you*)
   - ☐ I worry about it sometimes
   - ☐ It is affecting my health
   - ☐ It is hard to talk with anyone about it
   - ☐ I am concerned about my or my family's safety
   - ☐ I'm still paying for it financially
   - ☐ It doesn't affect me anymore

3. **What would you like to happen?**
   (*tick one or more*)
   - ☐ I would like some information
   - ☐ I would like to talk about it in confidence with someone
   - ☐ I would like some support or help
   - ☐ Nothing at this stage

Principal Reference

Sullivan S. (2007). Don't let an opportunity go by: Validation of the EIGHT gambling screen. *International Journal of Mental Health and Addiction*, 5 (4): 381-38

Used in a number of jurisdictions EIGHT has been validated in New Zealand, including with Māori and Pacific populations.

▪ Use

The EIGHT is a screening tool developed in New Zealand. It is a series of eight questions originally developed for use in primary health settings, but it is now used in many other health and social service settings as well. It is brief and helps identify whether gambling has become a problem and whether a longer conversation about current impacts of gambling, including safety, depression and anxiety problems (which commonly co-exist), is necessary. The EIGHT may be used by any practitioner who needs a reliable screening instrument to identify gambling-related problems.

▪ Administration and Scoring

The EIGHT is preferably a self-completed screen, but can be administered by another person if literacy or language barriers exist.

Guidelines for Scoring:

0	controlled gambling
1–2	low harm
3	low harm but at risk for moderate harm
4–5	harm is occurring from gambling
6–8	serious harm is occurring from gambling (and may meet criteria for Pathological Gambling Disorder)

▪ Training

No specific training is required.

▪ Availability

The EIGHT is open source and therefore free to use – with due acknowledgement to the source. Copies of the screen and guidelines for use can be obtained from **www.bpac.org.nz** (keyword: addiction-tools). Further information can be obtained at: **www.acts.co.nz**

Early Intervention Gambling Health Test **EIGHT SCREEN**

Most people in New Zealand enjoy gambling, whether it's Lotto, track racing, the pokies, or at the casino. Sometimes, however, it can affect our health. To help us check your well-being, please answer the questions below as truthfully as you are able from your own experience.

1. **Sometimes I've felt depressed or anxious after a session of gambling.**
   ☐ yes, that's true ☐ no, I haven't
2. **Sometimes I've felt guilty about the way I gamble**
   ☐ yes, that's true ☐ no, I haven't
3. **When I think about it, gambling has sometimes caused me problems.**
   ☐ yes, that's true ☐ no, never
4. **Sometimes I've found it better not to tell others, especially my family, about the amount of time or money I spend gambling.**
   ☐ yes, that's true ☐ no, never
5. **I often find that when I stop gambling I've run out of money**
   ☐ yes, that's true ☐ no, I haven't
6. **Often I get the urge to return to gambling to win back losses from a past session**
   ☐ yes, that's true ☐ no, I haven't
7. **Yes, I have received criticism about my gambling in the past**
   ☐ yes, that's true ☐ no, I haven't
8. **Yes, I have tried to win money to pay debts**
   ☐ yes, that's true ☐ no, I haven't

Principal Reference

Ferris J and Wynne H. (2001). *The Canadian problem gambling index: Final report – Phase 1*. Ottawa: Canadian Centre on Substance Abuse.

The Canadian Problem Gambling Index (CPGI) was developed for use with Canadian population studies. Embedded in the CPGI is the PGSI. The PGSI has been validated in a number of jurisdictions, but not with a New Zealand population.

▪ Use

The PGSI is a nine-question behavioural health screening tool, now used widely in clinical settings for adults. It is a short tool to identify low, moderate and severe gambling problems, and indicates whether a longer conversation is warranted about the impact of gambling.

▪ Administration and Scoring

The PGSI can be self-administered or administered by another. Bellringer *et al.* (2008) recommended to the New Zealand Ministry of Health[3] that practitioners complete the forms with clients to reduce problems for clients who have difficulty self-completing forms and those having comprehension difficulties.

Score the following for each response:

never = 0 sometimes = 1 most of the time = 2 almost always = 3

Guidelines for scoring:

0	non-gambler or non-problem gambler
1-2	low risk gambling with few or no identified negative consequences
3-7	moderate risk gambling leading to some negative consequences
8–27	problem gambling with negative consequences and a possible loss of control

▪ Training

No specific training is required. However, Bellringer *et al.* (2008), in their report on problem gambling assessment and screening instruments recommend that all practitioners should have formal training in the use and interpretation of screens.

▪ Availability

The PGSI is open source. Copies of the screen and guidelines for use can be found at **http://www.problemgambling.ca/EN/ResourcesForProfessionals/pages/problemgamblingseverityindexpgsi.aspx**

3 Bellringer M, Abbott M, Coombes R, Garrett N and Volberg R. (2008). Problem Gambling Assessment and Screening Instruments. Final Report for the Ministry of Health. Auckland: Gambling and Addictions Research Centre, Auckland University of Technology

Problem Gambling Severity Index PGSI

In order to assess the impact of gambling on wellbeing, could you think about the past 12 months and answer the questions to the best of your ability. There are no right or wrong answers.

1. **How often have you bet more than you could really afford to lose?**

   0☐ Never 1☐ Sometimes 2☐ Most of the time 3☐ Almost always

2. **How often have you needed to gamble with larger amounts of money to get the same feeling of excitement?**

   0☐ Never 1☐ Sometimes 2☐ Most of the time 3☐ Almost always

3. **How often have you gone back another day to try to win back the money you lost?**

   0☐ Never 1☐ Sometimes 2☐ Most of the time 3☐ Almost always

4. **How often have you borrowed money or sold anything to get money to gamble?**

   0☐ Never 1☐ Sometimes 2☐ Most of the time 3☐ Almost always

5. **How often have you felt that you might have problem with gambling?**

   0☐ Never 1☐ Sometimes 2☐ Most of the time 3☐ Almost always

6. **How often have people criticised your betting or told you that you had a gambling problem, regardless of whether or not you thought it was true?**

   0☐ Never 1☐ Sometimes 2☐ Most of the time 3☐ Almost always

7. **How often have you felt guilty about the way you gamble, or what happens when you gamble?**

   0☐ Never 1☐ Sometimes 2☐ Most of the time 3☐ Almost always

8. **How often has your gambling caused you any health problems, including stress or anxiety?**

   0☐ Never 1☐ Sometimes 2☐ Most of the time 3☐ Almost always

NICOTINE DEPENDENCE SCREENS

Principal Reference

Heatherton T.F., Kozlowski L.T., Frecker R.C., Rickert W and Robinson J. (1989). Measuring the Heaviness of Smoking: Using self-reported time to the first cigarette of the day and number of cigarettes smoked per day. *British Journal of Addiction*, 84 (7):791-799.

HSI is used in New Zealand, particularly the question regarding time between waking and the first cigarette. It has not been validated with New Zealand populations.

Use

The HSI was developed as a very brief screen to identify and indicate the severity of physical nicotine dependence among adults. It is simple and a quick way to assist practitioners make decisions about what interventions might be best applied (including medication) and also to predict craving once someone has stopped smoking.

The HSI is commonly used internationally and is considered a reliable and valid measure of physiological aspects of nicotine dependence particularly in those who smoke daily and when used with alcohol and other drug dependent smokers.

Administration and Scoring

The HSI can be self-administered by the client, or administered by the practitioner with the client. It is easily scored by adding up points allocated to the answers. The total score is then used to indicate the degree of dependence.

Training

No training is required to administer and score the instrument. There are no guidelines for use available.

Availability

The HSI is open source and therefore free to use.

Heaviness of Smoking Index HSI

Questions and Possible Answers	Score
How soon after you wake up do you smoke your first cigarette?	
≤ 5 min	3
6-30 min	2
31-60 min	1
≥ 61 min	0
How many cigarettes per day do you smoke?	
1-10 (≤ 0.5 pack)	0
11-20 (0.5 -1 pack)	1
21-30 (1 - 1.5 packs)	2
31+ (≥ 1.5 packs)	3
TOTAL SCORE: _____ (Max. Score = 6)*	

*5-6 points: High nicotine dependence
2-4 points: Moderate nicotine dependence
0-1 points: Low nicotine dependence.

YOUTH

CRAFFT

Principal Reference

Knight J, Sherritt L, Shrier L.M.P.H., Kim Harris S, and Chang G. (2002) Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. *Archives Paediatric Adolescent Medicine*, 156:607-614.

The CRAFFT is widely used in youth services. It has been validated in a number of settings but not for use with New Zealand populations

▪ Use

The CRAFFT is a behavioural health screening tool for use with adolescents. It consists of six questions that screen adolescents for high risk alcohol and other drug use. It is a short screening tool designed to assess whether a longer conversation about the risks and consequences of alcohol and other drug use is warranted. The CRAFFT items evaluate events and behaviours irrespective of when they occurred. It is a mnemonic acronym of first letters of key words in the six screening questions.

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

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

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

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

F – Does your family or **FRIENDS** ever tell you that you should cut down on your drinking or drug use?

T – Have you got into **TROUBLE** while you were using alcohol or drugs?

▪ Administration and Scoring

The CRAFFT can be self-administered by the client, or administered by the practitioner with the client. A score of three or more points is considered positive for heavy drinking (for example).

▪ Training

CRAFFT questions should be asked exactly as written, delivered in the style of a relaxed conversation rather than a clinical examination. No training is required to administer and interpret the instrument. There are no guidelines for use available.

▪ Availability

The CRAFFT is open source and therefore free to use. Copies of the screen and further information can be obtained from:

http://www.ceasar-boston.org/clinicians/crafft.php *or*
http://lib.adai.washington.edu/instruments/

Principal Reference

Sullivan S. (2005). A hidden curriculum: gambling and problem gambling among high school students in Auckland. *Health Promotion Journal of Australia*, 16 (3): 201 – 206

The EIGHT-Y is the youth version of the EIGHT screen and was developed and validated in New Zealand, including with Māori and Pacific populations.

▪ Use

The EIGHT-Y is a behavioural health screening tool developed with the help of youth focus groups. It is based on the adult EIGHT screen and helps identify whether gambling has become a problem for the young person, and whether a longer conversation about current impacts of gambling is necessary.

The EIGHT-Y may be used by any practitioner who needs a reliable screening instrument to identify gambling-related problems.

▪ Administration and Scoring

EIGHT Screen-Y is preferably self-completed, but can be administered by another person if literacy or language barriers exist.

A score of three 'yes' responses can indicate hazardous gambling that may develop into problem gambling. If four 'yes' responses are made, this suggests that a young person might be experiencing gambling–related problems.

▪ Training

No specific training is required

▪ Availability

EIGHT is open source and therefore free to use – with due acknowledgement to the source.

Copies of the screen and further information can be obtained from **www.acts.co.nz**

Early Intervention Gambling Health Test – Youth EIGHT-Y

Gambling is an entertainment that most adults enjoy, whether it's Lotto, playing the horses, gambling machines, or even going to a casino. Young people can often access gambling and, as with some adults, it can become increasingly important in our lives.

Sometimes it can also start to affect our health.

To help us check your well-being please answer the questions below as truthfully as you are able from your own experience:

1. **Sometimes I've felt depressed or anxious after a session of gambling.**
   ☐ yes, that's true ☐ no, I haven't
1. **Sometimes I've felt down or stressed out after a session of gambling.**
   ☐ yes, sometimes ☐ no, never
2. **Sometimes I've felt bad about the way I gamble.**
   ☐ yes, sometimes ☐ no, never
3. **When I think about it, gambling has sometimes caused me grief.**
   ☐ yes, sometimes ☐ no, never
4. **Sometimes I've found it better not to tell people, especially my friends, about the amount of time or money I spend gambling.**
   ☐ yes, sometimes ☐ no, never
5. **I often find that when I stop gambling I've run out of money.**
   ☐ yes, sometimes ☐ no, never
6. **I often feel like going gambling again to win back losses.**
   ☐ yes, sometimes ☐ no, never
7. **Some people have put me down about my gambling in the past.**
   ☐ yes, sometimes ☐ no, never
8. **I have tried to win the money that I owe others.**
   ☐ yes, sometimes ☐ no, never

Scoring

Four 'yes' responses suggests that the adolescent is experiencing gambling problems. A score of three 'yes' responses can indicate hazardous gambling that may develop into problem gambling.

If positive, enquire if the responses reflect their current situation.

Principal Reference

DiFranza J, Savageau J, Fletcher K, Ockene J, Rigotti N, McNeill A, Coleman M and Wood C. (2002). Measuring the loss of autonomy over nicotine use in adolescents: The development and assessment of nicotine dependence in youths (DANDY) study. *Archives of Pediatric Adolescent Medicine*, 156: 397 – 403.

The HONC is used mostly in youth services. It has not been validated with New Zealand populations.

▪ Use

HONC is a 10-question screen developed for use with adolescents with nicotine dependence, particularly diminished autonomy over tobacco use. It is sensitive also to the onset of dependence. The HONC can also be used with adults.

HONC identifies youths who would benefit from cessation support. It can be used to increase a client's motivation for change and improve the chances of quitting smoking.

▪ Administration and Scoring

The HONC can be administered by the client, or by practitioner with the client. The HONC is easily scored and interpreted. A "yes" to any question indicates loss of autonomy. The sum of these responses indicates the degree to which autonomy is lost.

▪ Training

No training is required to administer and score the instrument. There are no guidelines for use available.

▪ Availability

The HONC is open source and therefore free to use – with due acknowledgement to the source. Copies of the screen and guidelines for its use can be obtained from:

http://fmchapps.umassmed.edu/honc/

▪ Further information:

More information can be obtained from the Alcohol and Drug Abuse Institute Library, University of Washington. This library maintains a Substance Use Screening and Assessment Instrument database at the following link:

http://lib.adai.washington.edu/instruments/

Hooked on Nicotine Checklist HONC

	NO	YES
1. Have you ever tried to quit, but couldn't?		
2. Do you smoke now because it is really hard to quit?		
3. Have you ever felt like you were addicted to tobacco?		
4. Do you ever have strong cravings to smoke?		
5. Have you ever felt like you really needed a cigarette?		
6. Is it hard to keep from smoking in places where you are not supposed to?		
When you haven't used tobacco for a while OR When you tried to stop smoking		
7. did you find it hard to concentrate because you couldn't smoke?		
8. did you feel more irritable because you couldn't smoke?		
9. did you feel a strong need or urge to smoke?		
10. did you feel nervous, restless or anxious because you couldn't smoke?		

Scoring the Hooked on Nicotine Checklist (HONC)

The HONC is scored by counting the number of YES responses.

Measuring diminished autonomy (dichotomous scoring)

Individuals who score zero (by answering NO to all questions) have full autonomy over their use of tobacco.

Individuals who score 1-10 (by answering YES) have lost full autonomy.

Measuring severity of diminished autonomy (continuous scoring)

The number of symptoms a person endorses serves as a measure of the extent to which autonomy has been lost.

Principal Reference

Christie G, Marsh R, Sheridan J, Wheeler A, Suaalii-Sauni T, Black S and Butler R. (2007). The Substances and Choices Scale (SACS) - the development and testing of a new alcohol and other drug screening and outcome measurement instrument for young people. *Addiction*, 102 (9): 1390 – 1398

SACS was developed and validated in New Zealand populations, and has good specificity and reliability.

▪ Use

SACS is only to be used by health professionals working with young people who are engaged in a treatment agency or other specifically trained practitioners.

SACS is a twenty-three-question problematic substance use screening instrument that captures the past month's substance use and is useful for measuring changes in patterns of use over time. It has been specifically designed for use with adolescents.

The SACS has the potential to both complement and monitor the effectiveness of interventions with adolescents. It is recommended that it be used in conjunction with the SDQ (Strengths and Difficulties Questionnaire) to monitor changes in wellbeing.

▪ Administration and Scoring

The screen is a self-report instrument.

▪ Training

Training in the use of the SACS is available through Matua Raki (**www.matuaraki.org.nz**) on request.

▪ Availability

The SACS is copyrighted but free to use by non-profit health organisations. Guidelines for its use and scoring can be obtained from **www.sacsinfo.com/Information.html**

SUBSTANCES AND CHOICES SCALE

Name.....

Date of birth..... Number.....

The SACS is only to be used by health professionals working with young people who are engaged in a treatment agency.

The questions in part A) and B) are about your use of alcohol and drugs over the last month.
This does not include tobacco or prescribed medicines.
Please answer every question as best you can, even if you are not certain. Tick only one box on each row.

A) On how many times did you use each of the following in the last month?	*Never*	*Once a week or less*	*More than once a week*	*Most days or more*
1. Alcoholic drinks (e.g. beer, wine, spirits etc.)	☐	☐	☐	☐
2. Cannabis (e.g. weed, marijuana, pot, skunk etc.)	☐	☐	☐	☐
10. Other drug. *Name*.....	☐	☐	☐	☐
11. Other drug. *Name*.....	☐	☐	☐	☐
12. Other drug. *Name*.....	☐	☐	☐	☐

B) Mark one box (on each row), on the basis of how things have been for you over the last month.	*Not True*	*Somewhat True*	*Certainly True*
1. I took alcohol or drugs when I was alone.	☐	☐	☐
2. I've thought I might be hooked or addicted to alcohol or drugs.	☐	☐	☐
3. Most of my free time has been spent getting hold of, taking, or recovering from alcohol or drugs.	☐	☐	☐
4. I've wanted to cut down on the amount of alcohol and drugs that I am using.	☐	☐	☐
5. My alcohol and drug use has stopped me getting important things done.	☐	☐	☐
6. My alcohol or drug use has led to arguments with the people I live with (family, flatmates or caregivers etc.).	☐	☐	☐
7. I've had unsafe sex or an unwanted sexual experience when taking alcohol or drugs.	☐	☐	☐
8. My performance or attendance at school (or at work) has been affected by my alcohol or drug use.	☐	☐	☐
9. I did things that could have got me into serious trouble (stealing, vandalism, violence etc) when using alcohol or drugs.	☐	☐	☐
10. I've driven a car while under the influence of alcohol or drugs (or have been driven by someone under the influence).	☐	☐	☐
	SACS difficulties scale		

C) Finally, how often have you used tobacco (e.g. cigarettes, cigars) over the last month?	*Never*	*Once a week or less*	*More than once a week*	*Most days or more*
	☐	☐	☐	☐

Date completed .....

Clinician .....

SACScommunity

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Strengths and Difficulties Questionnaire SDQ

Principal Reference

Goodman R. (1997). The Strengths and Difficulties Questionnaire: A Research Note. *Journal of Child Psychology and Psychiatry*, 38: 581 – 586.

SDQ is in wide use in New Zealand, especially in Child Adolescent Mental Health Services (CAMHS). While it has not been validated with New Zealand populations, it has been well validated in Australia and described as having "sound psychometric" properties.

▪ Use

The SDQ is a twenty-five-item questionnaire concerning child and adolescent behaviour. SDQ is designed to screen for conduct problems, hyperactivity, emotional symptoms, peer problems, and pro-social behaviour. The SDQ is often paired with the SACS as a package to provide a more holistic screening process to assist development of appropriate treatment plans for adolescents.

▪ Administration and Scoring

The SDQ can be self-administered or administered by a practitioner. Different versions are also available for parents or teachers to administer depending on the age of the child or adolescent.

▪ Training

Formal training to use and interpret the SDQ is not available. It appears that a background in the health or education sectors would be helpful to make best use of the results.

▪ Availability

While the SDQ is copyrighted, it is free to download and use without modification. Full scoring instructions and guidelines for use can be obtained from: **www.sdqinfo.org/a0.html**

SDQ was developed in 1997 and has been translated into numerous languages over the intervening years. Translations are available at the above website.

Strengths and Difficulties Questionnaire SDQ

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of how things have been for you over the last six months.

Your name ..... Male / Female

Date of birth .....

	Not True	Somewhat True	Certainly True
I try to be nice to other people. I care about their feelings	☐	☐	☐
I am restless, I cannot stay still for long	☐	☐	☐
I get a lot of headaches, stomach-aches or sickness	☐	☐	☐
I usually share with others, for example CDs, games, food	☐	☐	☐
I get very angry and often lose my temper	☐	☐	☐
I would rather be alone than with people of my age	☐	☐	☐
I usually do as I am told	☐	☐	☐
I worry a lot	☐	☐	☐
I am helpful if someone is hurt, upset or feeling ill	☐	☐	☐
I am constantly fidgeting or squirming	☐	☐	☐
I have one good friend or more	☐	☐	☐
I fight a lot. I can make other people do what I want	☐	☐	☐
I am often unhappy, depressed or tearful	☐	☐	☐
Other people my age generally like me	☐	☐	☐
I am easily distracted, I find it difficult to concentrate	☐	☐	☐
I am nervous in new situations. I easily lose confidence	☐	☐	☐
I am kind to younger children	☐	☐	☐
I am often accused of lying or cheating	☐	☐	☐
Other children or young people pick on me or bully me	☐	☐	☐
I often offer to help others (parents, teachers, children)	☐	☐	☐
I think before I do things	☐	☐	☐
I take things that are not mine from home, school or elsewhere	☐	☐	☐
I get along better with adults than with people my own age	☐	☐	☐
I have many fears, I am easily scared	☐	☐	☐
I finish the work I'm doing. My attention is good	☐	☐	☐

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ASSESSMENT TOOLS and FRAMEWORKS

Brief Clinical Assessment

A brief clinical assessment can form the basis of a triage process in that it can help identify some key issues and possible interventions. It should be seen as part of a stepped care process that sits between a screen that identifies that a conversation needs to happen and a comprehensive assessment.

It is expected that assessors carrying out a brief clinical assessment have experience and training in the assessment and management of addiction-related conditions (including mental health and other complexities). A recovery-focused management plan will require a more comprehensive assessment than that offered by a brief clinical assessment.

The brief clinical assessment model is sometimes used as an initial assessment with subsequent sessions developing a more complete picture from which to negotiate a treatment plan. It has been a useful model for use in some primary care settings and in Courts where timeframes are often short. An assessor may need to complete a brief clinical assessment within the hour (e.g. if undertaken in a Court setting) and professional judgement will need to be exercised as to the most clinically relevant information to be collected and reported.

The purposes of a brief clinical assessment can be to establish whether there is an addiction-related problem requiring treatment; the degree of insight and motivation to address any identified problems; the need for a more comprehensive assessment to be undertaken and to give some indication of possible options. Although brief, the assessment should still seek to make sense of why someone is presenting in the way they are.

A summary of the brief clinical assessment might be given to whoever has asked for the assessment e.g. Court or a Board; but the 'full' assessment should be available if required by them, as well as being available to any provider of a service that the person might attend. If a brief clinical assessment is paid for then the information belongs to whoever paid for the assessment and access to the report (in part or total) needs to be negotiated with them or their agents.

Taking an accurate and clinically relevant history is important. The following has been gleaned from a number of formats provided (and these would have been shaped by training, experience and service need). It provides a useful guideline, with heading and prompts (e.g. grids) relevant to the line of investigation. This should be read in conjunction with and further to the sections related to comprehensive assessment and also providing information to Courts and Parole Boards.

1. Introduction

(name, age, occupation, relationship status, dependants, current living circumstances, hopes and goals for the future.)

2. Presentation

(nature of referral, including the view of the person being assessed as to their presenting issue(s) and expectations of help)

3. Presenting Problems

A. Alcohol and other drug

i. Substances used in life, including nicotine:
- ever used (including intravenously)
- age of first use
- age of first regular use
- any problems from use
- longest periods of abstinence

ii. Current or most recent use (last 6 months):
- current patterns of use (quantity and frequency)
- consequences of alcohol and other drug use
- current DSM criteria

DSM-criteria	Alcohol	Cannabis	Nicotine	Sedatives	Stimulants	Opioids	Hallucinogens
1							
2							
3							
4							
5							
6							
7							

(The above DSM criteria by substances grid originally developed by Prof. Doug Sellman and promoted in the National Addiction Centre courses)

iii. Person's stated or implied reasons for current using
iv. Treatment history (including use of self-help groups).

B. Behavioural addiction

i. Pathological gambling:
- exploration of patterns and consequences of gambling
- DSM criteria for pathological gambling
- person's stated reason for current gambling
- previous treatments.

4. Mental Health History

- current and past diagnoses and treatments and medication
- results of a Kessler 10 or other relevant mental health screen
- current problems and related issues
- identifying likely DSM criteria
- current risk of self-harm, suicidality, homicidality

5. Medical History

i. current prescribed medications
ii. past physical health issues/ diagnoses/ treatment, including head injuries

6. Insight and Motivation for Each Major Problem

7. Professional Judgement

i. Provisional 'Diagnoses'

Axis 1 Substance use disorders, behavioural addiction and other psychiatric disorders (including conduct disorder)

Axis 2 Personality disorder/ cognitive issues

ii. Individualised Problem List
Current issues:
- addiction (alcohol and other drug, smoking or problem gambling)
- physical health
- mental health
- relationship
- legal

iii. Formulation
'Why is this person presenting in this way at this time?' The 4x3 grid may help in organising ideas; however given the less than comprehensive nature of brief assessments a relevant management plan will require further investigation)

	Vulnerability (Predisposing)	Triggers (Precipitating)	Maintaining (Perpetuating)	Strengths (Protecting)
Biological				
Psychological				
Social/ Cultural				

The 4x3 grid promoted by the University of Otago PSME 404 course and *Te Ariari o te Oranga* (Todd, 2010) may help in organising ideas. Given the less than comprehensive nature of brief assessments a relevant management plan will require further investigation

8. Management

i. Indicative Management/ Treatment Goals
The key goals are drawn from the formulation and the problem list.

ii. Indicative Management Plan
Key areas to consider are:
1. setting
2. further information required
3. treatment of medical conditions
4. psychopharmacology
5. psychological interventions
6. self-help groups

9. Recommendation

The recommendation should identify:
– whether someone would seem to meet criteria for a particular addiction, physical or mental health disorder that could be addressed through an evidence-based intervention.
– potential services or programmes however without further assessment and discussion with the service provider there might be questions about the suitability of the person assessed for that service or programme.
– whether further assessment is needed.

Comprehensive Assessment and Management Plan

It is expected that practitioners completing comprehensive assessments have experience and advanced training in the assessment and management of addiction-related conditions and have a person-centred, recovery focused approach. Content and formats of comprehensive assessment in New Zealand have been significantly influenced by the training provided by tertiary training providers and service demands.Matua Raki appreciates the permission of Dr Fraser Todd to use the template for comprehensive assessment outlined in *Te AriAri o te Oranga* for this section and acknowledges Dr Todd's unique contribution to our sector in the assessment area. Any adaption to the template reflects practitioner contributions to this project and the purpose of this resource to promote pathways for best practice assessment.

History

Taking an accurate and clinically relevant history requires a significant amount of detail to be recorded. The following provides a useful guideline, with heading and prompts relevant to the line of investigation.

1. Introduction

(name, age, occupation, marital status, children, current social circumstances, key relationships) Hopes and goals for the future, identification of what wellbeing might mean to the client/ tangata whaiora.

2. Presentation

(nature of referral, including the view of the client/ tangata whaiora as to their presenting issue(s) and expectations of help)

3. History of Presenting Problems

(begin with the issue the client/ tangata whaiora believes is the most important – either alcohol and drug or a mental health problem)

4. Addiction History

A. Alcohol and other drug

i. Substances used in life, including nicotine:
- ever used
- regularly used
- recently used or currently using
- quantity and frequency of use
- ever used intravenously

ii. Pattern of substance use for each regularly used substance:
- current or most recent use
- age of first use
- age of first regular heavy use
- first problems from use
- heaviest three- to six-month period of use
- DSM symptoms during heaviest period of use
- current patterns of use
- current DSM symptoms
- longest periods of abstinence

iii. Person's stated or implied reasons for using

iv. Complications of alcohol and drug use

	DSM-IV	Alcohol	Cannabis	Nicotine	Sedatives	Stimulants	Opioids	Poly
1								
2								
3								
4								
5								
6								
7								

v. Dependence/ abuse status (i.e. DSM symptoms)
vi. Interactions between substance use and any mental health symptoms
vii. Treatment history (including use of self-help groups).

B. Behavioural addictions

i. Pathological gambling:
- exploration of patterns and consequences of gambling
- attempts to control or reduce gambling
- DSM criteria for pathological gambling
- interaction between gambling, substance use and mental health symptoms
- previous treatments.

ii. Other addictive behaviours

5. Mental Health History

This includes:

- key current problems and symptoms
- identifying likely DSM-IV diagnoses
- determining the onset of symptoms, problems and any vulnerability factors or prodromal symptoms (e.g. history of shyness and separation problems with current anxiety problems)
- the course of symptoms since onset and their relationship to significant life events
- considering constructing a timeline of the course of mental health symptoms relative to substance
- current and past diagnoses and treatments

A. Screening of Other Mental Health Problems

This includes, but is not limited to, the following:

i. **Generalised anxiety:** Have you ever worried a lot about terrible things that might happen, even when it was unrealistic to worry as much as you did?

ii. **Social anxiety:** Is there anything that you were ever afraid to do or felt uncomfortable doing in front of other people, like speaking, eating or writing? What were you afraid could happen when doing this?

iii. **Agoraphobia:** Were you ever afraid of going out of the house alone, being in crowds, standing in a line or travelling on buses or trains? What were you afraid could happen?

iv. **Panic:** Have you ever had a panic attack, when you suddenly felt frightened, anxious or extremely uncomfortable? Have you ever had one when you did not expect to at all?

v. **Post-traumatic stress disorder:** Have you ever experienced a very traumatic event which was extremely distressing?

vi. **Anorexia nervosa:** Have you ever had a time when you weighed much less than other people thought you ought to weigh but you continued to feel overweight?

vii. **Bulimia nervosa:** Have you ever had eating binges during which you ate a considerable amount of food in a short period of time and during which your eating was out of control?

viii. **Obsessive compulsive disorder:** Have you ever been bothered by thoughts that did not make any sense and kept coming back to you even when you tried not to have them? Was there ever anything that you had to do over and over again and could not resist doing, like washing your hands again and again or checking something several times to make sure you had done it right?

ix. **Dysthymia:** Have you ever been bothered by, or experienced, depressed mood most of the day, more days than not, for a period of several years?

x. **Major depressive syndrome:** Has there ever been a period of time when you were feeling depressed or down most of the day, nearly every day, for at least two weeks?

xi. **Manic syndrome:** What about ever having the opposite of depression, when you were feeling so good or high that other people thought you were not your normal self, or you were so high that you got in trouble?

xii. **Delusions (reference and persecutory):** Did it ever seem that people were talking about you or taking special notice of you? What about receiving special messages from the TV, radio or newspaper, or from the way things were arranged around you? What about anyone going out of their way to give you a hard time, or trying to hurt you?

xiii. **Hallucinations (auditory and visual):** Did you ever hear things that other people could not hear, such as noises, or the voices of people whispering or talking? Did you ever have visions or see things that other people could not see?

B. Exploration of self-harm, suicidality, homicidality and other areas of risk

(Past/current).

C. Interactions between substance use, gambling and mental health problems.

Identify mental health symptoms likely to be secondary to substance use or gambling as suggested by:

- amelioration of symptoms during abstinence
- absence of whānau, or family history of the mental health problem
- onset of mental health symptoms after onset of behaviour and possibly during a period of heavy use

Identify the relationship between substance use, gambling and mental health symptoms, including:

- the course of mental health symptoms during abstinence from behaviour
- mental health symptoms during periods of heavy substance use or gambling
- the effects on intoxication on symptoms

This should be informed by current research on interactions.

Note: It is important not to expect that certain interactions **should** *occur. While there is good evidence that depressive symptoms may often, but not always, be secondary to alcohol use and psychotic symptoms secondary to stimulant and hallucinogen use, the evidence for many other interactions is equivocal, despite 'clinical lore'.*

6. Medical History

This includes:

i. current prescribed medications

ii. past diagnoses/treatment, including head injuries

iii. current symptoms/problems in systematic review:
- nervous
- endocrine
- cardiovascular
- respiratory
- gastrointestinal
- genitourinary
- musculoskeletal

iv. estimated risk of infection

v. whānau or family disorders and problems in first and second degree relatives –especially Hep B, Hep C, HIV

7. Legal/Forensic History

This includes:
- convictions
- illegal activities not convicted of
- terms of imprisonment
- charges pending and current legal status
- relationship between substance use, gambling, mental health symptoms and offending

8. Whānau or Family History

This includes:
- structure of whānau or family of origin
- role within whānau or family
- whānau or family disorders and problems in first- and second-degree relatives:
  - alcohol and other drug use
  - problem gambling
  - psychiatric
  - medical
  - legal
  - living in the whānau or family while growing up
  - general whānau or family functioning
  - adequacy of specific relationships within whānau or family
  - occurrence of emotional/physical/sexual abuse
  - other behavioural disturbances
  - historical involvement with social agencies (e.g. Child, Young Persons and Families Service)
  - current relationships within whānau or family of origin
  - ability of whānau or family to fulfil key functions

9. Personal/ Developmental History

This may include:
- birth problems, early developmental milestones
- significant life events in infancy, including separations from parents
- nature and personality in infancy, early childhood

- significant early health problems
- schooling:
  - primary, intermediate and secondary
  - academic ability and performance, including periods of success and reduced performance
  - specific learning difficulties, estimate of baseline intellectual ability
  - socialisation –ability to make and sustain friendships, nature of peer affiliation
  - discipline and behavioural problems at school, attention problems
  - other behavioural disturbances, including conduct disorder
- adult relationships
- ability to establish and maintain friendships:
- psychosexual development and marriage
- key enduring friendships
- nature of peer relationships
- quality of social support networks
- sexual orientation
- occupational history
- personality:
  - including description by tangata whaiora and whānau or family
  - personality strengths
  - screening for presence of personality disorder, especially antisocial personality disorder and any other personality disorders
  - other issues (e.g. anger control problems)
- leisure skills:
  - interests, hobbies
- cultural history:
  - cultural identity
  - cultural practices
  - relevant cultural beliefs
- issues likely to affect cultural impact on CEP and treatment

10. Current Psychosocial Functioning

This includes:

- work
- relationships
- accommodation
- finances
- social networks
- on-going stresses
- coping skills
- problem-solving skills

11. Spiritual History

This includes:

- spiritual beliefs
- spiritual experiences
- spiritual practices
- impact of spirituality on substance use and mental health issues

12 Stage of Change for Each Major Problem

13 Current Mental State Examination

Note: the current mental state examination observes the mental state of the client/ tangata whaiora as they present currently i.e. during the current interview. For example, if delusional thinking is evident during the interview it is included, but if there is a recent history of delusional thinking over preceding days but not observable during the interview, it would be entered in the history section.

Appearance and behaviour:
- physical appearance
- clothing
- movements
- state of intoxication
- state of consciousness

Speech:
- speed
- articulation
- volume
- relevance

Affect and mood:
- depressed mood
- elation
- anxiety

Thought process:
- specific thought disorder

Thought content:
- preoccupations
- overvalued ideas
- delusions

Perception:
- illusions
- hallucinations

Insight/motivation and readiness to change:
- degree of awareness/acceptance and ability to co-operate with treatment
- stage of readiness to change

Cognitive screening:
- orientation (time/place/person); year, season, month, day, date, time

Registration of four unrelated objects
- Attention and concentration — '100-7 test', spell word (e.g. world) backwards
- Naming of objects — (e.g. name watch strap, clasp) and tell time
- General knowledge — (e.g. Prime Minister of New Zealand, capital city of Australia, closest planet to the sun)
- Interpretation of a proverb — concrete or abstract interpretation
- Constructional ability — (e.g. draw a clock face)
- Short-term recall of the four unrelated objects.

Comprehensive Assessment and Management Plan

Physical Examination

Opinion

1. Potential 'Diagnosis' (using first three axes of DSM-IV multi-axial system)

   Axis 1 Substance use disorders, behavioural addiction and other psychiatric disorders (including conduct disorder)

   Axis 2 Personality disorder

   Axis 3 Physical conditions and problems

2. Individualised Problem List

   Current issues:

   - physical health
   - mental health
   - work
   - whānau or family
   - relationship
   - accommodation
   - financial
   - legal
   - any other

3. Aetiological or Causal Formulation

   Note: The formulation is an explanatory statement, that attempts to answer a key clinical question: 'Why is this person presenting in this way at this time?'. It is a statement that links individual characteristics and issues (past and present) to diagnoses in a way that generates treatment goals and management plans. (The 4x5 grid [Todd 2010] may help in organising ideas)

	Vulnerability (Predisposing)	Triggers (Precipitating)	Maintaining (Perpetuating)	Strengths (Protecting)
Biological				
Psychological				
Whānau and Social				
Cultural				
Spiritual				

Feedback of shared understanding as a basis for negotiation of management plan

Management

1. Management Goals

The key goals of management are drawn from the opinion.

2. Management Plan

Ten key areas to address are:

1. setting
2. further information required
3. treatment of medical conditions
4. psychopharmacology
5. psychological interventions
6. whānau or family and social interventions
7. spiritual interventions
8. education/work/occupation
9. education of client tangata whaiora and significant others
10. self-help groups

All of the above are considered for the following phases of treatment:

- pre-treatment
- early treatment
- middle treatment
- late treatment
- autonomous independence

Prognosis

This includes:

- the natural course of the disorder
- positive factors that modify the course in this client/tangata whaiora
- negative factors that modify the course in this client/tangata whaiora
- synthesis and prediction (symptoms and general functioning)

Information to Courts and Parole Boards

Overview

There are a number of assessment formats currently being trialled in New Zealand Courts. At present there is no single nationally recommended set of guidelines for reporting assessments to the Judiciary or to Parole Boards; however this resource could be considered a starting place for promoting consistent practice in the addiction sector. There has been an expectation that assessments address similar content and be undertaken to a similar standard as for the comprehensive assessment outlined earlier in this resource. What might differ in final presentation to the end user might be the final format. Further discussion with members of the Judiciary will no doubt see this resource evolve to not only set standards of practice in the addiction sector but also set clear guidelines for providing information to Courts and the Parole Board.

In order to make informed decisions Courts and Parole Boards must obtain the best possible assessment. It should be noted that this assessment will likely be one of a number of different sources of information available to the Court or Parole Board in their decision-making process. It is also acknowledged that the time frames for completing assesments may on occasion be short and that the assessment may well have been asked for by someone other than the person being assessed. Assessments might be generated in a number of ways and include, but are not limited to, the following situations:

- The Court asks for an assessment to assist disposition – including sentencing
- The Probation Service asks for an assessment to assist them to make recommendations to Courts and/or the Parole Board
- The person (or a member of their whānau or family) before the Court or Board asks for an assessment
- The Parole Board requests an assessment to assist decision-making prior to release

Depending on the source of the referral there may be expectations that the assessor will not only assess whether the person has an addiction-related problem and outline best possible solutions but also that they might arrange referrals to specific programmes.

By providing assessment content guidelines in this resource, Matua Raki as the National Addiction Workforce Centre, is setting a benchmark for assessors that Courts and/or Parole Boards should be able to expect as a minimum standard for assessments provided to them. The standardisation of assessments is essential to improve the credibility of such reporting intended for the Court or Parole Board.

These guidelines will also be valuable to help readers of these assessments make better sense of the information presented.

Introduction

While many people may assess people, addiction-related assessments intended to inform the Courts and/or Parole Boards should be conducted only by practitioners with experience **and** training in the comprehensive assessment of addiction-related conditions, including problematic substance misuse, problem gambling and co-existing mental health problems. Assessors should also have a sound knowledge of available interventions and a working experience of New Zealand's criminal justice processes. Experience working with a range of offenders is also cruital.

Part of the engagement process in any assessment is discussing the limitations to confidentiality i.e. information shared with an assessor is not protected. The person being assessed needs to have this

explained and so they can decide for themselves if they wish to not disclose certain information. This of course can be problematic but generally can be worked through. It is also important to discuss whether they wish to allow the assessor to have access to pre-existing assessments or reports.

As stated in the introduction, an assessment should be the basis for the development of a tailored treatment plan. However, it should be noted that the assessor (or any agency the assessor might work for) providing information that might inform a Court or Board may not be involved actively in ongoing treatment planning or case management post sentencing or release. The implication of this is that the assessment can only be an indicator of an appropriate level of care to be prioritised, planned and potentially provided. This includes identifying necessary support services (primary healthcare or social services etc.) and matching people with the different types of services needed and available.

These addiction-related assesments will most likely be read in conjunction with and further to reports provided by the Department of Corrections. In general the assessment should cover (but not necessarily be limited to) the following components:

- The hopes and goals of the person being assessed, identification of what wellbeing might mean for them
- Addiction history (past and current patterns of use, dependence or abuse status; reasons for use, periods of abstinence etc)
- Offending
- Mental health history and current issues (including impact on substance use or gambling; suicidality and homicidality; risk etc);
- General medical and health status (including use of any medications including NRT and OST; infection or risk of infection; history of trauma, especially head injuries)
- Family and social support (including employment)
- Previous treatment
- Motivation and readiness to change
- Opinion
- Suggested treatment options and prognosis
- Summary

The documentation should be in narrative form, fully describing each section. Using a check-list is not acceptable as sole documentation. The information provided will normally be based on self-report by the person being assessed (and any corroboration from others), biochemical testing (if available), documentation provided by the Department of Corrections or previous assessments and clearly articulated clinical opinion.

A summary of the assessment might be given to the Court or a Board; but the full assessment should be available if required by them, as well as being available to any provider of a service that the person might attend post sentence or post release. If an assessment is paid for by the Court or the Department of Corrections then the information belongs to them and access to the report (in part or total) needs to be negotiated with them or their agents.

The assessment (or summary provided) must be signed and dated by the practitioner actually undertaking the assessment (including their registration number if a member of a professional body such as DAPAANZ).

Key Elements: Assessment for Court or Parole Board Purposes

When writing an assessment which will inform the Court or Parole Board it is important to provide information that is relevant to the context and needs of the Court or Parole Board. Thus, clarity of expectation is important – is it purely assessment or is it to arrange a referral to a programme. Often Court and all Parole Board appearances will be accompanied by reports from the Department of Corrections, e.g a 'probation report'. While these reports and the assessment should be complementary in nature, it is important to highlight and reinforce that an assessment of any behavioural addiction has a health focus for which the assessor has the appropriate training and experience. Given the amount of information the Judiciary and Board have to consider (including details of past and present offending) it might be appropriate to provide them with a summary of the assessment, outlining key factors that might assist their decision-making processes.

In terms of the assessment itself, the following might be considered to be the minimum information to be gathered and reported on:

Section one: **Introductory Details**

- Name
- Marital status
- Current social circumstances including status, e.g. on bail, remanded in custody or first appearance before the Parole Board
- Ethnicity and cultural identity

Presentation:

- Nature of referral and where the interview occurred
- What the person perceived to be their main problem and what their expectations were
- Who else was consulted and documents perused, e.g. probation report, most recent AOD or gambling assessment.

Example

This summary of assessment is provided after interviewing John Smith at the Paparua Remand Centre on the 1st of April 2010 (and subsequently on two other occasions), perusing a previous assessment provided from the Salvation Army Bridge Programme (from 2008) and discussions with his Probation Officer Matua Raki, who referred Mr Smith for assessment. He is for sentence on 14 April 2010 on three charges of excess breath alcohol. He indicated that he accepts he might have an alcohol problem for which he now is seeking help. Mr Smith said that his goal is to get a job, regain his licence and find someone to share his life with.

Mr Smith is a single 47-year-old New Zealand born male of Tongan descent. Prior to his remand in custody he lived in a central city flat on his own. He is currently in receipt of an invalid's benefit. He reported that he has a recurring back injury that stops him from working.

Section two: **Addiction History**

(i) Alcohol and other drug use

The assessor should have a clear picture of the following:

- Substances (including nicotine) ever used
- Substances regularly used
- Substances recently used or currently used
- Quantity and frequency of use

A complete substance use history should be obtained. Most people will often present with a history of having used a variety of substances and each substance used could potentially complicate treatment planning. Addressing all substance use is likely to improve treatment outcomes. For example, when treating severe cannabis dependence without addressing other substances (whether abuse or dependence) there is an increased risk of relapse and potential offending. If previous reports are available then the purpose of the assessment might be to confirm the information in them and to determine current status of substance use.

Patterns of substance use (including nicotine and any prescribed medication) should then be explored for the substances most regularly and currently used:

- Age of first use for each substance.
- Age of first regular use (and first problems).
- Heaviest three to six month period of use (as well as determining whether they met any DSM criteria during this time).
- Current patterns of use (including any current DSM criteria and or complications of use).
- If they use nicotine, how soon after waking do they have their first smoke.
- Longest period of abstinence including information about why and how this was achieved.
- Treatment history including attendance at self help groups.
- The person's stated or implied reasons for using.

Being incarcerated does not mean they are not currently using substances however it is most useful to look at the patterns of substance use in the 12 months before incarceration (including remands in custody) as well as current use. Some inmates might feel reluctant to disclose current substance use if they perceive negative consequences to any disclosure.

The assessor should investigate the presence or absence of any possible withdrawal symptoms at the time of incarceration and any incongruence between stated levels of use, withdrawal symptoms and any need for management of withdrawal.

(ii) Other behavioural addiction (e.g. problem gambling)

Similarly to the above, the assessor is seeking to explore patterns of use, stated reasons for starting to use and continuing to use and consequences as well as attempts at control. From this information the assessor is in a position not only to decide if DSM criteria is being met but also to determine potential interactions with substance use and mental health conditions.

(iii) Offending

The purpose of this section is to explore if there is a relationship between substance use or problem gambling and any offending. The assessor is looking for any patterns and, as ever, listening for any

cognitive distortions related to either offending or addiction. If the assessor does not have access to the previous conviction list then they need to state that the assessment is reliant on self-report.

An explanation of the factors that are likely to have contributed to an offence(s) does not have to be written as mitigation if professionally worded; again, the purpose is to look for and report patterns.

Example

Mr Jones' previous conviction list confirms he has an extensive offending history spanning some 15 years. He indicated in interview that he has offended when intoxicated, when he had consumed alcohol or other drugs in the 24 hours before his offending and when he was 'straight'.

Mr Jones admitted in interview that when he has been drinking he has been more prone to violence and to driving. He felt somewhat aggrieved about his convictions for drink driving and disqualified driving as he said he always 'felt he was in control and safe to drive and it was mainly that the local police were out to get him'. When asked about his convictions for assault and domestic violence he said that if he had been using cannabis he would often let things slide. He said drinking often helped him feel better about himself and he also drank with people he considered 'good mates'. He also said in interview "sometimes people just needed to know their place".

Excessive alcohol consumption has contributed to Mr Jones' dishibition and risk-taking which have heightened the likelihood of his driving or becoming violent. In interview he appeared to have limited insight with regard to this. He also indicated that his propensity for violence and driving sometimes occurs when he has not been drinking, an observation confirmed by his partner.

Section three: **Mental Health History**

A mental health assessment will help determine if and how a person's substance use or problem gambling might be affected by a coexisting mental health condition and vice versa. It might also indicate possible complications for treatment or longer-term recovery. It may also determine whether a more thorough mental health assessment is needed.

A competent assessor will have had training to be able to determine the following:

- Current problems and symptoms (identifying likely provisional DSM diagnosis)
- Aetiology and onset of symptoms, problems and vulnerability factors
- Course of symptoms since onset and their relationship to significant life events
- Current and past diagnoses and treatments (including medication)

An examination of the possible interaction between the client's mental health and any behavioural addiction.

Competent addiction assessors have an understanding of coexisting problems and will be able to screen or recognise and explore the following as a minimum:

- Anxiety disorders including social anxiety and post traumatic stress disorder
- Eating disorders
- Mood disorders including dysthmia and Bi-Polar Affective Disorder
- Suicidality (past and present)
- Homicidality (past and present)

- Schizophrenia and other psychotic disorders
- Personality disorders including antisocial and borderline disorders
- ADD/ADHD

Section four: General Medical and Health Status

A person's general medical and health status should be documented because some medical conditions will have an impact on the choice of treatment options and can have an impact on the potential effectiveness of proposed treatment. Documentation of this kind can identify risks to others during treatment or containment (including within a prison setting).

Medical and health status information should include:

- History of injury and trauma, chronic disease, physical disabilities.
- Sexual health status (need for treatment).
- Detail of current or prior use of medications and the identification of any allergies to medication and possible drug-drug interactions or adverse reactions.
- Any known or estimated risk of infection from hepatitis, HIV/AIDS, tuberculosis and other respiratory infections etc.
- Chronic pain conditions which are managed with pain medications like morphine or codeine and which may have an impact on pharmacotheraputic treatment options (such as opioid substitution treatment or naltrexone).

Section five: Family and Social Support

Social and family support, stability of home and social environments and a person's ability to interact in social or family settings should be explored. For potential parolees each of these matters impacts on the client's ability to re-integrate and affects the likelihood of relapse or treatment success. The Court and/or Parole Board will have reports from the Probation Service reporting on, and possibly exploring these further, but with an offending (or re-offending) focus.

Family and Social Support information should include:

- Family history of substance misuse, problem gambling and/or mental health problems.
- A description of the quality of social/family relationships, including significant history of abuse and disfunction, focusing on potential supports and/or barriers to change and sustaining behavioural change.

Employment and Education

Employment and education can impact on treatment options and outcomes. A direct relationship to the concept of health literacy exists here, and therefore any special requirements (in regards to the client's ability to communicate and comprehend) that could impact on treatment compliance, flow and understanding should be explored. Employment and education information should include:

- Employment/vocational status.
- Literacy and developmental disabilities.
- Interpersonal coping strategies, problem solving abilities, and communication skills.

Section six: **Previous Treatment:**

Prior involvement in treatment can give clues to what treatment plans or aspects of care impact positively, those which could be improved on or those which fail to impact at all.

Treatment information should include:

- Treatment history and response to, or compliance with treatment, including any mental health treatment:
  - the number and type of prior treatment experiences (was treatment voluntary or mandated), and those treatment outcomes.
  - prior and current counselling including date range, purpose, duration and provider.
- Prior experience with self help or other peer support groups.
- Self-efficacy in adopting lifestyle changes (e.g., maintaining abstinence, complying with medication). If a person has maintained any period of abstinence it is important to record why and how this occurred and why it might have ended.
- A person's concept of their treatment needs:
  - statement of needs, goals, and treatment expectations from the individual requiring treatment services.
  - family or whānau perceptions should also be obtained, when appropriate and available.
- Resources and limitations affecting the ability to participate in treatment (responsivity factors such as e.g. transportation problems, homelessness, child care needs, cultural or language preference, disability).
- Alternatives and referral sources should be detailed:
  - identify related and alternative services to contribute to or take over treatment to meet ongoing client needs (both in and out of prison).

Section seven: **Motivation and Readiness to change**

A key component of an assessment for Courts and/or Parole Board must be an assessment of motivation and also readiness to change. During the course of the assessment a competent assesor will be looking to elicit evidence of concern for any substance misuse or problem gambling as well as any comments for change.

Motivation in this context is the likelihood that someone will enter into, continue, and adhere to a specific strategy of change. There is a need to be cautious when assessing the reliability of an offender's stated motivation. During an assessment interview the assessor will be listening for inconsistencies in relation to stated motivation – cognitive distortions such as minimisations and justifications for substance misuse, gambling or offending as well as ambivalence about change. Cognitive distortions and ambivalence about change should be considered evidence the client has low or no readiness to change. Someone who recognises they have a problem and indicates they are prepared to make changes could be considered to be contemplative at best.

Evidence of a person being motivated and ready must include actions undertaken, not stated intentions. For example, the person has attended a programme, rather than just saying they intend to enrol in one.

Motivation and readiness to change needs to be identified and commented on for each issue or problem identified. While the assessor will be assessing motivation and readiness to change

throughout the interview, particular attention should be paid to assessing these factors once suggested interventions are discussed.

Low motivation or a lack of readiness for change in an assessment process does not mean that someone can't be engaged in a programme. An appearance before a Court or Parole Board may be an opportunity for change, even if that change is increased awareness and/or motivation.

Section eight: **Opinion**

This section should include:

- Assessment of criteria against at least the first three axes of the DSM multi-axial diagnostic system
- Individualised problem list
- Case formulation (a statement that helps to understand why someone is presenting in the way they are. The 5x4 grid for organising ideas that is shown on page 69 of this resource will be useful)

Section nine: **Treatment options and prognosis**

Feedback and discussion of the previous section will be the basis for negotiation of possible treatment options and a treatment plan. Depending on the nature of the referral the assessor might be expected to make general recommendations for treatment, e.g. residential vs community-based options; or specific recommendations, e.g. three months of individual and group sessions at Te Rangihaeata Oranga problem gambling service starting on 1 May 2010.

It is also important to think of the treatment plan and goals in the short, medium and longer term. There is a high likelihood that the issues identified will need to be worked step by step over time to achieve progress.

NOTE: Any reference to specific programmes must be accompanied by confirmation that discussion about a possible referral has taken place.

Section ten: **Summary**

The summary should detail the following:

- Substance dependence or abuse status or (pathological) gambling
- Presence of any coexisting mental health or physical health condition
- Assessment of motivation and readiness to change for each issue
- Possible interventions (These should be congruent with the content of the assessment)
- Any responsivity factors (factors that might limit or enhance engagement)
- Prognosis (in lay language)
- The assessor's DAPAANZ or other profession group registration number

The assessor does not have to commit to whether any intervention has to be pre or post custodial sentence. If an offender is before the Court or before a Parole Board on a serious charge the assessor needs to understand that potentially the result will be imprisonment or no parole. It is important that an assessor is careful not to take on the role of Probation Officer or judge.

Information to Courts and Parole Boards

Example

In summary, Mark Brown attended an assessment at Te Rito Arahi Addiction Resource Centre and has been assessed as Alcohol Dependent in Sustained Partial remission. This means that although for the past 12 months he has not had as many severe alcohol-related problems as previously, he still experiences enough problems to put his health and the safety of others at risk. He attributes his success at 'cutting down' on his drinking to the birth of his daughter nine months ago and his desire to be a better father than his own father was to him.

Although there appear to be no coexisting mental or physical health problems, given his levels of alcohol consumption over a long period and his jaundiced appearance at interview, a liver function test may well be warranted to investigate possible liver disease including risk of hepatitis.

In interview Mr. Brown stated he has an alcohol problem but appeared uncertain as to what needed to change further for him to address this. He has attended a range of residential and community-based treatment programmes previously, the most recent being two years ago. He is yet to complete a full programme. His stated goal remains abstinence from alcohol – however he does not wish to use medication.

Mark Brown would benefit from a brief period of relapse prevention (RP) training to help strengthen his motivation to maintain changes and to raise his awareness of his potential for relapse. He has been encouraged to attend the four week RP group offered at this Service on Friday between 5 and 7 pm. He was ambivalent about whether he could attend the proposed programme because he said he was often busy with friends on a Friday night.

The facilitators of this training are aware that Mr. Brown has limited literacy skills and indicate this is not a barrier to his participation. They also indicate they can pick him up and drop him off after the training, so reducing any perceived need on his part to drive. The RP group is an open one which means Mr. Brown, should he wish to attend, can start at any time.

Alcohol dependence is a chronic problem with a high probability of relapse. Failure to address his on-going drinking and the consequentially related problems will see further offending and imprisonment (especially related to drink driving and his fits of violence) and deteriorating health and relationships.

Mr. Brown and his partner have enrolled on a six week parenting course which it is confirmed starts next week. He clearly sees that this course can help him be the father he wishes to be but also he realises he must maintain his drinking goals if he is to get the maximum benefit from this course.

On the positive side, Mr. Brown has some employable skills, a desire to be a better father and partner and he has reduced both the frequency and quantity of his alcohol consumption. These factors could help him achieve his goal.

Mark Brown's previous history of alcohol use, relapse, alcohol related offending, on-going family and relationship problems, loyalty to peers for whom alcohol is a key feature and ambivalence to change in relation to alcohol may hinder him from achieving his goal.

Without formal support and monitoring the prognosis for Mark Brown is poor.

I. Mace Wan

Registered Competent Practitioner (DAPAANZ Reg. No. – 32)

April 2011

Leeds Dependence Questionnaire LDQ

Principal Reference

Raistrick D, Bradshaw J, Tober G, Weiner J, Allison J and Healey C. (1994). Development of the Leeds Dependence Questionnaire. *Addiction*, 89: 563 – 572.

LDQ was validated for both men and women in New Zealand populations by Paton-Simpson and MacKinnon (1999). These included some Māori and Pacific.

▪ Use

The LDQ is a 10-item measure of dependence severity which has been validated for alcohol, opioids and some "other drugs".

▪ Scoring and Administration:

LDQ is designed for self-administration. Responses to the LDQ are in relation to the past week, as the scale is designed to be sensitive to change during treatment.

▪ Training

No specific training is required.

▪ Availability

The LDQ is open source and therefore free to use with due acknowledgement to the source.

Guidelines for its use can be obtained from: **http://lib.adai.washington.edu/instruments/**

Leeds Dependence Questionnaire LDQ

Please think about your drinking or drug use DURING THE LAST WEEK when answering. Circle the answers that are most appropriate to you.

	Never	Sometimes	Often	Nearly always
1 Do you find yourself thinking about when you will next be able to have a drink or take drugs?	0	1	2	3
2 Is drinking or taking drugs more important than anything else you might do during the day?	0	1	2	3
3 Do you feel your need for drink or drugs is too strong to control?	0	1	2	3
4 Do you plan your days around getting drink or taking drugs?	0	1	2	3
5 Do you drink or take drugs in a particular way in order to increase the effect it gives you?	0	1	2	3
6 Do you drink or take drugs morning, afternoon and evening?	0	1	2	3
7 Do you feel you have to carry on drinking or taking drugs once you have started?	0	1	2	3
8 Is getting the effect you want more important than the particular drink or drug you use?	0	1	2	3
9 Do you want to take more drink or drugs when the effect starts to wear off?	0	1	2	3
10 Do you find it difficult to cope with life without drink or drugs?	0	1	2	3

Interpretation:

0	No dependence
1 – 10	Low to moderate dependence
11 – 20	Moderate to high dependence
21 – 30	High dependence

TOTAL ☐

Matalafi Matrix

Principal Reference

Suaalii-Sauni T and Dash S. (2009). *The Matalafi Matrix and the DSM-IV-Cultural Formulation Outline (OCF): Aligning cultural formulation tools – a qualitative analysis.* A report prepared for *Takanga a Fohe* (Pacific Mental Health and Addictions Services), Waitematā District Health Board

▪ Use

The Matalafi Matrix is a multi-item holistic assessment developed for use by Pacific practitioners for Pacific clients. It is linked to DSM–IV diagnostic criteria and thus ensures a Pacific perspective to the formulation within a comprehensive assessment. The Matalafi is a cultural bio-psychosocial assessment tool that ensures an assessor gathers relevant information on a Pacific person and their family.

The Matalafi (*Psychotria insularum*) is a herbal plant found growing in the Pacific Islands where the leaves are used for traditional Samoan healing practices (fofo). A traditional healer known as a 'taulasea' uses the matalafi leaves for their medicinal qualities. The legend associated with the plant is that when it is plucked by a taulasea it relocates and replenishes itself. This is analogous to the Pacific person entering a service whose situation may change and the need for practitioners to continually be aware of this and capture those changes. The Matalafi examines five domains:

Aiga – *Family*

Tino Atoa – *Physical*

Lagona – *Emotional and psychological wellbeing*

Aganu'u – *Cultural*

Fa'aleagaga – *Spirituality.*

The English definitions given above are approximate. Adding to this complexity is that each island group may have a different nuance within these domains.

The Matalafi Matrix is a tool currently used by Pacific health service providers in the Auckland region covering adult and youth mental health and addiction services. The evolving Pacific demographic has influenced its development and application. Practitioners have found that the tool assists in facilitating informed diagnosis, treatment planning and intervention types. Initial evaluation results from Waitematā District Health Board's Takanga A Fohe: Pacific Mental Health and Addictions service group suggests that the Matalafi matrix[4] complements existing assessment tools and processes.

▪ Training

The use of the Matalafi within a clinical setting requires experience and training. Contact Matua Raki for further information – (04) 499 9340 or via the website **www.matuaraki.org.nz** or contact Le Va (09) 373 2125 or via the website **www.leva.co.nz**

4 References: (www.crrc.co.nz/reports/Matalafi_report_Final_6.pdf) and (www.crrc.co.nz/reports/MATALAFI_II_Final_Report_09_03_26withISBN.pdf)

Section 65 Land Transport Act

Principal Reference

Ministry of Health (2006). *Guidelines for Assessing Substance Dependence and Risk of Re-offending of People Sentenced under Section 65 of the Land Transport Act 1998*. Wellington: Ministry of Health.

Use

The above guidelines set out the approved process and forms to be used for the assessment of people sentenced under section 65 of the Land Transport Act 1998 (the Act), who, after serving the mandatory minimum disqualification period, wish to have their disqualification removed (as per section 100 of the Act), and to re-apply for their driver licence. They also outline the criteria and process for approval as an assessment centre and the criteria assessment centres need to apply to assessors.

The road safety risks of alcohol and other drug use include:

- Impairment due to sedation effects
- Impaired motor function
- Risk taking
- Exacerbation of other medically related risks.

The process outlined in the guidelines was developed to minimise these road safety risks by promoting community safety by assessing the 'fitness to drive' of repeat offenders sentenced for offences involving alcohol and other drugs and driving. The assessment process and the Act provide an opportunity to promote a change of thinking and behaviour.

The likelihood of achieving these objectives is maximised by approved assessors utilising a comprehensive alcohol and other drug assessment and supporting medical evidence. The Director-General of Health and the Director of Land Transport have approved the assessment components outlined in the guidelines as:

- The identification of current alcohol and other drug use
- Individual issues that result in an assessment as per the criteria in the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association 1994)
- Relevant historical information relating to substance use (including previous episodes of treatment)
- Medical assessment and advice (including results of liver function tests and physical examination)
- An assessment of motivation and readiness to change substance use and driving behaviour.

An assessment for the purposes of the Act is conducted to determine whether a person meets the criteria for substance abuse or dependence and to indicate the likelihood they will continue to drive under the influence of alcohol and/or other drugs in the future. If a person is assessed with substance abuse or substance dependence, they are at greater risk of having road accidents if they drive. This risk is particularly escalated if they have a history of relapse and a history of driving after or during substance use.

Report

The report to Land Transport New Zealand must be given on the prescribed form. It is a summary of the screening and assessment process, justifying any recommendation about the offender's suitability for having the driver licence disqualification removed. The full assessment needs to be

kept on file by the assessment centre in case of appeal. In many respects the same considerations need to be given to an assessment for the purposes of completing this report as to assessments completed for the Court or Parole Board.

It is not mandatory for people to undergo any intervention in order to be able to resit their licence; however, doing so is a good indicator of motivation to change. For people who undertook education or intervention the report will consider any changes since the first interview and any evidence (i.e. more than self-reported information) of a commitment to change, such as the completion of any interventions. When the assessor reviews the case, some of the key elements for deciding whether to recommend that the offender regain their licence include:

- Assessment (current diagnoses using DSM criteria)
- Results of the liver function test (including GGT) and other tests
- Motivation and readiness to change their substance use and driving behaviour
- Previous offending (the greater the frequency of similar offending, the greater the risk of relapse)
- Treatment completion/outcome (the assessor should ask for comment and confirmation from the treatment provider)
- Other factors (e.g. changes in job, relationship and support systems).

The guidelines emphasise the need for the assessor to seek objective corroboration from the person's whānau or significant others as to the progress of the offender. In many situations this will be difficult to achieve and employers may also be a worthwhile source of corroborating information. The assessor also needs to be aware of the importance to the person of regaining their licence and the influence this could have on their veracity.

An assessor's recommendation must take into account an offender's attitude towards driving, and in particular those situations in which driving appears to them to be desirable or necessary. Questions relating to the perceived necessity for driving, social roles and recreation may be appropriate in determining the potential risk of re-offending, as may be monitoring for cognitive distortions such as minimisations and justifications. Where other medical conditions affect a person's fitness to drive, a recommendation can be made for further specialist assessment.

Availability

The guidelines are available on the Ministry of Health's website: **http://www.moh.govt.nz**

Final Report to Land Transport New Zealand (s65 Assessments)

Assessment centre: .....

Assessor: .....

Date report prepared: .....

Personal and contact details	
Full name	
Other or previous names (if any)	
Date of birth	
Current address	
Conviction and assessment	
Date of conviction	
Date of brief medical examination and explanation of blood tests etc. given	
Date(s) of alcohol and other drug assessment (Note the information contained in this report is based on information taken on the latest assessment date)	1. 2.
Results of screening	**Scores**
AUDIT	
LDQ	
Alcohol and other drug use	**Last six months**
Average alcohol use (standard drinks per week)	
Average cannabis use (per week)	
Other drug use (specify drug and average use per week)	
Assessment	**Abuse or dependence**
Alcohol	
Cannabis	
Other drug (please specify)	
Sustained remission Partial remission	Yes / No Yes / No
Liver function tests, including GGT level	
Analysis of blood and urine tests attached	Yes / No
Other mental health problems	1. 2. 3. 4.
Interventions recommended	

Alcohol and other drug treatments undertaken or completed	**Programme and date of completion**
Education	
Psychosocial intervention	
Residential treatment	
Summary of provider comments	
Comments of the programme provider attached to file	Yes / No
Motivation to change	**(Tick as appropriate)**
High	
Medium	
Low	
Prognosis for the individual's on-going substance use	
Other factors affecting 'fitness to drive'	
Is there any other condition that might affect the individual's ability to safely operate a motor vehicle? (Please specify)	

Recommendation for removal of disqualification

Yes (why?)

No (why?)

Further comments

Signature of assessor: .....

(DAPAANZ or other professional society membership number): .....

Date: .....

Severity of Dependence Scale SDS

Principal Reference

Gossop M, Darke S, Griffiths P, Hando J, Powis B, Hall W and Strang J. (1995). The Severity of Dependence Scale (SDS): psychometric properties of the SDS in English and Australian samples of heroin, cocaine and amphetamine users. *Addiction, 90* (5): 607 – 614.

The Severity of Dependence Scale (SDS) is very widely used internationally but has not been validated with New Zealand populations

▪ Use

The SDS is a five-item scale for measuring severity of dependence, validated for heroin, cocaine, amphetamines, benzodiazepines, ecstasy and cannabis. Originally developed to question symptoms in relation to the past year, the scale has also been modified to ask about the past month.

A great strength is its brevity and ability to be used for multiple substances.

▪ Administration and Scoring

The SDS is designed as a self-report instrument but it can be administered by a practitioner. A score of four or higher is indicative of probable drug dependence.

▪ Training

No specific training is required.

▪ Availability

LDQ is open source and therefore free to use – Guidelines for its use can be obtained from: **http://lib.adai.washington.edu/instruments/**

Severity of Dependence Scale SDS

Please indicate the most appropriate response, as it applied to your drug use in the past month.

1. Did you ever think your use of (substance) was out of control?

Never or almost never	0
Sometimes	1
Often	2

2. Did the prospect of missing a fix/hit make you very anxious or worried?

Never or almost never	0
Sometimes	1
Often	2

3. How much did you worry about your use of (substance)?

Not all	0
A little	1
Quite a lot	2

4. Did you wish you could stop?

Never or almost never	0
Sometimes	1
Often	2

5. How difficult would you find it to stop or go without (substance)?

Not difficult	0
Quite difficult	1
Very difficult	2

SDS SCORE

(Add up all the circled numbers to obtain the total score) ☐

OUTCOME and EVALUATION MEASURES

Alcohol and Drug Outcome Measure ADOM

Principal Reference

Deering D, Robinson G, Wheeler A, Pulford J, Frampton C, Dunbar L and Black S. (2009). *Preliminary work towards validating a draft outcome measure for use in the alcohol and drug sector*. Te Pou o te Whakaaro Nui: Auckland.

ADOM has been validated in New Zealand populations. Part A has been shown to have excellent reliability, validity and sensitivity to change. It is therefore recommended as a routine outcome measure for adult clients of alcohol and other drug treatment in New Zealand. Part B is not currently validated so should only be used with discretion to assist clinical planning of individual cases.

▪ Use

The ADOM was developed in New Zealand as a brief (5-10 minutes) outcome measure of adult alcohol and other drug treatment services.

There are 18 questions divided into two sections: Part A (11 questions) is focused on the type and frequency of substance use; Part B (7 questions) is focused on associated psychosocial issues.

▪ Administration and Scoring

ADOM is administered by the clinician collaboratively with the client, ideally in person but it may be conducted by phone. ADOM is designed to measure change over time and so should be administered as follows: on admission to treatment; then either at three-month intervals and/or at discharge; and then possibly post-discharge.

Data is collected at the beginning of treatment to form a baseline for later comparison when the effect of treatment is reviewed. The information collected is not summarised as a score.

▪ Training

Training and guidelines are recommended to administer and score the instrument, however these are not yet publicly available (as at 2010).

▪ Availability

The ADOM is open source. Further information can be obtained from Te Pou's website:
www.tepou.co.nz/files/view/listings/research1/

Alcohol and Drug Outcome Measure ADOM*

Service: ..... Client Name: .....

DOB: / / (D/M/Yr) Gender: M / F

Ethnicity: ..... (If Māori) Iwi: .....

NHI

■ ADOM Collection Stage: Admission [ ]

If the client has been in a 'controlled' environment such as a remand in custody, imprisonment, hospital or residential programme the first ADOM collection occurs based on a recollection of AOD use prior to imprisonment – MRB Initiative Collection Rule.

Post Treatment:

1m [ ]
3m [ ]
6m [ ]
12m [ ]

Interview Date: ..... Service/ Interviewer: .....

All questions relate to the past four weeks
The questions **do not** apply to prescribed medication; however any **misuse** of prescription medication should be included e.g. taking more than prescribed / injecting of medications not intend to be injected.

IN THE PAST FOUR WEEKS:	Days used (0 – 28)	
1. On how many occasions did you drink alcohol?		
2. How many standard drinks did you consume on a typical drinking day?		

IN THE PAST FOUR WEEKS, ON HOW MANY DAYS DID YOU USE:	Days used (0 – 28)	
3. Cannabis		
4. Amphetamine-type stimulants e.g. methamphetamine, speed, methylphenidate (Rubifen)		
5. Opioids		
6. Sedatives / tranquilisers e.g. diazepam (valium) temazepam		
7. Any other drugs e.g. ecstasy, hallucinogens, solvents, GHB etc. Specify what drugs: _____ _____ _____ *Interviewer: If 'other drugs' contains substances covered in the above questions please return to the appropriate question and recode*	_____ _____ _____	___ ___ ___
8. How many cigarettes have you smoked per day, on average *If non smoker enter zero*	*(No.Cigs av.)*	

9. Please put a tick in the right hand column to identify the main substance of concern
(for some clients there may be more than one)

* Adapted from the Methamphetamine Residential Beds Initiative)

IN THE PAST FOUR WEEKS:	Days used (0 – 28)	
10. On how many days have you injected drugs? If none enter zero and go to Q12		
11. Have you shared any injecting equipment? (Sharing means using someone else's equipment which has already been used or someone using yours regardless of whether you were both present at the same time or not. Equipment includes needles, syringes, water, dregs, tourniqets, spoons, filters)	Yes / No	

■ ADOM PART B

IN THE PAST FOUR WEEKS

12. How often has your physical health interfered with your day-to-day functioning?

Never	Less than weekly	Once or twice week	Three or four times a week	Daily or almost daily
☐	☐	☐	☐	☐

13. How often has your psychological or mental health interfered with your day-to-day functioning?

Never	Less than weekly	Once or twice week	Three or four times a week	Daily or almost daily
☐	☐	☐	☐	☐

14. How often has your alcohol or drug use led to conflict with friends or family members?

Never	Less than weekly	Once or twice week	Three or four times a week	Daily or almost daily
☐	☐	☐	☐	☐

15. How often has your alcohol or drug use interfered with your work or other activities? (include social, recreational, parenting/caregiving, study or other personal activities)

Never	Less than weekly	Once or twice week	Three or four times a week	Daily or almost daily
☐	☐	☐	☐	☐

16. How often have you engaged in paid employment, voluntary work, study, parenting or other caregiving activities?

Never	Less than weekly	Once or twice week	Three or four times a week	Daily or almost daily
☐	☐	☐	☐	☐

17. How often have you had difficulties with housing or finding somewhere stable to live?

Never	Less than weekly	Once or twice week	Three or four times a week	Daily or almost daily
☐	☐	☐	☐	☐

18. Apart from using illicit substances, how often have you been involved in any criminal or illegal activity (e.g. driving a motor vehicle under the influence of alcohol or drugs or supplying an illicit substance to another person)?

Never	Less than weekly	Once or twice week	Three or four times a week	Daily or almost daily
☐	☐	☐	☐	☐

APPENDICES

Appendix 1:
Diagnostic and Statistical Manual of Mental Disorders (DSM)

Appendix 2:
Other readings

Diagnostic and Statistical Manual of Mental Disorders DSM

The DSM is the standard diagnostic system used by mental health and addiction practitioners alike. Consistency of use of any diagnostic system helps promote appropriate treatment and care, common language and understanding between practitioners and reliable research.

DSM-IV TR is published by the American Psychiatric Association and is an updated version of the fourth edition or DSM-IV. This version contains minor text revisions in the descriptions of each disorder. DSM-IV TR covers categories of mental health disorders for both adults and children.

DSM-IV TR focuses mostly on describing symptoms. Each psychiatric disorder and corresponding diagnostic code is accompanied by a set of diagnostic criteria and descriptive details. These include associated features, prevalence data, familial patterns, age, culture and gender-specific features and discussion on differential diagnosis. Useful statistics concerning which gender is most affected by the illness, the typical age of onset, the effects of treatment, and common treatment approaches are also included.

DSM-IV TR is based on five different dimensions. This multi-axial approach allows clinicians to make a more comprehensive evaluation of a client's level of functioning.

- **Axis I: Clinical Syndromes**
  This axis describes clinical symptoms that cause significant impairment. Disorders are grouped into different categories, including substance use, pathological gambling, adjustment disorders, anxiety disorders, and pervasive developmental disorders.
- **Axis II: Personality and Mental Retardation**
  This axis describes long-term problems that are overlooked in the presence of Axis I disorders. Personality disorders cause significant problems in how a person relates to the world; these include antisocial personality disorder and histrionic personality disorder. Mental retardation is characterised by intellectual impairment and deficits in other areas such as self-care and interpersonal skills.
- **Axis III: Medical Conditions**
  This axis describes physical and medical conditions that may influence or worsen Axis I and Axis II disorders. Some examples may include HIV/AIDS and brain injuries.
- **Axis IV: Psychosocial and Environmental Problems**
  This axis describes any social or environmental problems that may impact on Axis I or Axis II disorders. These may include aspects such as unemployment, relocation, divorce, or the death of a loved one. Elements of cultural formulation are seen to fit best here.
- **Axis V: Global Assessment of Functioning**
  This axis allows the clinician to rate a person's overall level of functioning. Based on this assessment, clinicians can better understand how the other four axes are interacting and the effect of that on the individual's life.

While the DSM-IV TR is an important tool, practitioners should note that only those who have received specialised training are 'qualified' to diagnose.

The early drafts of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-V)* eliminate the disease categories for substance abuse and dependence and replace them with a new "behavioural addictions and related disorders" category. DSM-V is due for publication in 2013.

Further information can be obtained from
www.psych.org/mainmenu/research/ dsmiv/dsmivtr.aspx

Other Reading and Resources

Alberta Alcohol and Drug Abuse Commission (2004). *Review of Addiction-Related Screening and Assessment Instruments*. Alberta Health Service.

Dawe S, Loxton N, Hides L, Kavanagh D and Mattick R. (2002). *Review of diagnostic screening instruments for alcohol and other drug use and other psychiatric disorders (2 ed)*. Commonwealth Department of Health and Aging.

Deady, M. (2009). *A Review of Screening, Assessment and Outcome Measures for Drug and Alcohol Settings*. Network of alcohol & other Drug Agencies. New South Wales.

Hulse G, White J and Cape G. (eds.) (2002) *Management of Alcohol and Drug Problems*. New York. Oxford University Press

Knapp M, McDaid D and Parsonage M. (2011) *Mental Health Promotion and Mental Illness Prevention: The Economic Case*, London School of Economics.

National Health Committee. (1999). *Guidelines for Recognising, Assessing and Treating Alcohol and Cannabis Abuse in Primary Care*. Wellington: National Health Committee on Health and Disability.

Pulford J, Adams P & Sheridan J. (2009). Developing a clinical assessment model suited to use in an agency providing short-term substance use treatment: findings from a delphi survey of expert opinion. *Administration and Policy in Mental Health; 36* (5): 322 – 30.

Todd F.C. (2010). *Te Ariari o te Oranga: the Assessment and Management of People with co-existing Mental Health and Substance Use Problems*. Ministry of Health, Wellington.

Zimmerman M. (1994). *Interview Guide for Evaluating Dsm-IV Psychiatric Disorders and Mental Status Examination*. Philadelphia, PA: Psych Products Press.