

APPENDIX

Screening Tools: Alcohol and Other Drugs

Short Michigan Alcoholism Screening Test (SMAST)	49
Michigan Alcoholism Screening Test (MAST)	50
Various Alcohol and Other Drug Screening Questions	51
Simple Screening Instrument for AOD Abuse	52
CAGE-AID Questions	54
General Guidelines for Identifying Clients Who May Be Affected By Alcohol or Other Drug Use	55
Common Signs/Symptoms of the Five Basic Abused Substances	56

Short Michigan Alcoholism Screening Test

NAME _____

Date of Birth _____

Date of Administration _____

SMAST

YES NO

- 1. Do you feel you are a normal drinker? (By normal we mean you drink *less than* or *as much* as most other people.)
- 2. Does your wife, husband, a parent, and/or other near relative ever worry or complain about your drinking?
- 3. Do you ever feel guilty about your drinking?
- 4. Do friends or relatives think you are a normal drinker?
- 5. Are you able to stop drinking when you want to?
- 6. Have you ever attended a meeting of Alcoholics Anonymous?
- 7. Has drinking ever created problems between you and your wife, husband, a parent or other near relative?
- 8. Have you ever gotten into trouble at work or school because of drinking?
- 9. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?
- 10. Have you ever gone to anyone for help about your drinking? If YES, was this other than Alcoholics Anonymous or a hospital? (If YES, code as YES; if NO, code as NO.)
- 11. Have you ever been in a hospital because of drinking? IF YES: Was this for (a) detox; (b) alcoholism treatment; (c) alcohol-related injuries or medical problems, e.g., cirrhosis or physical injury incurred while under the influence of alcohol (car accident, fight, etc.).
- 12. Have you ever been arrested for drunken driving, driving while intoxicated, or driving under the influence of alcoholic beverages?
- 13. Have you ever been arrested, even for a few hours, because of other drunken behavior?

Michigan Alcoholism Screening Test (MAST) ¹

Answer Yes or No for each question as it applies to you.

- Yes(0) No(2) 1. Do you feel you are a normal drinker?
Yes(2) No(0) 2. Have you ever awakened the morning after some drinking the night before and found you could not remember a part of the evening before?
Yes(1) No(0) 3. Does your wife (or do your parents) ever worry or complain about your drinking?
Yes(0) No(2) 4. Can you stop drinking without a struggle in one or two drinks?
Yes(1) No(0) 5. Do you ever feel bad about your drinking?
Yes(0) No(2) 6. Do friends or relatives think you are a normal drinker?
Yes(0) No(0) 7. Do you try to limit your drinking to certain times of the day or to certain places?
Yes(0) No(2) 8. Are you always able to stop drinking when you want to?
Yes(5) No(0) 9. Have you ever attended a meeting of Alcoholics Anonymous (AA)?
Yes(1) No(0) 10. Have you gotten into fights when drinking?
Yes(2) No(0) 11. Has drinking ever created problems with you and your wife?
Yes(2) No(0) 12. Has your wife (or other family member) ever gone to anyone for help about drinking?
Yes(2) No(0) 13. Have you ever lost friends or girlfriends/boyfriends because of drinking?
Yes(2) No(0) 14. Have you ever gotten into trouble at work because of drinking?
Yes(2) No(0) 15. Have you ever lost a job because of drinking?
Yes(2) No(0) 16. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?
Yes(1) No(0) 17. Do you ever drink before noon?
Yes(2) No(0) 18. Have you ever been told you have liver trouble? Cirrhosis
Yes(5) No(0) 19. Have you ever had delirium tremens (DTs), severe shaking, heard voices, or seen things that weren't there after heavy drinking?
Yes(5) No(0) 20. Have you ever gone to anyone for help about your drinking?
Yes(5) No(0) 21. Have you ever been in a hospital because of drinking?
Yes(2) No(0) 22. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was a part of the problem?
Yes(2) No(0) 23. Have you ever been seen at a psychiatric or mental health clinic, or gone to a doctor, a social worker, or clergy for help with an emotional problem in which drinking had played a part?
Yes(2) No(0) 24. Have you ever been arrested, even for a few hours, because of drunk behavior?
Yes(2) No(0) 25. Have you ever been arrested for drunk driving after drinking?

Various Alcohol and Other Drug Screening Questions ²

¹ A score of 4 or more suggests evaluation by an AOD professional

² These are questions recommended by Dr. Kevin Downey, TASC

The following are examples of questions that batterers' programs may choose to utilize in their screening, depending on experience, type of batterers in the program, or characteristics of the man presenting for evaluation. Questions in **bold** type have been identified by men recovering from drug or alcohol problems as questions that are particularly important.

- Has a physician ever suggested that you quit or cut down on your drinking?
- **Has anyone in your family or close to you ever expressed concern about your drinking or drug use?**
- Have you ever missed school events for your children?
- Has any member of your family ever had a problem with drugs or alcohol?
- **Has anyone ever told you that when you drink or use drugs, you are a different person?**
- Have you ever been unable to remember parts of the night before when you were drinking?
- Have you ever done things to get alcohol or drugs that made you feel ashamed?
- **Have you tried to quit or cut down on alcohol on your own?**
- Have you been using more drugs or alcohol than normal?
- Have you ever thought about getting help or going into treatment?
- **Have you ever gone to counseling or self help (AA, etc.) to help with drinking?**
- Has your use of alcohol or drugs ever gotten you into trouble?
- **Have you ever gotten into a fight while using?**
- Are you a normal drinker?
- What is the most you have ever drank or used in a 24-hour period?
- **Do drugs or alcohol make you feel better?**
- **Do you ever wish that you didn't use alcohol or drugs?**
- How long have you been using drugs?
- How old were you when you got high or intoxicated on drugs or alcohol for the first time?
- Have you ever had a DUI?
- Do you like to drink before a party to relax or get ready?
- Do you look forward to certain times of the day because you know you can drink or use drugs?

Simple Screening Instrument For AOD Abuse Self-administered Form³

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

During the last 6 months:

1. Have you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants.)
 Yes No
2. Have you felt that you use too much alcohol or other drugs?
 Yes No
3. Have you tried to cut down or quit drinking or using alcohol or other drugs?
 Yes No
4. Have you gone to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors or a treatment program.)
 Yes No
5. Have you had any health problems? For example, have you:
 Had blackouts or other periods of memory loss?
 Injured your head after drinking or using drugs?
 Had convulsions, delirium tremens (“DTs”)?
 Had hepatitis or other liver problems?
 Felt sick, shaky, or depressed when you stopped?
 Felt “coke bugs” or a crawling feeling under the skin after you stopped using drugs?
 Been injured after drinking or using?
 Used needles to shoot drugs?
6. Has drinking or other drug use caused problems between you and your family or friends?
 Yes No
7. Has your drinking or other drug use caused problems at school or work?
 Yes No
8. Have you been arrested or had other legal problems? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession.)
 Yes No
9. Have you lost your temper or gotten into arguments or fights while drinking or using other drugs?
 Yes No
10. Are you needing to drink or use drugs more and more to get the effect you want?
 Yes No
11. Do you spend a lot of time thinking about or trying to get alcohol or other drugs?

³ Center for Substance Abuse Treatment (1994)

_____ Yes _____ No
12. When drinking or using drugs, are you more likely to do something you wouldn't normally do, such as break rules, break the law, sell things that are important to you, or have unprotected sex with someone?

_____ Yes _____ No
13. Do you feel bad or guilty about your drinking or drug use?
_____ Yes _____ No

The next questions are about your lifetime experiences.

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

_____ Yes _____ No
15. Have any of your family members ever had a drinking or drug problem?

_____ Yes _____ No
16. Do you feel that you have a drinking or drug problem now?
_____ Yes _____ No

**Scoring for the Simple Screening Instrument for AOD Abuse
Self-administered Form**

Name/ID No.: _____ Date: _____

Place/Location: _____

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

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

Total score: _____ Score range: 0-14

Preliminary interpretation of responses:

<u>Score</u>	<u>Degree of Risk for AOD Abuse</u>
0-1.....	None to low
2-3.....	Minimal
>4.....	Moderate

CAGE-AID QUESTIONS ⁴

YES

NO

1. Have you ever felt you ought to cut down or stop drinking or using drugs?
2. Has anyone annoyed you or gotten on your nerves by telling you to cut down or stop drinking or using drugs?
3. Have you felt guilty or bad about how much you drink or use?
4. Have you been waking up wanting to have an alcoholic drink or use drugs?

⁴ Any positive response to a CAGE-AID indicates a possible problem and suggests further evaluation by an AOD professional.

**GENERAL GUIDELINES FOR IDENTIFYING CLIENTS WHO
MAY BE AFFECTED BY ALCOHOL OR OTHER DRUG USE**

- **LOOK FOR CHANGE IN BEHAVIOR, ATTITUDE, OR APPEARANCE**
- **IDENTIFY BEHAVIOR WHICH DOESN'T SEEM RIGHT**
 - G Client can not stay awake
 - G Client unable to sit still
 - G Client is disoriented or confused for no apparent reason
 - G Client laughs or cries at inappropriate time
 - G Rapid shift in client's mood
 - G Client's speech is slurred
 - G Client's speech is rapid and loud, and it is difficult to follow his/her train of thought
- **DO NOT AUTOMATICALLY ASSUME BEHAVIOR IS CAUSED BY ALCOHOL OR OTHER DRUG USE. RULE OUT OTHER CAUSES FIRST**
 - G Client is physically ill (e.g., flu)
 - G Client is upset about some obvious problem (e.g., has been victimized by sexual partner or other person; client is concerned about her son's gang involvement)
 - G Client's physician has recently prescribed new medication, particularly for psychiatric reasons
- **DO NOT ARGUE WITH THE CLIENT REGARDING HIS/HER USE OF ALCOHOL OR OTHER DRUGS**

Common Signs/Symptoms of the Five Basic Abused Substances

Stimulants including speed, cocaine, caffeine, ephedrine, etc.	Depressants including barbiturates, minor tranquilizers, alcohol, opiates, etc.	Hallucinogens including LSD, acid, PCP, angle dust, wicki sticks, mushrooms, etc.	Cannabis also known as marijuana, pot, weed, reefer, dope, buds, etc.	Inhalants examples of what is commonly used: glue, gasoline, paint, etc.
Intoxication Characteristics:	Intoxication Characteristics:	Intoxication Characteristics:	Intoxication Characteristics:	Intoxication Characteristics:
dilated (large)pupils	slurred speech	pupils dilate(large)	increased appetite	dizziness
restlessness/excitement	drowsiness	fast heart rate	dry mouth	blurred vision
insomnia	staggering	sweating	fast heart rate	slurred speech
flushed face	impairment in attention or memory	blurring of visions	delusions	unsteady gait
increased urination	pupil constriction (small)	tremors	decreased body temperature	slowed reflexes
stomach problems	tremors	out of the ordinary behaviors	loss of coordination	muscle weakness
muscles twitching	smell of alcohol	hallucinations	panic	
rambling speech				
irregular heartbeat				
perspiration or chills				

Screening Tools: Domestic Violence

Interview Questions	58
Trait Anger Scale	59
Sample Screening Questions	60
Psychological Maltreatment of Women Inventory	61
Conflict Tactics Scale	62
Lethality Scale	63
Spouse Abuse Risk Assessment	64

Interview Questions

Please describe the FIRST incident of your violence or abuse in your most recent relationship.

Please describe the LAST (MOST RECENT) incident of your violence or abuse in your most recent relationship. (*Probe for description.*)

Please describe the TYPICAL incident of your violence or abuse in your most recent relationship. (*Probe for description.*)

Please describe the WORST incident of your violence or abuse in your most recent relationship. (*Probe for description.*)

Have you been the victim of violence or abuse in this relationship? (*Probe for description.*)

Did you see or hear your parents, or parent figures (grandparents, foster parents, etc.) being violent with one another when you were a child? (*Probe for description.*)

Were you physically or sexually abused by anyone as a child? (*Probe for description.*)

Trait Anger Scale

A number of statements that people have used to describe themselves are given below. Read the statements below and indicate how you *generally* feel by circling the appropriate number.

- 1 = Almost never
- 2 = Sometimes
- 3 = Often
- 4 = Almost always

	Almost Never	Sometimes	Often	Almost always
1. I have a fiery temper	1	2	3	4
2. I am quick tempered	1	2	3	4
3. I am a hotheaded person	1	2	3	4
4. It makes me furious when I am				

criticized in front of others	1	2	3	4
5. I get angry when I'm slowed down by others' mistakes	1	2	3	4
6. I feel infuriated when I do a good job and get a poor evaluation	1	2	3	4
7. I fly off the handle	1	2	3	4
8. I feel annoyed when I am not given recognition for doing good work	1	2	3	4
9. When I get mad, I say nasty things	1	2	3	4
10. It makes my blood boil when I am pressured	1	2	3	4

Sample Screening Questions

(Victim)

1. Within the past few years, have you been hit, slapped, kicked, pushed, shoved, or otherwise physically hurt by a family member, a person with whom you were in a relationship, or a care giver? Yes No
2. Within the past year, has anyone in your family, or anyone you have been in a relationship with forced you to participate in sexual activities against your will? Yes No
3. (If *yes* to either above): Are you afraid that the person who harmed you may do it again? Yes No

Sample Screening Questions (Perpetrator)

- Within the past few years, have you hit, slapped, kicked, pushed, shoved, or otherwise physically hurt a family member, a person with whom you were in a relationship, or a person to whom you were a care giver? Yes No
- Within the past year, have you forced anyone in your family, or anyone with whom you have been in a relationship, to participate in sexual activities against their will? Yes No
- (If *yes* to either above): Do you think that you may do it again? Yes No

Psychological Maltreatment of Women Inventory — Short Version
Richard Tolman, Ph.D.

Answer the following questions for your most recent relationship and during the time period of the last 12 months.

1 - NEVER
4 - FREQUENTLY

2 - RARELY
5 - VERY FREQUENTLY

3 - OCCASIONALLY

How often have you:

Called her/him names.	N	R	O	F	VF
	1	2	3	4	5
Swore at her/him.	N	R	O	F	VF
	1	2	3	4	5
Yelled and screamed at her/him.	N	R	O	F	VF
	1	2	3	4	5
Treated her/him like an inferior.	N	R	O	F	VF

	1	2	3	4	5	
Monitored her/his time and made her/him account for her/his whereabouts.	N 1	R 2	O 3	F 4	VF 5	
Used our money or made important financial decisions without talking to her/him about it.	N 1	R 2	O 3	F 4	VF 5	
Was jealous or suspicious of her/his friends.		N 1	R 2	O 3	F 4	VF 5
Accused her/him of having an affair with another man or woman.	N 1	R 2	O 3	F 4	VF 5	
Interfered in her/his relationships with other family members.	N 1	R 2	O 3	F 4	VF 5	
Tried to keep her/him from doing things to help herself/himself.	N 1	R 2	O 3	F 4	VF 5	
Restricted her/his use of the telephone.	N 1	R 2	O 3	F 4	VF 5	
Told her/him her/his feelings were irrational or crazy.		N 1	R 2	O 3	F 4	VF 5
Blamed her/him for my problems.	N 1	R 2	O 3	F 4	VF 5	
Tried to make her/him feel crazy.	N 1	R 2	O 3	F 4	VF 5	

Conflict Tactics Scale — Revised, Modified
Murray Straus, Ph.D.

During the last year, *how many times* has the person from whom you seek protection been *physically abusive* with you? Circle the "x" if he has done this prior to the past year. For example, if he had slapped you once six months ago,

but not before that, you would circle "1" for that item. If he slapped you two years ago, but not in the last year, you would circle "x". If he has slapped you two years ago and six months ago, you circle both "1" and "x".

- 0 Never in the past year
- 1 Once in the past year
- 2 2 times in the past year
- 3 3 to 5 times in the past year
- 4 6 to 10 times in the past year
- 5 11 to 20 times in the past year
- 6 More than 20 times in the past year
- x Not in the past year, but he has done this prior to the past year

Frequency of:	0	1x	2x	3-5x	6- 10x	11-20x	more than 20x	before last year
<i>(Circle the number that best reflects your answer)</i>								
1. Threw something at you	0	1	2	3	4	5	6	x
2. Twisted your arm or hair	0	1	2	3	4	5	6	x
3. Pushed or shoved you	0	1	2	3	4	5	6	x
4. Grabbed you	0	1	2	3	4	5	6	x
5. Slapped you	0	1	2	3	4	5	6	x
6. Punched or hit you with something that could hurt	0	1	2	3	4	5	6	x
7. Wouldn't let you go to sleep or stay asleep	0	1	2	3	4	5	6	x
8. Forced you to have sex when you didn't want to	0	1	2	3	4	5	6	x
9. Choked you	0	1	2	3	4	5	6	x
10. Slammed you against the wall	0	1	2	3	4	5	6	x
11. Beat you up	0	1	2	3	4	5	6	x
12. Burned or scalded you on purpose	0	1	2	3	4	5	6	x
13. Kicked you	0	1	2	3	4	5	6	x
14. Hit or tried to hit you with something	0	1	2	3	4	5	6	x
15. Threatened you with knife, gun, or other weapon	0	1	2	3	4	5	6	x
16. Used knife, gun, or other weapon	0	1	2	3	4	5	6	x

As a result of domestic violence, have you had any of the injuries listed below? The first column is for injuries you have had *in the past year* as a result of domestic violence, and the second column refers to injuries you have had *at*

some point in your life as a result of domestic violence. Please include domestic violence from all partners in your answer.

Have you, because of domestic violence . . .

- 17. Had a sprain, bruise, or small cut
- 18. Felt physical pain that still hurt the next day
- 19. Passed out from being hit on the head
- 20. Went to a doctor
- 21. Needed to see a doctor, but didn't go
- 22. Had a broken bone

In the PAST YEAR

- Yes No
- Yes No
- Yes No
- Yes No
- Yes No
- Yes No

If NO, then EVER?

- Yes No
- Yes No
- Yes No
- Yes No
- Yes No
- Yes No

Lethality Scale – Modified

Jackie Campbell, Ph.D.

Does the perpetrator:

- 1. Call you obscene names? Yes No
- 2. Blame you for things that happen to him? Yes No
- 3. Have access to weapons? Yes No
- 4. Have suicidal ideas or attempts? Yes No
- 5. Have access to you? Yes No
- 6. Seem unwilling to stay separated from you
(e.g., he tracks, stalks, or phones you)? Yes No
- 7. Make threats to you? Yes No
- 8. Have no desire to stop his violent behavior? Yes No
- 9. Get extremely upset or feel abandoned? Yes No
- 10. Get hostile, furious, or rageful? Yes No
- 11. Get extremely jealous and blame you for all sorts of behavior? Yes No
- 12. Threaten to kill pets (or kill pets)? Yes No
- 13. Damage property? Yes No
- 14. Been reported for child abuse? Yes No

SPOUSE ABUSE RISK ASSESSMENT

NAME _____

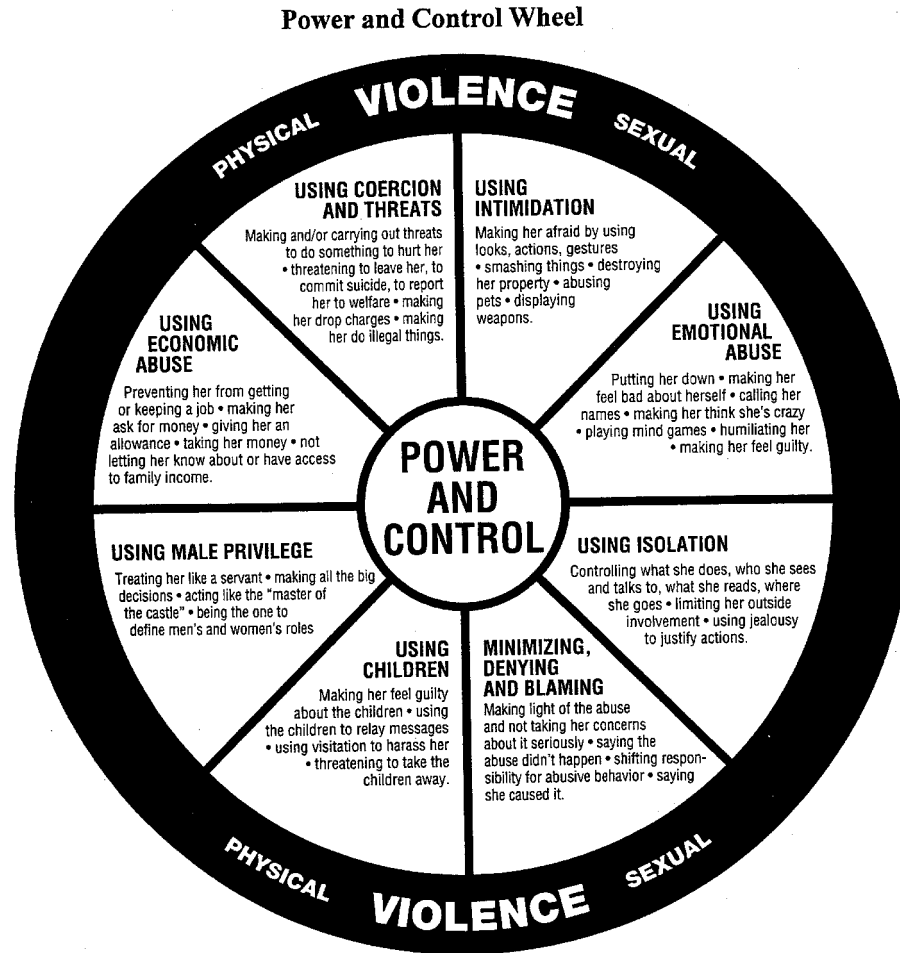
DATE _____

RISK FACTORS	LOW (L)	MODERATE (M)	HIGH (H)	COMMENTS
History of Abuse	No prior reports or injuries	Prior minor injuries	Subsequent incident or serious injury	
Substance abuse	None	Some use, non-contributing factor	Significant use, contributing factor	
Extent of physical injury	No medical treatment needed	Minor physical injuries/treatment	Major physical injury/hospitalization/injury during pregnancy	
Use of weapons	None	Weapons available, not used	Weapons used, or threat to use	
Emotional maltreatment	None/infrequent	Frequent/chronic	Threats of death or serious injury/stalking	
Location of Children	Known/no risk	Known/minimal risk	Unknown, or with perpetrator	
Forced sex	No evidence or allegation	Allegation with no evidence	Evidence of forced sex	
Family stressors	None	Minimal	Multiple	
Location of perpetrator	Known, no access to victim	Known, access to victim	Unknown, or at large	
Assault history	None	Infrequent/occasional episodes	Frequent/chronic episodes	
Fear of perpetrator	None	Minimal	Significant	
Safety plan	Appropriate	Vague	None	

Any "H" must be thoroughly evaluated; the victim of the assessment and

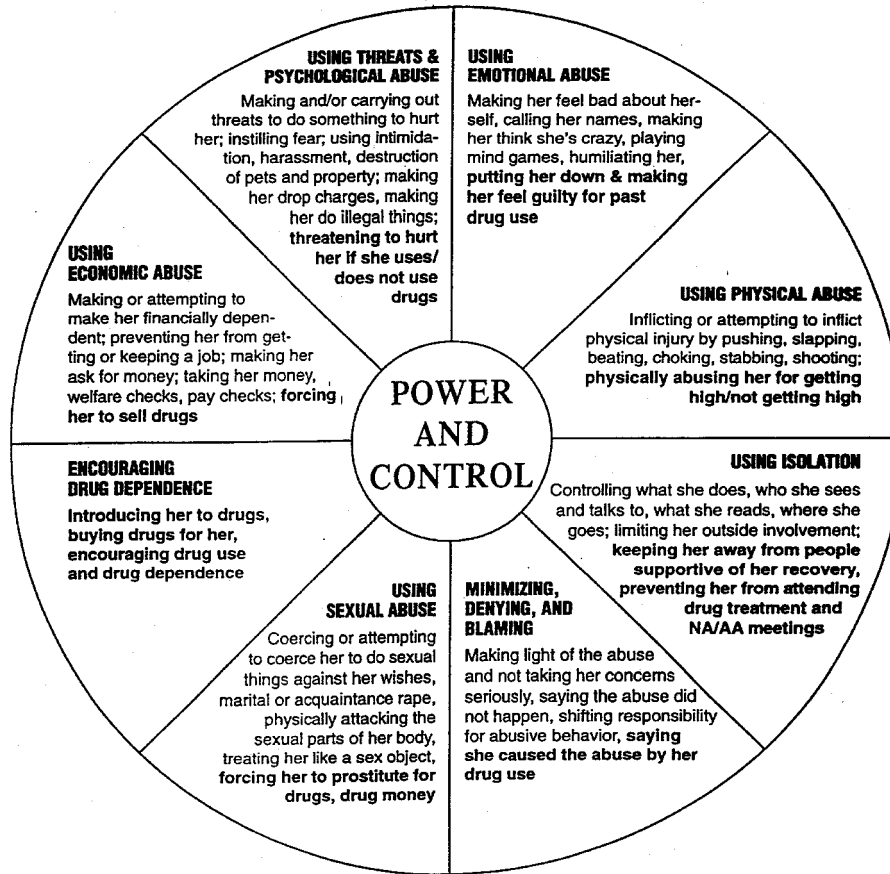
majority of "M"s require additional evaluation; advise recommendations

Warning/Protection Plan:



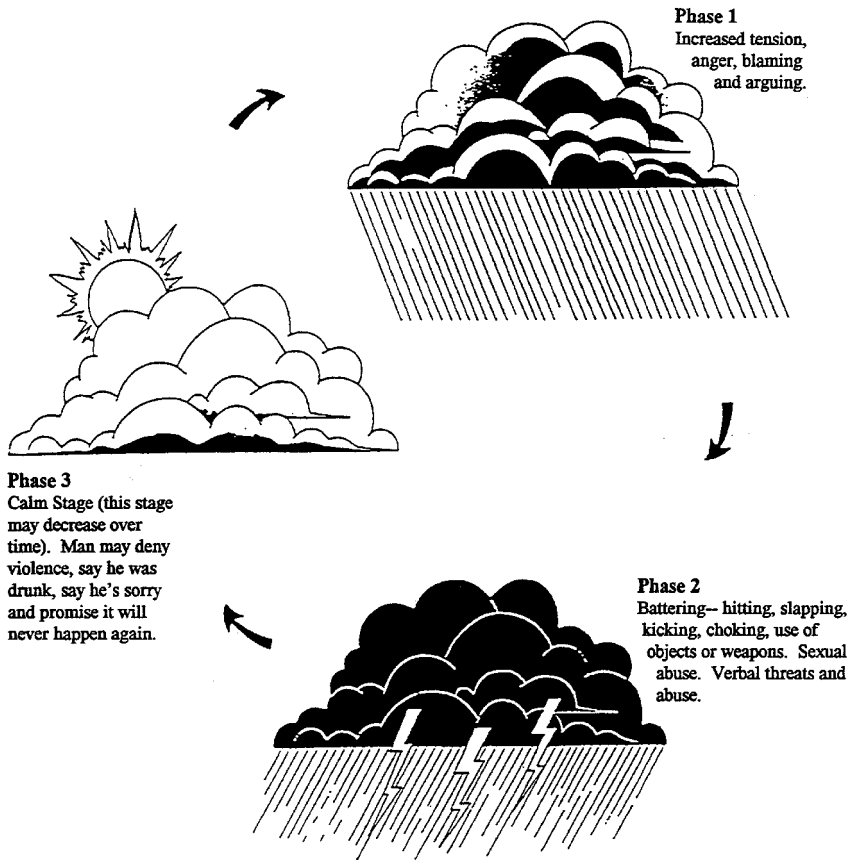
Domestic Abuse Intervention Project
206 West Fourth Street
Duluth, Minnesota 55806
218-722-4134

A Power and Control Model for Women's Substance Abuse



Copyright 1996 - Marie T. O'Neil
Adapted from: Domestic Abuse Intervention Project, Duluth, MN

Cycle of Violence



Phase 1
Increased tension,
anger, blaming
and arguing.

Phase 3
Calm Stage (this stage
may decrease over
time). Man may deny
violence, say he was
drunk, say he's sorry
and promise it will
never happen again.

Phase 2
Battering-- hitting, slapping,
kicking, choking, use of
objects or weapons. Sexual
abuse. Verbal threats and
abuse.

Manifestations of Violence

Abuse can occur in different forms. It can be physical, emotional, sexual, spiritual, social and/or economic. The lists below describe some of the tactics of abuse batterers use as they attempt to gain or maintain power and control over their intimate partners. Abuse does not always progress in regular steps as shown here. Sometimes the abuse may advance from pushing or hitting directly to more severe physical violence such as use of weapons. Although each relationship is unique, any type of abuse must be considered a serious cause for concern. Despite different circumstances, it is important to remember abuse can escalate (especially if intervention fails to occur). A coordinated community response holding batterers accountable for these abusive behaviors is essential as is a response acknowledging and respecting the rights of DV victims. **EXERCISE:** It is helpful for people to be aware of the tactics of domestic violence. Circle the type(s) of abuse you are now experiencing (or have experienced in the past). Notice if the violence is increasing in intensity, severity or frequency. Talk to a domestic violence advocate to develop or review your current safety plan or explore your options. Remember, domestic violence directed at you is never your fault (*even if you were drinking or using drugs*).

Emotional Abuse

insulting jokes		ignore feelings		jealousy		isolation		humiliation		harming pets		calls you 'crazy', 'drunk', or 'junkie'		homicide/suicide
silent treatment		insults		blaming/accusations		monitoring activities		threats		degradation				

Physical Abuse

scratch		slap		push		hit		target hit		kick		choke		beat		weapon use		murder
deny physical needs		bite		force drug use		punch		throw objects		burn		sleep deprivation		poison		disfigurement		

(Manifestations of Violence, continued)

Sexual Abuse

embarrassing comments	ignore sexual needs	forced to look at pornography	sex as duty	control contraceptives	forced prostitution for drugs	forced sex soon after pregnancy	death
sexual jokes	unwanted touching	treat like sex object, 13 th step	withhold sex as punishment	demand monogamy when abuser is promiscuous	sex after violence	rape	

Social / Environmental Abuse

uses gender myths / roles	destroys property	controls major decisions	controls money or finances	threats to victim's family/friends	complete isolation	convinces victims they are hysterical/paranoid/suicidal
degrades gender, profession, recovery from substance abuse, etc.	culture, religion	demonstration of strength	denies access to work	eliminates support system including access to health care or substance abuse treatment	child abuse/incest	suicide

Patricia J. Bland, M.A., CCDC
New Beginnings, Seattle

