ALCOHOL USE DISORDERS IDENTIFICATION TEST (AUDIT)

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Please Note: Alcohol is inclusive of: beer, wine, liquor or any other alcoholic beverage.

1. How often do you have a drink containing alcohol?
   (0) Never (1) Monthly (2) 2-4 times a month (3) 2-3 times a week (4) 4 or more times a week

2. How many drinks contain alcohol do you have on a typical day when you are drinking?
   (0) 1-2 (1) 3 or 4 (2) 5 or 6 (3) 7-9 (4) 10 or more

3. How often do you have six or more drinks on one occasion?
   (0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

4. How often during the last year have you found that you were unable to stop drinking once you started?
   (0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

5. How often during the last year have you failed to do what was normally expected of you because of drinking?
   (0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
   (0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

7. How often during the last year have you felt guilt or remorse after drinking?
   (0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

8. How often during the last year have you been unable to remember what happened the night before because of drinking?
   (0) never (1) less than monthly (2) monthly (3) weekly (4) daily or almost daily

9. Have you or someone else been injured as a result of your drinking?
   (0) no (2) yes, but not in the last year (4) yes, during the last year

10. Has a friend, relative, or doctor or other health worker been concerned about your drinking or suggested you cut down?
    (0) no (2) yes, but not in the last year (4) yes, during the last year

Total Score: _____

[Saunders JB, Aasland OG, Babor TF *et al*. Development of the alcohol use disorders identification test (AUDIT): WHO collaborative project on early detection of persons with harmful alcohol consumption]

SCORING THE AUDIT

Scores for each question range from 0 to 4, with the first response for each question (eg never) scoring 0, the second (eg less than monthly) scoring 1, the third (e.g. monthly) scoring 2, the fourth (e.g. weekly) scoring 3, and the last response (e.g. daily or almost daily) scoring 4. For questions 9 and 10, which only have three responses, the scoring is 0, 2 and 4 (from left to right).

A score of 8 or more meets the criteria for a positive screen, refer the individual to the Qualified Professional Substance Abuse for further assessment.
(Refer an **individual under age 21** with a score of 1 or more to the Qualified Professional Substance Abuse for further assessment.)

DRUG ABUSE SCREENING TOOL (DAST-10)

The following questions concern information about your possible involvement with drugs not including alcoholic beverages during the past 12 months.

"Drug abuse" refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis (marijuana, hashish), solvents (e.g., paint thinner), tranquilizers (e.g., Valium), barbiturates, cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or narcotics (e.g., heroin). Remember that the questions *do not* include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

1. Have you used drugs other than those required for medical reasons?	Yes	No
2. Do you abuse more than one drug at a time?	Yes	No
3. Are you unable to stop using drugs when you want to?	Yes	No
4. Have you ever had blackouts or flashbacks as a result of drug use?	Yes	No
5. Do you ever feel bad or guilty about your drug use?	Yes	No
6. Does your spouse (or parents) ever complain about your involvement with drugs?	Yes	No
7. Have you neglected your family because of your use of drugs?	Yes	No
8. Have you engaged in illegal activities in order to obtain drugs?	Yes	No
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	Yes	No
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding)?	Yes	No

Score: _____ (A score of 3 or more, refer the individual for Work First Program Substance Use Testing.)

SCORING THE DAST-10

For the DAST-10, score I point for each question answered "yes," except for Question 3 for which a "no point" receives 1.

DAST-10 INTERPRETATION

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	none at this time
1-2	Low level	monitor, re-assess at a later date
3-5	Moderate level	further investigation
6-8	Substantial level	intensive assessment
9-10	Severe level	intensive assessment

Applicant/Recipient Name _____ **Date** _____