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Behavioral Health Guidelines for Shelter-in-Place and Evacuation of Assisted Living and Long-term Care Facilities

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Contents

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Behavioral Health Guidelines for Shelter-in-Place and Evacuation of Assisted Living and Long-term Care Facilities

This document is intended to assist Nebraska facilities to meet behavioral health needs of residents in assisted living or long-term care in the event of a disaster or other emergency requiring sheltering in place or evacuation.

Disasters are typically chaotic and noisy. This can be overwhelming for residents, caregivers and responders. Facility administrators probably have plans already in place for most emergencies including evacuation and sheltering in place. Practicing the procedures related to implementing these plans will help residents and staff members deal with the chaos of an actual disaster better and could lessen everyone's anxiety. Having a specific plan in place to address the psychological and emotional consequences that accompany a disaster is equally as important. This is especially true for facilities with residents who are frail or have chronic health conditions. We know from previous disasters that residents of assisted living or long-term care facilities may be at a higher risk for developing psychological reactions to the disaster due to their pre-existing conditions. Although not all problems can be prevented, they may be less severe or more manageable when facilities have good plans in place to minimize them.

Including plans to address psychological and emotional consequences for facility personnel will also help ensure caregivers remain healthy and productive. Facility administrators must consider needs of personnel working with residents when deciding how to implement shelter in place or evacuation procedures. How these decisions are made and communicated can influence if and when personnel show up for work. For example, if you decide to shelter in place it may mean the anxiety level of staff members increase when they are unable to go home after a shift to care for their own family. In some cases facilities have pre-determined that families may join residents and workers to shelter within the facility. This ensures a workforce and decreases anxiety of staff. However it may increase stress for residents and create a more chaotic environment. Carefully considering your facility's policy related to inclusion of staff families in these circumstances should also include how and when you are going to communicate this policy or action to residents, their families and facility personnel. In some cases the residents' families may also wish to shelter at the facility. This should be considered early and your policy made clear to family members.

Evacuation removes residents from familiar surroundings, routine and people. These situations are stressful for residents and caregivers from the evacuated facility and the receiving facility. It is likely that some residents will make the transfer well and others may experience difficulty. Ensure that a copy of the resident's daily routine accompanies them to the receiving facility along with other important documents and medicines. Psychological and emotional health can be bolstered by returning to routine as soon as possible after the evacuation.

Minimizing psychological and emotional impacts of disaster

Disasters are anxiety producing and will create stress everyone touched by the event. See Appendix I for a list of common stress reactions to disaster situations. Good use of crisis communication and psychological first aid can minimize psychological and emotional consequences for disaster survivors during the stress of evacuation or sheltering in place.

Communicating in a crisis is different than regular communication. When people are stressed they take in and process information differently than when they are relaxed and feeling in control of their situation. Good crisis communication features an immediate statement of empathy followed by statements about the incident or your response that are succinct and easily understood. Each statement should contain no more than three major ideas and be issued using plain language. The Centers for Disease Control (CDC) recommends the following:

- Don't over reassure
- Acknowledge uncertainty if it exists
- Explain the processes you will rely upon to get information/answers

- Acknowledge people's fears
- Give people things to do

Psychological first aid is essentially crisis communication practiced one-on-one. The basics of psychological first aid may seem like common sense, but in a highly stressful situation it is helpful to remind everyone of the importance of being empathetic, respectful and action oriented.

- Make a statement of empathy within the *first 30 seconds*. For example:
  - "I know this is difficult for you"
  - "Looks like you're having a tough time"
- Introduce yourself, if the person doesn't know you, or may not remember you
- Be respectful from the start, even though you feel rushed and pressured
  - Use "please" and "thank you", "sir" or "ma'am"
- People do best when they can take some sort of action themselves
  - People in crisis want to be participants, not spectators
  - Give the person some task to accomplish
  - Allow people to make their own decisions when appropriate

The National Center for PTSD and National Child Traumatic Stress Network identify eight core actions making up psychological first aid:

- Contact and engagement
- Safety and comfort
- Stabilization
- Information gathering: Current needs and concerns
- Practical assistance
- Connection with social supports
- Information on coping
- Linkage with collaborative services

When someone is agitated (more than anxious)

- Remember to start with a statement of empathy
- Try to find a point of agreement
- Act calm, even if you're not (keep your voice calm, maintain soft eye contact)
- Approach from the side when possible
- Speak in a calm, neutral tone of voice
- Intervene only during the lulls if the person is talking or shouting
- Stand slightly at an angle to the person you are talking with
- If threatened, get out and get help

More information about psychological first aid (including handouts and helpful tips) is available in the *Psychological First Aid Field Operations Guide for Nursing Homes.* This booklet was adapted from the *Psychological First Aid Operations Guide (2nd Edition)*, with permission from the National Child Traumatic Stress Network and the National Center for PTSD.

More information at disaster behavioral health is available online at http://www.disastermh.nebraska.edu

Training in the Nebraska Psychological First Aid model can be accessed through Regional Behavioral Health Authorities. (Appendix II)

Behavioral Health Guidelines for Residents, Facility Staff/Volunteers and Resident Families

	Before an event	Shelter-in-place	Evacuation	Returning to normal
For Residents	• Provide information about common responses to disaster • Provide information in native language • Use a professional interpreter if needed • Use multiple modes to communicate information about stress (written/oral/pictures) • Involve residents in practice drills for evacuation and sheltering in place	• Provide basic supportive counseling (psychological first aid) • Communicate with resident families • Respond promptly to call lights • As appropriate encourage exercise; visits • Provide frequent updates on the situation • Limit exposure to media covering the event	• Assessment of mental status upon initiation and periodically throughout evacuation • Provide basic supportive counseling (psychological first aid) • Communicate with resident families • Allow and encourage reminders of home • Send a copy of daily routine with resident to receiving facility	• Refer to psychiatrist or licensed mental health practitioner for if needed • Employ suicide precautions as applicable • Be aware of common reactions to disaster and the potential to develop depression/anxiety symptoms • Arrange for resident participation in memorial, remembrance or anniversary events related to the disaster
For Facility Staff/Volunteers	• Provide information about facility disaster policies • Frequent updates to staff about upcoming media reports or press releases • Praise and thank workers • Dispense regular, accurate information to all staff • Hold in-service training for all staff and volunteers on psychological first aid	• Provide break area away from residents • Consider mandatory breaks • Hold regular staff meetings • Include mental health support in staff meetings • Encourage contact with own family • Consider enlisting confidential phone support from in-house or community mental health professionals • Supervisors regularly assess stress level, coping, and fitness for duty	• Supervisors regularly assess stress level, coping, and fitness for duty • Control rumors by dispensing regular, accurate information to all staff • Provide stress management resources and tools to staff members and volunteers	• Provide referral information for in-house or community resources (e.g., Employee Assistance Program) • Arrange for staff participation in memorial, remembrance or anniversary events related to the disaster

	Before an event	Shelter-in-place	Evacuation	Returning to normal
For Resident Families	• Obtain release of information from resident so family can be informed during disaster situations • Provide information about common reactions to disaster • Consider informing family prior to releasing information to media • Consider ways to keep family informed while they are away from the resident	• Provide information about sheltering in place policies • Encourage family members to take care of themselves while you are caring for their loved one • Encourage family to get adequate sleep and nutrition • Monitor stress and expressions of distress of family	• Provide information about evacuation policies • Release information about evacuation status of residents to families before it goes to the media	• Provide referral information for community resources that the family may access as needed

References

Nursing Homes in Public Health Emergencies: Special Needs and Potential Roles. (2007) Focus Group Discussions of Disaster Planning in Nursing Homes. Prepared for AHRQ by Root, E., Amoozegar, J and Bernard, S. AHRQ Publication No. 07-0029-1.

Dept of Health and Human Services, Office of Inspector General, Nursing Home Emergency Preparedness and Response During Recent Hurricanes, August 2006, OEI-06-06-00020.

Helget, V., Smith, P. (2002). Bioterrorism Preparedness: A survey of Nebraska health care institutions. Association for Professionals in Infection Control and Epidemiology. 30 (1).

Hospital Evacuation Decision Guide (2010). Prepared for AHRQ, by Zane, R., Biddinger, P., Hassol, A., Rich, T., Gerber, J, DeAngelis, J. AHRQ Publication No. 10-0009.

Reynolds, B. (2002). Crisis and Emergency Risk Communication. Centers for Disease Control and Prevention.

Rivers-Cochran, J., Kruppa, J., Youngerman, S. (2006). Disasters- Lessons Learned: How to Best Equip Your Organization for Both the Physical and Emotional Clean-up. Disaster-related Preparedness and Trauma Information Packet.

Smith, P., Hansen, K, Sayles, H., Brodersen, B., Medcalf, S. (2011). A Long-Term Care Facility Pandemic Influenza Preparedness Planning Assessment Tool. American Journal of Disaster Medicine, 6(4).

Zagurski, R., Bulling, D., Golba, L., Chang, R. (2010). Nebraska Psychological First Aid Curriculum. Lincoln, NE: University of Nebraska Public Policy Center

Appendix I Common stress reactions to disaster events

There are a number of reactions people commonly experience after a disaster. Reminding someone that their reaction is expected will help lower their anxiety. Manifestations of these reactions may come immediately or months after a disaster.

- Emotional:
  - Shock and disbelief
  - Fear
  - Helpless/Hopeless
  - Anxiety
  - Loss of trust and safety
  - Feeling detached from others
  - Irritable/Moody
  - Anger
  - Guilt
  - Restless
  - Sadness
  - Numbness
- Cognitive:
  - Flashbacks
  - Reminded of past experiences of loss/trauma
  - Nightmares
  - Difficulty concentrating
  - Forgetfulness
  - Suspicion or blaming
  - Difficulty making decisions
  - Belief that life will never get better
  - Confusion
  - Fear of future disasters
- Behavioral:
  - Isolating or cannot be alone for any period of time
  - Pacing
  - Fidgeting
  - Fighting/arguing
  - Fatigue that does not improve with sleep
  - Reckless or risk-taking behaviors
  - May become demanding or annoyingly assertive
- Physical:
  - Change in appetite
  - Change in sleeping
  - Easily startled
  - Hypervigilance
  - Headaches
  - Stomachaches
  - Rapid heart beat
  - Sweating
  - Chills
  - Tension
  - Bodily aches or pains
  - Edginess
  - Change in sex drive

Signs of trouble

Anytime common reactions begin interfering significantly with daily routines it is a sign of trouble. Consider referring to a trained clinician if these signs of trouble are out of the ordinary for the person you are concerned about:

- Difficulty communicating thoughts
- Difficulty sleeping over time
- Increased use of drugs or alcohol
- Persistent headaches or stomach problems
- Disorientation or confusion
- Overwhelming guilt and self-doubt
- Fear of crowds, strangers, or being alone
- Suicidal thoughts or statements about wanting to die
- Frequent, unexplained agitation

U.S. Department of Health and Human Services. (2005). *A guide to managing stress in crisis response professions* (DHHS Publication No. SMA 05-4113). Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

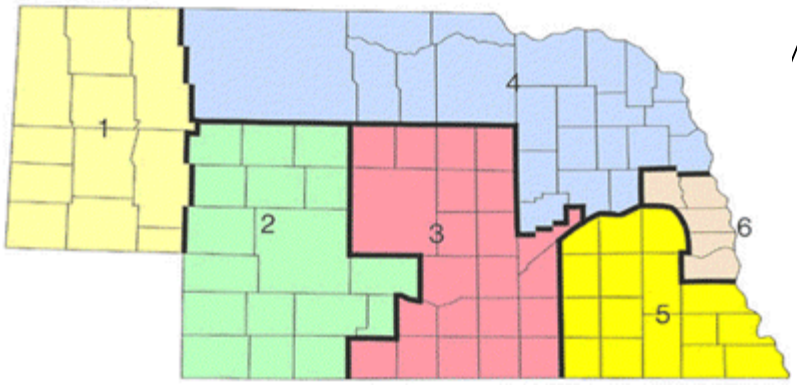
Appendix II Nebraska Regional Behavioral Health Authority Contacts

Contact your Regional Behavioral Health Authority for referrals for psychological first aid training and follow up behavioral health services.

Region 4 Behavioral Health Authority
206 Monroe Avenue
Norfolk, NE 68701
(402) 370-3100 ext. 115
Website: www.region4bhs.org/story.html

Region 1 Behavioral Health Authority
4110 Avenue "D"
Scottsbluff, NE 69361
Phone: (308) 635-3171
FAX: (308) 635-7026
Website: http://www.pmhc.net/

Region 6 Behavioral Health Authority
3801 Harney Street
Omaha, NE 68131
(402) 444-7719
http://www.regionsix.com



Region 2 Behavioral Health Autho
110 North Bailey Street
PO Box 1208
North Platte, NE 69103
Phone: (308) 534-0440
FAX: (308) 534-6961
Website: http://www.r2hs.com/

Region 5 Behavioral Health Authority
1645 N Street, Suite A
Lincoln, NE 68508
(402) 441-4356
http://www.region5systems.net/

Region 3 Behavioral Health Authority
4009 E. 6th Ave
Suite 65
Kearney, NE 68847
(308) 237-5113 - Ext.234
Website: http://www.region3.net/

Appendix III Template Policies and Protocols

Template
Policy and Procedure

Subject: Resident Behavioral Health Needs Associated with Sheltering in Place and Evacuation

1. Purpose:
   Provide guidelines to identify and address behavioral health needs of residents and their families impacted by facility sheltering in place and/or evacuation.

2. Policy:
   It is the policy of [*Insert facility name]* to use facility and community resources to plan for and respond to the behavioral health needs of residents and resident families impacted by sheltering in place and/or evacuation.

3. Procedures

   [Insert guidelines that have been customized and adopted by the facility.]

   Example:

   A. Residents
      1. Facility staff will review common behavioral health reactions to disaster with residents and/or the resident's family upon initiation of sheltering in place precautions or evacuation to an alternate care site.
      2. Written information about common behavioral health reactions to disaster will be sent with residents and provided to caregivers at alternate care sites during evacuation.
      3. The resident's psychological well-being will be assessed by the appropriate staff upon initiation of shelter in place precautions or evacuation and daily thereafter.
      4. The primary physician will be consulted regarding the need for referral to a psychiatrist or licensed mental health professional if the resident's mental status deteriorates or the resident becomes a danger to themselves or others.

   B. Family Members
      1. Facility personnel will document efforts to inform family members prior to releasing information to the media regarding precautions or concerns related to sheltering in place or evacuating the facility.
      2. Facility personnel in contact with family members will monitor family stress and expressions of distress, particularly as it impacts the emotional well-being of residents during or after sheltering in place or evacuation procedures.

   [Note: These are generic examples. Specific procedures should be formulated using the background information provided that incorporates local resource information]

Template
Policy and Procedure

Subject: Facility Staff and Volunteer Behavioral Health Needs Associated with Sheltering in Place and Evacuation

1. Purpose
   Provide guidelines to identify and address behavioral health needs of facility personnel and volunteers affected by sheltering in place and/or evacuation.

2. Policy:
   It is the policy of [*insert facility name*] to use facility and community resources to plan for and respond to the behavioral health needs of facility personnel (staff and volunteers) impacted by sheltering in place and/or evacuation.

3. Procedures:

   [Insert guidelines that have been customized and adapted by your facility.]

   Example:
   1. Facility staff meetings held each shift will include behavioral health information related to stress management, psychological first aid, common reactions to disaster and/or information appropriate to the stage of the disaster.
   2. A break area for staff and volunteers will be designated during and after the disaster event.
   3. Information about local behavioral health resources available to facility personnel will be provided during or after a disaster situation resulting in evacuation or sheltering in place.

[Note: These are generic examples. Specific procedures should be formulated using the background information provided that incorporates local resource information]

Sample Suicide Precautions Protocol
(From: Health Care Professional's Network, http://www.wlm-web.com/hcnet/index2.htm)

Purpose

To reduce the risk of harm to self and/or others for the resident in crisis or severe depression.

Supportive Data

Interventions for safety are of primary importance for patients whose behavior may be destructive to themselves or others. The goal is to provide protection for the patient in the least restrictive environment that allows for necessary level of observation and/or physiologic monitoring. Interventions range from periodic and regular observation to 1:1 contact in an observation room or secluded area.

The level of precautions needed may be ordered by the attending physician, resident physician, or initiated by nursing staff. Should the nursing staff initiate any level of observation, rationale for this decision is recorded in the medical record and the patient's physician notified as soon as possible. If the physician concurs, an order must be written. Orders for "suicide precaution" must specify which level of observation is intended. Level of observation can be reduced only by physician order.

Observation must be provided by an RN, or by LPN or PCT under the direct supervision of an RN. Use of family members and/or significant others as observers is determined by attending physician and nursing staff (case-by-case basis) only after careful assessment of these individuals; the physician must document approval of family/SO in medical record.

The need for suicide precautions must be re-evaluated every 24 hours by the physician and nursing staff; discontinuations or change in level can be made by the attending physician or consulting psychiatrist; current clinical state and reason for continuing, modifying or discontinuing precautions must be documented by physician.

Psychiatric consultation should be requested on all residents requiring suicide precautions.

Assessment

1. Assess for presence of destructive, suicidal, or homicidal behavior, thoughts, verbalizations and/or intent at least every 8 hours or as condition changes.
2. Assess for need to assign a "Precaution" level to provide unobtrusive surveillance at least every 8 hours or as condition changes.
3. Assess risk for suicide using "Suicide Clues & Behavior Rating Scale" of patient on Suicide CareMap®.
4. Monitor need to move patient to a more controlled environment to decrease stimuli which may be influencing moods, behavior or emotions.
5. Mental Health Unit (MHU): Assess for need to assign Elopement precautions using elopement criteria on Admission Database.

Levels of Observation

6. Assign one of the following "Precaution" levels for the protection of the patient:

   a. Watch Closely - observe every 30 minutes for patient safety; initiate frequent verbal contact (indications: expressed vague suicidal ideation without a plan; no demonstrated self-destructive behavior; may have chronic suicidal thoughts; exhibits poor impulse control).

   b. PSR (possible suicide risk) - observe every 15 minutes (indications: patients admitted for medical stabilization following suicide attempt; active suicide ideation with or without suicidal plan).

   c. SSR (serious suicide risk) - observation with 1:1 contact at all times (indications: verbalizes clear intent to harm self; has concrete/specific plan; exhibits disorganized and/or psychotic behavior; also indicated for medically stabilized patient following suicide attempt)

   d. Mental Health Unit only: Elopement (patient at risk of leaving unit) - observe every 30 minutes. Patient placed in locked observation area on the Mental Health Unit.

Consult with Physician

7. Obtain physician order for appropriate "Precaution" level as soon as possible.
8. Contact physician regarding obtaining behavioral health consult when suicidal statements, self-destructive behavior, or threatening comments about others occurs. Consult should be completed within 24 hours.
9. Consult with Mental Health Unit staff/CCM for assistance with Precaution level determination and/or identifying specific, helpful interventions (supportive statements; statements to avoid).

Report To Physician

10. Report to physician/other care team members the effectiveness of interventions (behavior/mood changes, any increase or decrease in suicidal ideation, verbalization of positive self/future planning) and discuss need to increase or decrease the level of the precaution at least once daily.

Interventions

11. Communicate initiation of Suicide Precautions and level of observation to care team members.
12. Initiate Suicide Attempt CareMap® if actual suicide attempt has been made.
13. Provide for patient safety by removing potentially harmful objects or contraband from patient and environment (e.g., sharp objects, glass items, belts, straps, ties, drugs, hair dryer, curling iron, purse, cosmetics in glass containers). Itemize items removed and give to family as soon as possible; call Security to dispose of contraband.
14. Allow only cordless razors.
15. Search any object or package brought to patient by visitors.
16. Consider serving meals on paper plates, using only paper/plastic containers, plastic forks and spoons; have USR order "isolation tray" (necessary for SSR).
17. Observe patient when he/she uses shower; observe SSR patient using bathroom or shower.

18. Do not allow patient to leave unit for any reason without staff escort. If patient becomes resistant or belligerent, call Security and/or Supervisor for assistance. (Consult with Supervisor regarding involuntary admission to Mental Health Unit).
19. Refrain from criticizing actions or minimizing patient's feelings; avoid offering solutions; avoid statements like "I know how you feel".
20. Facilitate discussion of factors or events which precipitated the suicidal thoughts/destructive behavior; respond with active listening; demonstrate concern.
21. Offer to contact Pastoral Care for spiritual guidance.
22. Inform patient/family of availability of Behavioral Health Services.

Teaching

23. Explain "Precaution" level, associated restrictions, and rationale to patient and family.
24. Inform family/visitors that potentially harmful items (glass, scissors, etc.) are not to be given to the patient.
25. Explain to patient/family that suicidal thoughts are a common symptom of depression.
26. Encourage support of patient by family/friends.
27. Instruct family about possible warning signs or pleas for help patient may use. Notify Mental Health Unit regarding availability of educational materials.

Documentation

28. Assessment findings.
29. Suicide precautions maintained; level of precautions and observation intervals; effectiveness of interventions.
30. Physician notification.
31. Items removed from patient or environment.
32. Patient/family teaching and response.

References:

Hogarty, S. & Rodaitis, C. (1987). A suicide precaution policy for the general hospital. *Journal of Nursing Administration, 17*(10), 36-42.

Lego, S. (1996). *Psychiatric Nursing: A Comprehensive Reference*. Philadelphia: Lippincott.

Tucker, S. M. (1996). *Patient Care Standards: Collaborative Practice Planning Guides*. St. Louis: Mosby.

Screening Resources

The following resources can be considered for use by facility personnel for screening or triage of residents.

Emotional health

Many of the brief screening tools and psychosocial screening protocols are proprietary and cannot be reproduced in this document. In general, protocol should include routine conversation with and observation of the resident related to their emotional health and well-being while sheltering in place or in evacuation. Questions are included here that personnel can use to ask about emotional or psychological health.

1. How are you holding up emotionally right now?
   (Common responses include anger, anxiety, or sadness. Residents that answer "I'm fine" may benefit from provision of information about common emotional reactions to help normalize how they might be feeling. Pushing people to respond to this question may not always be advisable. Moving to the next question may help the person identify how they have coped successfully with stressful situations in the past.)

2. Tell me about a time when you were in an unfamiliar or stressful situation and how you got through it.
   (Listen for ways the patient has coped successfully in the past that can be applied to this situation)

3. What mood would you say you are in most of the time? Happy, mad, sad, crabby or worried?
   (Listen for their description and notice if it matches their behavior.)

4. Have you been feeling down or sad most of the day? (If yes, continue to question a)
   a. How long have you felt this way?
   (It is not uncommon for people in these situations to feel anxious and sad. It is potentially concerning if this feeling of sadness is pervasive and unrelenting. Notice if the feelings of sadness preceded shelter in place or evacuation precautions. Ask the patient or family about how they successfully dealt with these emotions in the past.)

5. Have you found yourself wishing you were dead or thinking everyone would be better off if you were dead?
   (It would not be unusual for a person to think about death after a disaster situation. Allow the resident to talk about their feelings. Just because they may wish they were dead does not necessarily mean they are actively trying to end their life. Follow up with the next question about suicide.)

6. Have you been thinking about hurting yourself in any way? (If yes, continue to ask questions a – d)
   (Asking about thoughts of suicide does not cause someone to be suicidal. Most experts believe that asking directly about these thoughts gives the person permission to talk about them and may actually be beneficial. Consider the use of suicide precautions if clinically indicated.)
   a. What has kept you from killing yourself?
   b. Who are the people who you feel closest to?
   c. What have you thought about doing?
   d. What helps you when you feel this way?

7. Do you ever hear or see things other people say they don't hear or see?
   (The goal of asking this question is to see if the person is experiencing any type of hallucinations. The cause of any hallucinations may be related to the physical condition of the resident and not indicative of a psychological problem. It is important to help the person understand that regardless of the cause of these symptoms, there is hope for their resolution.)

Drug and alcohol screening tools

Screening for drug and alcohol problems at admission to the facility is recommended. Two quick tools are included in this appendix, the CAGE & Consumption questions for adults and the CRAFFT for adolescents. In addition to these brief screening tools, a number of other instruments available in the public domain are listed below:

Alcohol Use Disorders Identification Test (AUDIT), available at:
http://libdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf

Drug Abuse Screening Test (DAST), available at:
http://www.projectcork.org/clinical_tools/pdf/DAST.pdf

Alcohol, Smoking and Substance Involvement Screening Test (ASSIST), available at:
http://www.who.int/substance_abuse/activities/assist_v3_english.pdf

Alcohol Screening and Brief Intervention for Trauma Patients: COT Quick Guide, available at:
http://sbirt.samhsa.gov/documents/SBIRT_guide_Sep07.pdf

Consumption + CAGE Questions

Description: This screening method combines 3 alcohol consumption questions that identify a patient's current drinking pattern with the CAGE questionnaire.

The CAGE utilizes 4 questions to identify patients with alcohol dependence syndrome;

1. Have you ever felt you should Cut down on your drinking?
2. Have people Annoyed you by criticizing your drinking?
3. Have you ever felt bad or Guilty about your drinking?
4. Have you ever had an Eye opener first thing in the morning to steady nerves or get rid of a hangover?

Together, the consumption questions and the CAGE identify patients whose drinking puts them at risk of having alcohol problems in addition to identifying the likelihood of dependence.

The consumption questions are:

1. On average, how many days per week do you have a drink containing alcohol?
2. On a typical day when you drink alcohol, how many drinks do you have?
3. How many times in the past year have you had x (x=5 for men; x=4 for women) or more drinks in a day?

Use: This method can be administered in about 2 minutes by an interviewer or completed by the patient on paper or by computer. In interview or computer format, questioning can stop if the first question is 0 or none and if the response to question 3 is 0. Preface the screening by explaining that the consumption questions relate to drinking in the prior month and what constitutes a drink, i.e., one beer, one glass of wine (5 oz.), or one standard mixed drink (one shot or 1.5 oz. of 80 proof spirits). Note that the four CAGE questions refer to the patient's lifetime drinking experience.

Cutoff Scores: The patient is considered positive if:

• The product of responses to questions 1 and 2 produces a total number of drinks per week exceeding the recommended weekly guidelines (7 for women and anybody older than 65; 14 for men under age 66);
OR
• The response to question 3 is more than 0;
OR
• The patient answers "yes" to 2 or more of the 4 CAGE questions.

This material is taken from: Alcohol Screening and Brief Intervention for Trauma Patients: COT Quick Guide

Original Source: Ewing, J. A. (1984). Detecting alcoholism, the CAGE questionnaire. *Journal of the American Medical Association, 252*(14), 1905-1907.

CRAFFT

Description: This instrument was specifically designed to screen for alcohol and drug problems in adolescents. Rather than asking direct questions about quantities and frequencies of alcohol and drug consumption, it asks 6 questions about behaviors that are reliable indicators of consumption and risk.

Use: No prior explanation to the patient is required.

Cutoff Scores: Two or more positive answers indicate a possible problem.

Advantages: The instrument was designed especially for adolescent

1. Have you ever ridden in a Car driven by someone (including yourself) who was high or had been using alcohol or drugs?
2. Do you ever use alcohol or drugs to Relax, feel better about yourself, or fit in?
3. Do you ever use alcohol or drugs while you are by yourself Alone?
4. Do you ever Forget things you did while using alcohol or drugs?
5. Do your Family or Friends ever tell you that you should cut down on your drinking or drug use?
6. Have you ever gotten into Trouble while you were using alcohol or drugs?

This material is taken from: Alcohol Screening and Brief Intervention for Trauma Patients: COT Quick Guide

Original Source: Knight, J. R., Sherritt, L., Shrier, L. A., Harris, S. K. , Chang, G. (2002). Validity of the CRAFFT substance abuse screening test among adolescent clinic patients. *Archives of Pediatrics & Adolescent, 156*(6), 607-614.

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