WELCOME TO OPTUM

The following information is provided to assist you in understanding our services as well as your rights as a client.

Counselling Staff
All our counsellors have the professional credentials of a Masters or Doctorate in Counselling, Psychology, Social Work or equivalent. We invite you to ask your counsellor about his/her training and qualifications.

Confidentiality
You are entitled to privacy and to expect that all communication and records will be kept confidential. Optum maintains a record which documents all contacts, the date and time of each and the services provided. You may request to review the record with your counsellor. We will release information only with your written permission or under a court order. We are, however, legally required to inform appropriate authorities in the case of child neglect or abuse, or the possibility of danger to you or others. Be aware that email communications on a company computer are owned by the company and are not secure.

Counselling
You may be seen individually, with your partner, or with your family. Your immediate family members may also be eligible for services. Your counsellor will discuss with you the service for which you and your family members are eligible through Optum.

Counselling will involve: clarifying the problem(s) that brought you to counselling; developing a plan to address these concerns; and working with the support of your counsellor to enact the changes that will alleviate the problem. Counsellors do not diagnose or provide evaluations of fitness to work or return to work. **Your counsellor's role is neutral and impartial and does not provide for advocating on your behalf in legal or work-related matters.** Counselling is a partnership between the counsellor and the client.

Emergency After-hours Service
A counsellor is on-call after-hours seven days per week to assist with emergency or crisis situations. The emergency after-hours number is 1-800-663-9099. We ask that you use this service only in an emergency or a crisis.

Cancellations
If you are unable to keep your appointment, please provide at least 24 hours notice so that your allotment of service is not affected and your organization is not charged for the time. It will enable us to offer your appointment time to someone else. Please call during regular office hours to cancel appointments. You may discontinue counselling at any time, but we ask that you discuss this with your counsellor first.

Client Feedback
We are continually reviewing our program to ensure we maintain a professional, accessible service of optimum quality. With your permission, you may be contacted by a counsellor to provide an evaluation of our services. Your participation is completely voluntary and your response will be kept anonymous and confidential. Your participation would be appreciated.

Service Concerns
We are committed to providing you with quality service. If you have any concerns, we encourage you to discuss them with your counsellor. You may also contact Optum's Director, Clinical Services at 1-800-663-9099 or 604-431-8200.

Client Name: _____

STATEMENT OF UNDERSTANDING

Optum provides you and your eligible family members with short-term counselling, assessment, referral and case management services to assist you with personal problems and concerns. **Your counsellor's role is neutral and impartial, and does not provide for advocating on your behalf in legal or work-related matters.** Use of Optum services is voluntary and is intended for brief rather than on-going, long-term therapy. The cost of Optum services is covered by contract with your own or your family member's employer or professional association.

Counselling will involve clarifying the problem(s) that brought you to counselling, developing a plan to address it/them and working with the support of your counsellor toward problem resolution. Counselling is a partnership between counsellor and client.

In some cases, a referral to another resource may be indicated. If so, your counsellor will assist you with this process. With your permission, your counsellor may contact a community resource to ensure a smooth transition. There may be a cost for such resources: this would be your own responsibility.

CONFIDENTIALITY AND CLIENT RIGHTS

1) All EFAP counselling services are confidential. Your workplace/professional association will not receive any information disclosing identities of those who utilize our services unless authorized in writing by you. Information transmitted from company computers may be tracked by the company or organization and is therefore not secure.
2) A record is kept of services provided to you. All records are confidential and are the property of Optum.
3) No information about your attendance will be provided to anyone outside of Optum, without your signed, informed consent.
   There are some important exclusions to the above:
   - Child welfare concerns.
   - Imminent self-harm, danger to others, or medical emergency.
   - Subpoena or court order.
   - Professional and confidential third-party audit for quality assurance purposes.

CONSENT TO COUNSELLING

- I verify that I am eligible to utilize Optum's services through my own or my family member's employer or professional association.
- I consent that reasonable non-identifiable data can be shared with third parties.
- I understand that 24 hours notice (one business day) is required to cancel an appointment. Failure to provide this will result in a session being counted toward my use of service.
- I consent that an Optum counsellor may telephone me during and/or after active counselling to review and discuss my wellbeing.

I HAVE READ THE ABOVE, UNDERSTAND ITS CONTENTS, AND CONSENT TO THE COUNSELLING PROCESS.

_____ _____
Client Signature Witness

_____ _____
Client Signature Date

I _____ consent to an Optum counsellor contacting me upon completion of counselling to discuss my experience with Optum's services. I can be reached during the day at (_____) _____.

_____
Client Signature

*Revised September 2014

Satisfaction Survey

Optum is committed to providing the highest quality Employee and Family Assistance Program (EFAP). Your comments will be used to improve the Program. Optum also provides a summarized report to your organization based on the opinions of those who use our service. Counsellors are provided with summarized information as part of our quality improvement commitment. Your confidentiality will be protected at all times. The file number on this survey may be linked to an individual if safety issues or significant service concerns must be addressed.

Please indicate the extent to which you agree or disagree with the following statements:

Quality of Your Experience: strongly agree (5) agree (4) neutral (3) disagree (2) strongly disagree (1)

	Please circle				
❋ My counsellor helps/helped me feel comfortable in discussing my problems.	5	4	3	2	1
❋ My counsellor's efforts and suggestions are helping/helped me develop a plan for addressing my problems.	5	4	3	2	1
❋ My counsellor has/had the skills and expertise to assist me with my concerns.	5	4	3	2	1
❋ My overall counselling experience with Optum is/was positive.	5	4	3	2	1
❋ I would use the Employee & Family Assistance Program (EFAP) in the future if I required assistance.	5	4	3	2	1
❋ My experience with the EFAP meets/met my expectations.	5	4	3	2	1
❋ I would recommend the Optum program to a colleague or family member who needed assistance.	5	4	3	2	1
❋ I feel this is a valuable benefit.	5	4	3	2	1

Program Effectiveness (only to be completed if you are the employee/member):

	Please circle				
❋ The issue(s) that led me to seek assistance interfered with my home life.	5	4	3	2	1
❋ The assistance I received made things better at home.	5	4	3	2	1
❋ The issue(s) that led me to seek assistance interfered with my work life.	5	4	3	2	1
❋ The assistance I received made things better at work.	5	4	3	2	1
❋ If this program were not available, my performance at work would have been affected (e.g. ability to concentrate; enthusiasm for work).	5	4	3	2	1

Comments: If you would like to comment further on the quality of Optum's services please do so below.

It is important to us that you were satisfied with your experience at Optum. We may wish to speak with you about opinions or your comments. Is it acceptable for an Optum representative (other than your counsellor) to contact you by phone about your comments?

- ❑ **Yes.** I am willing to be contacted. My first name is_____ and the phone number I can best be reached at is _____. I am most likely to be available during the **day / afternoon / evening**.

  Is it OK to leave a message at this number? Yes ❑ No ❑

- ❑ **No.** I do not wish to be contacted by an Optum representative about this survey.

To be completed by Optum Counsellor

File Number: _____ Date: __ __ /__ __ / __ __ __ __
M M D D Y E A R

Organization: _____ Counsellor Name: _____

Accessibility Survey

Optum is committed to providing the highest quality Employee and Family Assistance Program (EFAP). Your comments will be used to improve the Program. Optum also provides a summarized report to your organization based on the opinions of those who use our service. Counsellors are provided with summarized information as part of our quality improvement commitment. Your confidentiality will be protected at all times. The file number on this survey may be linked to an individual if safety issues or significant service concerns must be addressed. Please indicate the extent to which you agree or disagree with the following statements:

Quality of Your Experience: strongly agree (5) agree (4) neutral (3) disagree (2) strongly disagree (1)

	Please circle				
❋ Optum's phone number was easy to find.	5	4	3	2	1
❋ The phone response was warm, receptive, and helpful.	5	4	3	2	1
❋ The intake counsellor was helpful in arranging my first appointment.	5	4	3	2	1
❋ An appointment was offered at a convenient time.	5	4	3	2	1
❋ An appointment was offered in a convenient location.	5	4	3	2	1
❋ I received the necessary information to find the location for my first appointment.	5	4	3	2	1
❋ I was satisfied with the time between my initial call and my first appointment.	5	4	3	2	1

Comments: If you would like to comment further on the accessibility of Optum services, please do so below.

It is important to us that you were satisfied with your experience with Optum. We may wish to speak with you about your opinions or your comments. Is it acceptable for an Optum representative (other than your counsellor) to contact you by phone about your comments?

- ❑ **Yes.** I am willing to be contacted. My first name is_____ and the phone number I can best be reached at is _____. I am most likely to be available during the **day/afternoon/ evening.**
- ❑ **No.** I do not wish to be contacted by an Optum representative about this survey.

To be completed by Optum Counsellor

File Number:_____ Date: __ __ /__ __ / __ __ __ __
M M D D Y E A R

Organization: _____

Initial Client Questionnaire

Client's Initials(Optional): _____

Sex: _____ ☐ **Female** ☐ **Male** **Date of Birth:** _____

Employer/Organization: _____

Today's Date: _____ ☐ Employee/Member ☐ Family Member

Note to Counsellor:

Please **add** all columns and **enter final score.**

File#: _____

Client initials: _____

Score: _____***!***

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	**Several days** (1)	**More than half the days** (2)	**Nearly every day** (3)
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

Are you taking any medication for depression, anxiety, stress, or sleep problems? ☐ Yes ☐ No

If YES, please list:

_____

! If the client's score on the PHQ-9 is **15 or greater** OR client has endorsed anything other than **not at all** on Q #9, you must complete a *Client at Risk Assessment* form and follow its protocols for completion/consultation.

For Counsellor Use Only:

Interpretation of Total Score – PHQ-9

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

Lam Employment Absence and Productivity Scale *

Although all forms of work including house work, child care, and others are important, the next questions are about the employed or self-employed **PAID** work that you may do.

What is your level of job satisfaction? ☐ **High** ☐ **Medium** ☐ **Low**

Have you been working in **paid employment over the last 2 weeks**? ******Please do not include house work, volunteer work, or school work**.****

NO ☐ Please check box that best reflects your situation.
☐ homemaker ☐ medical leave/disability ☐ fulltime student ☐ not seeking work ☐ vacation
☐ other _____ (describe) **You have completed the questionnaire. Thank you.**

YES ☐ **Please answer the following questions.**

1. What kind of paid work do you do? _____

2. **Over the past 2 weeks**, how many hours were you scheduled or expected to work? _____

3. **Over the past 2 weeks**, how many hours of work did you miss because of the way you were feeling? _____

4. **Over the past 2 weeks,** how often at work were you bothered by any of the following problems? Please limit your answers to the time when you were at work.

Please circle your ratings.	**None of the time (0%)**	**Some of the time (25%)**	**Half the time (50%)**	**Most of the time (75%)**	**All of the time (100%)**
a) Low energy or motivation.	0	1	2	3	4
b) Poor concentration or memory.	0	1	2	3	4
c) Anxiety or irritability.	0	1	2	3	4
d) Getting less work done.	0	1	2	3	4
e) Doing poor quality work.	0	1	2	3	4
f) Making more mistakes.	0	1	2	3	4
g) Having trouble getting along with people, or avoiding them.	0	1	2	3	4

Total Score _____

FOR COUNSELLOR USE ONLY

1. Pre-screening Question Prior to AUDIT-C: ASK:
Do you sometimes drink beer, wine or other alcoholic beverages? If response is ***NO*****,** further alcohol screening is **NOT** necessary. If response is YES, complete the AUDIT-C. Client's Response: YES / NO

2. Pre-screening Question Prior to the DAST: ASK:
During the past 12 months have you used drugs other than those required for medical reasons? If response is ***NO***, further drug screening is **NOT** necessary. If response is YES, complete the DAST-10. Client's Response: YES / NO

LEAPS Score	Work Impairment
0-5	None to minimal
6-10	Mild
11-16	Moderate
17-22	Severe
23-28	Very severe

OPTUM™

** Initial Screening **

File No. _____ Client Initials: _____

Today's Date:

Alcohol Use Disorder Identification Test (AUDIT/AUDIT-C)

Interview Version

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. (see below, What is a Standard Drink?) Code answers in terms of "standard drinks". Place the correct answer number in the box at the right.

Questions* **1 – 3 = AUDIT-C**	**0**	**1**	**2**	**3**	**4**	**Score**
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4 or more times per week	
2. How many drinks containing alcohol do you have on a typical day of drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 +	
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					AUDIT-C Score (add items 1-3) ***Positive screen = 4 men/3 women and adults over age 65***	
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	
					AUDIT Score (add items 1-10)	

*Questions that use the term "alcohol" refer to any form of alcohol, including beer, wine, liquor, or any other alcoholic beverage.

AUDIT Scoring

- Questions 1–8 are scored 0, 1, 2, 3, or 4 points. Questions 9 and 10 are scored 0, 2, or 4 only.
- Scores are generated by adding up points.
- AUDIT-C score of 4+ for men, and 3+ for women and anyone over age 65 indicates a positive alcohol prescreen (older adult cut-off adapted to reflect U.S. recommended guidelines).
- AUDIT score of 8+ generally indicates at-risk, harmful, or hazardous drinking.

What's a Standard Drink?

Below is information on what defines a standard drink in the U.S. People often are unaware of what a standard drink is and underestimate their consumption when responding to screening items such as "How many drinks containing alcohol do you have on a typical day of drinking?" The standard drink table below can be used during screening to help a person more accurately quantify the amount of alcohol consumed.

12 oz. of beer or cooler	**8-9 oz. of malt liquor** 8.5 oz. shown in a 12-oz. glass that, if full, would hold about 1.5 standard drinks of malt liquor	**5 oz. of table wine**	**3-4 oz. of fortified wine** (such as sherry or port) 3.5 oz. shown	**2-3 oz. of cordial, liqueur, or aperitif 2.5 oz. shown**	**1.5 oz. of brandy** (a single jigger)	**1.5 oz. of spirits** (a single jigger of 80-proof gin, vodka, whiskey, etc.) Shown straight and in a highball glass with ice to show level before adding mixer*
						
12 oz.	**8.5 oz**	**5 oz.**	**3.5 oz.**	**2.5 oz.**	**1.5 oz.**	**1.5 oz.**

AUDIT/AUDIT-C:

- Developed by the World Health Organization (WHO) http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf
- Detects alcohol problems experienced in the last year.
- Administered quickly (verbally, written, or by computer) in < 5 min.
- AUDIT-C (items 1-3) administered in ~1-2 min. as a *prescreen* to see if further screening (items 4-10) is needed.
- The full AUDIT is 10 items. "Box 2" shows item domain and content.

Box 2

Domains and Item Content of the AUDIT

Domains	Question Number	Item Content
Hazardous Alcohol Use	1	Frequency of drinking
	2	Typical quantity
	3	Frequency of heavy drinking
Dependence Symptoms	4	Impaired control over drinking
	5	Increased salience of drinking
	6	Morning drinking
Harmful Alcohol Use	7	Guilt after drinking
	8	Blackouts
	9	Alcohol-related injuries
	10	Others concerned about drinking

AUDIT Scores & Recommended Level of Intervention

World Health Organization (WHO) original:

AUDIT score	Risk Level	Intervention
0-7	Zone I	Alcohol education
8-15	Zone II	Simple advice
16-19	Zone III	Simple advice plus brief intervention and follow-up with continued monitoring if possible
20-40	Zone IV	Referral to a specialist for diagnostic evaluation and treatment

Workplace Adaptations Tested in EAP/MBHO Settings:

Risk	Intervention (3 levels)	AUDIT score
Level I - Low	▪ Alcohol Education	0-7
Level II - Moderate	▪ Alcohol Education ▪ Normative Feedback ▪ Simple Advice ▪ Brief Intervention (with/without MI-informed - focused on behavior change) ▪ Follow-up	8-19
Level III - High	▪ Alcohol Education ▪ Normative Feedback ▪ Simple Advice ▪ Brief Intervention (with/without MI-informed – focused on connecting to referral) ▪ Referral to Specialist for Diagnostic Evaluation and Treatment ▪ Follow-up	20-40

McPherson, T.L. (October 25, 2010) AFA SBIRT/MI Training Handout.

For more information about screening, brief intervention, and referral to treatment (SBIRT) for alcohol, drugs, tobacco, and depression; or the BIG Initiative, please contact Dr. Tracy McPherson at George Washington University at 202-994-4307 or esap1234@gmail.com.

OPTUM™

** Initial Screening **

File No. _____ Client Initials: _____

Today's Date:

Drug Abuse Screening Test—DAST-10

These Questions Refer to the Past 12 Months

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 (eg, memory loss, hepatitis, convulsions, bleeding)?	Yes	No
	DAST Score (Each "Yes" response = 1, **add items 1-10)**		

Guidelines for Interpretation of DAST-10

Interpretation (Each "Yes" response = 1)

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	Encouragement and education
1-2	Low level	Risky behavior – feedback and advice
3-5	Moderate level	Harmful behavior – feedback and counseling; possible referral for specialized assessment
6 - 10	Substantial level	Intensive assessment and referral

Skinner HA. The Drug Abuse Screening Test. *Addictive Behavior*. 1982;7(4):363-371.
Yudko E, Lozhkina O, Fouts A. A comprehensive review of the psychometric properties of the Drug Abuse Screening Test. *J Subst Abuse Treatment*. 2007;32:189-198.

OPTUM™ ** 60 Day AUDIT **

File No. _____ Client Initials: _____
Today's Date:

Alcohol Use Disorder Identification Test (AUDIT/AUDIT-C)

Interview Version

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 **the past 60 Days**." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. (see below, What is a Standard Drink?) Code answers in terms of "standard drinks". Place the correct answer number in the box at the right.

Questions*	0	1	2	3	4	Score
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4 or more times per week	
2. How many drinks containing alcohol do you have on a typical day of drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 +	
3. How often do you have five or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
60 Day Follow Up = Conduct Full AUDIT, Questions 1-10						
4. How often during the past 60 days 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 past 60 days 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 past 60 days 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 past 60 days 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 past 60 days 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	
AUDIT Score (add items 1-10)						

*Questions that use the term "alcohol" refer to any form of alcohol, including beer, wine, liquor, or any other alcoholic beverage.

AUDIT Scoring

- Questions 1–8 are scored 0, 1, 2, 3, or 4 points. Questions 9 and 10 are scored 0, 2, or 4 only.
- Scores are generated by adding up points.
- AUDIT-C score of 4+ for men, and 3+ for women and anyone over age 65 indicates a positive alcohol prescreen (older adult cut-off adapted to reflect U.S. recommended guidelines).
- AUDIT score of 8+ generally indicates at-risk, harmful, or hazardous drinking.

What's a Standard Drink?

Below is information on what defines a standard drink in the U.S. People often are unaware of what a standard drink is and underestimate their consumption when responding to screening items such as "How many drinks containing alcohol do you have on a typical day of drinking?" The standard drink table below can be used during screening to help a person more accurately quantify the amount of alcohol consumed.

12 oz. of beer or cooler	**8-9 oz. of malt liquor** 8.5 oz. shown in a 12-oz. glass that, if full, would hold about 1.5 standard drinks of malt liquor	**5 oz. of table wine**	**3-4 oz. of fortified wine** (such as sherry or port) 3.5 oz. shown	**2-3 oz. of cordial, liqueur, or aperitif 2.5 oz. shown**	**1.5 oz. of brandy** (a single jigger)	**1.5 oz. of spirits** (a single jigger of 80-proof gin, vodka, whiskey, etc.) Shown straight and in a highball glass with ice to show level before adding mixer*
						
12 oz.	**8.5 oz**	**5 oz.**	**3.5 oz.**	**2.5 oz.**	**1.5 oz.**	**1.5 oz.**

AUDIT/AUDIT-C:

- Developed by the World Health Organization (WHO) http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6a.pdf
- Detects alcohol problems experienced in the last year.
- Administered quickly (verbally, written, or by computer) in < 5 min.
- AUDIT-C (items 1-3) administered in ~1-2 min. as a *prescreen* to see if further screening (items 4-10) is needed.
- The full AUDIT is 10 items. "Box 2" shows item domain and content.

AUDIT Scores & Recommended Level of Intervention

World Health Organization (WHO) original:

AUDIT score	**Risk Level**	**Intervention**
0-7	Zone I	Alcohol education
8-15	Zone II	Simple advice
16-19	Zone III	Simple advice plus brief intervention and follow-up with continued monitoring if possible
20-40	Zone IV	Referral to a specialist for diagnostic evaluation and treatment

Workplace Adaptations Tested in EAP/MBHO Settings:

Risk	**Intervention (3 levels)**	**AUDIT score**
Level I - Low	▪ Alcohol Education	0-7
Level II - Moderate	▪ Alcohol Education ▪ Normative Feedback ▪ Simple Advice ▪ Brief Intervention (with/without MI-informed - focused on behavior change) ▪ Follow-up	8-19
Level III - High	▪ Alcohol Education ▪ Normative Feedback ▪ Simple Advice ▪ Brief Intervention (with/without MI-informed – focused on connecting to referral) ▪ Referral to Specialist for Diagnostic Evaluation and Treatment ▪ Follow-up	20-40

OPTUM™ ** 60 Day DAST-10 **

File No. _____ **Client Initials:** _____

Today's Date:

Drug Abuse Screening Test—DAST-10

These Questions Refer to the Past 60 Days

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 (eg, memory loss, hepatitis, convulsions, bleeding)?	Yes	No
	DAST Score (Each "Yes" response = 1, **add items 1-10)**		

Guidelines for Interpretation of DAST-10

Interpretation (Each "Yes" response = 1)

Score	Degree of Problems Related to Drug Abuse	Suggested Action
0	No problems reported	Encouragement and education
1-2	Low level	Risky behavior – feedback and advice
3-5	Moderate level	Harmful behavior – feedback and counseling; possible referral for specialized assessment
6 - 10	Substantial level	Intensive assessment and referral

Skinner HA. The Drug Abuse Screening Test. *Addictive Behavior*. 1982;7(4):363-371.
Yudko E, Lozhkina O, Fouts A. A comprehensive review of the psychometric properties of the Drug Abuse Screening Test. *J Subst Abuse Treatment*. 2007;32:189-198.

Closing Client Questionnaire

Client's Initials (Optional): _____

Sex: _____ ☐ **Female** ☐ **Male** **Date of Birth:** _____

Employer/Organization: _____

Today's Date: _____ ☐ Employee/Member ☐ Family Member

Note to Counsellor:

Please **add** all columns and **enter final score.**

File#: _____

Client initials:_____

Score: _____ ***!***

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all (0)	**Several days** (1)	**More than half the days** (2)	**Nearly every day** (3)
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐

Are you taking any medication for depression, anxiety, stress, or sleep problems? ☐ Yes ☐ No

If YES, please list:

_____

! If the client's score on the PHQ-9 is **15 or greater** OR client has endorsed anything other than **not at all** on Q #9, you must complete a *Client at Risk Assessment* form and follow its protocols for completion/consultation.

For Counsellor Use Only:

Interpretation of Total Score – PHQ-9

Total Score	Depression Severity
1-4	Minimal depression
5-9	Mild depression
10-14	Moderate depression
15-19	Moderately severe depression
20-27	Severe depression

Lam Employment Absence and Productivity Scale *

Although all forms of work including house work, child care, and others are important, the next questions are about the employed or self-employed **PAID** work that you may do.

What is your level of job satisfaction? ☐ **High** ☐ **Medium** ☐ **Low**

Have you been working in **paid employment over the last 2 weeks**? ****Please do not include house work, volunteer work, or school work**.****

NO ☐ Please check box that best reflects your situation.
☐ homemaker ☐ medical leave/disability ☐ fulltime student ☐ not seeking work ☐ vacation
☐ other _____ (describe) **You have completed the questionnaire. Thank you.**

YES ☐ **Please answer the following questions.**

1. What kind of paid work do you do? _____

2. **Over the past 2 weeks**, how many hours were you scheduled or expected to work? _____

3. **Over the past 2 weeks**, how many hours of work did you miss because of the way you were feeling? _____

4. **Over the past 2 weeks,** how often at work were you bothered by any of the following problems? Please limit your answers to the time when you were at work.

Please circle your ratings.	**None of the time (0%)**	**Some of the time (25%)**	**Half the time (50%)**	**Most of the time (75%)**	**All of the time (100%)**
a) Low energy or motivation.	0	1	2	3	4
b) Poor concentration or memory.	0	1	2	3	4
c) Anxiety or irritability.	0	1	2	3	4
d) Getting less work done.	0	1	2	3	4
e) Doing poor quality work.	0	1	2	3	4
f) Making more mistakes.	0	1	2	3	4
g) Having trouble getting along with people, or avoiding them.	0	1	2	3	4

Total Score _____

For Counsellor Use Only:

LEAPS Score	Work Impairment
0-5	None to minimal
6-10	Mild
11-16	Moderate
17-22	Severe
23-28	Very severe