COMS Reports: Interpretations and Scoring

DRUG AND ALCOHOL USE DOMAIN

Severity of Dependence Scale

The SDS was devised to provide a short, easily administered scale which can be used to measure the degree of dependence experienced by users of different types of drugs . It contains five items, all of which are concerned with the psychological aspects of dependence, specifically- impaired control over drug taking and preoccupation and anxieties about drug use. The SDS is an excellent measure of substance dependence as defined in the DSM-V, with high specificity and sensitivity that is validated across a range of drug groups, including heroin, cannabis, cocaine, amphetamine and benzodiazepines. The SDS has been validated in a range of translations and used in both adolescent and elderly populations as well as among Aboriginal and Torres Strait Islanders in research studies. Furthermore, the SDS has been found to retain high validity in populations with coexisting disorders.

Scoring

The SDS scores range from 0-15 with higher scores indicating a higher level of dependence. In relation to question 4 "do you wish you could stop?", if an individual has not used any drugs in the previous three months, they will generally answer "never/almost never", however even if the individual is in a treatment program that requires total abstinence, it is still important that every question, including question 4, is answered.

As the SDS is a measure of psychological dependence, preoccupations and impaired control, often SDS scores remain elevated even after a person has stopped using or significantly decreased their use. SDS scores often show a higher level of dependence than the person may initially self-report (e.g. they think it's "not that bad") and potentially may initially rise with an increased awareness through the process of treatment of impaired control, preoccupations and anxieties. NADAbase COMS allows for tracking of a primary substance of concern at each stage after intake as well as tracking the original drug of concern if that is different, to take into consideration those persons who may change their primary drug of concern.

Studies have shown that an SDS score of 3 (out of 15) is correlated with a DSM-V, diagnosis of current substance dependence with a high level of specificity and sensitivity. Some studies have shown that a score of 4 may be a more appropriate cut off for younger cannabis users (14-18 years) or a score of 6 may be a more appropriate cut off for prescription drug abuse, particularly benzodiazepines. The screening aspects of the SDS are important in determining dependence on the substance; however, the change in score over time in treatment is what makes the SDS an outcome measure. The COMS will graph and tabulate the change in score through the stages and this is a measure of change in substance dependence over time in treatment and at follow up.

Drug and Alcohol Use: items from BTOM and AATOM

This outcome measure measures the actual number of days spent using all substances over the previous 4 weeks, or 28 days. It is therefore in contrast to the Severity of Dependence Scale that is an outcome measure focused on the primary drug of concern with a time frame of three months. The measure for illicit substances and tranquilisers (benzodiazepines) is number of days used in the previous 28 days. Illicit drugs can be highly variable in quality and potency and only number of days used is able to provide an objective outcome measure. Other measures such as number of injections, number of joints, number of lines tell little about the actual quantity of the drug taken and may be misleading or variable.

The measure for alcohol is number of days on which alcohol was consumed and number of standard drinks ingested on those days. The alcohol measure includes a further measure of how many of those days were spent drinking more heavily than normal and number of drinks consumed on those days. The amount of alcohol in a standard drink is an objective measure. The appendix of this user manual contains a standard drink chart. The measures for tobacco are number of days the person has smoked tobacco and quantity of tobacco smoked (measured in cigarettes).

The drug and alcohol use measure tracks all drug and alcohol use including but not limited to the primary drug of concern. As a screening tool it can identify other drugs the person consumes. As an outcome tool this can assist in tracking changes in drug and alcohol use as a result of treatment. For example, reduction in use of primary drug of concern with a consequent increase in some other substance or a reduction in all substance use. This tool is able to be used in goal setting and case management as well as in harm reduction, tracking changes against goals the person defines for themselves or against risky levels of use. The tool screens, tracks and assists in goal setting for tobacco use also. Reduction in, or cessation of, tobacco use is a feature of some drug and alcohol treatment programs and is an important health outcome in any program.

The outcomes in the drug and alcohol use domain may also be read in conjunction with outcomes from the BBV exposure risk taking domain such as frequency of sharing injecting equipment and frequency of overdose. This could provide information with regards to whether reduction of use has been associated with reduction in risky using behaviour for example.

PSYCHOLOGICAL HEALTH DOMAIN

Psychological Health

The Kessler 10+ scale is a widely used, simple self-report measure of psychological distress. This measure was designed for use in the general population to detect high prevalence mental health disorders (e.g. anxiety and depression). It can also detect mental health disorders with lower population prevalence (e.g. schizophrenia). It also can be used to simply measure an individual's levels of nervousness, agitation and psychological fatigue.

The Kessler 10+ has good sensitivity and specificity from its lowest to its highest score. It is simple and easy to use and score and is appropriate for a wide range of clients and service types. It has been translated into a wide range of languages and has been validated with a number of different cultural groups. The K10+ has no significant biases for gender or education and has been successfully used in a range of Australian settings and populations including rural populations and drug and alcohol using populations.

The K10+ is well understood outside drug and alcohol settings and is often used by GPs. The K10+ is used by the Australian National Survey of Mental Health and Well Being, surveys in New South Wales for the Chief Health Officer and surveys of Aboriginal populations in Western Australia and the Northern Territory.

Scoring

The scoring of the K10+ only relates to scores for the first 10 questions, each question being scored from 1 (none of the time) to 5 (all of the time), with a total score thus being from 10-50.

- **Low Risk** (10-15): one quarter of the population risk of meeting criteria for anxiety or depressive disorder and are unlikely to make a suicide attempt in their life time.

- **Moderate Risk**(16-21)/High Risk (22-29): three times the population risk of having a current anxiety or depressive disorder and three times the population risk of ever having made a suicide attempt.

- **Very High Risk** (30-50): ten times the population risk of meeting criteria for anxiety and depression and twenty times the population risk of ever having made a suicide attempt.

The additional 4 questions (the '+') do not contribute to the total score but are chosen as variables relevant to the distress that may be being experienced by the person and are available for staff and the person to use as additional information to assist in the interpretation of the K10 score.