The CRAFFT Screening for Drugs & Alcohol

The following questions are about your drug or alcohol use within the last 12 months. Please answer all questions honestly and your answers will be kept confidential

**Part A – During the past 12 months, did you: NO YES**

|  |
| --- |
| 1. Drink any alcohol (more than a few sips)?

If you answered NO to ALL these, answer B1 below then stopIf you answered YES to ANY of these, answer questions below |
| 1. Smoke any cannabis?
 |
| 1. Use anything else to get high?
 |

**Part B**  No YES

|  |  |  |
| --- | --- | --- |
| 1. Have you ever ridden in a CAR driven by someone (including yourself) who was ‘high’ or had been using drugs or alcohol?
 |  |  |
| 1. Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?
 |  |  |
| 1. Do you ever use alcohol or drugs while you are by yourself or ALONE?
 |  |  |
| 1. Do you ever FORGET things you did while using alcohol or drugs?
 |  |  |
| 1. Do your FAMILY or FRIENDS ever tell you that should cut down on your drinking or drug use?
 |  |  |
| 1. Have you ever gotten into TROUBLE while you were using alcohol or drugs?
 |  |  |

**Scoring for Part B – 1 point for each YES answer**

|  |  |  |
| --- | --- | --- |
| **CRAFFT Score** | **Degree of problem related to alcohol or substance use** | **Suggested Action** |
| 0-1 | No problems reported | None at this time |
| 2+ | Potential of a significant problem | Further assessment required – Complete brief intervention or contact Switch |

Referral form

Switch is a voluntary service. Therefore, it’s important the young person has a level of commitment to engage with the team. We are free and confidential, and will support young people and their families around any substances

**1. Client details**

|  |  |
| --- | --- |
| **First name:**  |  |
| **Surname:** |  |
| **Date of birth:** |  |
| **Gender:** MALE 🞏 FEMALE 🞏 *(please tick)* |
| **Address:****Postcode:** |
| **Telephone:** |  |
| **Who does the client live with?** |  |
| **Ethnicity:** |  |
| **Disability? YES 🞏 NO 🞏** *(if ‘yes’ give details)* |
| **Pregnant? YES 🞏 NO 🞏** *(if ‘yes’ give details)* |
| **Any Children? YES 🞏 NO 🞏** *(if ‘yes’ give details)* |
| **Does the client have an Early Help? YES  NO ** *(if ‘yes’ name lead professional)* |
| **Client’s GP name and address:** |
| **Alternative client contact details:***(if different from above):* |

**2. Problem substances**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Problem substance** | **Age of first use** | **How often it is used** | **Quantity used** | **How it is taken** |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
| **Does the young person mainly use substances with their friends?** |
| **Are you referring for early intervention group work or 1:1 structured work?** |

**3. How does the client wish to be contacted?**

|  |  |  |  |
| --- | --- | --- | --- |
| Letter 🞏 | Telephone 🞏 | Either 🞏 | Via referring agency 🞏 |

**4. Professional agencies**

|  |
| --- |
| Please list professionals and agencies involved: |

**5. Client information**

|  |
| --- |
| Please give details about the young person’s education/employment/training *(including where, attendance levels, achievements/difficulties)* |
| Please give details about any behaviour problems *(including ADHD, conduct disorder, offending)* |
| Please give details about any emotional health problems *(including self-harm, suicide, anxiety)* |
| Please give details about any social care involvement |
| Any other information that would be helpful to support our work? |

**6. Referrer information**

|  |  |
| --- | --- |
| **Form completed by:** |  |
| **Date:** |  |
| **Name of referrer:** |  |
| **Practice/agency:** |  |
| **Telephone:** |  |
| **Signature:** |  |
| Does this young person consent to this referral? **YES  NO **  |
| Is the parent/carer aware of this referral? **YES  NO **  |
| Where did you hear about Switch? |

**Returning this form**

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**Web** – <https://www.cranstoun.org/service/switch-bucks/>