Initial Screen for AOD Use and Co-morbidity

For use by non-Government AOD service providers

Purpose

To identify the prevalence of problematic substance use and any mental health disorders, as well as any risk to self, children or others to determine eligibility to service and whether a further assessment or referral to specialist service is required.

Advice

- Explain the purpose, proceedings and duration of the initial screen including confidentiality and mandated responsibilities to the client before commencing (maximum 30 minutes)
- To be conducted in a non-formal, interview setting with client
- Case workers to use questions as prompts and notate responses from client
- Write legibly – other case workers might need to reference information gathered in the assessment
- Ensure that your name, designation and date are recorded on each page of the assessment form.

Conducted by _____

Position/Designation _____

Date _____

STAFF USE ONLY Practitioner Name: _____ Position: _____ Date: _____

Privacy, Confidentiality and the Sharing of Information

Information for Clients

Details of Organisation

Name _____

Type of service (e.g. counselling) _____

What information will we collect?

At your first appointment (known as your screen or assessment), we will ask you to provide your personal details along with other information in regards to your substance use and any associated concerns. Each time you visit us after that, we will collect and record any information relevant to your treatment, including (but not limited to) intervention summaries, case coordination actions and outcomes, communication exchanges, case workers observations etc.

You have a right to request access to your information at any time and to ask for it to be corrected if necessary. If you have any questions or concerns about your personal information, please talk to your Case Worker.

Why do we collect this information?

Having a thorough understanding of your personal information and experiences allows us to identify which treatment-types or interventions would best suit your needs. We collect your information to develop and maintain an Individual Treatment Plan, stay up-to-date with your treatment progress and outcomes and to identify and coordinate any other services that will be able to assist you.

From time-to-time we may need to also provide de-identified statistical information in reports to the government agency(s) that provide funding for our program. De-identified information means it does not contain your name, contact details, or any information that could identify you as an individual.

Who else has access to this information?

We understand the importance of the need to protect your personal information so your client files will be stored securely in accordance with the relevant Privacy and Information Acts at both Commonwealth and State and Territory levels at all times. We may store your information in both hard-copy and electronic formats and only the designated employees of this organisation are allowed to access your information.

It is also important to note that every adult in the NT (people over the age of 18 years) has a mandated responsibility to report, in accordance with the Domestic and Family Violence Act, the Care, the Protection of Children Act and any other legislation that requires him/her to provide information to the police. Being 'mandated' means we have a responsibility to do something by law.

Will your information be shared?

We will not share any of your information unless you have given your permission to do so.

To ensure you are receiving the required treatment or care however, we may need to involve and work with other services or organisations, which will mean your personal information relevant to your treatment may need to be shared. The details of the organisation(s), including the types of services and the specific-information shared, will be provided to you and will be kept up-to-date by your Case Worker at all times. Any information that is shared will be for the purposes of professional intent only.

Please talk to your Case Worker if you wish to withdraw your consent to share your information at any time.

STAFF ONLY

I, _____ have discussed and explained the contents of this document and I am confident that the client understands.

Signature (Case workers) _____ Date _____

STAFF USE ONLY Practitioner Name: _____ Position: _____ Date: _____

Client Consent Form

Privacy and Confidentiality

I, _____ (client name – please print clearly) have read (with or without assistance) or had read to me the Privacy, Confidentiality and Sharing of Information; Information for Clients document and its contents.

By providing my consent, I acknowledge and understand that my personal information will be collected and shared with other services for the purposes of professional intent only and under the Privacy Amendment (Private Sector) Act 2000, to ensure I am being provided with the required care and support to assist with my needs.

My consent to the sharing of my information is valid for the period in which I am engaged in treatment or support-interventions with the identified services providers as per my Individual Treatment Plan.

I also acknowledge that these services may need to provide my de-identified information for the purposes of statistical data, contractual reporting requirements or service-monitoring to the relevant Commonwealth or State or Territory Department.

I am aware that I have the right to withdraw my consent at any time.

Signed _____

Dated _____

STAFF USE ONLY Practitioner Name: _____ Position: _____ Date: _____

Consent to Share Information

Identification of Organisations/Agency and all associated information to be completed by designated Case Co-ordinator

Client Name /ID #: _____

D.O.B: _____

Case Co-ordinator _____

Review Date _____

I give consent for my confidential, personal and treatment information to be exchanged, released or received by the following organisations/agencies, limited to the purposes of the development, monitoring, co-ordination and evaluation of my treatment or care plan

Name of Organisation/ Agency	**Service Type** (E.g. Counselling, Residential Rehabilitation)	**Specific Information to be shared** (E.g. All relevant information, Medical only)	**Purpose of Exchange** (E.g. Referral, Shared- care, Development of Care Plan etc.)

This authority expires upon completion of my agreed treatment or engagement period with the services as listed above.

I understand I may revoke consent for release of information except where authorised information has been released prior to my withdrawal of consent.

Signed: _____

Dated: _____

STAFF USE ONLY Practitioner Name: _____ Position: _____ Date: _____

Client Information

Personal Details Form

Family name: _____ **Given name(s):** _____

Preferred name(s): _____

Have you ever been known by any other name(s)? Yes No

If yes, please details: _____

Gender: Male Female Other **Date of birth:** _____

Address:

_____

_____

_____

Postal address (if different from above):

_____

_____

_____

Other addresses:

_____

_____

_____

Daytime telephone: _____ **Mobile:** _____

Do you identify as being Aboriginal and/or Torres Strait Islander? Yes No

Country of birth ('kantri' or nation): _____

Cultural background: _____

Preferred language: _____

Interpreter required: Yes No

_____
Client Name /ID #:

_____
D.O.B:

STAFF USE ONLY Practitioner Name: _____ Position: _____ Date: _____

Do you have any medical conditions (including allergies)? Yes No

If yes, please provide details _____ **What medications are you currently taking?** _____

Do you have any disabilities? Yes No

If yes, please provide details: _____

Emergency Contact

Name: _____

Relationship to you: _____

Address: _____

Telephone: _____ **Mobile:** _____

04

Client Name /ID #: _____

D.O.B: _____

STAFF USE ONLY Practitioner Name: _____ Position: _____ Date: _____

GP/ Clinic Services

Do you have a GP/Clinic Doctor? Yes No

If yes, please provide their details:

Name of organisation: _____

_____

Address: _____

_____

_____

Telephone: _____

Do you use any other services? Yes No

If yes, please provide their details:

Name of organisation: _____

_____

Address: _____

_____

_____

Telephone: _____

Name of organisation: _____

Address: _____

_____

_____

Telephone: _____

Name of organisation: _____

Address: _____

_____

_____

Telephone: _____

Name of organisation: _____

Address: _____

_____

_____

Telephone: _____

Do you have any legal concerns? Yes No

If yes, please provide details: _____

_____

_____

_____

_____

Client Name /ID #:

D.O.B:

STAFF USE ONLY Practitioner Name: _____ Position: _____ Date: _____

Is the client pregnant or likely to be? Yes* No

Does client currently appear intoxicated? Yes* No

If yes, action taken _____

_____

_____

_____

Client Name /ID #: _____

D.O.B: _____

Has the client stopped using alcohol or drugs in the last 24hours? Yes* No

Does client present any current signs of withdrawal? Yes* No

If yes, action taken

_____

_____

_____

*Consider immediate referral to hospital, clinic or specialist service (Provide referral details in Outcome of Initial Screen- Summary of Actions)

Reasons for referral and presenting issues

"What is your reason for coming to (insert name of your organisation) today? / Does this worry you?"

_____

_____

_____

_____

_____

"Have you thought about getting help for this in the past?" If yes, please explain

_____

_____

_____

_____

_____

"Were you referred by someone? / If yes, why do you think they referred you?"

_____

_____

_____

_____

STAFF USE ONLY Practitioner Name: _____ Position: _____ Date: _____

Screening for AOD Use

AUDIT- C

- It is recommended that the case worker conducts screen and notes client's responses
- Ensure feedback is given to client at the completion of screen in regards to the score indication

Client Name /ID #: _____

D.O.B: _____

Please circle the answer that is correct for you

1. How often do you have a drink containing alcohol?

Never (0)	Monthly or less (1)	Two to four times a month (2)	Two to three times per week (3)	Four or more times a week (4)	Score
○	○	○	○	○	_____

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

1 or 2 (0)	3 or 4 (1)	3 or 4 (1)	7 to 9 (3)	10 or more (4)	Score
○	○	○	○	○	_____

3. How often do you have six or more drinks on one occasion?

Never (0)	Less than monthly (1)	Monthly (2)	Two to three times per week (3)	Four or more times a week (4)	Score
○	○	○	○	○	_____

Total Score (Add the number for each question to get your total score) _____

STAFF USE ONLY Practitioner Name: _____ Position: _____ Date: _____

Score	Degree of risk	Action	Outcome (√)
0 points	No risk	Intervention not required	_____
1-3 points for males 1-2 points for females	Low risk	Brief Intervention to encourage continued low-risk use	_____
4-5 points for males 3-5 points for females	At risk	Brief Intervention, brief counselling and continued monitoring. Referral for Comprehensive Assessment (provide referral details in Outcome of Initial Screen)	_____
6-7 points	High risk	Referral to medical or specialist service for physical examination or withdrawal Referral for Comprehensive Assessment (provide referral details in Outcome of Initial Screen) More intensive intervention required	_____
8-12 points	Severe risk	Immediate referral to medical or specialist service for physical examination and withdrawal Referral for Comprehensive Assessment (provide referral details in Outcome of Initial Screen) More intensive intervention required	_____

- Utilise the Northern Territory Government Patient Handycard; Drink Less when providing feedback to your client
- After completing an initial screen using the AUDIT-C tool, it is recommended that you consult the AUDIT-C Alcohol Consumption Questions; an effective Brief screening test for problem drinkers guide for further clarification.
- You can also complete the AUDIT -Interview version instead if this screen.

A copy of this assessment and accompanying documents can be found at **http://www.health.nt.gov.au/library**

04

_____

Client Name /ID #:

_____

D.O.B:

STAFF USE ONLY Practitioner Name: _____ Position: _____ Date: _____

DUDIT

- It is recommended that the case worker conducts screen and notes client's responses
- Ensure feedback is given to client at the completion of screen in regards to the score indication

Client Name /ID #: _____

D.O.B: _____

Complete only if client has used drugs other than alcohol in the past 12 months	(0)	(1)	(2)	(3)	(4)
1. How often do you use drugs other than alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times week
2. How often do you use more than one drug on the same occasion?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times week
3. How many times do you take drugs on a typical day when you use drugs?	0	1 or 2	3 or 4	5 or 6	7 or more
4. How often are you influenced heavily by drugs	Never	Less than monthly	Monthly	Weekly	Daily or almost
5. Over the past year, have you felt your longing for drugs was so strong that you could not resist?	Never	Less than monthly	Monthly	Weekly	Daily or almost
6. Has it happened, over the past year that you have not been able to stop taking drugs once you started?	Never	Less than monthly	Monthly	Weekly	Daily or almost
7. How often over the past year have you taken drugs and then neglected to do something you should have done?	Never	Less than monthly	Monthly	Weekly	Daily or almost
8. How often over the past year have you needed to take a drug the morning after heavy drug use the day before?	Never	Less than monthly	Monthly	Weekly	Daily or almost

STAFF USE ONLY Practitioner Name: _____ Position: _____ Date: _____

	(0)	(1)	(2)	(3)	(4)
9. How often over the past year have you had guilty feelings or a bad conscience because you used drugs?	Never ○	Less than monthly ○	Monthly ○	Weekly ○	Daily or almost ○
10. Have you or anyone else been hurt (mentally or physically because you used drugs?	No ○		Yes, but not in the last year ○		Yes, during the last year ○
11. Has a relative or friends, a doctor or a nurse or anyone else been worried about your drug use or said to you that you should stop using drugs?	No ○		Yes, but not in the last year ○		Yes, during the last year ○

Score	Degree of risk	Action	Outcome (√)
0 to 7	Low risk	Brief Intervention recommended but not required	_____
8 to 15	Moderate risk of harm	Brief Intervention, brief counselling to identify harms associated with harmful drug use	_____
16 to 19	High risk or harmful level	Referral to medical or specialist service for physical examination or withdrawal Referral for Comprehensive Assessment (provide referral details in Outcome of Initial Screen) More intensive intervention required	_____
20 or more	High risk or dependence likely	Immediate referral to medical or specialist service for physical examination and withdrawal Referral for Comprehensive Assessment (provide referral details in Outcome of Initial Screen) More intensive intervention required	_____

_____
Client Name /ID #:

_____
D.O.B:

STAFF USE ONLY Practitioner Name: _____ Position: _____ Date: _____

IRIS

- Can be used instead of AUDIT-C and DUDIT for Indigenous clients
- It is recommended that the case worker conducts screen and notes client's responses
- Ensure feedback is given to client at the completion of screen in regards to the score indication

Client Name /ID #: _____

D.O.B: _____

Instructions for scoring

1. Calculate the scores from the IRIS Screen Instrument pertaining to each risk
2. Compare the client's scores for Alcohol and Other Drug against the risk cut-off scores

Alcohol and Other Drug Risk	(1)	(2)	(3)	(4)	(5)	(6)
1. In the last 6 months have you needed to drink or use drugs more to get the effects you want?	No ○	Yes, a bit more ○	Yes, a lot more ○			
2. When you have cut down or stopped drinking or using drugs in the past, have you experienced any symptoms, such as sweating, shaking, feeling sick in the tummy/vomiting, diarrhoea, feeling really down or worried, problems sleeping, aches and pains?	Never ○	Sometimes when I stop ○	Yes, every time ○			
3. How often do you feel that you end up drinking or using drugs much more than you expected?	Never/ Hardly ever ○	Once a month ○	Once a fortnight ○	Once a week ○	More than once a week ○	Most days/ Every day ○
4. Do you ever feel out of control with your drinking or drug use?	Never/ Hardly ever ○	Sometimes ○	Often ○	Most days/ Every day ○		
5. How difficult would it be to stop or cut down on your drinking or drug use?	Not difficult at all ○	Fairly Easy ○	Difficult ○	I couldn't stop or cut down ○		
6. What time of the day do you usually start drinking or using drugs?	At night ○	In the afternoon ○	Sometime in the morning ○	As soon as I wake up ○		

STAFF USE ONLY Practitioner Name: _____ Position: _____ Date: _____

	(1)	(2)	(3)	(4)	(5)	(6)
7. How often do you find that your whole day has involved drinking or using drugs?	Never/ Hardly ever ○	Sometimes ○	Often ○	Most days/ Every day ○		

Alcohol and Other Drug Risk Score (Questions 1 – 7) _____

Emotional Well Being Risk (Mental Health Risk)	Never/Hardly ever	Sometimes	Most days/ Every day
8. How often do you feel down in the dumps, sad or slack?	○	○	○
9. How often have you felt that life is hopeless?	○	○	○
10. How often do you feel nervous or scared?	○	○	○
11. Do you worry much?	○	○	○
12. How often do you feel restless and that you can't sit still?	○	○	○
13. Do past events in your family, still affect your well-being today (such as being taken away from family)?	○	○	○

Mental Health and Emotional Well Being Risk Score (Questions 8 – 13) _____

Alcohol & Other Drug Risk

Add scores for questions 1-7

Total Score: _____

Cut off Score = 10

Note: If client falls above risk cut off scores proceed to Brief Intervention.

Mental Health & Emotional Well Being Risk

Add scores for questions 8-13

Total Score: _____

Cut off Score = 11

Note: If client falls above risk cut off scores proceed to Brief Intervention and recommended referral to Mental Health Service

_____

Client Name /ID #:

_____

D.O.B:

STAFF USE ONLY Practitioner Name: _____ Position: _____ Date: _____

Screening For Mental Health Disorders

K10

- It is recommended that the case worker conducts screen and notes client's responses
- Ensure feedback is given to client at the completion of screen in regards to their score

Client Name /ID #: _____

D.O.B: _____

For all of the questions, please tick the appropriate response

In the past 4 weeks;	None of the time (+1)	A little of the time (+2)	Some of the time (+3)	Most of the time (+4)	All of the time (+5)
1. About how often did you feel tired for no good reason?	○	○	○	○	○
2. About how often did you feel nervous?	○	○	○	○	○
3. About how often did you feel so nervous that nothing could calm you down?	○	○	○	○	○
4. About how often did you feel hopeless?	○	○	○	○	○
5. About how often did you feel restless or fidgety?	○	○	○	○	○
6. About how often did you feel so restless you could not sit still?	○	○	○	○	○
7. About how often did you feel depressed?	○	○	○	○	○
8. About how often did you feel that everything is an effort?	○	○	○	○	○
9. About how often did you feel so sad that nothing could cheer you up?	○	○	○	○	○
10. About how often did you feel worthless?	○	○	○	○	○
Totals (Total of each column)	_____	_____	_____	_____	_____

Score (Total of all scores) _____

STAFF USE ONLY Practitioner Name: _____ Position: _____ Date: _____

Score	Degree of risk for substance abuse	Degree of risk for substance abuse	Outcome (√)
10 to 15	Low risk or no risk	Intervention not required	
16 to 19	Medium risk	Refer for primary-care mental health assessment (Provide referral details in Outcome of Initial Screen- Summary of Actions)	
30 to 50	High risk	Refer for specialist mental health assessment (Provide referral details in Outcome of Initial Screen- Summary of Actions)	

Do you have any current or past psychiatric or mental illness diagnoses? Yes No

Please detail _____

_____

_____

_____

_____

04

_____

Client Name /ID #:

_____

D.O.B:

STAFF USE ONLY Practitioner Name: _____ Position: _____ Date: _____

Assessment of Risk to Self, Children or Others

Client Name /ID #: _____

D.O.B: _____

Environment associated with Substance Use

Describe the environment or context of client's substance use

E.g. "Tell me about where you usually smoke ganja",
"Do you usually smoke with other people?"
"When you buy drugs, it is on the street or do you go to someone's house?"
"Does you partner use these drugs as well?"

Self-harm and/or Suicidal Risk

Have you ever attempted suicide or tried to harm yourself? Yes No
Do you ever think about killing or harming yourself? Yes No
Do you ever think about hurting someone else? Yes No
Have you ever hurt anyone else like your partner, children, family or friends? Yes No
If yes to any of the above, please provide further details Yes No

Is the client identified as being high-risk for suicide or self-harm? *Yes No

*Consider immediate referral to hospital, clinic or specialist service
(Provide referral details in Outcome of Initial Screen)

STAFF USE ONLY Practitioner Name: _____ Position: _____ Date: _____

Outcome of Initial Screen

Conducted by _____

Position _____

Date _____

Client Name /ID #: _____

D.O.B: _____

- ○ Screening scores indicated need for further assessment
- ○ Immediate referral to specialist service/ hospital/ clinic required
- ○ Client not eligible for this service (please detail actions for referrals to other services)
- ○ Client does not wish to continue with service

Screening Tool _____ Degree of Risk _____

Screening Tool _____ Degree of Risk _____

Screening Tool _____ Degree of Risk _____

Screening Tool _____ Degree of Risk _____

Summary of Actions (Including referrals, worker/agency actions etc.)

Date	Details of Action	Signed

Details of appointment for Comprehensive Assessment _____

STAFF USE ONLY Practitioner Name: _____ Position: _____ Date: _____