Comprehensive Assessment for AOD Use & Co-morbidity

Purpose

To further explore the client's current substance use, history, behaviours and concerns including any co-morbidities and stage of readiness to change, to identify any areas of need which will then inform the basis of their Individual Treatment Plan.

Advise

- To be attached to client's Initial Screen
- Use the Initial Screen as source of information where possible to ensure questions aren't repeated
- Explain the purpose, proceedings and duration* of the Comprehensive Assessment including confidentiality and mandated responsibilities to the client before commencing
- Case workers to use questions as prompts and notate responses from client in summary of notes
- 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.

*Comprehensive Assessment may be completed over various engagements with client. It is recommended that engagements are no longer than 30minutes at any one time

Conducted by ______________________________

Position/Designation ______________________________

Date ______________

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

Current AOD Use

Client Name /ID #:

D.O.B:

Does client currently appear intoxicated? Yes No

If yes, action taken

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

If yes, action taken (consider immediate referral to hospital or clinic)

	Substance Type		
Alcohol or Drugs used in the past month (Including method of route of use E.g. If injecting, please see Q5)	1/	2/	3/
Day last used (E.g. Today, yesterday, last week)			
Days Used in Past Week or Month? (Can be an average)			
Age at First Use?			
Age when use became more regular?			
Is use regular or opportunistic (i.e. will drink or use drugs whenever available to them?) **If regular, describe average use** (Including quantity e.g. number of cans, cones, grams etc., situation or environment, triggers, influences, and cost of average use)			

STAFF USE ONLY Practitioner Name: Position: Date:

AOD History and Behaviours

Client Name /ID #:

D.O.B:

Any periods of abstinence ('stopping')?
Please define which substance(s), duration, reason and when?

Any withdrawal symptoms experienced at this time? Please tick

- ○ Shakiness/tremulousness
- ○ Nervousness/anxiety
- ○ Increased appetite
- ○ Irritability/ Restlessness
- ○ Strange/wild dreams
- ○ Sweating
- ○ Decreased appetite
- ○ Headaches
- ○ Trouble sleeping (insomnia)
- ○ Fatigue, tiredness, yawning
- ○ Depressed mood
- ○ Increased anger or aggression
- ○ Nausea or stomach pains
- ○ Trouble concentrating

Any past history of interventions such as treatment or hospitalisations for substance misuse? (Such as rehabilitation, overdose or associated-harms?) Please define which substance, intervention-type, duration and result.

Has the substance-use been the reason for any harm (mental or physical) shown towards any family, friends or significant other? What happened? Why?

Has the client ever engaged in risky injecting practices? (E.g. sharing or re-using equipment?) Please detail.
(Only to be completed if route of use for substance is injecting)

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

Co-Morbidity Assessment

- It is recommended that a comprehensive mental health examination is conducted by the relevant specialist service.

Client Name /ID #: ____________________

D.O.B: ____________________

Specialist Mental Health Assessment attached? Yes No

Current diagnosed conditions (as per Mental Health Assessment)

○ Depression ○ Anxiety ○ Psychosis ○ PTSD ○ Bi-Polar Disorder ○ FASD

○ Other ____________________

Do you know if anyone in your family has a history of any mental illness? Yes No

Please detail ____________________

Do you have any history of abuse or neglect? Yes No

Please detail ____________________

Have there been any major stressful or traumatic events in your life? Yes No

Please detail ____________________

If yes, what are some of the coping strategies or activities you have used? ____________________

Observation of client's current mental state (E.g. appearance, behaviour, speech, mood, affect, perceptions, cognition)

____

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

Social, Emotional and Domestic Violence Screen

Client Name /ID #:

D.O.B:

Have you any worries or concerns about anything in your life right now? (Could be related to family, not having enough money for food, work stress etc.)

Have you ever been hit, punched, slapped or hurt in other ways by your partner or ex-partner? Yes No

Are you frightened of your partner of ex-partner? Yes No

Has your child/children been hurt or seen domestic violence? Yes No

Are you worried about the safety of your child/children? Yes No

Who is looking after your child/children? Where are they now?

Are you safe to go home when you leave here? Yes No

Would you like some help with anything? Yes No

Accommodation and Living Situation

How would your client rate their current living situation in regards to risk of violence, abuse or harassment, state of shelter or facilities, risk of homelessness or eviction, and/or over-crowdedness etc.

- ◯ Safe & Stable
- ◯ Some risks – 'some of the time'
- ◯ Moderate Risk – 'most of the time'
- ◯ High Risk – 'all of the time'

Please detail client's response

How would your client rate their level of well-being in their current living situation in relation to access to food & sanitation, clothing, sleep etc.)

- ◯ Not adequately met
- ◯ Basic needs met
- ◯ Needs met

Does your client have enough money to buy food? Yes No

Referral to Accommodation Support Service or Emergency Relief required? (Provide referral details in Outcome of Initial Screen- Summary of Actions) Yes No

STAFF USE ONLY Practitioner Name: Position: Date:

You will find a comprehensive service directory of agencies that provide crisis, transitional, short term, low cost, and supported accommodation, and other support services in the NT at **http://shelterme.org.au/**

Client Name /ID #:

D.O.B:

Family and Social Connectedness

How would your client describe the quality of the relationships or social connections in their life?

Physical Health & Wellbeing

How would your client describe their physical health (including level of motivation) with respect to their health? (E.g. relates to hygiene, nutrition, exercise, sexual behaviours and dental health etc.)

Employment and Education

Please describe your client's current employment and/or education status (including motivation to engage)

STAFF USE ONLY Practitioner Name: Position: Date:

Client Needs - Identification

- Case worker to ask client about their worries/concerns in relation to the areas of their life and notate responses in space provided.
- Assist client to identify their strengths and how they can use these to help them overcome their worries

Client Name /ID #:

D.O.B:

Area of my life	What are my concern(s)? E.g. "My father died of a stroke when he was young and the Doctors say it was because of his heavy drinking. I don't want to die the same way."	My strengths in this area? E.g. "I have 3 kids who want to help me to cut down on my drinking."
Alcohol and/ or Drug Use		
Family, Children or Relationships		
Culture		
Legal Issues		
Health (Physical or Mental)		
Money		

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

Area of my life	What are concern(s)?	My strengths in this area?
Housing		
Work/ Training		
Friends or Social Life		

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

Stage of Readiness to Change

- The highest score represents the client's current stage of change
- Once questionnaire has been completed, add the totals of each stage and record the scores below
- Could also be conducted in Initial Screen

Client Name /ID #:

D.O.B:

Readiness to Change Questionnaire for AOD	Strongly Disagree (-2)	Disagree (-1)	Unsure (0)	Agree (+1)	Strongly agree (+2)	Stage of change
1. I don't think I use too many drugs/drink too much alcohol	○	○	○	○	○	P
2. I am trying to use less drugs/alcohol than I used too	○	○	○	○	○	A
3. I enjoy using drugs/alcohol, but sometimes I do use too much	○	○	○	○	○	C
4. Sometimes I think I should cut down on using drugs/drinking alcohol	○	○	○	○	○	C
5. It's a waste of time thinking about my use of drugs/alcohol	○	○	○	○	○	P
6. I have just recently changed my drug/alcohol habits	○	○	○	○	○	A
7. Anyone can talk about wanting to do something about using drugs/drinking alcohol, but I am actually doing something about it	○	○	○	○	○	A
8. I am at the stage where I should think about using less drugs/drinking less alcohol	○	○	○	○	○	C

STAFF USE ONLY Practitioner Name: ______________________ Position: ______________________ Date: ____________

Readiness to Change Questionnaire for AOD	Strongly Disagree (-2)	Disagree (-1)	Unsure (0)	Agree (+1)	Strongly agree (+2)	Stage of change
9. Using drugs/drinking alcohol is a problem for me sometimes	○	○	○	○	○	C
10. There is no need for me to think about changing my use of drugs/alcohol	○	○	○	○	○	P
11. I am actually changing my use of drugs/ alcohol right now	○	○	○	○	○	A
12. Using less drugs/drinking less alcohol would be pointless for me	○	○	○	○	○	P

Key P= Pre-contemplation, C= Contemplation, A= Action

Pre-contemplation ____________

Contemplation ____________

Action ____________

Stage of change result
(P, C or A?) ____________

It is recommended that you consult The Cycle of Behaviour Change' (Department of Health and Families, 2008)

You can find it at http://health.nt.gov.au/Alcohol_and_Other_Drugs/Alcohol/Advice_for_Health_Practitioners/index.aspx

Client Name /ID #: ____________

D.O.B: ____________

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

Case Formulation

Conducted by ______________________

Position/Designation ______________________

Date ______________

Client Name /ID #:

D.O.B:

Overview of Alcohol and Other Drug Use

(Briefly summarise findings from assessment) ______________________

Overview of Mental Health/Co-morbidity Concerns

(Briefly summarise findings from assessment) ______________________

STAFF USE ONLY Practitioner Name: ______________ Position: ______________ Date: ________

Recommendations for Addressing Issues or Concerns

(In order of priority or immediate needs)

Presenting issues/concerns	Recommendation (for referral, action, intervention or treatment type

Client Name /ID #:

D.O.B:

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