



Government of **Western Australia**
Drug and Alcohol Office

Alcohol and Other Drugs Assessment
Clinicians' Booklet

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Note – The Drug and Alcohol Office is the business name of the Western Australian Alcohol and Drug Authority, which is an independent statutory authority established in November 1974. Its functions are set out in the *Alcohol and Drug Authority Act 1974*.

This work has been adapted from the Integrated Services Assessment Instruction Booklet (2010) developed by the Drug and Alcohol Office with the intention of offering a useful resource for clinicians from other services.

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Rationale and aim:

Assessment is an integral aspect of alcohol and other drugs (AOD) treatment. Whilst alcohol and other drugs services use a variety of assessment tools that may appear quite different, in reality, there are significant commonalities across those tools.

This booklet comprises

- PART A: a standard 'alcohol and other drugs assessment form' and
PART B: a clinicians' guide to using the standard AOD assessment form.

Part A offers an example of a standard AOD assessment and can be adapted to suit individual agency needs. Part B provides guidance on how to complete the standard AOD assessment, i.e. Part A. It also suggests how information may be recorded so that key information is retained.

The standard assessment form outlined in the booklet may be adapted to suit individual agency needs and the supporting instructions may be used as part of induction training or as an ongoing resource for staff.

Note: General medical assessment is included in the standard assessment form for those agencies that can provide medical services or that can make direct referrals for medical treatment. Non-medical agencies are advised to omit the medical assessment from the overall process.

How to use the booklet:

- This booklet provides an overview of questions that are likely to be asked in a comprehensive assessment. It provides basic information on the purpose of the question and the information sought.
- For most sections, an example of how the clinician could broach the question is provided. The example also covers the kind of questions that could be asked to elicit the most information. The example is not prescriptive and each clinician will adapt it to suit their own style. The suggested prompts are also not definitive – the clinician may need to probe further depending on the client's responses.
- For most sections, an example of how the clinician may record the client's response is provided. This is intended to provide guidance on the depth of information required.
- Any additional 'tips' are provided in italics.

General principles:

- Use a pen to complete an assessment form.
- Write legibly – other clinicians will need to reference the assessment information you have collated.
- If using abbreviations, include the complete words/name/description in the first instance (with the abbreviation in brackets) so that the meaning of the abbreviation is clear thereafter throughout the document.
- Always ensure that your name, signature, designation and date are recorded on each page of the assessment form.
- Explain to the client what the assessment is for and reiterate information about confidentiality. Emphasise that it is a shared process between them as client and you as clinician.
- It may not be possible to complete the assessment in one session. The assessment is also an opportunity to start building a relationship with the client and very often it takes time to explore answers with the client. This should not be rushed through as a paper exercise.
- If information is retrospectively added to the assessment document, sign and date the entry. Similarly, if any information needs to be changed, strike through the information to be replaced (so that it is still legible) and sign and date the amendment. Do not use 'white out'.
- During the assessment, you will be asking a lot of questions. It may feel less interrogative for the client if you use different approaches to this (e.g. 'I wonder if you would feel comfortable talking about.....', 'Are you happy for me to ask questions about.....' etc.).
- Where the client is accompanied by a support person, who may be involved in treatment (or where family members or significant others are likely to be involved in treatment), discuss the parameters of this with the client. It is important that those other individuals are included to the extent that supports the client and the treatment process.
- Write up your responses as soon as possible so that details aren't lost along the way. Allow yourself time for writing up as well as for the interview itself.
- During the assessment, you may come across client issues about which you feel inexperienced or insufficiently skilled. In such cases, discuss with your line manager, or in their absence, the most senior clinical staff member available. You may also use your supervision to improve your understanding and knowledge of these areas and to address any concerns you may have.

Why do we assess?

An assessment provides the client with a number of opportunities: These include:

- To re-appraise alcohol and other drug (AOD) use and in so doing, enhance motivation to change
- To acknowledge their own strengths, skills and resilience and therefore increase confidence in their ability to change
- To identify the link between current problems and AOD use
- To recognise their patterns of use and associated problems

An assessment serves a number of functions for the clinician: These include:

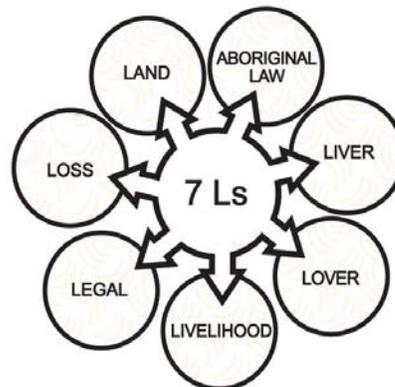
- The opportunity to develop a non-judgmental working relationship with the client
- To get an understanding of the client's motivation to change
- To engage the client in treatment for issues raised
- To tailor treatment to individual needs

Introducing the assessment

Assessment needs to be handled sensitively in order to create a caring and compassionate atmosphere so enabling the difficulties facing the client to be acknowledged (Helfgott, 2009).

Throughout the assessment, it is helpful to keep in mind the 4/7 Ls model (Roizen, cited in Heather & Robertson, 1985, and Casey & Keen, 2005). These models consider the impact of drug and alcohol use across a number of areas:

- Liver (health)
- Lover (relationships)
- Livelihood (work, hobbies, financial etc.)
- Legal (legal issues)
- Law (traditional law and culture)
- Land (the connection to country)
- Loss (grief and loss)



For each client, some parts of the assessment may feel particularly intrusive (e.g. legal issues, history of self harm/attempted suicide/child concerns). It is important to balance an understanding of the client's reticence around these issues and an understanding of the importance of obtaining the information. It may help if the clinician reassures the client that they are not judging them or their AOD use, but simply building a comprehensive picture of their situation so that they can work together to decide the most appropriate way forward.

Assessment is a comprehensive and important therapeutic process which leads to:

- The disclosure of information that can be used by clients to arrive at decisions about their problems as well as their drug use behaviour (Helfgott, 2009).
- An understanding by the clinician of what the client's key issues are and the treatment that may be most appropriate.

Tip: *An assessment is a process that is shared by the clinician and the client.*

Before taking a detailed assessment, the clinician should ensure that any preliminary mandatory forms have been discussed with, and signed by the client. These may include:

- Rights and Responsibilities
- Privacy statement
- Authority to Release and Obtain Information (AROI)

Note: The privacy statement and AROI provide an opportunity to discuss with the client the agency's policies and practices around confidentiality, information storage and access to information (i.e. by whom and in what circumstances).

- Some services may require clinicians to complete screening tools such as the Kessler 10 and the Severity of Dependence Scale).

It is also important to explain how the assessment will work and why it happens. The clinician should explain that a number of questions will be asked in an attempt to understand more fully what is going on for the client. The client's right to refuse to disclose information, if she/he is not ready, should also be acknowledged.

Introducing the assessment could begin:	'We are going to work through a number of questions now. These all form part of an assessment and it gives you the opportunity to share information with me so that we can both get a better picture of what is going on for you at the moment. Having a good understanding of the issues that you are concerned about helps to make sure that you get the best outcome possible from your contact with this agency. It may feel like I am asking you to share a lot of personal information and this can be difficult so if there are things you would prefer not to talk about for now, that is fine. Just let me know and we can move on to something else.'
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PART A: STANDARD ALCOHOL AND OTHER DRUGS ASSESSMENT FORM – MAY BE ADAPTED TO SUIT INDIVIDUAL AGENCY NEEDS

THE ALCOHOL AND OTHER DRUGS ASSESSMENT FORM	Client Name: Client Address:
Date of assessment: _____ GP: _____	
Referred by: _____ _____	
Presenting issues: _____ _____ _____	
Reasons for seeking treatment: _____ _____ _____	
Treatment goals: _____ _____ _____	
Drug and alcohol history: _____ _____ _____	
Clinician's Name:Work Role:Signature: Date:	

Other agencies involved:

Drugs used today:

Drugs used yesterday:

Drugs used last week:

Current prescribed medication:

Complete where appropriate:

Breathalyser:

Urine Test:

Pregnancy Test:

Clinician's Name:Work Role:Signature: Date:

ALCOHOL AND OTHER DRUGS ASSESSMENT

Key: U – Age first Used
 P – Age first Problematic
 D – Age first Dependent

Drug types:

History of use:

ALCOHOL: U: P: D:	
BENZOS: U: P: D:	
OPIOIDS: U: P: D:	
STIMULANTS: <input type="checkbox"/> Amphetamines <input type="checkbox"/> Dexamphetamines U: P: D:	
T.H.C: U: P: D:	
NICOTINE: U: P: D:	
OTHER: U: P: D:	

Clinician's Name:Work Role:Signature: Date:

Associated risk behaviours and problems:

Exposure to injecting:

Age first injected:

PRESENTING SITUATION:

Current accommodation:

Employment:

Education/training

Legal issues:

Interests and hobbies:

Clinician's Name: Work Role: Signature: Date:

SOCIAL SUPPORT:

Important people:

Current supports and supports provided:

Supports during treatment:

MENTAL HEALTH ASSESSMENT:

Past mental health issues:

Current mental health issues:

Past or current self-harm or attempted suicide:

Agency risk assessment form completed: Yes No

MENTAL STATE EXAMINATION: *See Part B (clinician's guide) for information regarding additional training*

Appearance:

Clinician's Name:Work Role:Signature: Date:

Behaviour:

Speech:

Mood:

Affect:

Thoughts:

Perception:

Cognition:

Clinician's Name:Work Role:Signature: Date:

MEDICAL HISTORY: (Note: Medically oriented questions should only be asked if the agency is in a position to provide a related service, refer on and/or follow up on responses. Otherwise, this part of the assessment should be omitted from the assessment process)

Family illnesses:

Medical/surgical history:

Current general health:

Practicing safe sex:

Gardasil vaccination:

Last STI check:

HIV:

Current status:

Hep A:

Hep B:

Hep C:

Other tests:

Last blood tests date:

Clinician's Name: Work Role: Signature: Date:

DOCTOR EXAMINATION: (If applicable and where medical treatment options are available)

Evidence of physical dependence:

Physical appearance/stigmata:

Injection sites:

Current physical signs of intoxication or withdrawal:

Pulse..... Blood Pressure.....
Height..... Weight.....

Cardiovascular	Gastrointestinal
Respiratory	Neurological

Other findings

Doctor's Name: Signature: Date:

CASE SUMMARY/FORMULATION:

Alcohol and other drug problem/diagnosis:

Mental health issues:

Physical health issues:

Identified risks:	Self harm/suicide Harm from other	Drug overdose Aggression/violence	Parenting concerns STI/BBV
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Allergies: _____

Treatment/management plan:

Referral to: _____

Plan for involvement of significant other:

Clinician's Name:Work Role:Signature: Date:

PART B: A CLINICIAN'S GUIDE TO ALCOHOL AND OTHER DRUGS ASSESSMENT

This section offers guidance to clinicians working through the AOD assessment form with clients. It explains the rationale behind the questions and offers suggestions on how to introduce the questions with clients. It also offers suggestions on how responses may be recorded.

Date of assessment:

This is the date on which the assessment commences.

GP:

Where possible include General Practitioner (GP) name as well as practice location. If the client states that they do not have a current GP, remember to ask if the client is currently taking any prescription medications or if they are receiving treatment for other medical conditions as this may prompt the client to identify other medical professionals that are involved.

Tip: This can also be a good opportunity to discuss with the client the important role of a GP in their general health care. Alcohol and other drug services are not General Practices, so if a client does not have a GP, it is useful to suggest that they seek one out.

Referred by:

Where possible identify:

- The name of the individual who is referring the client
- The agency for which they work and their role within the agency, if applicable.

Tip: Remember, it is useful to have the name of an individual contact within an agency, however, staff turnover means that individuals come and go, so the work role of the person making the referral is just as important.

Referrers may include:

Self, family, friend, other professional, other agency/service, GP, medical officer/specialist, mental health service, hospital, social/welfare services, other community/health care services, police diversion, court diversion, corrective services, counselling agency/service, Department of Child Protection.

Presenting issues:

Primarily, this question references current drug use (for the client or their significant other if the client is not the user) and any problems that the drug use is exacerbating. It asks the question:

What is *the drug of concern* and what are *the current issues* that you wish to address?

Whilst this is an introductory question that allows the client the opportunity to articulate what they see as the issues that they currently wish to address, it is important not to let the client go off on a tangent. The questions that follow will allow for greater exploration of the issues – this question is about getting a broad overview of the client’s current drug use and how it is impacting on them.

This enquiry could begin:	‘Tell me a little about your drug use (or your partner’s/child’s drug use) and the problems you are facing at the moment that led you to contact us...’ ‘Can you tell me a little about what’s been happening for you recently ?’
Responses could be recorded as:	Key issue = alcohol use. Recent increase in alcohol consumption now causing problems at work and at home. Drinking has increased from weekend binges (10 -14 units between Fri - Sun) to daily use (3 – 4 units per day) in addition to the weekend binges.

Tip: *If a client is going off on a tangent, it can be useful to bring them back on track. You could simply say:*

‘That is really useful information and we will come back to it later, but for now, let’s get back to what you were saying about what you see as the problems you are having at the moment with your drug use....’

Reasons for seeking treatment:

This question aims to identify the client’s reasons for seeking assistance **at this particular time** (Why now? Are there specific precipitating factors? What has motivated the client?). It serves a number of purposes:

- It identifies current crises – what triggered the decision to seek treatment?
- It helps to identify what Stage of Change the client is in, e.g. pre-contemplation
- It helps to identify specific motivating factors (e.g. potential job loss)
- It allows the clinician to get a sense of what the client expects from the service and to ensure that expectations are realistic (e.g. if the client wishes to be drug free in a week for a job on the mines, this might not be realistic).
- The conversation that takes place can be used to build trust and rapport with the client

This enquiry could begin:	‘Can you tell me why you have decided to seek treatment for your alcohol use now?’ ‘I wonder if something has changed recently that has made you decide to want to cut down/stop? Can you tell me more about this?’
Responses could be recorded as:	Client reports that he no longer enjoys drinking. Is aware of tension in his relationship and problems at work (absenteeism, lateness) as a result of his increased

	drinking. Is afraid that he may lose relationship or job if he doesn't 'sort himself out'. Client has tried but feels unable to cut down by himself. Is unsure of what help he needs. Partner suggested this service.
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Tip: *It can be difficult for a client to seek treatment – doing so is, in itself, an achievement. Recognising this and reflecting it back to the client can help to reinforce their commitment to change. It can also support the establishment of the therapeutic relationship.*

Treatment goals:

What does the client hope to get from treatment? Is this realistic?

The client's response will be dependant on a number of factors including:

- Client's treatment history – what worked before, what didn't? Does the client want to repeat the same treatment, or try something different?
- Client's knowledge of treatment options – if client is unaware of treatment options, he/she may not be able to articulate goals
- Client's position in Stages of Change model

This enquiry could begin:	'Have you thought about what you would like to get from coming to this service? ' <i>(It may help to provide some options: abstinence, reduction, reducing the harm of use, e.g. BBVs)</i>
Responses could be recorded as:	Client wants to cut down his alcohol use. Wants to be able to drink socially at the weekends and remain alcohol free during the week. or Client unsure – no particular goals identified <i>In the event of the client being 'unsure of treatment goals', it is advisable to revisit this question in a later session</i>

The client may also express views on the kind of treatment they want and this should also be recorded:

Responses could be recorded as:	Client does not want to be medicated. He would like to have counselling as this was helpful previously.
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Sometimes, the client's treatment goals may be unrealistic or unsafe, for example, it is inappropriate for a pregnant woman on benzodiazepines to stop taking them immediately

Responses could be recorded as:	Client has long history of benzodiazepine use. Currently 3 months pregnant. Wishes to stop benzo use now. Inappropriate treatment option – discussed with client.
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Alcohol and other drug treatment history:

This question helps to build a picture of the client’s drug using and treatment experiences. It provides information on what treatments the client found helpful and unhelpful as well as how long since first/last treatment episodes?

Tip: Sometimes when clients present for treatment they are in crisis and can be somewhat chaotic. It can be difficult for them to provide comprehensive information on previous treatment. As such, it may be helpful to review agency data (to ascertain if they have had previous contact with the service) before your interview with client.

This enquiry could begin:	'Have you had any help for your alcohol use in the past? When was this? Was this counselling or something else? How long did you attend? What was helpful about this treatment? What was unhelpful?'
Responses could be recorded as:	Client saw a counsellor at '..... AOD Agency' 4 yrs ago. Attended weekly sessions for 3 months. Followed escalation in alcohol use as a result of father's death. Used a drink diary and discussed alternative coping strategies. Client managed to reduce alcohol use with this support.

Tip: Remember if a client notes that they have previously undergone detox, it is important to clarify the type of detox (inpatient, self/unsupervised, home/supervised)

Other Agencies Involved:

Very often, clients will be currently engaged with other services. It is useful for the clinician to be aware of what links might be useful or required (e.g. information regarding Court-directed clients will need to be shared with their Community Corrections Officer or where there is Child Protection agency involvement, there may need to be some information sharing regarding the client's treatment plan/progress).

Tip: *Where other agencies are involved, the clinician will need to remind clients about Release of Information procedures and Confidentiality policies. Remember to advise clients that information may be shared if the client or someone else, is at risk or if they are giving details around illegal activity.*

This enquiry could begin:	'It is useful for us to know if you are also seeing anyone from another service. Sometimes, it helps if we share information because it can make sure that we are all working towards the same goals but this would only be with your consent. If we do need to share information with another worker, e.g. a community corrections officer, we will discuss this with you first. So, do you have any contact with other agencies? For example, Child Protection, or Community Corrections or other counselling service?
Responses could be recorded as:	Child Protection involvement since Jan 09. John Doe, case manager, city office. Good relationship with Case Manager. Substance users' peer organisation for informal support – on and off for a number of years. Corrective Services – since Dec 08. John Doe, case manager, city office. Finds Case Manager difficult to talk to – has missed some appointments.

Drugs used today/ yesterday/ last week:

These questions provide the opportunity to get specific information on the client's *current* drug use. It is important that the clinician ask about licit (including misuse of prescription drugs) and illicit drugs used. The clinician is seeking to find out what drug/s and how much was used on each occasion.

It is important to keep the client focused on current and very recent use. The next section will allow for more discussion around drug using history.

This enquiry could begin:	'We will discuss your drug use history in a moment but first, I will ask you a few questions about your current drug use. The more specific you can be about your use, the more helpful it will be, in terms of helping to determine the best treatment plan. So, can you tell me if you have used any drugs today – any prescription medication or any other drugs? How much did you use? And what about yesterday? How much of that did you use? And can you remember what you used last week? How
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	much of that did you use?’
Responses could be recorded as:	Today: nil Yesterday: ½ bottle of wine, 2 x10mg diazepam (from a previously prescribed supply) Last week: ½ bottle of wine each day. Occasional use of diazepam – can’t remember how many but probably daily.

Current Prescribed Medication:

It is important to know if the client is currently on any prescribed medication. The clinician is aiming to find out what medication is prescribed, what is it for, who is it prescribed by and how long the client has been taking it.

This enquiry could begin:	‘Are you on any prescribed medication? What is that for? Who prescribed it and how long have you been taking it?’
Responses could be recorded as:	Name of medicine, dosage, prescribing GP, purpose of medicine (if known) and duration of use.

Breathalyser: This may be done as part of a full assessment when a client presents with alcohol as the problem substance. It may also be helpful when clients present in alcohol withdrawal or if suspected alcohol intoxication is current. *Note: if client has a positive alcohol reading and is in obvious alcohol withdrawal the information can provide the clinician with a better sense of the client’s level of tolerance.*

Urine: Some agencies may do a urinalysis as part of the full assessment for clients presenting with drug use history. Urinalysis may be used to confirm the presence of illicit and/or prescription drugs. It is particularly important to confirm the presence of opiates when clients are requesting opiate pharmacotherapy.

Pregnancy test: If the agency provides medical services, it may need to know if a client is pregnant. In such cases, the clinician may be required to ask if there is any chance the client could be pregnant. With the clients’ permission, a pregnancy test can be helpful to inform treatment decisions. This is particularly important when considering treatment options for opiate dependence. **Opiate withdrawal can increase the risk of early labour or miscarriage.** Pregnant clients requiring Buprenorphine as an opiate pharmacotherapy are prescribed Subutex rather than the usual Suboxone. *Note: Methadone is the first treatment of choice for pregnant women seeking opiate pharmacotherapy.*

For medical services, the doctor will need to know if a client is pregnant before making treatment decisions.

ALCOHOL AND OTHER DRUGS ASSESSMENT:

This section provides an opportunity for the clinician to discuss the client's use of alcohol, benzodiazepines, opioids, stimulants (amphetamines, dexamphetamines), cannabis, nicotine and any other drugs (hallucinogens, MDMA/ecstasy, illicit prescription medications and solvents, e.g. glue, petrol).

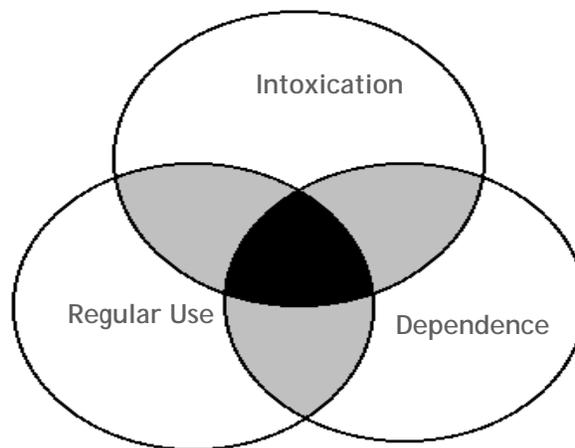
Clinicians should note that often clients will have poly drug use issues, and therefore, it is important to ask clients about each category of drugs.

The client is asked to provide information relating to age each drug was first used, age first problematic and age first dependant (if applicable) and a history of use. This latter category provides the opportunity to find out about patterns and frequency of use of all substances, any periods of abstinence, how the drug was used, quantities used, withdrawal symptoms, and interaction of each drug with others.

Some sections will have significantly more comprehensive answers, depending on client's drugs of concern.

If a client does not use a particular substance, indicate this in the relevant section (e.g. never used, not used for 5 years)

Tip: *It may be useful to keep Thorley's model in mind when exploring these particular issues with the client – what is the client's experience of 'intoxication', 'dependence' and 'regular use'*



Thorley(1980)

Intoxication: Problems can arise from a single occasion of use (e.g. road crashes, accidents, fights, unsafe sex, drink driving)

Regular use: Problems can arise from continued use over a longer period of time (e.g. medical and health issues, financial, family problems, child neglect)

Dependence: When a person becomes physically or psychologically reliant on the substance. Level of dependence can vary between individuals and over time. Problems may include those associated with Intoxication and regular use as well as withdrawals, isolation, anxiety, etc.)

Many clients may experience problems in more than one dimension (e.g. regular use and intoxication are not exclusive of each other) and over time they may move from one dimension to another (e.g. from regular use to dependence).

Key: U. Age first **U**sed
 P. Age first **P**roblematic
 D. Age first **D**ependent

Tip: It is helpful to differentiate between problematic and dependent use: clients may not define their use as dependent but may recognise that it has caused problems.

Drug Types	History of Use
Alcohol U: P: D:	Include Frequency of use: daily, weekly, binge Is there a regular pattern – e.g with a particular friend/ in particular situations? Use in conjunction with other substances Type of alcohol: e.g. spirits, beer, wine Amount: glasses, bottles, casks or units per day/week Degree of intoxication: e.g. tipsy, drink to pass out What type of withdrawals: shaking, sweating, seizures, nausea, vomiting, memory loss Describe last episode of non-using - this can help to gauge levels of dependence and tolerance. Ask questions around <ul style="list-style-type: none"> - When client last had a period of non-use? - How long did that last? - Did client experience withdrawals? - How soon after ceasing use did withdrawals begin? - How long did the withdrawals last? Positives/negatives of use
Benzodiazepines U: P: D:	Include: Frequency of use Is there a regular pattern? Is the client using prescribed medications? If so, who is prescribing them and is the client taking them as prescribed? Does the client see more than one GP for prescriptions? How many on each occasion / cost? Use in conjunction with other substances What type of withdrawals: insomnia, anxiety, irritability, restlessness, tremor, dizziness Describe last episode of non-using - this can help to gauge levels of dependence and tolerance. Ask questions around <ul style="list-style-type: none"> - When client last had a period of non-use? - How long did that last? - Did client experience withdrawals? - How soon after ceasing use did withdrawals begin? - How long did the withdrawals last? Positives/negatives of use

<p>Opioids</p> <p>U: P: D:</p>	<p>Include:</p> <p>Type</p> <p>Frequency of use</p> <p>Route -e.g. oral, intravenous, smoking</p> <p>Is there a regular pattern?</p> <p>If injecting, how often?</p> <p>How much on each occasion – weight, cost?</p> <p>Use in conjunction with other substances</p> <p>What type of withdrawals/effects: dilated pupils, yawning, tearing, goose flesh</p> <p>Describe last episode of non-using - this can help to gauge levels of dependence and tolerance. Ask questions around</p> <ul style="list-style-type: none"> - When client last had a period of non-use? - How long did that last? - Did client experience withdrawals? - How soon after ceasing use did withdrawals begin? - How long did the withdrawals last? <p>Positives/negatives of use</p>
<p>Stimulants</p> <p><input type="checkbox"/>Amphetamines</p> <p><input type="checkbox"/>Cocaine</p> <p>U: P: D:</p>	<p>Include:</p> <p>Type (e.g. methamphetamine, dexamphetamines, ice)</p> <p>Frequency of use</p> <p>Route - if injecting, how often?</p> <p>Is there a regular pattern?</p> <p>Illicit prescriptions or illicit use of prescribed medication</p> <p>How much on each occasion – weight, number of tabs, cost?</p> <p>Use in conjunction with other substances</p> <p>What type of effects?</p> <p>What type of withdrawals/effects: irritability, lethargy, hunger</p> <p>Describe last episode of non-using - this can help to gauge levels of dependence and tolerance. Ask questions around</p> <ul style="list-style-type: none"> - When client last had a period of non-use? - How long did that last? - Did client experience withdrawals? - How soon after ceasing use did withdrawals begin? - How long did the withdrawals last? <p>Positives/negatives of use</p>
<p>Cannabis</p> <p>U: P: D:</p>	<p>Include:</p> <p>Frequency of use</p> <p>Route</p> <p>Is there a regular pattern?</p> <p>How much on each occasion of use?</p> <p>Use in conjunction with other substances?</p> <p>What type of effects?</p> <p>What type of withdrawals: anxiety, disturbed sleep, vivid dreams, night sweats</p> <p>Describe last episode of non-using - this can help to gauge levels of dependence and tolerance. Ask questions around</p> <ul style="list-style-type: none"> - When client last had a period of non-use? - How long did that last?

	<ul style="list-style-type: none"> - Did client experience withdrawals? - How soon after ceasing use did withdrawals begin? - How long did the withdrawals last? Positives/negatives of use
Nicotine U: P: D:	Include: Frequency of use How many? Is there a regular pattern? Use in conjunction with other substances e.g. alcohol? Describe any period of non-use – what works, how long did period last, what symptoms did you experience, why did you resume? Positives/negatives of use
OTHER <input type="checkbox"/> Hallucinogen <input type="checkbox"/> MDMA – Ecstasy <input type="checkbox"/> Illicit Rx/Rx use* <input type="checkbox"/> Solvents U: P: D:	Include: Type Frequency of use Route Is there a regular pattern? How much on each occasion of use? What type of effects? What type of withdrawals: dependent on substance Describe last episode of non-using - this can help to gauge levels of dependence and tolerance. Ask questions around <ul style="list-style-type: none"> - When client last had a period of non-use? - How long did that last? - Did client experience withdrawals? - How soon after ceasing use did withdrawals begin? - How long did the withdrawals last? Use in conjunction with other substances? Positives/negatives of use This section covers any substance not already discussed in the categories above, e.g. using over the counter medication for purposes other than the intended purpose or in quantities above dosage recommendations. The clinician should explore drugs in this category in the same way as outlined for previous categories.

Illicit Rx (Rx denotes prescription): This relates to instances where the client obtains prescriptions illicitly, i.e. the medication has not been prescribed by a medical practitioner for that person. An example is where the client forges a prescription, or buys a prescription from another person (e.g. clients who buy dexamphetamines 'on the street').

Illicit Rx use: The illicit use of prescribed medications is where the client takes his/her own medication other than as prescribed by a medical practitioner. An example is where a client takes more medication than is prescribed (e.g. painkillers, sleeping tablets, etc).

Illicit prescriptions and illicit use of prescribed medications are covered in the last category, OTHER, in the above table.

Associated risk behaviours and problems:

This question allows the client and clinician to discuss issues such as injecting behaviour, safe sex practices, overdoses and BBV status.

It also covers areas such as does the client drink (use drugs) and drive? If the client has children, how does he/she balance child care and drug-using practices (e.g. only using when children are out of the house, keeping equipment away from children, where is substance stored).

This enquiry could begin:	'I would like to ask you some questions about how you use so that I can get a good idea of what some of the main issues are. Is that okay with you? Great... so can you tell me a little about how you use? Do you use alone? Do you have your own equipment?' Or 'You mentioned that your use has increased and that you are now injecting every day. This probably makes it more difficult to manage the kids – can you tell me a bit about how you cope with that? Have you concerns around this?'
Responses could be recorded as:	Chaotic use – often shares needles, often uses alone or with others Or Has own equipment – keeps it out of reach of kids and uses once kids go to school. Has started to use once kids are in bed. Uses alone – is fearful of overdose and of kids finding her. Is fearful of losing custody of kids if use escalates further.

Exposure to injecting:

This question expands on the previous one and is more specifically about injecting habits.

Has the client ever injected? When was this?

Has the client witnessed other people injecting (e.g. parents) and how do they feel about this?

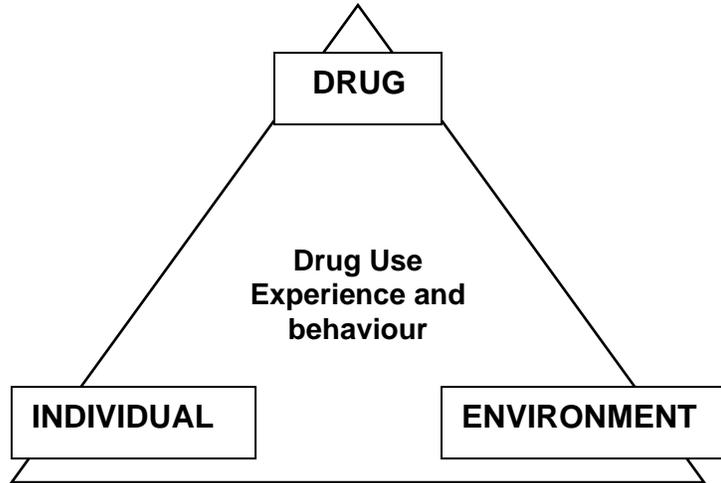
Does the client self-inject? Do they inject any one else? When did they last share equipment? Have they been tested for BBVs? Do they need to be re-tested after 3 month window?

Age first injected:

This needs to be completed if the client has indicated that they have injected at any time. Otherwise 'n/a' may be recorded.

PRESENTING SITUATION:

Tip: A drug and alcohol assessment considers more than just drug and alcohol use. It looks at drug/alcohol use (including factors such as the type of drug, the quantity, purity and route of administration), the individual (including factors such as physical and mental health, age, sex, personality and mood) and their environment (including factors such as cultural norms, legality, family beliefs etc.) This is presented in the Drug Individual Environment (Interaction) model (Zinberg 1984).



The following questions help to get a comprehensive picture of what contributing factors and/or consequences there might be to the person’s drug/alcohol use.

Current accommodation:

This question provides useful information on the client’s situation.

- Are they in stable accommodation – how long have they lived there, how long can they stay there?
- Is there drug use at the accommodation?
- Are there any financial stresses in relation to their accommodation, e.g. mortgage or rental arrears?
- Are they isolated or living with friends/family?
- Do they live with others who use?
- Does the client feel that this is a safe place to be?

This enquiry could begin:	‘Where are you living at the moment? Is that a rental property? Do you live alone? If not, who do you share with? How does that work for you? It sounds like it can be quite stressful sharing with someone who uses when you’re trying to quit – can you tell me some more about this? Would you say that you feel ‘safe’ living there, or do you have concerns for your safety? Do you want to tell me a bit more about this?’
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Responses could be recorded as:	No stable accommodation. Currently staying with friends who also use. Not happy there but has no money for alternative accommodation. Finds that he uses more in this environment. Feels physically safe, but emotionally vulnerable in this environment.
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Employment/education/training:

Is the client engaged in any of these at the moment? Is the work/education/training part-time, full-time or casual? Does the client enjoy the work etc? How does their use impact on this – e.g. do they use at work, are they hung-over at work, has their employer raised their use as a problem? Has this contributed to their decision to seek treatment?

This enquiry could begin:	'Are you working or studying or doing some training? How does your drug use affect this? Do you use at work? Has this caused any problems? Do you enjoy your work? '
Responses could be recorded as:	Client is on a final warning at work – is often late for work due to drug use. This has been a key reason for him deciding to seek treatment. Wants to limit use to weekends so that it doesn't affect his work so much.

Legal issues:

This question helps to identify if there is a relationship between client's drug use and offending behaviour. Did the client's legal issues arise because of drug use (e.g. driving under the influence) or did the client commit offences to support drug use (e.g. theft, fraud). Are legal issues past, present or pending? Have they got any legal commitments – e.g. seeing a probation officer, community work? Have these legal issues been a motivating factor in seeking treatment?

Whilst potentially relevant to all clients, mandated clients in particular are likely to have specific legal issues – check for upcoming Court dates and any conditions that may have been imposed on them by the Court.

It is useful to remind the client that you may have an obligation to disclose certain information that they might divulge (in the instance of you becoming aware that they or someone else is at risk or has come to harm because of their actions).

This enquiry could begin:	<p>'Can you tell me if you have any legal issues? I can understand that this might be difficult to discuss but it would help me get a good picture of what is going on for you if you could tell me a little more about that? Do you have any charges against you? Any convictions? When did that happen? Was it connected to your drug use? You mentioned earlier that you were seeing a Community Corrections Officer in the city office. Can you tell me more about this? When is your Court date due? '</p> <p><i>(it can be useful to cross reference information you may have obtained earlier in the session or in a previous session to make sure that the information you have is comprehensive)</i></p>
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Responses could be recorded as:	Client has DUI charge. Due in Court next month. Would like to be in treatment by then to show that he is addressing his drinking. Previous arrests for assault (2002, 2003). Both under the influence. Given good behaviour bonds.
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Hobbies and interests:

Does the client have other interests separate to or connected with their drug use? How does this compare to their hobbies/interests before their drug use? Helps to build a picture of the impact of drug use on client’s life and helps to identify what might motivate the client to address drug use – are there things they would like to take up again if they addressed their drug use? Do they like solitary or social activities?

This enquiry could begin:	‘Tell me a little about what you like to do in your spare time? Has your drug use affected this? How is this different to before your drug use caused you problems?’ So, you like taking part in quizzes – where do you do this? Do you think that drinking is an important part of this for you?’
Responses could be recorded as:	Used to enjoy quizzes. Pub based so very linked to drinking. Tends not to bother anymore. Would like to do something completely different. Is shy in other people’s company unless drinking.

SOCIAL SITUATION:

A genogram identifies the family relationships in a person’s life through graphic representation. It is a useful and simple visual tool that provides a snapshot of the individual’s family history and current situation. It can help to provide clarity for sometimes complex family relationships. It is useful to include as many members of the individual’s family as possible but especially those that the client sees as significant in their lives.

The genogram may help the client to make sense of relationships in their lives. It may be the first time that they have seen a visual representation of those relationships and their interconnectedness. Exploring the genogram may trigger emotional responses for the client, as in certain situations it may be a confronting experience (e.g when a death in the family or severed relationships are included in the diagram).

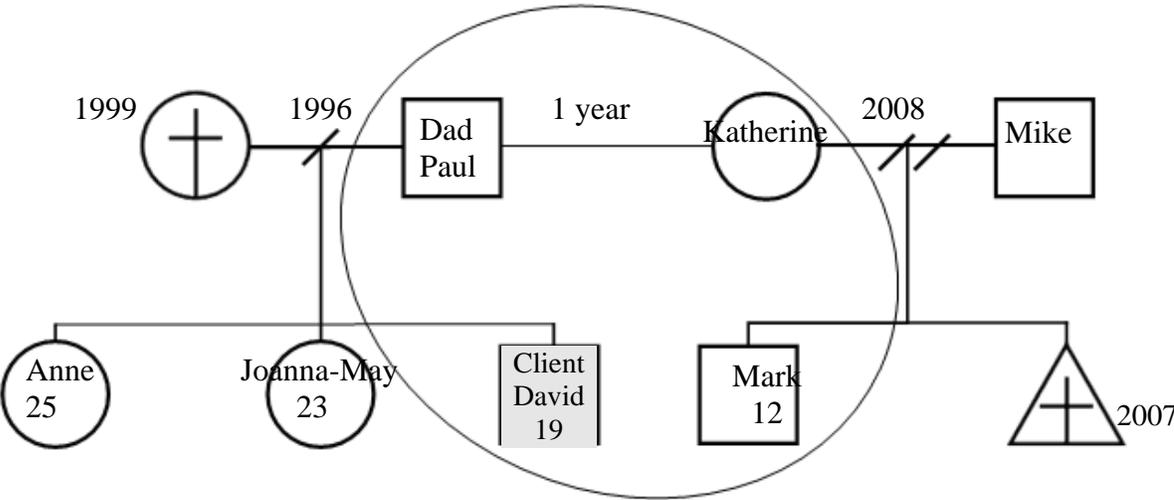
Tip: *Make sure your diagram is legible and uses recognised symbols only. It is only helpful when it is clear and not overly complex. Include children’s names and ages – if they don’t fit on the genogram itself, have a supporting legend that provides the information.*

Introducing the Genogram:	It's often helpful to do what we call a 'genogram'. This is where we 'map' your relationships – drawing a picture of them, if you like. It can really help to get a sense of who's in your life. Is that okay with you? It may bring some things up for you, for example if you've lost contact with someone who was special to you. If that happens, we can talk about it, or slow the process down. Is it okay if we try the genogram?
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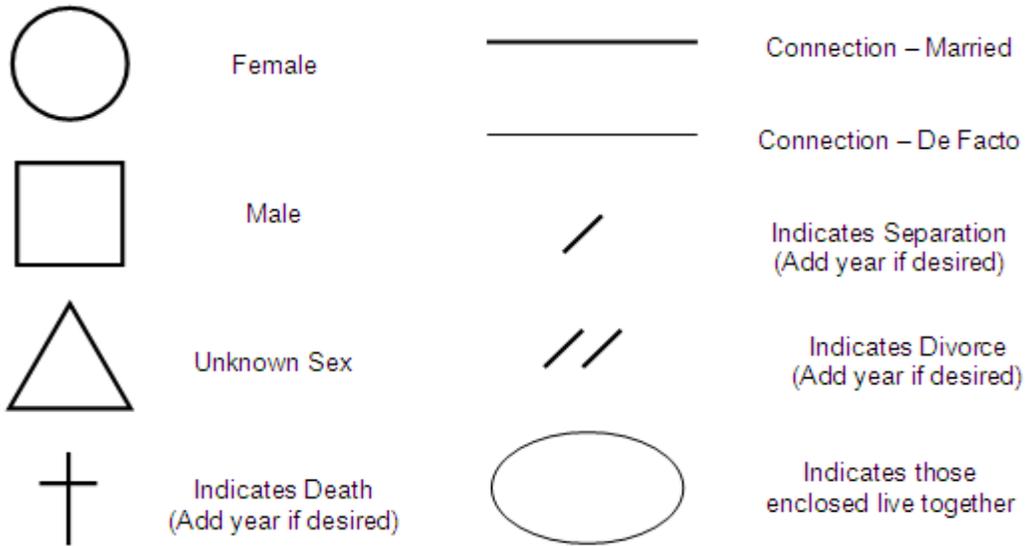
In the example below, David is the client. From the genogram, we immediately know that:

- David is 19.
- He lives with his dad (Paul) and his dad's partner, Katherine and Katherine's son Mark.
- Paul and Katherine have been together for one year.
- David has two older sisters (Anne and Joanna-May) who live away from the home.
- Katherine had another child (sex not known) who died in 2007.
- She divorced from Mike in 2008.
- David's parents separated in 1996 and his mum died in 1999.

At a glance, we have a snapshot of David's family situation!



Symbols commonly used in a genogram:



Current relationship:

By now, the client may already have shared information regarding a partner or spouse. However, this is a good opportunity to check that you have comprehensive information in this regard. If you don't have the following information, this question gives you the opportunity to discuss with the client in more detail.

- Is the client in a relationship?
- How long have the client and partner been together?
- Is the partner working?
- Is the partner supportive of the client seeking treatment?
- What is the partner's drug use/drinking behaviour?
- Is there an indication of domestic/family violence?

Tip: *Domestic and family violence is a complex issue, incorporating a range of behaviours and attitudes. It is not limited to physical abuse.*

“Domestic and family violence is when one person in a relationship wants to have power and control over the other person in the relationship. It involves the use of force, threats or intimidation by one person to control and manipulate others....there are many forms of abuse including physical, verbal, emotional, financial, using social isolation, sexual and psychological”.

(Women's Council for Domestic and Family Violence Services (WA), 2005)

This enquiry could begin:	'You mentioned that you have a partner, Robbie. Are you comfortable with telling me a bit more about him? How long have you been together? Would you say that Robbie supports you? In what way?'
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	<p>'Sometimes, relationships can be tricky and stressful – is there anything about your relationship that is particularly difficult? '</p> <p>'You mentioned that Robbie often gets frustrated with you? What happens then?'</p> <p>'We can come back to this again in another session and look at ways you can deal with this.'</p>
Responses could be recorded as:	Partner Robbie, 28. Living together 5 yrs. Robbie uses amphetamines occasionally, often verbally abusive towards client. Client feels that her drug use annoys Robbie and leads to DV. Is frightened that DV may become physical. To be discussed again in future sessions.

Children:

Whilst this question doesn't relate only to dependent children, it does recognise that clients often have specific concerns around children who are in their care. These concerns include:

- Feelings of inadequacy in parenting role/efforts to hide drug use from children and others because of shame.
- Fear around children being removed from their care.
- Concern around children's own using and behaviour (e.g. truancy, petty crime, peer group).
- How to manage use safely when living with dependent children?
- If the client doesn't have custody of children, how much contact do they have?

It can be helpful to normalise these fears and to encourage the client to articulate them.

This enquiry could begin:	<p>'Earlier you told me a little bit about your children. Can we just go back to that for a moment? You have two boys and they are both at school, is that right? And what are their names?'</p> <p>'Do you have any concerns around either of the boys?'</p> <p>'So what you're saying is that John is having a bit of trouble at school? Can you tell me more about this?'</p> <p>'You seem worried that the boys might be taken away from you by Child Protection services? Why do you think this?'</p> <p>'I can understand your fears around this. It might help you though, to focus on the fact that you are here to get help for your drug use and as part of that we can look at some ways of making parenting a bit easier.'</p>
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Responses could be recorded as:	'2 sons, Tim and John, 9 and 7. Older boy, Tim, truanting/misbehaving at school. Threatened with suspension. Client fearful of Department of Child Protection and possibility of boys being removed from her care. Discussed referral to parent support service.'
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Services may have specific policies around child protection and reporting procedures. These policies may offer further support in dealing with child protection issues.

Tip: *Take time to recognise the client's strengths, not only the problems that they are experiencing.*

Social and family history:

The key issue in this part of the assessment is identifying significant events and experiences in the client's history. Generally, the clinician is aiming to obtain information concerning:

- Client's childhood experiences
- Relationship with parents
- Relationship with siblings
- School (primary and secondary) experience
- Traumatic events – e.g. divorce, bereavements, domestic violence, sexual violence
- Parental history of AOD/mental health issues.

Open-ended questions can prompt some helpful discussion. It may not be possible to discuss issues raised here in depth, so it is helpful to remind the client that you can revisit certain issues/areas of concern in future sessions.

This enquiry could begin:	'Were there any times or experiences that were particularly difficult for you when you were growing up?'
Responses could be recorded as:	Only child, parents divorced when client was six. Did not see dad after that – occasional contact by letter. Dad died 5 yrs ago. Client reports that he 'hated school' – was bullied during high school. Started using cannabis then to cope. Mum had depression, client felt she was emotionally unavailable. Had good relationship with paternal grandmother.

Tip: It may be that this question prompts disclosure of abuse. The clinician needs to acknowledge the client's experience and reassure the client that supporting them to address this can be part of the treatment plan.

It is also important to reassure the client that it is not necessary to disclose the details of the abuse if they don't feel that this would be helpful.

The clinician will need to balance the tasks of information gathering with supporting and containing the client so that they don't leave the assessment feeling overly exposed and vulnerable.

Be aware of the possible need to inform the client of mandatory reporting requirements.

Tip: Marsh, A., Dale, A., & Willis, L., 'A Counsellor's Guild to Working with Alcohol and Drug Users', 2nd Ed, p7 offers useful guidance regarding disclosure of trauma during assessment.

SOCIAL SUPPORT

Tip: Remember that for some clients, family will be very important. Family is not restricted to immediate relatives but can refer to a much wider system. Peer groups can also be very important, especially for young people.

This section encourages a systemic and family inclusive approach to practice. It recognises that individuals do not live in isolation and the relationships they have with others can potentially impact on, and ideally support, their recovery. It also recognises that those people who are important to a client are not limited to family members.

However, if the client feels lonely or isolated, and if they feel that they don't have supportive people in their lives at the moment, they may need to be reassured that there is no right or wrong answer.

It may be useful to break down this section into the following components. These questions allow the clinician to explore who is important in the client's life and what supports, if any, the client has in place.

Important people:

Are there significant others in their lives?

(Remember that the client may have someone they see as important in their lives but who doesn't necessarily support them)

Current supports and support provided:

Who does the client have in their lives that they are able or willing to rely on? What support do these people offer the client (e.g. emotional, practical, financial etc)?

Is there another professional that they feel they can trust?

This question helps to identify if the client has support from others. It gives the clinician a sense of whether the client has non-drug using people in their lives and if these people know about the client's drug use.

By considering what support the client has, it is often possible to identify what support isn't available to the client. During treatment, the clinician may work with the client to determine how such supports can be established.

This enquiry could begin:	'Sometimes it is good to know who is there to support us when we need some help. Who would you say are the most important people in your life right now? It can be family but it doesn't have to be....it could be anyone that you feel is important in your life right now. How would you say these people support you? Remember they might support in a number of ways, for example, by listening to you, by helping you out with money if you need it, by encouraging you to attend here today? '
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Responses could be recorded as:	Parents are important to client and provide financial support but client doesn't feel that he can discuss emotional issues with them. Has an old friend that he sees regularly who used to use but doesn't anymore, and client feels that he can talk to him. Parents know that he is coming today and expect him to come home with a treatment plan. Client feels some stress around this.
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Supports during treatment:

Would the client like significant other/s to be involved in treatment? In what way would the client like this to happen (e.g. family counselling, information sharing, practical support during home detox, etc.)

This question in particular may help the client to feel they have some control over their treatment. It is up to them to what extent and how they would like others to be involved (e.g. a young person may not want their parent involved in all aspects of their treatment).

***Tip:** It may be useful or necessary to remind clients that you will not share information about them with others without their knowledge and consent – refer to Authority to Release and Obtain Information. Note that the Authority to Release and Obtain Information only refers to advising family members if a client attended (if the client indicates their permission for this). It does not give authority to discuss the content of the session. If the client wishes a family member to be more involved in the process, you could discuss with the client the option of having them attend one, or more, of the treatment sessions.*

This enquiry could begin:	'Is there anyone you can think of who might be a good support for you as you address your drug use? Would you like them to be involved? In what way would you like for them to be involved? Do you think you could talk to them about that?'
Responses could be recorded as:	Client would like parents to be involved so they understand how difficult it is. Would like parents to understand that he is trying to quit but can't make any promises yet. Would like some family sessions so that they could talk about this. Just wants his family to try to understand what's going on.

***Tip:** Don't forget to ask about other attachments the client may have. For example, sometimes a pet has great emotional significance for a person and may influence the kind of treatment that they engage in (e.g. residential treatment may not work for someone who has no one to care for their pet).*

MENTAL HEALTH ASSESSMENT:

Why do we need to do a mental health assessment as part of the drug and alcohol assessment?

- Research indicates that up to 80% of people in for substance use problems have co-occurring mental health problems (*Burns and Teesson 2002*).
- Up to one third of mental health clients have an AOD problem (*Teesson et al 2001*).
- Even greater numbers have “sub clinical” symptoms which may result in significant distress and impact on relapse.
- People with co-occurring problems have a poorer prognosis, therefore effective management of comorbidity is essential.

Past mental health issues: Has the client had previous diagnoses of mental health conditions? Does the client have concerns around their own mental health (not necessarily diagnosed conditions)? If there is a history of mental health issues, when did these occur? Has the client been treated previously? If so, how? What is the client’s experience of treatment (positive, negative)? Any in-patient admissions? If so, where and for how long?

This section provides an opportunity to screen for possible signs of depression, anxiety or psychosis.

Tip: *Sometimes, a client may not actually consider, or recognise that they have a condition such as depression. Asking questions other than ‘have you ever been/are you depressed?’, can give you a broader picture of the client’s experience.*

<p>This enquiry could begin:</p>	<p>‘Have you ever had periods where you felt really down or low that lasted for more than a day or so? Was there something that caused you to feel like that, for example we can often have a re-action to losing a job or ending a relationship and feel low for a while afterwards.’</p> <p>‘Have you ever been prescribed anti-depressants by a GP?’</p> <p>‘Are there any situations or events that make you feel particularly anxious or nervous?’</p> <p>‘Do you ever have thoughts that upset or confuse you? Can you tell me a bit more about that?’</p>
<p>Responses could be recorded as:</p>	<p>States feeling hopeless and worthless and finds it hard to concentrate. Has felt like this for some time - started about 2yrs ago following divorce. Was on GP prescribed anti-depressants for 6 months – stopped because didn’t feel they were helping. Alcohol use increased since and helps to mask the feelings.</p> <p>Feels anxious in social situations. Uses alcohol to cope.</p>

Current mental health issues: This question allows the clinician to establish if the client has diagnosed, or self-reported, current mental health issues. Is he/she on treatment? If so, by whom, what is it, dose and how does the client feel it is working?

Past or current self harm or attempted suicide: This may already have been discussed under the above headings. If not, it is important to ascertain if the client has had any past or current episodes of self harm or attempted suicide.

Remember that this may be a particularly sensitive area for the client. It may help to let them know that discussing any past experiences around self-harm, attempted suicide helps to make sure that any current or future risks for the client can be managed as well as possible.

This enquiry could begin:	'You mentioned that you have experienced depression for a long time. At any stage, have you tried to hurt yourself, or have you attempted suicide?'
Responses could be recorded as:	History of self-harm (cutting) during adolescence – no treatment. Attempted suicide 3 years ago – overdose of sleeping tablets. Hospitalised for 1 week. Outpatient sessions with psychiatrist – Mr. Brown, Wembley – for six months.

Risk assessment form completed: If the client expresses suicide ideation, conduct a suicide risk assessment.

Tip: For support in undertaking a suicide risk assessment, review your agency's policies/procedures that deal with clients' suicide ideation.

MENTAL STATE EXAMINATION (MSE):

Tip: Agencies may consider accessing specific training on the MSE. Contact WANADA or Workforce Development at DAO for information on available training options.

Alcohol and other drug workers are often more experienced with mental health issues than they realise. After all, many of their clients will present with co-occurring conditions. Whilst the mental state examination is used to assess clients presenting with a wide range of mental health issues and in a variety of settings, drug and alcohol workers can use it as a base-line tool to get an overview of a client's presentation from a mental health perspective. It may be helpful, therefore, to incorporate the MSE into an alcohol and other drug assessment.

Note: Information on Mental State Examination outlined below has been adapted from Dickson, K., (2000). Mental State Examination, Reader. *Metropolitan Mental Health Service, Fremantle Hospital and Health Service, Department of Health.*

Tip: When conducting a mental state examination, bear in mind the age of the client. Young people are not neurologically mature until their mid twenties, therefore what may

appear as limited insight, or poor cognition, for example, may simply reflect their particular developmental stage.

Appearance: A description of the person’s general appearance is typically the first element of a mental health examination. It consists predominantly of the assessor’s impressions and observations of what the person looks like and can provide the clinician with clues by which to further investigate other areas of the mental state.

Consider: age, gender, ethnicity, self care, hygiene, physical appearance, tattoos.

Example	A young male client presents for treatment. As part of the mental state assessment, note his general appearance.
Your observations may be recorded as:	Caucasian male, aged 30, clean shaven with short brown hair. Suitably dressed for situation and climate. Appears in good health.

Behaviour: Incorporates a description of several areas such as eye contact, movements and motor activity, the use of expressive gestures and the person’s cooperativeness throughout the interview process.

Consider: abnormal movement, motor activity, gait, gestures, mannerisms, body language and ability to co-operate.

Example	Client appears fairly relaxed. Remains seated during the session and appears engaged in the interaction. No obvious unusual mannerisms.
Your observations may be recorded as:	Displays socially acceptable mannerisms and body language whilst interaction is occurring. Maintained good eye contact. Behaviour exhibited is within client’s cultural norms.

Tip: Remember that there are cultural variances in behavioural norms – for instance, some people may, for cultural reasons, avoid eye contact and find it uncomfortable if the clinician seeks to establish such contact.

Speech: It is important to describe details of a person’s speech and language assessment as part of the overall mental health examination. It should be noted that abnormalities of speech may be due to physical causes rather than a sign of psychiatric pathology.

Consider: articulation disturbances, tone, mutism, volume, quantity, poverty, pressure and rate of speech.

Example:	Client is talking rapidly, with few or no pauses. It is difficult to keep up with what he is saying. His voice is raised to the level of shouting though this not necessarily related to expression of anger (out of context).
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Your observations may be recorded as:	Speech is pressured – extremely rapid and difficult to interpret. Volume is loud and inappropriate to setting.
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Mood: Is a person’s subjective description of his/her predominant internal feeling state at a given time. Virtually no particular mood is in itself abnormal or pathological – mood should, therefore, be assessed in the context of a person’s situation, history and overall mental health assessment.

Most moods are within a range of six descriptions: euthymic (within the normal range), dysphoric (sad, low, depressed), euphoric (elevated, elated, ecstatic), angry (annoyed, hostile, frustrated), anxious (fearful, tense, nervous) and apathetic (indifferent, lethargic, numb).

When describing mood, try to include the client’s own description.

Example:	Generally, this categorisation is based on the client’s self-report.
Response may be recorded as:	Mood appears dysphoric – client reports feeling ‘down in the dumps’ and tearful for no particular reason.

Affect: This is the outward manifestation of a person’s internal emotional state and hence is present in all individuals. It is dynamic, in that it is subject to change. It may or may not match a person’s stated mood. Affect is assessed in terms of its intensity, range, variability and degrees of correspondence to the content of conversation (congruity).

Example:	The client demonstrates little or no emotional expression, face immobile and voice monotonous.
Your observations may be recorded as:	Flat affect with narrow range.

Thoughts (delusions, suicidal ideation): The aim is to document an assessment of the client’s organisation, flow and production of thought. The form of a symptom in psychiatry refers to how it is experienced as opposed to what is experienced.

Consider: thought form: amount of thought, rate of production, continuity of ideas, disturbances in language.

Thought content: self-harm, harm to others. delusional beliefs, people controlling or stealing their thoughts.

Responses may be recorded as:	Denies thoughts of self harm/plan/intent. Clearly indicates intent to harm his family if he feels endangered. Threatened father with an axe prior to being brought to hospital.
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	Describes being 'bombarded by thoughts that his family are out to get him' 'Keeps going round and round in his head'. Persecutory delusions, believes that family want to harm him and they are "sucking thoughts out of [his] head".
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Perception (hallucinations): These are unprovoked, perceptual experiences that occur in the mind of the client. They occur in any sensory modality (sight, hearing, taste, smell, touch) in the absence of any external physical stimulation. Illusions, by contrast, are the exaggeration, distortion or misinterpretation of an actual physical stimulus.

Example of auditory hallucination:	Client hears a voice inside his head telling him to kill his father because he is evil.
May be recorded as:	Client reports hearing a voice inside his head telling him to kill his father because he is evil.

Sometimes hallucinations may be accompanied by delusions.

Example of auditory hallucination/delusion:	Client hears a voice inside his head telling him to kill his father because he is evil. Client believes that God implanted a chip in his brain so that he could communicate directly with him. God is telling him, via this chip, to kill his father.
May be recorded as	Client reports hearing a voice inside his head telling him to kill his father because he is evil. Client reports that God implanted a chip in his brain so that he could communicate directly with him. This is the voice that is telling him to kill his father.

Hallucinations are often prominent in schizophrenia, where they occur in all sensory modalities, however auditory hallucinations are most common.

Cognition: This is the ability to know and think using intellect, logic and reasoning, memory and all higher cortical functions.

Insight: Refers to the individual's awareness of his or her situation and illness. There are varying degrees of insight. For example, a person may be aware of his or her problem but may believe that someone else is to blame for the problem. Alternatively, the individual may deny that the problem exists at all.

Example	Client presents as alert, engaged in the interaction and able to re-call events. Loses focus a little during the session – seems preoccupied by voices he hears. Knows why he was here and knows what counsellor's role is. Unable to answer questions around his hallucination/delusions. Vehement that he doesn't need any treatment. Repeatedly states that he is perfectly well.
May be recorded as:	Cognition: Fully conscious, memory appears intact, concentration a little distracted, possibly in response to auditory hallucinations. Orientated to time, person, and place. Insight: No insight into present situation and beliefs that he holds. Unable to explain why God would have implanted a chip in his brain to communicate with him. Does not believe that he needs treatment and emphatically states that he will not engage with services or take medication. Judgement significantly impaired at this time.

MEDICAL HISTORY: (This is relevant for services that offer medical treatment options)

An alcohol and other drugs assessment may include an assessment of the client's overall physical health. Where counselling services are co-located with medical services, a counsellor may gather the initial health and medical history information as part of the overall assessment.

Tip: The assessing clinician's role is to gather basic information around the client's medical status. They are not expected or required to provide medical information or advice to clients. If the client wishes to discuss their medical details in more detail, it is useful to clarify that they will need to do this with a doctor.

Family illnesses:

Often there can be a genetic component to medical conditions. As such it is important to ask the client about any illnesses in the family.

This enquiry could begin:	'Do you know if there are any significant illnesses in your family?'
Responses could be recorded as:	Fa – Type 2 Diabetes (Onset at 50+) Ma – Breast Cancer 15 year ago. Now clear. High blood pressure. Older brother, 28, has schizophrenia

Medical/surgical history:

Include here known medical/surgical details of client.

This enquiry could begin:	'Can you tell me a bit about your own medical history? Have you had any operations?'
Responses could be recorded as:	Appendectomy aged 15 years 2 emergency C-sections 1999, 2002 Hypertension

Allergies: Is the client allergic to anything and if so, what reaction do they have?

Current general health:

Include here anything not covered above but which may be relevant. Useful questions to ask here include:

'Are you sleeping well?', 'Are you eating well?'

Don't forget to ask about dental health - this can be a neglected area that has been affected by drug use and lifestyle.

Example	<p>Client states that she is currently recovering from flu. Still feeling lethargic and some nasal congestion still present.</p> <p>Would like to be BBV tested.</p> <p>Client notes that she has lost a lot of weight recently – BMI 18</p>
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Practicing safe sex: This is important as it relates to BBVs and STIs.

Gardasil vaccination: Yes/No

Last STI check – if appropriate: Date and results, if known

HIV: Has the client been tested? Do they know their HIV status?

Current status:

Hep A:

Hep B:

Hep C:

Detail status – positive, negative, when tested and when vaccinated.

Other tests: Are there any other tests that the client has had? Do they know their results?

Last blood tests date: Note here who requested the tests and where they were done so that results can be obtained if necessary.

NOTE: A doctor's examination is only applicable for those services that provide medical treatment options.

DOCTOR EXAMINATION: To be completed by a doctor

Evidence of physical dependence:

The assessment of physical dependence takes into account the persons recent history of drug use and their symptoms and signs of tolerance and withdrawal. The more physically dependent the person is on a drug the greater will be their tolerance and the more severe will be their withdrawal symptoms. There are critical issues to assess prior to the prescribing of any medication.

Tolerance:

Easier to gauge with alcohol, i.e. patient with significant BAL who shows no sign of intoxication. However' it is also possible to get a sense of tolerance relating to other drugs by gathering information from the history on changes in the quantity and frequency of drug use and the subsequent effects.

Withdrawal:

The following symptoms and signs may be evidenced.

- Alcohol: shakes, sweats, anxiety, rapid pulse, increased BP
- Benzodiazepines: insomnia, anxiety, restlessness, agitation, tremor, dizziness
- Opiates: dilated pupils, yawning, tearing, goose flesh
- Amphetamines: irritability, lethargy, cravings, hunger, overwhelming desire to sleep or difficulty in sleeping
- Cannabis: anxiety, disturbed sleep, increase in vivid dreams, night sweats
- Nicotine: irritability, mood swings, depression and anxiety, increased appetite and hunger, cravings, dizziness

See Drug and Alcohol Assessment, p 13

Physical appearance/stigmata:

Stigmata are the characteristic physical features.

For alcohol, stigmata include flushed face, parotid hypertrophy, palmer erythema, muscle wasting.

For opiates, stigmata include needle track marks, thin body habitus, dental caries.

Injection sites:

Check elbows, hands, neck, ankles, feet and groin.

Current physical signs of intoxication or withdrawal:

See evidence of physical dependence.

General medical examination:

Pulse:

Blood pressure:

Height:

Weight:

Cardiovascular Medical assessment of client's cardiovascular system	Gastrointestinal Medical assessment of client's gastrointestinal system and abdomen
Respiratory Medical assessment of client's respiratory system	Neurological Medical assessment of client's neurological system

Other findings:

Include any other findings from the general physical examination. This may include injuries, signs of infection, tattoos etc.

CASE SUMMARY/FORMULATION:

'This consists of a summary of the presenting issues, a formulation of those presenting issues in terms of their aetiology and maintenance within the context of the client's life and a summary of client strengths.' (Marsh et al, 2007, p.6)

Marsh further notes that 'case formulation' refers to the process of pulling together the results of an assessment into an explanation, using some sort of theoretical framework, of how a client's presenting problems appear to be caused and maintained. ***This explanation is always a hypothesis, to be adjusted as more information becomes apparent.*** A clear case formulation indicates the causal and maintaining factors that will need to be addressed in a treatment plan to help the client resolve their presenting problems.

A case formulation should be developed after the initial assessment is completed and prior to developing a treatment plan.

ASSESSMENT → CASE SUMMARY AND FORMULATION → TREATMENT PLAN

Marsh et al suggests using the 5Ps model to structure the formulation.

Presenting Issues & Case Summary – this provides a brief overview of the client and their presentation. It includes statements covering:

1. Demographic characteristics (age, gender, relationship status, employment status, accommodation)
2. Reason for the client's presentation and their goals
3. Brief summary of client's drug use
4. Key findings from past history (AOD treatment, significant mental health or physical health issues)
5. Key finding from mental state and physical examination.

Predisposing factors – these are issues in the client's childhood, adolescence and adulthood that predispose them towards experiencing their AOD and other current difficulties.

Precipitating factors – these are the factors that have brought the client's difficulties to a head and resulted in them seeking treatment.

Perpetuating factors – these are the factors in the client's life, behaviour, beliefs and psychological state that maintain the presenting issues.

Protective factors- these are the client's strengths and resources.

(Marsh et al, 2007, p6)

A good formulation helps the clinician and the client to:

- Recognise the client's strengths
- Understand the overall picture
- Clarify hypotheses and questions
- Prioritise issues and problems
- Plan treatment strategies
- Predict responses to interventions
- Identify barriers to progress

Tip: Based on your formulation, you may hypothesise where in the Stages of Change the client is and this is likely to help identify appropriate treatment options.

Example	<p>Presentation/Summary Demographics: Joe is a 30 year old unemployed male living alone. Reason: Self-referred. Wants to change drug use – not sure if he wants to cut down or give up. Drug history: Self-reported heavy amphetamine user. Has used IV for 5 years, in last year use increased to daily and then twice daily for the last month. Past history: Has not had previous D&A treatment. Hepatitis C. Examination: Looks miserable, needle track marks.</p> <p>Precipitating Recent increased use linked to relationship breakdown.</p> <p>Predisposing Reports feeling 'depressed' most of the time. On GP prescribed anti-depressants. Father was heavy drinker, mum left the home when Joe was 12. Dad drank more after mum left.</p> <p>Perpetuating Tends to use to cope with feelings of depression and isolation. Now feels dependent and feels that he needs to use every day. Has no contact with Father and doesn't have close friends. Only casual friends who are also users.</p> <p>Protective Has managed to keep his job as a plumber and enjoys this. Does not want to lose job. Generally, in good physical health, though slightly underweight. Job is motivating factor in addressing drug use. Joe appears to be in the 'Preparation' Stage of change.</p>
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Alcohol and other drug problem/diagnosis:

This provides an opportunity to state clearly the drug and alcohol aspect of the case formulation.

Example:	Dependent amphetamine use 2 x daily for past year. IV for 5 years.
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Mental health issues:

This provides an opportunity to summarise the client's mental health issues.

Example:	GP diagnosed depression. Has been on anti-depressants (Prozac) for six months. Still feels 'down'. Uses amphetamines to cope.
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Physical health issues:

This provides an opportunity to summarise the client’s physical health issues:

Example:	Slightly underweight but otherwise good physical health.
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Identified current risks:

Self harm/suicide	Drug overdose	Parenting concerns
Harm from other	Aggression/violence	STI/BBV

Allergies: Is the client allergic to anything and if so, what reaction do they have?

Where applicable further assessments to be carried out (e.g. suicide risk assessment, BBV counselling and testing).

This also provides an opportunity to identify any specific risks that may impact on treatment, e.g. risk of homelessness, child protection risks, peer group (e.g. lack of non-using support persons) etc. It can be seen as a checklist that these areas have been covered in the assessment.

Treatment/management plan:

Having discussed the case formulation with the client, in language and terms that they can understand, a treatment plan is developed.

A treatment plan is developed in consultation with the client.

The plan outlines the different steps and clarifies what is required and who should be doing what. It also includes timeframes (e.g. how often the client will attend the service, by what time they should have carried out actions to which they have committed, etc.)

A treatment plan also includes involvement of significant others and any referrals to other services.

Example	<p>Sophie plans to reduce cannabis use from 4 to 3 cones per day. She plans to delay first cone until 6pm.</p> <p>Sophie to attend weekly counselling sessions at Community Drug Service and will make GP appointment regarding feelings of depression.</p> <p>She will also find out if there are exercise classes at local recreation centre.</p> <p>Clinician will bring information pamphlets to next session on cannabis to discuss with Sophie.</p> <p>Clinician to liaise with “No Name AOD agency” for info on previous treatment (Authority to Obtain and Release Information signed).</p>
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The Treatment/Management Plan informs the ongoing Client Care Plan.

Referral to: Complete where a client is being referred to another service

Example	Referral to “..... parenting service” to develop improved behaviour management strategies for children. Referral faxed 20/05/10.
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Plan for involvement of significant other: Provide details where a significant other is involved.

Example	Sophie’s partner, Tom to attend next counselling session. Session will explore options for ongoing involvement.
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