

# Alcohol and Other Drugs Assessment Form

## Clinicians' Guide

October 2018

© Workforce Development, Mental Health Commission

**This work has been adapted from the Integrated Assessment Instruction Booklet for Clinicians (2018) developed by The Mental Health Commission with the intention of offering a useful resource for clinicians from other services.**

This work is copyright. It may be reproduced in whole or in part for study or training purposes subject to an inclusion of an acknowledgement of the source and no commercial usage or sale. Reproduction for purposes other than those above requires written permission of:

Workforce Development  
Alcohol, Other Drugs and Prevention Services  
Mental Health Commission  
GPO Box X2299, Perth Business Centre  
WA 6847

Website: [www.mhc.wa.gov.au](http://www.mhc.wa.gov.au)

# Contents

Rationale and Aim.....	6
How to use the Clinicians' Guide.....	6
General Principles.....	7
Introducing the Assessment.....	8
Part B: A Clinicians' Guide to the Alcohol and Other Drugs Assessment.....	18
Referred by .....	18
GP.....	18
Other agencies involved.....	18
Presenting issues.....	19
Reasons for seeking treatment.....	19
Treatment goals .....	20
Drug and alcohol treatment history.....	21
Drugs used today/ drugs used yesterday/ drugs used last week .....	21
Current prescribed medication .....	22
Breathalyser.....	22
Urine .....	22
Pregnancy test.....	22
Current Hepatitis status.....	22
Practising safe sex.....	22
Last STI check – if appropriate.....	22
HIV.....	22
Other tests .....	23
Last blood tests date .....	23
Recommendations .....	23
Drug and Alcohol Assessment.....	23
Associated risk behaviours and/or concerns .....	26
Exposure to injecting.....	27
Age first injected.....	27
Mental Health Assessment.....	27
Past mental health issues .....	27
Current mental health issues.....	28
Past or current self-harm (and triggers).....	28
Past or current attempted suicide (and triggers) .....	28
Past/current mental health treatment.....	29
Mental State Assessment .....	29
Appearance.....	29
Behaviour.....	30
Mood.....	30
Affect.....	30
Speech.....	31
Thought content .....	31
Perception.....	31
Cognition.....	32
Insight and judgment.....	32
Suicide Risk Assessment .....	32
Psychosocial Assessment.....	33
Current accommodation .....	33
Employment/Education/Training.....	33
Legal issues .....	34

Interests and hobbies .....	34
Current relationship/s .....	34
Children (ages) .....	35
Social and developmental history .....	36
Cultural identity .....	37
Current supports .....	37
Important people .....	38
Supports during treatment .....	38
Genogram .....	38
Current general health .....	40
Medical/Surgical history .....	40
Allergies .....	40
Withdrawal history (including seizures etc.) .....	40
Baseline observations .....	40
Medical Assessment .....	41
Presenting issues .....	41
Treatment requested .....	41
Substance use history .....	41
Drugs used last week .....	42
Features of physical dependence .....	42
Past substance use treatment .....	42
Past mental health history .....	42
Medical/Surgical history .....	43
Current status .....	43
Current prescribed medication .....	43
Allergies .....	43
Family history of illnesses .....	43
Current general health .....	43
Current mental health .....	43
Mental State Assessment .....	43
Appearance .....	44
Behaviour .....	44
Mood .....	44
Affect .....	44
Speech .....	44
Thought content .....	44
Perception .....	45
Cognition .....	45
Insight and judgment .....	45
Suicide Risk Assessment required .....	45
Physical Appearance .....	45
Stigmata/injection sites .....	45
Signs of intoxication or withdrawal .....	45
Other findings: .....	46
Medical Summary .....	46
Drug and alcohol diagnosis: .....	46
Mental health diagnosis .....	46
Physical health diagnosis .....	46
Planned medical treatment/investigations: .....	46
Identified risks .....	46
Case Summary/Formulation .....	46

Case Management/Treatment Plan.....48  
References and further reading:.....49

## **Rationale and Aim**

Assessment is an integral aspect of alcohol and other drugs (AOD) treatment. Whilst AOD services use a variety of assessment tools that may appear quite different, in reality, there are significant commonalities across these tools. The AOD Assessment Form aims to provide a resource that clinicians can use to conduct a comprehensive AOD assessment.

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 form and can be adapted to suit individual agency needs. Part B provides guidance on how to complete Part A. It also suggests how information may be recorded so that key information is retained.

The AOD Assessment Form supports a comprehensive assessment process. The process provides the client with an opportunity to share information with the clinician. This information helps the clinician to develop a solid understanding of the complex issues that may impact on the client's treatment.

The standard form 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 Clinicians' Guide**

This booklet provides an overview of each question asked in a comprehensive AOD assessment. It provides basic information on the purpose of the question and the information sought.

A key aspect of an assessment is to support the process of building a relationship with the client. As such, it is important that the clinician does more than ask questions and record answers. Clinicians may approach an assessment in different ways – some may find it helpful to work through the assessment as set out in the AOD assessment form and booklet, especially if they are not very familiar with all components of the assessment. Other clinicians may use a conversational style that integrates the areas covered in the assessment. The importance of using the assessment tool and booklet in a way that recognises and validates the clinician's style is acknowledged.

This Booklet aims to support the clinician to enhance the therapeutic experience for the client. It is advised that clinicians, especially those who are new to the service, discuss the process of client assessment, and the role of this booklet, in supervision.

For most sections of the assessment, an example of how the clinician could ask 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 and the text is shaded.

## **General Principles**

It is important to explain the limits of confidentiality and the purpose of the assessment to the client before beginning an assessment. It is important to be familiar with agency policy and procedures around confidentiality and how the information obtained from an assessment will be treated.

The assessment is an opportunity to start building a relationship with the client and often it takes time to explore answers with the client. This should not be rushed through as a ‘tick-box’ exercise. It may not be possible to complete the assessment in one session. Emphasize that it is a shared process between them as client and you as clinician.

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.

Many clients who attend AOD services have experienced traumatic events in their lives, sometimes as far back as childhood. People often manage trauma-related symptoms with AOD use and when they stop their AOD use those symptoms can be exacerbated. Additionally, AOD use may make clients more vulnerable to further trauma such as family violence and sexual assault. Throughout the assessment and counselling processes, it is important to be sensitive to the possibility that clients may be affected by trauma and to ensure that they feel safe in the counselling environment.

When completing the assessment use a black pen to record information and write legibly. Other staff may need to access client information from the assessment information you have recorded.

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/role and date are recorded on each page of the assessment form.

Client records are legal documents. Therefore, if information is retrospectively added to the assessment document, sign and date the entry. Similarly, if any information needs to be changed, do not use ‘white out’, strike through the information to be replaced (so that it is still legible) and sign and date the amendment.

Write your responses as soon as possible after the session, so that details aren’t forgotten. Allow yourself time for writing 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 the issue 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.

## Introducing the Assessment

Assessment needs to be handled sensitively in order to create a caring and compassionate atmosphere, enabling the difficulties facing the client to be acknowledged (Helfgott & Allsop, 2009). Assessment may take longer than one session, and building rapport will increase the likelihood of clients discussing any sensitive areas during the assessment.

Throughout the assessment, it is helpful to keep in mind the 4Ls (attributed to Roizen, 1979) and the culturally secure 7 Ls (Casey & Keen, 2005) models. These models consider the impact of AOD use across a number of areas:

- Liver (health);
- Lover (relationships);
- Livelihood (work, education, hobbies, financial etc.);
- Legal (legal issues);

and the additional areas described in the 7Ls model:

- 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 welfare 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 you reassure the client that you are not judging them or their AOD use, but simply building a comprehensive picture of their situation so that you 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 utilised by clients to arrive at decisions about their problems as well as their AOD-use behaviour (Helfgott, 2009).
- An understanding by the clinician of what the client's key issues are and to work with the client to explore which treatment options may be most appropriate.

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

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

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

*Note: The privacy statement and Authority to Release and Obtain Information 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. 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 they are 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 what is called 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. 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.'
---	---

<b>THE ALCOHOL AND OTHER DRUGS (AOD) ASSESSMENT FORM</b>		Client Name:	
		Client Address:	
		Client Date of Birth:	
<b>Referred by</b>			
GP		Phone	
Other Agencies involved		Contact person	
<b>Presenting Issues</b>			
<b>Reasons for seeking Treatment</b>			
<b>Treatment Goals</b>			
<b>AOD Treatment History</b>			
<b>Drugs used today</b>			
<b>Drugs used yesterday</b>			
<b>Drugs used last week</b>			
<b>Current prescribed medication</b>			
Complete where appropriate:		Pregnancy test	
breathalyser		Urine test	
Current status: Hep A		Hep B	Hep C
Oractising safe sex		Last STI Check (if appropriate)	HIV
Other tests		Last blood tests date	
<b>Recommendations</b>			
Clinician		Signature	Designation Date

<b>THE ALCOHOL AND OTHER DRUGS (AOD) ASSESSMENT FORM</b>		Client Name:	
		Client Address:	
		Client Date of Birth:	
<b>AOD ASSESSMENT</b>		<b>Key:</b>	<b>U Age First Used</b>
<b>Drug Types</b>	<b>History of Use</b>		<b>P Age First Problematic</b>
			<b>C Current Use Y /N</b>
<b>ALCOHOL</b>			
U			
P			
C			
<b>BENZODIAZEPINES</b>			
U			
P			
C			
<b>OPIOIDS</b>			
U			
P			
C			
<b>AMPHETAMINES</b>		<b>(base, powder, ice)</b>	
U			
P			
C			
<b>CANNABIS</b>			
U			
P			
C			
<b>NICOTINE</b>			
U			
P			
C			
<b>OTHER</b>			
<input type="checkbox"/>	HALLUCINOGENS		
<input type="checkbox"/>	MDMA – Ecstasy		
<input type="checkbox"/>	SOLVENTS		
<input type="checkbox"/>	SYNTHETICS		
<input type="checkbox"/>	EMERGING		
<b>Associated risk behaviours and/or concerns</b>			
<b>Exposure to injecting</b>			
			<b>Age first injected</b>
Clinician	Signature	Designation	Date
<b>Doctor</b>	Signature	Designation	Date

<b>THE ALCOHOL AND OTHER DRUGS (AOD) ASSESSMENT FORM</b>	<b>Client Name:</b> <b>Client Address:</b> <b>Client Date of Birth:</b>		
<b>MENTAL HEALTH ASSESSMENT</b> <b>Past Mental Health Issues</b>			
<b>Current Mental Health Issues</b>			
<b>Past or current self-harm</b>			
<b>Triggers</b>			
<b>Past or current suicide attempts</b>			
<b>Triggers</b>			
<b>Past or current mental health treatment</b>			
<b><u>Always consider undertaking and documenting a suicide risk assessment (SRA) in the following circumstances:</u></b>			
<ul style="list-style-type: none"> <li>• Client reports current or recent suicidal thoughts</li> <li>• Client has attempted suicide in the last year</li> <li>• Client has a significant history of suicidal or self-harming behaviour</li> <li>• Client has significant mental health problems</li> </ul>	<ul style="list-style-type: none"> <li>• Client has recently been discharged from an inpatient psychiatric facility</li> <li>• Client has experienced a recent significant stressor which may increase risk (e.g. prison release and experiencing a difficult transition, significant loss, rejection, failure etc.)</li> </ul>		
<b>Suicide Risk Assessment Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No</b>			
<b>MENTAL STATE ASSESSMENT</b>			
<b>Appearance</b>			
<b>Behaviour</b>			
<b>Mood and affect</b>			
<b>Speech</b>			
<b>Language (form of thought)</b>			
<b>Thought content</b>			
<b>Perception</b>			
<b>Cognition</b>			
<b>Insight and judgment</b>			
Clinician	Signature	Designation	Date

<b>THE ALCOHOL AND OTHER DRUGS (AOD) ASSESSMENT FORM</b>	<b>Client Name:</b> <b>Client Address:</b> <b>Client Date of Birth:</b>
<b>PSYCHOSOCIAL ASSESSMENT</b>	
<b>Current accommodation (duration, stability)</b>	
<b>Employment/Education/Training</b>	
<b>Legal Issues</b>	
<b>Interests and hobbies</b>	
<b>Current relationship/s</b>	
<b>Children (ages)</b>	
<b>Social and developmental history</b>	
<b>Cultural identity</b>	
<b>Current supports</b>	
<b>Important people</b>	
<b>Supports during treatment</b>	
<b>Clinician</b>	<b>Signature</b>
<b>Designation</b>	<b>Date</b>



# THE ALCOHOL AND OTHER DRUGS (AOD) ASSESSMENT FORM

Client Name:  
Client Address:  
Client Date of Birth:

## MEDICAL ASSESSMENT

Presenting issues

Treatment requested

Substance use history

Drugs used last week

Features of physical dependence

Past substance use treatment

Past mental health history

Medical/surgical history

Current status:	Hep A	Hep B	Hep C
	STI	HIV	

Date last blood tests

Current prescribed medication

Allergies

Family history of illness

Current general health

Current mental health

Doctor

Signature

Date

<b>THE ALCOHOL AND OTHER DRUGS (AOD) ASSESSMENT FORM</b>		Client Name:	
		Client Address:	
		Client Date of Birth:	
<b>MEDICAL:ASSESSMENT</b>			
<b>MENTAL STATE ASSESSMENT</b>			
Appearance			
Behaviour			
Mood and affect			
Speech			
Language (form of thought)			
Perception			
Cognition			
Insight and judgement			
<b>Suicide Risk Assessment Required</b>		<b>Yes</b>	<b>No</b>
Physical appearance			
Stigmata/injection sites			
Signs of intoxication or withdrawal			
<b>P</b>	<b>BP</b>	<b>Ht</b>	<b>Wt</b>
<b>Cardiovascular</b>		<b>Gastrointestinal</b>	
<b>Respiratory</b>		<b>Neurological</b>	
<b>Other findings</b>			
Doctor		Signature	Date



<b>THE ALCOHOL AND OTHER DRUGS (AOD) ASSESSMENT FORM</b>	Client Name: Client Address: Client Date of Birth:				
<b>MEDICAL SUMMARY</b>					
<b>Drug and alcohol diagnosis</b>					
<b>Mental health diagnosis</b>					
<b>Physical health diagnosis</b>					
<b>Planned medical treatment/investigations</b>					
<b>IDENTIFIED RISKS</b>					
Self-harm	Suicide	Drug overdose	Parenting concerns	STI/BBV	Harm from other
Aggression/violence		Allergies:		Other:	
<b>Suicide Risk Assessment Completed?</b>			<input type="checkbox"/> Yes	<input type="checkbox"/> No	
<b>CASE SUMMARY/ FORMULATION</b>					
<b>CASE MANAGEMENT/ TREATMENT PLAN</b>					
<b>Plan for involvement of significant other</b>					
<b>Referral to</b>					
<b>Clinician</b>	Signature	Designation	Date		
<b>Doctor</b>	Signature	Date			

## Part B: A Clinicians' Guide to the Alcohol and Other Drugs Assessment

### ***Referred by***

Where possible identify:

- The name of the individual who is referring the client
- Their designation and the agency for which they work, if applicable.
- A contact phone number if known

**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 designation of the person making the referral is just as important.

Referrers may include:

Self, family, friend, other professional, other agency/service, general practitioner (GP), medical officer/specialist, mental health service, hospital, social/welfare services, other community/health care services, Police Diversion, Court Diversion, Department of Justice, counselling agency/service, the Department of Communities, Child Protection and Family Support (CPFS).

### ***GP***

Include the GP name, as well as practice location and phone number.

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.

### ***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 CPFS 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 an illegal activity which is serious in nature.

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 probation officer, we will discuss this with you first. So, do you have any contact with other agencies? For example, Child Protection and Family Support, or Department of Justice or other counselling service?'
Responses could be recorded as:	CPFS since Jan 11. Jane Doe, case manager, Midland office. Good relationship with CM. Peer Based Harm Reduction WA for informal support – on and off for a number of years. DoJ – since Dec 12. John Doe, CCO, Midland office. Finds CM difficult to talk to – has missed some appointments.

### ***Presenting issues***

Primarily, this question references current AOD use (for the client or their significant other if the client is not the user) and any problems that may be increased by, or that are increasing the AOD use. 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. There are questions later in the assessment that allow for greater exploration of the issues. This question is about getting a broad overview of the client's current AOD use and how it is impacting on them.

This enquiry could begin:	'Tell me a little about your alcohol or drug use (or your partner's/child's alcohol or drug use) and the problems you are facing <b>at the moment</b> that led you to contact us...' 'Can you tell me a little about what's been happening for you <b>recently</b> ?'
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-topic, 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 factors that have triggered this (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 where the client is in the Stages of Change model (Prochaska & DiClemente, 1986)
- 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 AOD-free in a week for a job on a mining site, 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.

**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 dependent 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 Prochaska and DiClemente’s (1986) Stages of Change model

This enquiry could begin:	‘Have you thought about what you would like to get from coming to this service?’  (It may help to provide some options: abstinence, reduction, reducing the harm of use, e.g. Blood-borne viruses)
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  In the event of the client being ‘unsure of treatment goals’, it is advisable to revisit this question in a later session

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
---------------------------------	--

Sometimes, the client’s treatment goals may be unrealistic or unsafe. For example, it is unsafe for a pregnant woman on benzodiazepines to stop taking them immediately without medical supervision. Likewise, an individual who is drinking six or more standard drinks of alcohol per day may require a supervised and planned detoxification program rather than immediate cessation of use. In such cases:

Responses could be recorded as:	Client has long history of benzodiazepine use. Currently 3 months pregnant. Wishes to stop benzo use now. Unsafe treatment option – discussed with client and recommended medical review.
---------------------------------	---

## ***Drug and alcohol treatment history***

This question helps to build a picture of the client's AOD 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 Cyrenian 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/DAWN)

## ***Drugs used today/ drugs used yesterday/ drugs used last week***

These questions provide the opportunity to get specific information on the client's *current* AOD 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 AOD use history.

This enquiry could begin:	'We will discuss your alcohol and other drug use history in a moment but first, I will ask you a few questions now about your alcohol and other drug use at the moment. 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 alcohol or other 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 much of that did you use?'
Responses could be recorded as:	Today: nil Yesterday: ½ bottle of wine, 2 x10mg diazepam (old 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 med, dosage, prescribing GP, purpose of medication (if known) and duration of use.

## ***Breathalyser***

This may be done as part of full assessment when a client presents with alcohol as the problem substance. It is also 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***

Urinalysis may be done as part of the assessment for clients presenting with drug use history. The aim is 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***

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 opioid dependence. **Opioid withdrawal can increase the risk of early labour or miscarriage.** Pregnant clients requiring buprenorphine as an opioid pharmacotherapy are prescribed Subutex rather than the usual Suboxone. Note: *Methadone is the first treatment of choice for pregnant women seeking opioid pharmacotherapy*

The doctor will need to know if a client is pregnant before making treatment decisions.

## ***Current Hepatitis status***

Hepatitis A, hepatitis B, hepatitis C:

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

## ***Practising safe sex***

This is important as it relates to blood-borne viruses (BBVs) and sexually transmitted infections (STIs) and provides the clinician an opportunity to discuss harm reduction.

## ***Last STI check – if appropriate***

Date and results, if known

## ***HIV***

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

## ***Other tests***

Are there any other tests that the client has completed? 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.

## ***Recommendations***

Detail any other recommendations relating to BBVs and/or pregnancy etc. (i.e. Refer to hepatitis C clinic).

## **Drug and Alcohol Assessment**

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

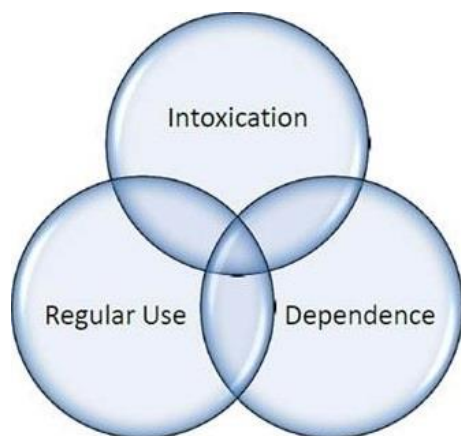
Clinicians should note that often clients will have poly-drug use issues, and therefore, it is important to ask clients about each category of drugs.

The client is asked to provide information relating to age each drug was first used, age first problematic and age first dependent (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 the client's drugs-of-concern.

If a client does not use a particular substance, include any additional information such as 'never used', 'not used for 5 years' in the relevant section of the form.

**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', 'dependency' and 'regular use'*



*Figure 1: Thorley's model of problematic drug use*

**Intoxication:** Problems can arise from a single occasion of use (e.g. 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 those that relate to dependence such as withdrawal, 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  
 C. Current Usage **Y/N**

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

Drug Types	History of Use
Alcohol U: P: C:	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/wk 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"> <li>- When client last had a period of non-use?</li> <li>- How long did that last?</li> <li>- Did client experience withdrawals?</li> <li>- How soon after ceasing use did withdrawals begin?</li> <li>- How long did the withdrawals last?</li> </ul> Positives/negatives of use
Benzodiazepines U: P: C:	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"> <li>- When client last had a period of non-use?</li> <li>- How long did that last?</li> <li>- Did client experience withdrawals?</li> <li>- How soon after ceasing use did withdrawals begin?</li> <li>- How long did the withdrawals last?</li> </ul> Positives/negatives of use



<p>Opioids</p> <p>U:</p> <p>P:</p> <p>C:</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"> <li>- When client last had a period of non-use?</li> <li>- How long did that last?</li> <li>- Did client experience withdrawals?</li> <li>- How soon after ceasing use did withdrawals begin?</li> <li>- How long did the withdrawals last?</li> </ul> <p>Positives/negatives of use</p>
<p>Amphetamines</p> <p>U:</p> <p>P:</p> <p>C:</p>	<p>Include:</p> <p>Type (e.g. methamphetamine, dexamphetamines, or base, powder, 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"> <li>- When client last had a period of non-use?</li> <li>- How long did that last?</li> <li>- Did client experience withdrawals?</li> <li>- How soon after ceasing use did withdrawals begin?</li> <li>- How long did the withdrawals last?</li> </ul> <p>Positives/negatives of use</p>
<p>Cannabis</p> <p>U:</p> <p>P:</p> <p>C:</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"> <li>- When client last had a period of non-use?</li> <li>- How long did that last?</li> <li>- Did client experience withdrawals?</li> <li>- How soon after ceasing use did withdrawals begin?</li> <li>- How long did the withdrawals last?</li> </ul> <p>Positives/negatives of use</p>
<p>Nicotine</p> <p>U:</p> <p>P:</p> <p>C:</p>	<p>Include:</p> <p>Frequency of use</p> <p>How many?</p> <p>Is there a regular pattern?</p>

	<p>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</p>
<p>OTHER  <input type="checkbox"/> Hallucinogen  <input type="checkbox"/> MDMA – Ecstasy  <input type="checkbox"/> Solvents  <input type="checkbox"/> Synthetics  <input type="checkbox"/> Emerging  U:  P:  C:</p>	<p>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</p> <ul style="list-style-type: none"> <li>- When client last had a period of non-use?</li> <li>- How long did that last?</li> <li>- Did client experience withdrawals?</li> <li>- How soon after ceasing use did withdrawals begin?</li> <li>- How long did the withdrawals last?</li> </ul> <p>Use in conjunction with other substances?  Positives/negatives of use</p> <p>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</p>

\*Illicit Rx/Rx use (Rx denotes prescription): This related 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/or concerns***

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).

<p>This enquiry could begin:</p>	<p>‘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</p> <p>‘You mentioned that your use has increased and that you are now injecting</p>
----------------------------------	--

	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 anyone 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.

## **Mental Health Assessment**

Why do we need to do a mental health assessment as part of the AOD assessment?

- Studies indicate that between 50-76% of clients of Australian AOD services meet diagnostic criteria for at least one co-occurring mental health disorder (Marel, Mills, Kingston, Gournay, Deady, Kay-Lambkin, Baker & Teesson, 2016)
- Approximately one in two people will develop a mental health disorder at some point in their life (Marel et al., 2016).
- 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 co-occurring problems 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 inpatient 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.

This enquiry could begin:	<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 reaction 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 doctor?’</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>
Responses could be recorded as:	<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***

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

### ***Past or current self-harm (and triggers)***

This may already have been discussed under the above headings. If not, it is important to ascertain if the client has any history of, or current episodes of self-harm. It is important to distinguish self-harm as distinct from suicide attempts and often people who self-harm (also referred to as non-suicidal self-injury) may do so for reasons that are not related to wanting to commit suicide. Self-harm can be a sign of severe emotional distress or of wanting to avoid suicide. Whatever the reasoning, it should be addressed separately to suicide attempts.

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, helps to make sure that any current or future risks for the client can be managed as well as possible. If possible, discuss with the client what was happening in their life for them at the time they self-harmed.

This enquiry could begin:	<p>‘You mentioned that you have experienced anxiety for a long time. At any stage, have you tried to injure yourself?’</p> <p>‘The last time you self-harmed, what was happening in your life at that time? Are you aware of the triggers that make you feel like self-harming?’</p>
Responses could be recorded as:	<p>History of self-harm (cutting) during adolescence – no treatment. Hospitalized for 1 week. Outpatient sessions with psychiatrist – Dr. Brown, Wembley – for six months.</p>

### ***Past or current attempted suicide (and triggers)***

This may already have been discussed under the above headings. If not, it is important to ascertain if the client has a history of past or recent suicide attempts.

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 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. Have you attempted suicide?' 'When you last attempted suicide, what was happening in your life at that time?' Or 'What made you think that life wasn't worth living?'
Responses could be recorded as:	Attempted suicide 3 years ago – overdose of sleeping tablets. Hospitalized for 1 week. Outpatient sessions with psychiatrist – Dr. Brown, Wembley – for six months. Triggers could be recorded as relationship breakdown; domestic violence; loss of job.

### ***Past/current mental health treatment***

It is important to note any mental health support and treatment that client may have received as discharge summaries and/or treatment plans will be relevant to future AOD support. If the client has been an inpatient in a hospital for mental health issues or has previously had, or currently receives psychiatric support, these will be important services to link with in providing a holistic AOD support service.

This enquiry could begin:	'You mentioned that you have experienced mental health issues in the past, have you ever been admitted to a hospital for mental health issues?'
Responses could be recorded as:	3 week stay at Graylands in August 2010; subsequent admission to Fiona Stanley in 2015 (ED only – no inpatient stay).

### **Mental State Assessment**

AOD 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 assessment is used to assess clients presenting with a wide range of mental health issues and in a variety of settings, AOD workers can use it as a baseline tool to get an overview of a client's presentation from a mental health perspective. Workers may participate in further mental state assessment/examination training if they wish to develop more comprehensive skills in this area.

**Tip:** *When conducting a mental state assessment, 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, 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 assessment. 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, dress, tattoos etc.

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, ability to cooperate

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.

## **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, 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 congruity with the content of the conversation or situation. A 'flat' affect refers to extremely severe lack of expressive affect and is rarely recorded.

Example:	The client demonstrates little or no emotional expression, face immobile and voice monotonous
----------	---

Your observations may be recorded as:	Restricted affect with a narrow range of expression. Face immobile and voice monotonous.
---------------------------------------	--

### ***Speech***

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

Consider: articulation disturbances, monotonous, mutism, loud, quiet, quantity, poverty, pressured, rate

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).
Your observations may be recorded as:	Speech is pressured – extremely rapid and difficult to interpret. Volume is loud and inappropriate to setting.

### ***Thought content***

The aim is to document an assessment of the consumer's content, organisation, flow and production of thought.

Consider: Thought form: refers to a description of thought processes apparent from observation or inquiry. This includes amount of thought, rate of production, continuity of ideas, disturbances in language, logical flow, relevance, organisation, and coherence of thought in response to general questioning during the interview.

Thought content: refers to the nature of what is said by the client and can include speech that references self-harm, harm to others, delusional beliefs, preoccupations, 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. 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'.
-------------------------------	--

### ***Perception***

Hallucinations are 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 and judgment***

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 understands the role of the counsellor. 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. Judgment significantly impaired at this time.

### ***Suicide Risk Assessment***

If the client expresses suicidal 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' suicidal ideation.



# Psychosocial Assessment

**Tip:** An AOD assessment considers more than just AOD use. It looks at AOD use, the individual (including factors such as physical and mental health, age, gender, 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 us to get a comprehensive picture of what contributing factors and/or consequences there might be to the person's AOD use.

## Current accommodation

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

- Are they in stable accommodation – how long have they lived there (duration), how long can they stay there (stability)?
- Is there AOD 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?'
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.

## 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 the client's drug use and offending behaviour. Did the client's legal issues arise because of AOD 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?</p> <p>You mentioned earlier that you were seeing a Community Corrections Officer in Midland. Can you tell me more about this? When is your Court date due?'</p> <p>(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)</p>
Responses could be recorded as:	<p>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.</p> <p>Previous arrests for assault (2012, 2013). Both under the influence. Given good behaviour bonds.</p>

## ***Interests and hobbies***

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

This enquiry could begin:	<p>'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?'</p> <p>'So, you like taking part in quiz nights – where do you do this? Do you think that drinking is an important part of this for you?'</p>
Responses could be recorded as:	<p>Used to enjoy going to quiz nights. Pub based so very linked to drinking. Tends not to bother anymore. Would like to do something completely different.</p> <p>Is shy in other people's company unless drinking.</p>

## ***Current relationship/s***

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

“Family and Domestic Violence is usually not an isolated event but is a pattern of ongoing, repetitive and purposeful use of physical, emotional, social, financial and/or sexual abuse used to intimidate and instil fear. Such behaviour enables the one person to control and have power over another person in an ‘intimate’ or family relationship” (Department of Health Western Australia, 2014, p.3).

This enquiry could begin:	<p>‘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?’</p> <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 verbal abuse. Is frightened that DV may become physical. To be discussed again in future sessions.

### **Children (ages)**

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.

Additionally, where possible, request and record the children’s dates of birth. This is helpful if referrals are made to other agencies.

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? 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>
Responses could be recorded as:	‘2 sons, Tim, 9 (dob: 11.03.94) and John, and 7 (dob: 03.11.96). Tim, truanting/misbehaving at school. Threatened with suspension. Client fearful of CPFS and possibility of boys being removed from her care. Discussed referral to parent support service.’

Services may have specific policies around child protection and reporting procedures. These policies may offer 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 developmental history***

The key issue here 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:	<p>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.</p> <p>Had good relationship with paternal grandmother.</p>

**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., O'Toole, S., Dale, A., Willis, L., & Helfgott, S. (2013). *Counselling guidelines: Alcohol and other drug issues*, 3<sup>rd</sup> Ed. p.13 offers useful guidance regarding disclosure of trauma during assessment.

## **Cultural identity**

It is important to understand, where possible, what a client's cultural identity may be, how this influences their day to day life and how this may support recovery and treatment plans as well as the relationship you have with the client. At all times clinicians should respect a person's right to choose an identity and their cultural rights and customs.

This section encourages a systemic and family sensitive 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 re-assured that there is no right or wrong answer.

**Tip:** Remember 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.*

## **Current supports**

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?

These questions help to identify if the client has support from others. It gives the clinician a sense of whether the client has non-AOD using people in their lives and if these people know about the client's AOD 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 to 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?'
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.
--	--

### ***Important people***

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.

Are there significant others in their life (remember that the client may have someone they see as important in their life but who doesn’t necessarily support them)?

### ***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 some control over their treatment. It is up to them to what extent and how they would like others to be involved.

**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 unless there are serious concerns – refer to your agency’s policies on confidentiality and authority to release and obtain information. 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).*

### ***Genogram***

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:** *Other staff may need to access client information you have obtained. Clear representations using recognised symbols will assist in accurate understanding. Include children’s names and ages – if they don’t fit on the genogram itself, have a supporting legend that provides the information.*

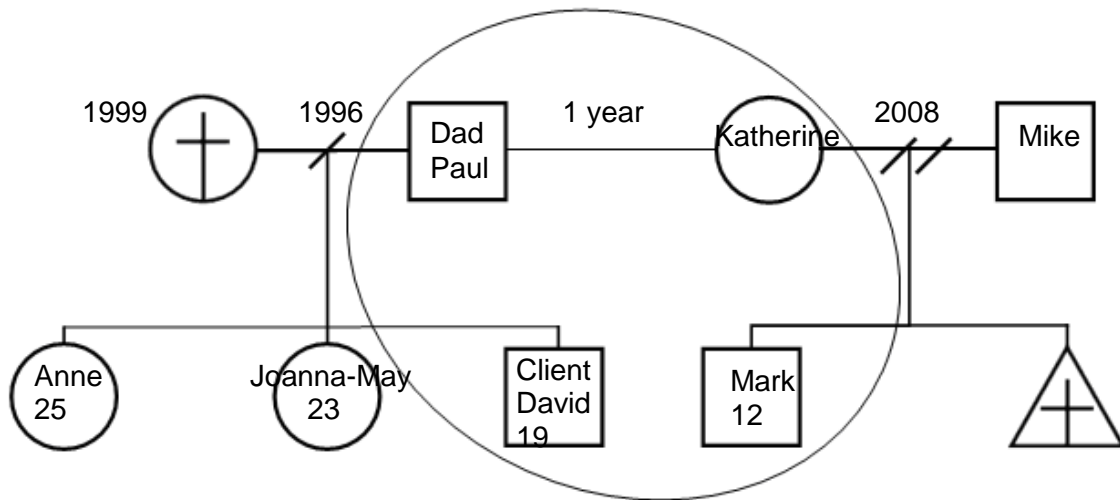
Introducing the Genogram:	It’s often helpful to do what we call a ‘genogram’. This is where we ‘map’ your relationships – drawing a picture of them, if you like. It can
---------------------------	--

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?'

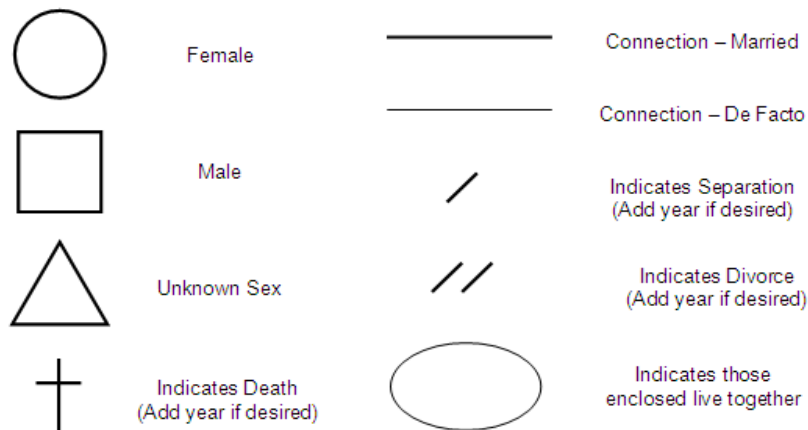
In the example below, David is the client. From the genogram, we immediately know that:

- David is 19 and 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:



**Note:** Confidentiality and third-party names in files: Whilst it is generally preferable to limit using third-party names in client files, it is considered acceptable to collect and record third-party details where this is directly relevant to client care. In terms of client assessments, gathering a comprehensive family history is a key aspect of treatment. The following link provides more information on this:

[Privacy Act 1988 - Part VI - Public Interest Determination No. 12 - Collection of Family, Social and Medical Histories](#)

As a full assessment requires information on a person’s physical health as well as their AOD use and their social situation, it is important that this section is not overlooked. You do not need specific medical expertise to ask the following questions, however it is important that you have an understanding of the issues being discussed. Discuss your training needs in this regard with your supervisor or line manager:

**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.

**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	Client states that she is currently recovering from flu. Still feeling lethargic and some nasal congestion still present. Would like to be BBV tested. Client notes that she has lost a lot of weight recently – BMI 18
---------	---

**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?

**Withdrawal history (including seizures etc.)**

Clients who have outlined their AOD use history may have had past or recent periods of abstinence or times when they didn’t use. Understanding how they felt during these periods, and their symptoms, will facilitate the clinicians understanding of their level of dependence and appropriate treatment options.

You might ask the client questions such as: ‘Has there been a time recently when you didn’t use/drink and what happened during this time?’ or ‘Can you recall a day when you didn’t use / drink? How did you feel in the morning / afternoon / evening?’ or ‘What would a 24 hour period look like if you didn’t use / drink. How do you think you would feel in the morning / afternoon / evening?’

Also enquire about any assisted withdrawal episodes the client may have experienced as either an inpatient or home-based withdrawal. Include the dates/years that this occurred if known.

**Baseline observations**

Where able to do so, the clinician should record baseline observations of the following:

- Blood pressure
- Resting Pulse rate



- Respiration rate
- Temperature

Some of the above may indicate signs of withdrawal and further medical advice should be sought immediately.

## Medical Assessment

The following sections are completed by the doctor. Some sections will repeat information already provided to the case manager but should be asked again as it is important to ensure that information gained during the assessment is accurate and complete.

Note: *Non-medical agencies are advised to omit the medical assessment from the overall process.*

### Presenting issues

Primarily, this question references current AOD use (for the client or their significant other if the client is not the user) and any problems that the AOD 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 AOD use and how it is impacting on them.

**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....'*

### Treatment requested

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 where the client is in the Stages of Change model
- 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

**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.*

### Substance use history

This section provides an opportunity for the doctor 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).

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

## ***Drugs used last week***

These questions provide the opportunity to get specific information on the client's *current* AOD use. It is important that the doctor ask about licit (including misuse of prescription drugs) and illicit drugs used. The doctor 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 AOD using history.

## ***Features of physical dependence***

The assessment of physical dependence takes into account the person's recent history of AOD 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 blood alcohol level (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

## ***Past substance use treatment***

This question helps to build a picture of the client's AOD 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 the client.

## ***Past mental health history***

Has the client had previous diagnoses of mental health conditions? Does the client have concerns about 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.

## ***Medical/Surgical history***

Has the client had any past medical concerns? What illnesses may they have been diagnosed with? Have they had any surgical interventions? Were the procedures undertaken in WA (list hospital, dates etc.) or interstate/overseas?

## ***Current status***

Hepatitis A, hepatitis B, hepatitis C. Detail status – positive, negative, when tested and when vaccinated.

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

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

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

## ***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 it is prescribed by and how long the client has been taking it.

## ***Allergies***

It is important to know if the client has any known allergies, particularly to any previously prescribed medications.

## ***Family history of 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.

## ***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 AOD use and lifestyle.

## ***Current mental health***

This question allows the doctor 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?

## **Mental State Assessment**

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-morbid conditions. Whilst the mental state assessment is used to assess clients presenting with a wide range of mental health issues and in a variety of settings, AOD workers can use it as a base-line tool to get an overview of a client’s presentation from a mental health perspective. Workers may participate in further mental state assessment/exam training if they wish to develop more comprehensive skills in this area.

**Tip:** When conducting a mental state assessment, 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 assessment. 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, dress, tattoos etc.

## ***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, ability to co-operate

**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.

## ***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.

## ***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).

## ***Speech***

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

Consider: articulation disturbances, monotonous, mutism, loud, quiet, quantity, poverty, pressured, rate

## ***Thought content***

The aim is to document an assessment of the consumer's content, organisation, flow and production of thought.

Consider: Thought form: refers to a description of thought processes apparent from observation or inquiry. This includes amount of thought, rate of production, continuity of ideas, disturbances in language, logical flow, relevance, organisation, and coherence of thought in response to general questioning during the interview.

Thought content: refers to the nature of what is said by the client and can include speech that references self-harm, harm to others, delusional beliefs, preoccupations, people controlling or stealing their thoughts

## ***Perception***

Hallucinations are 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.

Sometimes hallucinations may be accompanied by delusions.

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 and judgment***

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.

## ***Suicide Risk Assessment required***

If the client expresses suicidal ideation, check to see if a suicide risk assessment has already been conducted or conduct a suicide risk assessment.

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

## ***Physical Appearance***

What is the client's general physical appearance? Comment on:

- Presentation
- Posture
- Teeth
- Hair
- Skin
- Or any other physical points of note

## ***Stigmata/injection sites***

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.

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

## ***Signs of intoxication or withdrawal***

- See Features of physical dependence (page 43).

**P:** Pulse

**BP:** Blood Pressure

**Ht:** Height

**Wt:** 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.

**Medical Summary**

This section should include a summary of the doctor's views towards the client's assessed concerns, goals for treatment and any barriers or challenges that will need to be addressed as part of the case management program of support.

***Drug and alcohol diagnosis:***

This provides an opportunity to state clearly the AOD aspect of the case formulation.

***Mental health diagnosis***

This provides an opportunity to summarise the client's mental health issues and state clearly any mental health diagnoses.

***Physical health diagnosis***

This provides an opportunity to summarise the client's physical health issues and state clearly any physical health diagnoses.

***Planned medical treatment/investigations:***

This provides a summary of treatment and investigations required.

***Identified 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?

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.

Has a suicide risk assessment been completed where suicide is an identified risk?

**Case Summary/Formulation**

Marsh et al. (2013) note 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 or CARE PLAN

Marsh et al., (2013) suggest using the 5Ps model to structure the formulation. This model includes:

**Presenting Issues and 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., 2013, p.26)

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 hypothesize where the client is in the Stages of Change and this is likely to help identify appropriate treatment options.

Example	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 Precipitating
---------	---

	<p>Recent increased use linked to relationship breakdown</p> <p>Predisposing</p> <p>Reports feeling 'depressed' most of the time. On GP prescribed anti-depressants.</p> <p>Father was heavy drinker; mum left the home when Joe was 12. Dad drank more after mum left.</p> <p>Perpetuating</p> <p>Tends to use to cope with feelings of depression and isolation.</p> <p>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</p> <p>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.</p> <p>Joe appears to be in the 'Preparation' stage of change.</p>
--	--

## Case Management/Treatment 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 that they have committed to, 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 Palmerston for info on previous treatment (Authority to Obtain and Release Information signed)</p>
---------	---

The Treatment/Management Plan informs the ongoing Client Recovery Plan.

**Plan for Involvement of Significant Other:** Provide details where a significant other is involved.

Example	<p>Sophie's partner, Tom to attend next counselling session. Session will explore options for ongoing involvement.</p>
---------	--

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

Example	<p>Referral to Hearth's parenting service to develop improved behaviour management strategies for children Referral faxed 20/05/10</p>
---------	--



## References and further reading:

- Casey, W. & Keen, J. (2005) *Strong Spirit Strong Mind Aboriginal alcohol and other drugs worker resource. A guide to working with our people, families and communities*. Perth: Aboriginal Alcohol and other Drugs Program, Drug and Alcohol Office.
- Department of Health Western Australia. (2014) *Guideline for responding to family and domestic violence*. Perth: Women's Health Clinical Care Unit, Women and Newborn Health Service, Department of Health Western Australia. Retrieved from <http://www.health.wa.gov.au/circularsnew/attachments/894.pdf>
- Dickson, K. (2000). *Mental State Examination, Reader*. Fremantle: Metropolitan Mental Health Service, Fremantle Hospital and Health Service, Department of Health
- Helfgott, S. & Allsop, S., (2009). *Helping Change: The drug and alcohol counsellors' training program*. Perth: Drug and Alcohol Office.
- Marel, C., Mills, K. L., Kingston, R., Gournay, K., Deady, M., Kay-Lambkin, F., Baker, A., & Teesson, M. (2016) *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings (2<sup>nd</sup> edition.)* Sydney, Australia: Centre of Research Excellence in Mental Health and Substance Use. National Drug and Alcohol Research Centre, University of New South Wales. Retrieved from <https://comorbidity.edu.au/sites/default/files/National%20Comorbidity%20Guidelines%202nd%20edition.pdf>
- Marsh, A., O'Toole, S., Dale, A., Willis, L., & Helfgott, S. (2013). *Counselling guidelines: Alcohol and other drug issues*. (3<sup>rd</sup> Ed). Perth: Drug and Alcohol Office.
- Prochaska, J. & DiClemente, C. (1986). Towards a comprehensive model of change. In Miller, W. & Heather, N. (eds) *Treating addictive behaviours: Processes of change*. New York: Plenum Press.
- Thorley, A. (1980). Medical responses to problem drinking. *Medicine*, 35, 1816-1822.
- Women's Council for Domestic and Family Violence Services (WA) retrieved from <http://www.womenscouncil.com.au/>
- Zinberg, N.E. (1984). *Drug, set and setting: The basis for controlled intoxicant use*. New Haven: Yale University Press.