AODTS003

PATIENT LABEL

UR Number:

Surname:

Given name:

Date of birth:

AOD COMPREHENSIVE ASSESSMENT

PURPOSE OF AOD COMPREHENSIVE ASSESSMENT

To ensure that the clients comprehensive treatment needs are adequately assessed so they can access the services most suitable to their needs.

FOR STAFF ONLY

Clinician name: Agency:

Catchment: Referral source: Date referral received:

Signature: Date:

Version No. 2

AOD COMPREHENSIVE ASSESSMENT INSTRUCTIONS

- Use the intake tool as a starting point so that you can refer back instead of repeating questions that the client may have already answered
- Complete the core part of the assessment
- Complete any Optional Modules as appropriate
- Complete final case summary sheet and your agency's care plan, and review regularly - including risk assessments
- Review of the Victorian AOD Intake & Assessment Tool's Clinical Guide and e-learning package should be undertaken before using this tool

OPTIONAL MODULES

Individual modules can be found in the links below *(scroll down to locate information required).*

OPTIONAL MODULE 1: Physical Examination

OPTIONAL MODULE 2: ABI Referral Tool for Neuropsychology Assessment

OPTIONAL MODULE 3: Mental Health

OPTIONAL MODULE 4: PsyCheck

OPTIONAL MODULE 5: Quality of Life

OPTIONAL MODULE 6: Gambling

OPTIONAL MODULE 7: Goals

OPTIONAL MODULE 8: Assessment of Recovery Capital

OPTIONAL MODULE 9: Strengths

~~OPTIONAL MODULE 10:~~ Replaced by MARAM Tools / Practice Guides for Victim Survivors

OPTIONAL MODULE 11: Impact of AOD use on Family Member (Significant Other Survey)

OPTIONAL MODULE 12: Forensic Module

NEW MARAM Practice Guides and Tools (Victim Survivors ONLY):

Appendix 3: **Screening and Identification Tool**
Screen and identify family violence for Victim Survivors only

Appendix 4: **Basic Safety Plan**
The MARAM template for conducting the family violence safety plan

Appendix 5: **Brief Risk Assessment Tool**
Family violence risk assessment for time sensitive circumstances (briefer) for Victim Survivors Only

Appendix 6: **Adult Intermediate Risk Assessment Tool for Victim Survivors Only**
The standard family violence risk assessment tool for AOD agencies

Appendix 7: **Child Victim Survivor Risk Assessment Tool**
Assess and manage family violence risk involving children

All MARAM practice guides and tools are found here

UR Number:

1. ALCOHOL AND OTHER DRUGS (AOD)

1A) CURRENT LEVELS OF AOD USE

(check intake tool for additional information. If client was in hospital/prison/rehab in the previous month, record their substance use in the four weeks before that)

SUBSTANCE USE (Detail name of specific substances used)	AGE AT FIRST USE	AGE OF REGULAR USE	ROUTE OF USE (ingests, smokes, injects, sniffs powder, inhales vapour etc.)	AVERAGE DAILY USE (Quantity per day in past four weeks, cost, no. of injections, binge use etc)	DAYS USED IN PAST WEEK	DAYS USED IN PAST FOUR WEEKS	DAYS INJECTED IN PAST FOUR WEEKS	DATE OF LAST USE	SEEKING HELP FOR THIS DRUG
Tobacco products Smoking cessation support desired? ☐ Yes ☐ No Quitline number (13 7848)									
Alcoholic beverages									
Cannabis (marijuana, pot, grass, hash, synthetic cannabis etc)									
Cocaine									
Methamphetamine (ice, speed, base)									
Other amphetamine type stimulants (MDMA/ecstasy, diet pills, synthetic ATS etc)									

FOR STAFF ONLY

Clinician name: Position: Signature: Date:

UR Number:

SUBSTANCE USE (Detail name of specific substances used)	AGE AT FIRST USE	AGE OF REGULAR USE	ROUTE OF USE (ingests, smokes, injects, sniffs powder, inhales vapour etc.)	AVERAGE DAILY USE (Quantity per day in past four weeks, cost, no. of injections, binge use etc)	DAYS USED IN PAST WEEK	DAYS USED IN PAST FOUR WEEKS	DAYS INJECTED IN PAST FOUR WEEKS	DATE OF LAST USE	SEEKING HELP FOR THIS DRUG
Inhalants (nitrous, glue, petrol, paint thinner, Amyl etc)									
Non-prescribed sedatives or sleeping pills (benzodiazepines, xanax, valium, serapax, rohypnol, stilnox etc)									
Prescribed sedatives or sleeping pills									
Hallucinogens (LSD, acid, mushrooms, PCP, ketamine, synthetic hallucinogens etc)									
Non-prescribed opioids (heroin, codeine, methadone, oxycodone, morphine etc)									
GHB									
Prescribed opioids									
Other (steroids, caffeine/energy drinks, Phenergan, new and emerging drugs etc)									

FOR STAFF ONLY

Clinician name: Position: Signature: Date:

UR Number:

1B) CURRENT DRUG USE STATE (signs of intoxication, withdrawal, BAC)

1C) AOD USE HISTORY AND BEHAVIOURS

TICK AS MANY BOXES AS RELEVANT TO INDICATE WHEN EXPERIENCED	NOTES
Periods of abstinence Current (within the last four weeks) ☐ Past ☐ Never ☐	
Treatment / interventions Current (within the last four weeks) ☐ Past ☐ Never ☐	
Hospitalisations/ED presentations related to AOD use Current (within the last four weeks) ☐ Past ☐ Never ☐	
Drug overdose Current (within the last four weeks) ☐ Past ☐ Never ☐ Aware of naloxone? No ☐ Yes ☐	
Withdrawal and related complications (seizures, delirium, hallucinations etc) Current (within the last four weeks) ☐ Past ☐ Never ☐	
Risky injecting practices (shares equipment, is injected by another etc) Current (within the last four weeks) ☐ Past ☐ Never ☐	
Uses alone Current (within the last four weeks) ☐ Past ☐ Never ☐	
Drives while intoxicated (or under the influence of other drugs) Current (within the last four weeks) ☐ Past ☐ Never ☐	

Notes/actions/patterns of use:

FOR STAFF ONLY

Clinician name: Position: Signature: Date:

UR Number:

2. PSYCHOSOCIAL

(check INTAKE TOOL. OPTIONAL MODULE 5: QUALITY OF LIFE; OPTIONAL MODULE 6: GAMBLING; OPTIONAL MODULE 7: GOALS also available)

2A) RESOURCES AND SUPPORTS (OPTIONAL MODULE 8: ASSESSMENT OF RECOVERY CAPITAL & OPTIONAL MODULE 9: STRENGTHS available)

Informal:

Formal:

Other services involved:

2B) GENOGRAM / ECOMAP / SOCIOGRAM

FOR STAFF ONLY

Clinician name: Position: Signature: Date:

UR Number:

2C) FAMILY, CHILDREN, DEPENDANTS AND SOCIAL RELATIONSHIPS

(include responsibilities for children/dependants, the impact of substance use on these, whether they are vulnerable, risk of harm to others, DHHS/child protection involvement and responsibility for pets)

Are children /dependants safe? ☐ No ☐ Yes

Details:

DHHS/Child Protection Involvement? ☐ No ☐ Yes

If yes, current Child Protection Worker name and contact details:

Children's names & DOB's:

2D) HOUSING

Are you supported around housing? ☐ No ☐ Yes

Details:

Have you ever been forced out of housing by a partner/family member? ☐ No ☐ Yes (Victim Survivors Only)

Have you ever needed to stay in emergency housing or refuge? ☐ No ☐ Yes

Details:

FOR STAFF ONLY

Clinician name: Position: Signature: Date:

UR Number:

2E) FINANCES, EMPLOYMENT AND TRAINING (consider main income source such as benefits or employment, unpaid fines/bills and/or and need for financial counselling)

Does anyone have access to your bank account or control your finances? ☐ No ☐ Yes

Details:

2F) CURRENT LEGAL STATUS (OPTIONAL MODULE 12: FORENSIC available}

Have you recently been charged with a crime? ☐ No ☐ Yes

Details:

Are you currently:

Awaiting charges (charges pending) ☐ Awaiting trial/court (specify date: / /) ☐

On bail ☐ On parole (If yes, provide contact details and office of parole officer) ☐

On a post sentence supervision order ☐ On a drug treatment order ☐ On a community corrections order (CCO) ☐

On drug-diversion (courts, police, etc.,) ☐ Involved with youth justice ☐ Corrections officer/CISP manager ☐

Details (CCO name, phone, justice office location, etc):

Other (please specify):

Current Family Violence Intervention Order (FVIO)? ☐ No ☐ Yes

As AFM ☐ As Respondent ☐ Are children included on FVIO? ☐ Any breaches of FVIO (current or historical)? ☐

Details of order:

2G) FAMILY VIOLENCE (Victim Survivors Only)

MARAM assessment undertaken at intake ☐ No ☐ Yes

NOTE: Before asking the following, check that client feels safe to answer questions about family violence

a) Is there a partner or family member(s) who does things that make you or your children feel unsafe? ☐ No ☐ Yes

Examples include:

- Controlled your day-to-day activities (eg. who you see, where you go)
- Physically hurt you or your children (eg. Hit, slapped, kicked)
- Made threats to hurt you or your children in any way

b) Do you have concerns about your immediate safety? ☐ No ☐ Yes

c) Do you and your children feel safe when you leave here today? ☐ No ☐ Yes

Details:

*(Note - if you are concerned about the **immediate safety** of your client – escalate to your supervisor, call Safe Steps on 1800 015 188 or call police if necessary).*

- If Family Violence is disclosed or identified use the MARAM Intermediate Risk Assessment Tool to assess risk.
- Use MARAM safety plan or MARAM aligned basic family violence safety plan in section 7 on page 15.

FOR STAFF ONLY

Clinician name: Position: Signature: Date:

UR Number:

3. MEDICAL HISTORY

(OPTIONAL MODULE 1: PHYSICAL EXAMINATION available)

3A) PROBLEM/CONDITION/EXPERIENCE

CONDITIONS (tick as many as relevant)	**History of conditions, hospital admissions, past and needed investigations, actions, or treatments where appropriate**
☐ **Allergies**	
☐ **Dietary requirements**	
☐ **Cardiac or respiratory problems** (e.g. asthma, emphysema, high blood pressure, heart attack/angina)	
☐ **Gastrointestinal/hepatic problems** (e.g. liver disease, pancreatitis, gastric ulcer, reflux)	
☐ **Physical injuries or problems** (e.g. back injury, limb fracture or injury)	
☐ **Endocrine problems** (e.g. diabetes)	
☐ **Neurological problems** (e.g. fits, seizures, epilepsy, migraines)	

FOR STAFF ONLY

Clinician name: Position: Signature: Date:

UR Number:

CONDITIONS (tick as many as relevant)	**History of conditions, hospital admissions, past and needed investigations, actions, or treatments where appropriate**
☐ **Head injuries or Acquired Brain Injury (ABI)** (Optional Module 2: ABI Referral Tool available)	
☐ **Dental problems**	
☐ **Chronic pain condition**	
☐ **Pregnancy**	
☐ **Skin conditions**	
☐ **STIs (e.g. Chlamydia, gonorrhea, herpes etc.)** Would the client like to be tested? No ☐ Yes ☐	
Blood borne viruses Has the client been tested for blood borne viruses? No ☐ Yes ☐ Would the client like to be tested for blood borne viruses? No ☐ Yes ☐ Would the client like info about current treatments (e.g. Prep, Hep C)? No ☐ Yes ☐	
☐ **Other**	

FOR STAFF ONLY

Clinician name: Position: Signature: Date:

UR Number:

4. MENTAL HEALTH

4A) CURRENT DIAGNOSED CONDITIONS (consider administering OPTIONAL MODULE 3: MODIFIED MINI SCREEN or OPTIONAL MODULE 4: PSYCHECK if possible undiagnosed mental health issues suspected or indicated by K10)

CURRENT DIAGNOSED CONDITIONS (tick as many as relevant)	**History of conditions, who diagnosed it and when, investigations, and treatments where appropriate**
Mood [affective] disorders ☐ Depressive disorder ☐ Bipolar affective Disorder ☐ Mood Disorder (Unspecified) ☐ Other	
Anxiety disorders ☐ Generalised Anxiety Disorder ☐ Post-Traumatic Stress Disorder ☐ Social phobia ☐ Panic disorder ☐ Specific phobias ☐ OCD ☐ Other	
Psychotic disorders ☐ Schizophrenia /schizoaffective disorder ☐ Psychosis ☐ Drug-induced psychosis ☐ Other	
Personality disorders ☐ Borderline Personality Disorder ☐ Anti-social Personality Disorder ☐ Personality Disorder (other)	

FOR STAFF ONLY

Clinician name: Position: Signature: Date:

UR Number:

CURRENT DIAGNOSED CONDITIONS (tick as many as relevant)	**History of conditions, who diagnosed it and when, investigations, and treatments where appropriate**
Behavioral Addictions ☐ Pathological Gambling ☐ Other (e.g. sex addiction)	
Eating disorders ☐ Bulimia Nervosa ☐ Anorexia Nervosa ☐ Other	
Other disorders ☐ Intellectual Disability ☐ Dementia ☐ Attention Deficit Hyperactive Disorder (ADHD) ☐ Autism ☐ Other. Please Specify:	

Client has a mental health case manager or other mental health worker? No ☐ Yes ☐

If Yes, worker name and contact details

Client has a MH care plan from GP No ☐ Yes ☐

If Yes details

Current undiagnosed mental health concerns No ☐ Yes ☐

If Yes details

FOR STAFF ONLY

Clinician name: Position: Signature: Date:

UR Number:

4B) MENTAL STATE

Appearance/Behaviour Grooming, hygiene, eye contact, motor activity, abnormal movements	
Speech Rate, volume (loud, quiet, whispered), quantity (poverty of speech, monotonous, mutism), fluency (stuttering, slurring, normal)	
Mood/Affect Client (Self) rated mood on a scale of 1-10. Staff observed affect; Anxious, elevated, blunted, labile (uncontrollably/excessively sad, happy, angry), incongruent, range and intensity	
Thoughts: Form Amount and speed of thought, poverty of ideas. Flight of ideas, perseveration, loosening of associations, continuity of ideas, disturbances in language (incoherence)	
Thoughts: Content Delusions, suicidal thought, obsession and phobias	
Perceptions Hallucinations (auditory, visual taste, touch, smell), depersonalisation, derealisation, illusions, distortion of senses, misinterpretation of true sensation	
Cognition Level of consciousness & alertness, memory (recent and past), orientation, concentration	
Insight/Judgement Client's knowledge of problem and need for treatment. Reasoned, poor or impaired judgement	

FOR STAFF ONLY

Clinician name: Position: Signature: Date:

UR Number:

5. CURRENT PRESCRIBED MEDICATIONS

(including methadone, psychotropic medication, over-the-counter-drugs, and complementary medicines)

MEDICATION	PRESCRIBED DOSE AND DURATION OF TREATMENT	REASON FOR PRESCRIPTION/USE	TAKEN AS PRESCRIBED. If no, reason?	PRESCRIBER/ PHARMACY & PICK-UP ARRANGEMENTS & CONTACT DETAILS

Notes and actions:

FOR STAFF ONLY

Clinician name: Position: Signature: Date:

UR Number:

6. SUICIDE & SELF-HARM RISK

Complete your agency's risk assessment form. The below table is just a guide, and not a replacement for your current risk assessment.

6A) SUICIDE AND SELF-HARM RISK (based upon SAFE-T approach)

Risk	Comments
☐ Sense of hopelessness/worthlessness ☐ Current/past psychiatric diagnoses ☐ Ongoing medical illness ☐ History of abuse/neglect trauma ☐ Intoxication ☐ Stressful or triggering events ☐ Previous attempts of suicide or self-harm	
Suicidal inquiry	**Comments**
☐ Ideation (Do you ever think about killing/harming yourself) ☐ Intent (Do you want to kill/harm yourself) ☐ Plan (How would you do it) ☐ Lethality (Is the method likely to be lethal) ☐ Accessibility to means ☐ Suicide/attempted-suicide of significant other or family member	
Protective factors	**Comments**
☐ Internal (coping ability, resilience spirituality, work etc.) ☐ External (responsibility to children or pets, social support, therapeutic relationships, meaningful activities)	
High risk?	**If YES, action taken (ie. referral etc)**
☐ No ☐ Yes Reason/s:	

FOR STAFF ONLY

Clinician name: Position: Signature: Date:

UR Number:

SAFETY PLAN: when do you need to call someone?
What happens before you reach this point? How to recognise when this is happening

People you can call:

Phone numbers:

Lifeline - Call 13 11 14 for 24 hour crisis support & suicide prevention

SuicideLine Victoria - Call 1300 651 251 for 24 hour suicide prevention using qualified counsellors

DirectLine - Call 1800 888 236 for 24 hour free and confidential advice, counselling and referral for any alcohol or other drug related issues

Emergency services - 000

Actions for you:

Who has a copy of plan?

Provide a copy of this page to the client

FOR STAFF ONLY

Clinician name: Position: Signature: Date:

UR Number:

7. FAMILY VIOLENCE

Basic MARAM Aligned Safety Plan- with a range of referral options

(MARAM risk assessment and management tools and practice guides available- including MARAM Safety plan)

FAMILY VIOLENCE SAFETY PLAN

- This template is to support and guide your safety planning with victim/survivors of family violence. It should be led by victim/survivors as evidence shows that they are the best predictor of their own risk
- Safety planning is not a static process and any /all safety plans need to be reviewed for effectiveness as the elements of risk and circumstance change

Note: it may not be safe for the client to take a copy of this plan with them. Record details of this plan for handover and monitoring on page 16.

Protective Factors:
What is currently working to keep you / you and your children safe?

What resources do you currently have? Eg. Cash, phone with safe sim, car, Myki card, important documents/scripts are hidden away in safe place
Who are the safe people in your life who could support you at this point in time?
Who else do you need to consider on your safety plan eg. Children, pets?
How would you get to safety if you needed to leave your home quickly?
Where If you needed to leave where could you go to be safe?
When If you needed to leave, when would be a good time or opportunity?
Is Tech safety required Turn off Find my Phone, change social media settings, new sim, access to safe Internet?

Options for crisis intervention/in immediate danger:
Safesteps (24/7) 1800 105 188 the statewide crisis service for family violence/referral to refuge
Sexual Assault crisis line (24/7) 1800 806 292 immediate crisis response for sexual assault
000 (24/7) to utilize police to come to the home **victim/survivors, especially rural clients, may not choose this option. Victim/survivors are the best predictor of their risk and must lead*

Referral Needs:	**Existing supports:**
☐ Specialist Family Violence Service in your area	
☐ 1800Respect (1800 737 732), 24/7 Counselling service, information & referrals (non-crisis)	
☐ The Orange Door	
☐ Culturally-specific services to include on plan (eg. Aboriginal, LGBTIQA+, disability)	
☐ Male Victims: Men's Referral Service (MRS)1300 766 491	
☐ Other	Consent to contact: ☐ No ☐ Yes

Any clinician follow-up actions to be completed:

Agreed date to review this safety plan:

Permission to share information:

FOR STAFF ONLY

Clinician name: Position: Signature: Date:

UR Number:

8. FINAL CASE SUMMARY SHEET

Allergies:

GOALS AND REASONS FOR PRESENTATION (including client demographics e.g. gender, age & presenting issues)

MAIN SUBSTANCES OF CONCERN:

1

2

3

Main substance

Other substances

SUBSTANCE USE AND MENTAL HEALTH

AUDIT score:

0-7 low risk
8-15 moderate risk
16-19 high risk
>20 dependence likely

DUDIT score:

Potentially harmful use:
>1 and the client is female
>5 and the client is male

0-24 dependence unlikely
>24 dependence likely

RISK

K10 score:

10-19 low psychological distress
20-24 mild psychological distress
25-29 moderate psychological distress
30-50 high psychological distress

Suicide, Self Harm, Harm to Others Risk:

- Risk Assessment completed? ☐ No ☐ Yes
- Safety Plan completed? ☐ No ☐ Yes
- Risk of harm to others ☐ No ☐ Yes

Tier (1-5):

1 = Not dependent and no complexity factors
2 = Not dependent and complexity factors
3 = Dependent and 0-1 complexity factors
4 = Dependent and 2-3 complexity factors
5 = Dependent and 4+ complexity factors

Details:

Family Violence:

- MARAM Victim Risk Assessment completed? ☐ No ☐ Yes
- Safety Plan completed? ☐ No ☐ Yes
- FVISS/CISS utilised? ☐ No ☐ Yes

Risk level:

- Requires immediate protection ☐
- Serious Risk ☐
- Elevated Risk ☐
- At Risk ☐

Details:

Safety plan actions with handover notes to treating clinician if required:

Person identified as using/perpetrating family violence *(disclosed, referred or court ordered for mandated engagement, is the respondent on a family violence intervention order, identified through information sharing entity)* ☐ No ☐ Yes

Details:

FOR STAFF ONLY

Clinician name: Position: Signature: Date:

UR Number:

OTHER KEY ISSUES (e.g. Medical, psychosocial etc.)

BRIEF CASE FORMULATION

Predisposing:

Precipitating:

Perpetuating:

Protective:

FOR STAFF ONLY

Clinician name: Position: Signature: Date:

UR Number:

TREATMENT TYPE/S REQUIRED	DATE REFERRAL MADE	AGREED ACTIONS (note referrals including agency name, contact worker, referral reason, & appointment time and date, & if referral letter sent, etc)
☐ Brief intervention		
☐ Bridging support		
☐ Standard counselling		
☐ Complex counselling		
☐ Residential withdrawal (include general hospital)		
☐ Non-residential withdrawal		
☐ Residential rehabilitation		
☐ Therapeutic day rehabilitation		
☐ Care and recovery coordination		
☐ Pharmacotherapy		
☐ Family support		
☐ Youth outreach		
☐ Other (please specify)		

Date Assessment completed: Number of sessions to complete assessment:

Number of assessment sessions the client did not attend:

Setting where assessment was completed: ☐ Residential ☐ Non-residential ☐ Home ☐ Off-site ☐ Phone ☐ Other

Has the agency 'consent to share information' form been completed? No ☐ Yes ☐

FOR STAFF ONLY

Clinician name: Position: Signature: Date: