IN THE MATTER OF THE ROYAL COMMISSION INTO FAMILY VIOLENCE

ATTACHMENT JA-7 TO STATEMENT OF JUDITH DORENE ABBOTT

Date of document: 14 July 2015
Filed on behalf of: State of Victoria
Prepared by:
Victorian Government Solicitor's Office
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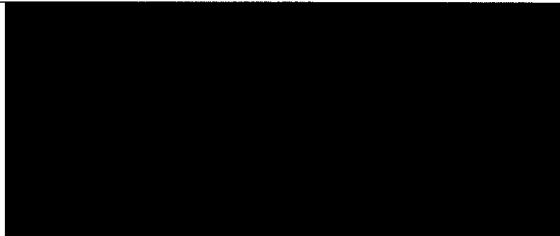
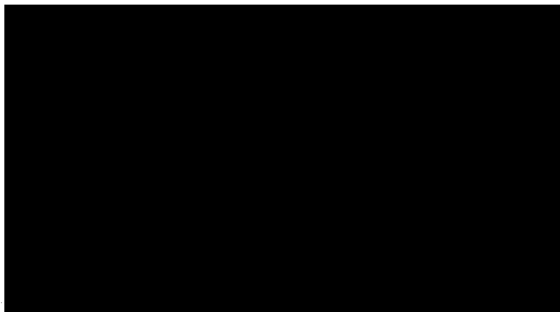


This is the attachment marked "**JA-7**" produced and shown to **JUDITH DORENE ABBOTT** at the time of signing her Statement on 14 July 2015.



An Australian Legal Practitioner within the meaning of the Legal Profession Uniform Law (Victoria)

FOR STAFF ONLY

UR Number:

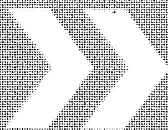
Surname:

Given name:

Date of birth:

(Please fill in if no label available)

SELF COMPLETE INITIAL SCREEN FOR ALCOHOL AND OTHER DRUG PROBLEMS



Please complete the following form as best as you can to help us understand you and your needs.

Tick the boxes that best describe your situation, and write in the spaces provided.

Don't worry if you cannot complete all the questions. Your worker will go over everything with you. And if you prefer not to complete it at all, that's OK too.

FOR STAFF ONLY

Clinician name: Position: Signature: Date:

Agencies using the SCTT Single Page Screener of Health and Social Needs – Where drug or alcohol issues are identified in the SCTT Single Page Screener, this should trigger use of The Self Complete Initial Screen for AOD problems.

STEP 1: SELF-COMPLETE INITIAL SCREEN FOR ALCOHOL AND OTHER DRUG PROBLEMS

FOR STAFF ONLY
UR Number:
Surname:
Given name:
Date of birth:
(Please fill in if no label available)

ABOUT YOU – PLEASE COMPLETE THE FOLLOWING QUESTIONS TO HELP US UNDERSTAND YOUR NEEDS

Family name: Given name(s):

Gender: ☐ Male ☐ Female ☐ Other Date of birth: Day Month Year

Address:

Daytime telephone: Mobile:

Do you identify as being Aboriginal? ☐ Yes ☐ No Do you identify as being Torres Strait Islander? ☐ Yes ☐ No

Country of birth: Cultural background:

Preferred language: Interpreter required: ☐ Yes ☐ No

Do you have any allergies? ☐ Yes ☐ No If yes, what type?

WHO CAN WE CONTACT IN AN EMERGENCY? (E.G. FAMILY MEMBER, PARTNER, FRIEND, ANOTHER WORKER)

Name: Relationship to you:

Address:

Telephone: ( ) Mobile:

YOUR DOCTOR'S DETAILS (WHERE APPLICABLE)

Do you have a GP? ☐ Yes ☐ No If yes, please provide their details (if not already provided)

Name: Address:

Phone no: ( )

Do you use any other services? ☐ Yes ☐ No If yes, please provide their details (if not already provided)

ABOUT YOUR USE OF ALCOHOL AND DRUG SERVICES

Have you used alcohol and drug services previously? ☐ Yes ☐ No If Yes, which program/s?
e.g. counselling services (including court-ordered), withdrawal services (including residential), pharmacotherapy (methadone/suboxone prescribing)

What is your reason for coming here today?

If you were referred (e.g. GP, case manager, lawyer) please provide their details. Name:

Relationship to you (your GP etc): Phone no: ( )

Agency/Service:

FOR STAFF ONLY

Clinician name: Position: Signature: Date:

FOR STAFF ONLY

UR Number:

Surname:

Given name:

Date of birth:

(Please fill in if no label available)

SOME MORE INFORMATION ABOUT YOU

Are you employed? ☐ Yes ☐ No

How many days of paid work (not including voluntary work) have you had in the past four weeks?

If not employed, what type of benefit do you receive?

How many days of school, tertiary education, vocational training have you had in the past four weeks?

If you gamble are you concerned about your gambling? ☐ Yes ☐ No ☐ I don't gamble at all

Are you currently receiving support for any gambling issues? ☐ Yes ☐ No

Have you been arrested in the past four weeks? ☐ Yes ☐ No

Do you have any current/pending legal issues? ☐ Yes ☐ No

Are you currently receiving support for any legal issues? ☐ Yes ☐ No

What type of accommodation do you live in:

☐ Private rental ☐ Public rental ☐ Boarding house ☐ Own home ☐ Homeless ☐ Couch surfing

Have you been homeless in the past four weeks? ☐ Yes ☐ No

Have you been at risk of eviction in the past four weeks? ☐ Yes ☐ No

Do you live in a place where you feel safe? ☐ Yes ☐ No If no please briefly explain in the space below:

Details:

Are you currently receiving any support for any housing issues? ☐ Yes ☐ No Are you pregnant? ☐ Yes ☐ No

Who do you currently live with? ☐ Family ☐ Friends ☐ Alone ☐ Out of Home care ☐ Other

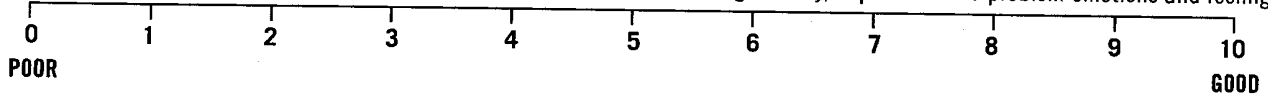
Have you, at any time in the past four weeks, been a primary caregiver for or living with any child/children? ☐ Yes ☐ No

How old are each of the children you care for? (please write ages in the boxes below starting with the youngest child)

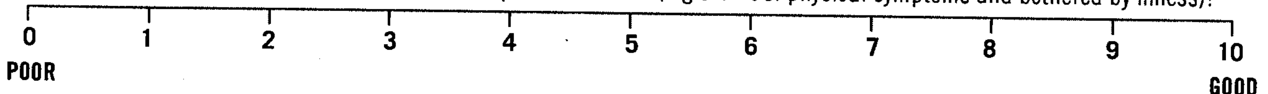
☐ 1. Youngest child ☐ 2. Next oldest child ☐ 3. Next oldest child ☐ 4. Next oldest child ☐ 5. Next oldest child

☐ 6. Next oldest child ☐ 7. Next oldest child ☐ 8. Next oldest child ☐ 9. Next oldest child ☐ 10. Next oldest child

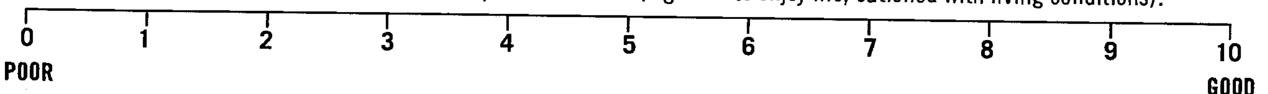
How would you rate your psychological health status in the past four weeks (e.g. anxiety, depression and problem emotions and feelings)?



How would you rate your physical health status in the past four weeks (e.g extent of physical symptoms and bothered by illness)?



How would you rate your overall quality of life in the past four weeks (e.g. able to enjoy life, satisfied with living conditions)?



FOR STAFF ONLY

Clinician name: Position: Signature: Date:

ALCOHOL AND OTHER DRUG USE (ASSIST)

FOR STAFF ONLY	
UR Number:	
Surname:	
Given name:	
Date of birth:	
(Please fill in if no label available)	

The following questions are about the alcohol and other drugs you have been using over the last month, and by answering them you will help to give us a picture of what's been happening for you recently. Please tick the response that best describes alcohol and other drugs that you may or may not use

In the past month, how often have you used the following substances?

	NEVER	ONCE OR TWICE	MONTHLY	WEEKLY	DAILY
a) **Tobacco products** (cigarettes, chewing tobacco, cigars, etc.)					
b) **Alcoholic beverages** (beer, wine, spirits, etc.)					
c) **Cannabis** (marijuana, pot, grass, hash, synthetic cannabis, etc.)					
d) **Cocaine** (coke, crack, etc.)					
e) **Amphetamine type stimulants** (speed,meth, ice, diet pills, ecstasy, etc.)					
f) **Inhalants** (nitrous, glue, petrol, paint thinner, etc.)					
g) **Sedatives or Sleeping Pills** (benzodiazepines, xanax, valium, sere-pax and rohypnol, etc.)					
h) **Hallucinogens** (LSD, acid, mushrooms, PCP, Special K, etc.)					
i) **Opioids** (heroin, codeine, morphine, methadone, etc.)					
j) **Other – please specify:**					

FOR STAFF ONLY

Clinician name: Position: Signature: Date:

FOR STAFF ONLY	
	UR Number:
	Surname:
	Given name:
	Date of birth:
	(Please fill in if no label available)

ALCOHOL USE (AUDIT)

The following questions will give us a picture of your recent alcohol use, and will help us determine how best to help you. Please circle the response that best describes your drinking. If you haven't been drinking alcohol you don't need to answer the questions.

Have you drunk any alcohol in the last year? (Please tick yes or no)

☐ Yes Please answer the questions below ☐ No If you answer no, skip to the next page

		0	1	2	3	4
1	How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
2	How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
3	How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4	How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5	How often during the last year have you failed to do what was expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6	How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7	How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8	How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9	Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year
10	Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year

FOR STAFF ONLY

Clinician name: .... Position: .... Signature: .... Date: ....

USE OF DRUGS OTHER THAN ALCOHOL (DUDIT)

FOR STAFF ONLY
UR Number:
Surname:
Given name:
Date of birth:
(Please fill in if no label available)

The next questions will help us to understand whether use of all drugs other than alcohol is a problem for you. This *includes* illicit drugs & pharmaceutical medications (e.g. sleeping pills, pain killers). It does *not include* medication that you take as *prescribed* by your doctor. Please circle the response that best describes your use of all drugs (other than alcohol). If you haven't been using any, then you don't need to answer the questions.

Have you used drugs other than alcohol in the last year?

☐ Yes Please answer the questions below ☐ No If you answer no, skip to the next page

		0	1	2	3	4
1	How often do you use drugs other than alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
2	How often do you use more than one drug on the same occasion?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
3	How many times do you take drugs on a typical day when you use drugs?	0	1 or 2	3 or 4	5 or 6	7 or more
4	How often are you influenced heavily by drugs?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5	Over the past year, have you felt your longing for drugs was so strong that you could not resist it?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6	Has it happened, over the past year, that you have not been able to stop taking drugs once you started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7	How often over the past year have you taken drugs and then neglected to do something you should have done?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8	How often over the past year have you needed to take a drug the morning after heavy drug use the day before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9	How often over the past year have you had guilt feelings or a bad conscience because you used drugs?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
10	Have you or anyone else been hurt (mentally or physically) because you used drugs?	No		Yes, but not in the last year		Yes, during the last year
11	Has a relative or a friend, a doctor or a nurse, or anyone else been worried about your drug use or said to you that you should stop using drugs?	No		Yes, but not in the last year		Yes, during the last year

Have you injected drugs in the past four weeks? ☐ Yes ☐ No

FOR STAFF ONLY
Clinician name: Position: Signature: Date:

HOW HAVE YOU BEEN FEELING DURING THE PAST 30 DAYS? (K10)

FOR STAFF ONLY
UR Number: ....
Surname: ....
Given name: ....
Date of birth: ....
(Please fill in if no label available)

The following questions ask about how you have been feeling during the past 30 days. It's important to understand how you are feeling and where you are at. For each question, tick the box that best describes how often you had this feeling.

DURING THE PAST 30 DAYS, HOW OFTEN DID YOU FEEL		NONE OF THE TIME 1	A LITTLE OF THE TIME 2	SOME OF THE TIME 3	MOST OF THE TIME 4	ALL OF THE TIME 5
1	...tired for no good reason?					
2	...nervous?					
3	...so nervous that nothing could calm you down?					
4	...hopeless?					
5	...restless or fidgety?					
6	...so restless that you could not sit still?					
7	...depressed?					
8	...so depressed that nothing could cheer you up?					
9	...that everything was an effort?					
10	...worthless?					

Thank you for completing this form. Please hand it to the worker at the start of your session with them. They will review the answers you have provided to address any questions you have and so they can find out a bit more about you.

FOR STAFF ONLY

Clinician name: .... Position: .... Signature: .... Date: ....