IN THE MATTER OF THE ROYAL COMMISSION INTO FAMILY VIOLENCE

ATTACHMENT JA-8 TO STATEMENT OF JUDITH DORENE ABBOTT

Date of document: 14 July 2015
Filed on behalf of: State of Victoria
Prepared by:
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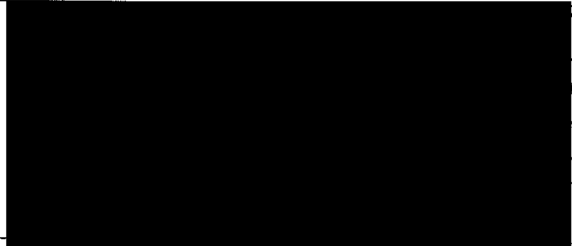
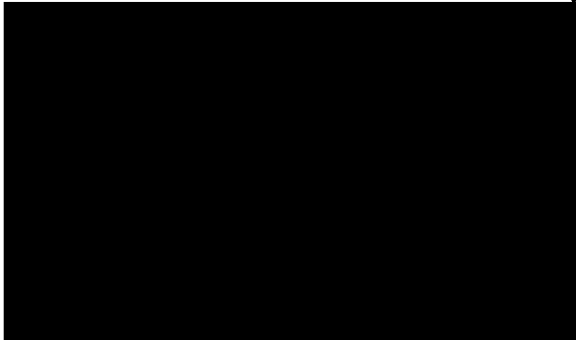


This is the attachment marked "**JA-8**" produced and shown to **JUDITH DORENE ABBOTT** at the time of signing her Statement on 14 July 2015.



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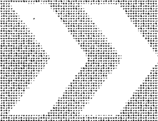

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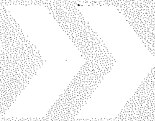
STEP 2: AOD COMPREHENSIVE ASSESSMENT



PURPOSE OF STEP 2: 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.

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State Government Victoria

AOD COMPREHENSIVE ASSESSMENT INSTRUCTIONS

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- Use the initial screen and case summary sheet as starting points that you can refer back to instead of repeating questions that the client may have already answered
- Complete the core part of the assessment
- Complete any Optional Modules as appropriate or if desired
- Complete final case summary sheet and your agency's care plan, and review regularly

THE OPTIONAL MODULES

OPTIONAL MODULE 1: **Physical Examination**

OPTIONAL MODULE 2: **ABI referral tool**

OPTIONAL MODULE 3: **Mental Health (Modified MINI Screen)**

OPTIONAL MODULE 4: **PsyCheck**

OPTIONAL MODULE 5: **Quality of Life (WHOQOL-BREF)**

OPTIONAL MODULE 6: **Gambling (Problem Gambling Severity Index)**

OPTIONAL MODULE 7: **Goals**

OPTIONAL MODULE 8: **Assessment of recovery capital**

OPTIONAL MODULE 9: **Strengths**

OPTIONAL MODULE 10: **Family violence (DHS Identifying family violence recording template)**

OPTIONAL MODULE 11: **Impact of AOD use on family member (Significant Other Survey)**

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1. ALCOHOL AND OTHER DRUGS (AOD)

1A) CURRENT LEVELS OF AOD USE (check screen for additional information)

SUBSTANCE USE HISTORY (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	LAST USE
Tobacco products								
Alcoholic beverages								
Cannabis (marijuana, pot, grass, hash, synthetic cannabis etc)								
Amphetamine type stimulants (speed, meth, ice, diet pills, ecstasy etc)								
Inhalants (nitrous, glue, petrol, paint thinner etc)								
Sedatives or Sleeping pills (benzodiazepines, xanax, valium, serapax, rohypnol etc) Prescribed: ☐ yes ☐ no								
Hallucinogens (LSD, acid, mushrooms, PCP, Special K etc)								
Opioids (heroin, codeine, methadone, oxycodone, morphine etc) Prescribed: ☐ yes ☐ no								
Other (cocaine, GHB etc)								

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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 ☐	
Overdoses Current (within the last four weeks) ☐ Past ☐ Never ☐	
Withdrawal and related complications (seizures, delirium, hallucinations etc) Current (within the last four weeks) ☐ Past ☐ Never ☐	
Risky injecting practices (shares equipment etc) 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 ☐	
Have you or someone else (e.g. children, family significant others, friends etc.) been hurt (mentally or physically) because of your drinking or use of drugs other than alcohol? Current (within the last four weeks) ☐ Past ☐ Never ☐ Check AUDIT Q9 and DUDIT Q10 from screen	

Notes/actions/patterns of use:

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2. MEDICAL HISTORY

(OPTIONAL MODULE 1: PHYSICAL EXAMINATION available)

2A) PROBLEM/CONDITION/EXPERIENCE (tick appropriate)

☐ **Allergies**	☐ **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)	☐ **Skeletal injuries or problems** (e.g. back injury, limb fracture or injury)
☐ **Endocrine problems** (e.g. diabetes)	☐ **Neurological problems** (e.g. fits, seizures, epilepsy, migraines)	☐ **Head injuries or ABI** (Optional Module 2: ABI Referral Tool available)	☐ **Dental problems**
☐ **Chronic pain condition**	☐ **Pregnancy**	☐ **Other:**	

Would the client like to be tested for blood borne viruses? Yes ☐ No ☐

History of conditions, investigations and treatments where appropriate:

2B) ROLE OF AOD USE IN MEDICAL ISSUES (client and clinician perspective)

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2C) CURRENT PRESCRIBED MEDICATIONS (including methadone, psychotropic medication, over-the-counter-drugs, and complementary medicines)

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

Notes and actions:

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3. MENTAL HEALTH

3A) **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 in initial screen)

☐ Depression	☐ Anxiety	☐ Psychosis	☐ PTSD	☐ Bi-polar disorder
☐ Other:				

History, Treatments and outcomes (current diagnosis, community treatment order, past diagnosis, history of trauma, hospitalisations):

3B) **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)	

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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	

3D) NOTES (role of AOD use in mental health issues, actions etc)

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4. RISK

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

4A) 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?	
☐ Intoxication?	
☐ Suicide/attempted-suicide of significant other or family member?	
☐ Stressful or triggering events?	
☐ Accessibility?	
☐ Previous attempts of suicide or self-harm?	
Protective factors	**Comments**
☐ Internal (coping ability, resilience spirituality etc.)?	
☐ External (responsibility to children or pets, social support, therapeutic relationships, meaningful activities)?	
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?)	
High risk?	**If YES, action taken (ie. referral etc)**
☐ Yes ☐ No Reason/s:	

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4B) **HARM TO OR FROM OTHERS** (history of violence to or from others including assaults, family violence, children present, threats to kill, sexual)

(OPTIONAL MODULE 10: FAMILY VIOLENCE available to record family violence as appropriate)

In the past four weeks have you been violent (incl. domestic violence) towards someone? Yes ☐ No ☐

In the past four weeks has anyone been violent (incl. domestic violence) towards you? Yes ☐ No ☐

Are dependent children safe? Yes ☐ No ☐

5. PSYCHOSOCIAL

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

5A) **RESOURCES AND SUPPORTS** (OPTIONAL MODULE 8: ASSESSMENT OF RECOVERY CAPITAL & OPTIONAL MODULE 9: STRENGTHS available)

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5B) GENOGRAM / ECOMAP

5C) FAMILY, CHILDREN AND SOCIAL RELATIONSHIPS (child care responsibilities and impact of substance use on these, child protection involvement, child's perception of a caregiver's substance use and their perception of impacts)

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5D) HOUSING

5E) FINANCES, EMPLOYMENT AND TRAINING

5F) CURRENT LEGAL STATUS

- [ ] No criminal justice involvement
- [ ] Parole
- [ ] Bail/charged
- [ ] Court order
- [ ] Bond
- [ ] Combined custody and treatment order
- [ ] Community correction order
- [ ] Compulsory treatment (Severe Substance dependence Act 2011)
- [ ] Other

Charges pending, offences, and legal history:

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6. FINAL CASE SUMMARY SHEET

Allergies:

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

ASSIST:

1 Main substance used

2 Other substances used

3

SUBSTANCE USE AND DEPENDENCE

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 TO SELF, CHILDREN AND OTHERS: (if high risk suspected, document actions to be taken)

MEDICAL

MENTAL HEALTH

K10 SCORE:

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

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PSYCHOSOCIAL (family, children & social relationships, housing, employment and training, legal history)

BRIEF CASE FORMULATION

TREATMENT TYPE(S) REQUIRED

WORKER/AGENCY ACTIONS

Date Action

REFERRALS

Note the following information: agency name, contact worker, referral reason, appointment time/date made, referral letter sent

Your agency's detailed care/treatment plan complete:

☐ Not yet completed, on: (insert date, and complete as soon as possible)

☐ Yes, completed on: (insert date, and revisit periodically – STEP 3: REVIEW available)

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