PROBLEMATIC ALCOHOL AND OTHER DRUG USE IN THE AUSTRALIAN AVIATION SECTOR

COMPREHENSIVE ASSESSMENT GUIDELINES
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Preface and acknowledgements

On the eve of the Civil Aviation Safety Regulations Part 99’s passage into law, the need for a guidance document explaining the role of non-addiction medicine specialists and psychiatrists in conducting comprehensive assessments (as defined in Part 99), became clear. With the assistance of the Chapter of Addiction Medicine, CASA convened a working group, comprising addiction medicine specialists from the Chapter, an occupational physician, and an alcohol and drug professional. After examining existing definitions of substance use and dependence, the group proposed a new set of definitions, outlined in this booklet. It is hoped that these guidelines will help, not only in the assessment of personnel as required by Part 99, but also in the assessment of others affected by alcohol and drugs, as well as providing some assistance to those with an interest in impairment assessment.

The working group consisted of the following (in alphabetical order):

Ms Donna Bull
Dr Carolyn Edmonds
Dr Matthew Frei (Chair)
Dr Tony Gill
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CASA would like to acknowledge the assistance of Dr James Bell, President Chapter of Addiction Medicine, and all the members of the working group, who spent time and intellectual effort in preparing these guidelines.

Pooshan Navathe
Principal Medical Officer
CASA

Matthew Frei
Chair
Purpose of the Guidelines

These guidelines have been produced by the Civil Aviation Safety Authority (CASA) to assist health professionals to meet the unique requirements for aviation sector employees engaged in safety sensitive aviation activities (AASS) following the return of a positive alcohol and other drugs (AOD) test result.

Aviation sector employees are subject, under the Civil Aviation Safety Regulations Part 99, to a workplace AOD testing regime where they are:

1. performing safety sensitive aviation activities;
2. available to perform safety sensitive aviation activities.

The regulations require that following the return of a positive test result, employees must cease performance of, or availability for, safety sensitive aviation activities and must not return to such activities until they have:

3. undergone a comprehensive assessment with a suitably qualified health professional/s;
4. commenced any recommended therapeutic episode;
5. supplied a further body sample that tests negative to the presence of prohibited levels of AOD;
6. been cleared ‘fit-for-duty’ by a medical review officer (MRO).

During 2008 CASA convened a working group with members of the Australian Chapter of Addiction Medicine (AChAM) to consider issues associated with CASA’s requirement for employees to undergo comprehensive assessment. The guidelines presented here are the result of those expert deliberations.

Outcome of the Comprehensive Assessment

There are two primary outcomes of the Comprehensive Assessment sought by CASA:

7. categorisation of the extent of the aviation employee’s AOD use; and
8. a recommendation regarding the most suitable treatment option.

Background

As a result of a fatal accident on Hamilton Island in 2004, the Australian Transport Safety Bureau recommended that the Department of Transport and Regional Services and the Civil Aviation Safety Authority (CASA) jointly examine the safety benefits of a testing regime for AOD in the aviation sector. Following receipt of the joint Department of Transport and Regional Services–CASA report, the Australian Government directed CASA to commence work to implement the AOD initiative, including AOD testing for aviation safety sensitive personnel.

The major component of the initiative is the introduction of drug and alcohol management plans (DAMP), which are to be implemented by holders of air operator certificates (AOC) and certificates of approval (CoA). The plans are subject to audit, oversight and monitoring by CASA.

The AOD testing component of the initiative covers all safety-sensitive personnel, including those not covered by the DAMP scheme. In addition to AOC and CoA holders, private pilots, contractors and all others undertaking safety-sensitive aviation activities are subject to random testing. CASA estimates coverage of approximately 120,000 personnel.
The aim of the initiative is to minimise AOD-related risks associated with the performance of safety-sensitive activities in the aviation industry. It is not aimed at identifying people who may have used AOD at times when this use did not impact on aviation safety.

Random testing is conducted by CASA via an outsourced provider who collects samples, performs initial tests and is responsible for ensuring the reliability of the collection process. The testing provider sends the initial positive specimens to an accredited laboratory for confirmatory testing. All confirmatory tests conducted by the laboratory are reported to the medical review officer within CASA for verification.

A regulatory offence regime exists for those identified through random testing as having confirmed positive tests. The regulatory regime supports key enforcement action that is proportional to the offence. This regime only applies to random testing.

**Rationale for Assessment**

Completion of a comprehensive assessment is required to guide decision-making about appropriate strategies to achieve the best health and safety outcomes for aviation sector employees who return a positive AOD test result.

**Who Can Perform a Comprehensive Assessment**

Under regulation, an aviation sector employee who returns a positive AOD test must undergo a comprehensive assessment with a suitably qualified health professional/s, prior to being permitted to return to availability for safety sensitive aviation activities. To meet the standard of the regulation, the comprehensive assessment requires thorough examination of physiological and psycho-social indicators.

For the purpose of the regulation, a comprehensive assessment may be conducted by:

1. a psychiatrist; or
2. a medical practitioner who is a Fellow of the Australasian Chapter of Addiction Medicine (FACHAM); or
3. jointly by
   a. a person entitled to practise as a medical practitioner under a law of a State or Territory; and
   b. an appropriately qualified drug and alcohol professional.

An appropriately qualified drug and alcohol professional is a person who:

1. materially works as a provider of clinical drug and alcohol treatment services; and
2. holds a bachelor degree, or postgraduate degree, in at least one of the following fields:
   a. health sciences;
   b. medical science;
   c. social sciences; or
   d. behavioural sciences.

**Joint assessment**

Where an assessment is to be conducted jointly by a medical practitioner who is neither a psychiatrist nor a FACHAM, and an AOD professional, there is no strict protocol for allocation of various aspects of the assessment to each of the providers, nor for the order in which the aspects are to be addressed. It is advised however, that to take advantage of the specific skill-sets and experience of each clinician, in majority of cases the most productive allocation of components of assessment is likely to be:

- the medical practitioner take responsibility for the medical and medication history, the physical examination and urine/blood collection; and;
- the AOD professional take responsibility for undertaking the assessment of signs of intoxication and withdrawal, AOD use career and psychological/psycho-social aspects.
It is recommended that the mental health assessment should be performed by both the medical practitioner and the AOD professional.

Throughout these guidelines you will find suggestions for allocation of assessment components.

Where a joint assessment is conducted, it is likely that many aviation sector employees may prefer that their own general practitioner (GP) conduct those components of the assessment requiring medical qualifications. CASA regulations permit this course of action.

The aviation sector employee is responsibility for locating and making an appointment with appropriately qualified clinicians and for meeting the costs associated with the assessment.

Categorising AOD Problems

For CASA, the primary output of the comprehensive assessment, for CASA purposes, is to determine the magnitude and severity of use (categorising the AOD problem) and to the develop of an appropriate treatment plan.

*Categorising AOD Problems – conducted by psychiatrist, FACHAM, or AOD professional*

During 2008, CASA convened a working group with members of the Australian Chapter of Addiction Medicine to consider issues associated with CASA’s requirement for employees to undergo comprehensive assessment.

The expert panel examined the usefulness and relevance of existing diagnoses for AOD dependence or abuse (and other AOD related disorders), with a specific view to whether these diagnoses met the needs and requirements of CASA in its role as the aviation safety regulator.

The Diagnostic and Statistical Manual of Mental Disorders 4th edition (DSM-IV) published by the American Psychiatric Association, and the World Health Organisation International Classification of Diseases 10th edition (ICD-10) both offer classifications for describing AOD use and AOD-related problems. These international classifications include terms such as ‘abuse’ and ‘misuse’ that are generally avoided in the AOD field in Australia due to their negative or value-laden nature. In Australia the preferred term is ‘problematic use’ (Alcohol and Other Drugs: a handbook for professionals 2004, Australian Government Department of Health and Ageing).

The working group noted that AOD use occurs on a continuum, with abstinence at one end and dependence at the other end, and that ‘what occurs in between’ may be difficult to pin down and is not clearly categorised or defined. The group agreed that for the purposes of assessment and treatment in this context, the focus is less on the amount and type of drug/s (including alcohol) used and more on the outcome, consequences, and/or effects of that use.

As a result of these deliberations, the working group agreed that AOD use in this context would best be categorised as follows:

» **Non-problematic use:** AOD use at a rate, level, time and in a context that presents no evident identifiable risk or problem for the individual in the workplace;

» **Hazardous use:** AOD use at a rate, level, time and in a context that presents potential direct or indirect risk to the individual or the workplace (including colleagues, others on-site, equipment and plant);

» **Problematic use:** AOD use at a rate, level, time and in a context that presents identified risk to the individual or the workplace (including colleagues, others on-site, equipment and plant).

Examples of each of the categories are provided below.
Non-problematic use: AOD use at a rate, level, time and in a context that presents no evident identifiable risk or problem for the individual in the workplace.

Example 1:
Client is a 30 year old male engineer. He has been referred as a result of a random urine drug test conducted by his employer which revealed a level of THC slightly above permitted level.

Client reports that he had returned from a week of recreational leave the day prior to the test and that he had been using cannabis during that period. He has brought his leave record with him and this confirms his period of leave.

During the interview the client is anxious, but cooperative and demonstrates awareness of the potential safety and health impacts of cannabis use. He tells you that he never uses during the working week. He says his use is infrequent and generally situational. Other drug use is limited to alcohol, sometimes at levels that pose short-term risk to health.

The client appears to be in good health and medical records brought with him support this. He is concerned about the potential ramifications of returning a positive test and the outcome of the comprehensive assessment for his future career and livelihood. Working through the elements of the comprehensive assessment, it is apparent that there are no significant risks posed for the workplace and that the client is unlikely to present again under these circumstances.

You determine that the client’s use can be categorised as non-problematic in the context of work safety, and you recommend to the MRO that the client be returned to work. You provide the client with information regarding cannabis, and also advise him of the risks associated with his alcohol consumption.

Example 2:
Client is a 42 year old male manager of a transport organisation based at a regional airport. He presents following a CASA random AOD test which resulted in a positive reading for alcohol (BAC of 0.04). The client tells you that he was called into work unexpectedly after a colleague fell ill and the site was left short-staffed. As he was not anticipating having to go to work the next day, the client had spent the previous night at a family celebration where he admits he had consumed ‘quite a bit’ of alcohol.

The client is concerned about the result of the test, and admits it was foolish of him to go into work but says he did so because the organisation is under quite a bit of pressure to achieve results and meet expectations at the moment. He had thought at the time that he was setting a good example for others.

Upon examination, the client appears to be in a very good state of physical and mental health, and there are no psycho-social issues of any concern. He tells you he does not use any drugs other than alcohol. You are satisfied that the client’s positive BAC is the result of poor decision-making in unusual circumstances and after discussion with him about alcohol elimination rates you are confident that he will not make the same mistake again. You recommend to the MRO that the client’s AOD use be categorised as non-problematic in the context of workplace safety and recommend that he be returned to work.
Hazardous use: AOD use at a rate, level, time and in a context that presents potential direct or indirect risk to the individual or the workplace (including colleagues, others on-site, equipment and plant).

Example 1:
Client is a 24 year old, female flight attendant. She has been referred as a result of a random breath test conducted by CASA, which indicated a BAC of 0.035.

The client tells you that she had definitely not been drinking within eight hours of commencing duty as she ‘knows’ this is how long it takes to get back to 0.00 BAC. She estimates that she had consumed around ten standard drinks the evening before the test, over a period of about four hours (between 7pm and 11pm). She cannot understand how she possibly returned a positive test, and is both distressed and disbelieving. She says that she sometimes drinks far more than she did the night prior to the test and that she is perfectly fine for work. The test must be wrong.

While carrying out the comprehensive assessment you find that the client is in a good state of physical and mental health. Her drug use is generally limited to alcohol, although she reports infrequent MDMA and Amyl Nitrate use also – ‘when out partying’. She admits that she sometimes can’t quite remember all that happened on these nights, or when she has been drinking a lot, but asserts that happens to everyone she knows and is quite normal.

After completing the comprehensive assessment you determine her alcohol use to be in the hazardous category in the context of the workplace and recommend to the MRO that she return to work immediately, but engage in an AOD education intervention with an appropriately skilled and qualified provider to minimise the risk associated with her AOD use.

Example 2:
Client is a 48 year old female security officer. She presents following a CASA random AOD test which was positive for opiates above the permitted level, due to codeine use.

The client tells you that she is ‘in a bit of a mess’, her ‘nerves are shot’, and she’s ‘having real trouble coping with everything’. She has recently separated from her husband and is looking after four children on her own as well as working full-time. She becomes very distressed during the assessment, and says she is under a lot of stress due to her financial situation after the marriage breakdown - she is about to be forced out of her home as she cannot afford to maintain it on a single income.

She has been taking some old Panadeine Forte that she found in the bathroom cupboard to relieve the headaches she has been suffering from during the past couple of weeks. She thinks that the tablets are left over from a prescription that she had filled following some minor dental surgery about 18 months ago, and there was also an unopened packet that belonged to her husband. She has also found that an over the counter (OTC) product (Disprin Forte) has a higher level of codeine than OTC Panadeine, so she has bought up a few packets of this so that the Panadeine Forte lasts longer. She says that she had heard that taking codeine could result in a positive drug test under the CASA program, but she thought that her chances of getting caught were very low so it was worth the risk.

As a result of the client’s revelations during the assessment, your observations of her state of mental health and the apparent psycho-social issues, you determine that her AOD use should be categorised as hazardous in the context of workplace safety and you explain this to her. You make a recommendation to the MRO that the client commence a course of treatment to assist her in addressing these issues, and that she be returned to work as soon as possible after completing mandatory requirements.
Problematic use: AOD use at a rate, level, time and in a context that presents identified risk to the individual or the workplace (including colleagues, others on-site, equipment and plant).

Example 1:
Client is a 47 year old male maintenance worker who presents as a result of an ‘on suspicion’ alcohol test that revealed a BAC of 0.09. The test was conducted one hour after the client commenced his shift, after it was reported to the site DAMP supervisor by one of the client’s colleagues that the client was smelling of alcohol. During the interview the client reveals that he routinely consumes 12 stubbies of full strength beer in the evenings after work, and follows with a bourbon ‘chaser’. On weekends he consumes approximately twice this amount. He reports that it is only when he’s feeling particularly ‘shaky’ that he drinks alcohol in the morning – to steady himself and ‘get the cobwebs out’. He tells you that he would be a far greater safety risk if he didn’t have this ‘nerve-steadier’, and maintains that as he is a very experienced drinker and of a heavy set build so he can cope with much more alcohol than the CASA 0.02 level allows. The client reports trouble sleeping, and tells you that his alcohol consumption in the evenings is partly to help him to sleep. He reveals that he has two alcohol-related driving offences (with a licence suspension four years ago as the result of a traffic accident while driving with a low-range BAC). He has also had a series of minor injuries that have occurred while he has been intoxicated. Other drug use includes tobacco (twenty five per day), and regular OTC tablets (paracetamol/codeine) to treat frequent headaches.

While awaiting laboratory results, you determine that the client’s AOD use should be categorised as problematic in the context of work safety, on the basis of the physical examination and completion of the comprehensive assessment. You advise the client of your determination and explain how you have reached this decision. The client is shocked by your determination, and tells you he is committed to change his behaviour as he enjoys his job and does not want to risk losing it as a result of this test … he tells you he’s also ‘copping some nagging’ about his drinking from his wife and grown children. You recommend to the MRO that the client be supervised to reduce his alcohol consumption to low-risk levels, and provide advice regarding his OTC and tobacco use. Your recommendation includes options for appropriate intervention, including brief intervention with an AOD treatment agency or engagement in an online or correspondence computer based training intervention program. As a result of the client’s report of occasional drinking in the morning you may also recommend a period of abstinence, at least initially and the client may also need some intervention to treat alcohol withdraw
Example 2:

Client is a 30 year old male catering worker. He has been referred to you following a random urine drug test conducted by his employer which revealed methamphetamine and THC above the permitted level.

The client tells you that he has been using cannabis regularly for 15 years, and started using methamphetamine about five years ago. He currently uses cannabis on a daily basis, and methamphetamine several times per week. He tells you that his use of methamphetamine has been increasing steadily over the past year and has risen particularly rapidly over the last few months. He has been on a few methamphetamine binges during this time where he has used continuously for two or three days without rest. He now finds that he needs to use more and more cannabis to help ‘come down’ after methamphetamine use. He reports that he used heroin on and off in the past, but not much over the last few years. He enjoys the energy and sharpness he gets from methamphetamine, and says that he prefers this feeling to that received from heroin.

The client becomes visibly agitated during the interview and tells you that he believes a range of people are out to get him. The positive drug test, he maintains, is just a part of the plot. He is extremely restless during the interview, he appears confused and distracted, and makes several statements indicative of a level of paranoia. During the physical examination of the client, you discover several injection sites that have become infected.

As a result of the client’s level of reported drug use and his potential psychosis, you determine that a categorisation of problematic AOD use is appropriate and necessary. You recommend to the MRO the client undertake a period of residential rehabilitation in a program equipped to manage clients with complex comorbid mental health issues, and that a further review be conducted after completion of this treatment to consider options for the client to be returned to work safely.

Components of a Comprehensive Assessment

The comprehensive assessment assists in gaining a thorough understanding of the client’s or patient’s needs so that a suitable treatment plan can be formulated for the client. CASA require a comprehensive AOD assessment for individuals who have returned an AOD test result that is not a negative result.

The CASA Comprehensive Assessment Guide provides service providers with a common tool for assessment. The comprehensive assessment is most appropriately completed in a semi-structured, narrative style. It is primarily an assessment tool, not an information collection instrument for administrative or service monitoring purposes.

The design and content of the comprehensive assessment is based on consultations with the CASA/AChAM working group.

A comprehensive AOD assessment includes examination of physiological and psycho-social indicators and requires the following components to be considered:

- Pattern and recent history of AOD use;
- Physical examination;
- Mental health history;
- Psychosocial issues;
- Brief medical and medication history;
- Laboratory markers;
- Assessment recommendations and treatment plan.

More detailed information regarding each of these components is provided in Sections 2 and 3 of these guidelines.
SECTION 2: HOW TO CONDUCT COMPREHENSIVE ASSESSMENT

Initial Presentation

There are several circumstances by which an aviation sector employee may present for comprehensive assessment:

» following voluntary disclosure about problematic AOD use to their employer (self-referral);
» following the provision of a breath sample at the workplace that has been analysed and found to have prohibited levels of alcohol;
» following the provision of a urine or oral fluid sample at the workplace that has been analysed and found to have prohibited levels of a drug, or drugs, other than alcohol.

AOD testing within the aviation sector is conducted:

» prior to gaining eligibility for deployment to a safety sensitive aviation activity;
» post-accident or serious incident;
» on suspicion that an employee is AOD affected;
» on a random basis;
» prior to returning to work following a suspension event, if that suspension was AOD related.

Aviation sector employees should present for comprehensive assessment with a copy of their AOD test result and other documentation associated with the test, including the reason for the test. They are advised that the following information will also assist clinicians to undertake a sound and thorough comprehensive assessment:

» a list of their duties and responsibilities (ie a job statement);
» work history, including absenteeism, any performance management undertaken, and involvement in accidents or serious incidents;
» previous results of AOD tests (positive or negative);
» letter from their treating doctor advising current medications and health status;
» a copy of their pre-employment medical information;
» a signed consent form for release of information to their employer.

Conducting an Assessment

Introduction

Under regulation, an aviation sector employee who returns a positive AOD test must undergo a comprehensive assessment with a suitably qualified health professional/s, prior to being permitted to return to availability for safety sensitive aviation activities. To meet the standard of the regulation, the comprehensive assessment requires thorough examination of physiological and psycho-social indicators.

For the purpose of the regulation, a comprehensive assessment may be conducted by:

1. a psychiatrist; or
2. a medical practitioner who is a Fellow of the Australian Chapter of Addiction Medicine (FACHAM); or
3. jointly by:
   a. a person entitled to practise as a medical practitioner under a law of a State or Territory; and
   b. an appropriately qualified drug and alcohol professional.

An appropriately qualified drug and alcohol professional is a person who:

1. materially works as a provider of clinical drug and alcohol treatment services; and
2. holds a bachelor degree, or postgraduate degree, in at least one of the following fields:
   a. health sciences;
   b. medical science;
   c. social sciences; or
   d. behavioural sciences.
Features of the Assessment

To meet the needs of CASA regulations, a comprehensive assessment will comprise physiological and psycho-social elements. There is no standard format for a CASA-compliant comprehensive assessment; however, there are standard components.

The required components are:

1. AOD use career – conducted by psychiatrist, FACHAM, or AOD professional

Substance use summary - Completion of a substance use summary enables identification of the age of onset and AOD use experience. Collect a history of substance use by first asking what substances the client has used in the past and what age they first used. It is optimal to ask about all substances in order to provide a comprehensive substance use assessment. Identify which substances they are currently using and the pattern of use (intermittent, heavy use or daily). For each substance then ask how much they use on a typical day: both in cost and quantity. Ask about the route of administration for each substance. The amount used might be described in terms of money or weight. If the amount is given in one unit (eg a gram), ask how much that costs. Likewise, if the client responds in terms of how much money they spend, ask how much of the substance that is. Most substances are sold by weight, but there is no ‘typical’ daily amount used. Ask clients to explain the quantity and frequency of substance use. An example of a substance use summary appears in Section 3.

Previous treatment episodes. - It is useful to record how previous treatment/support options worked or did not work for the client.

Other issues pertaining to drug use. Ask the client about the usual place of AOD use—eg party, home, nightclub. Explore consequences of use, ask the client to describe in terms of the five ‘L’s: liver (health), love (relationships), legal, livelihood (employment/income) and lifestyle (housing, safety and security, stability, etc). Ask the client whether they use alone, or with others.

Readiness to change - Readiness to change is an important mediating variable in treatment outcomes, so enhancing the client’s level of motivation may be an important aspect of treatment. Assessment of the client’s readiness to change is valuable in assisting in the selection of appropriate treatment options – readiness to change is measured as part of the comprehensive assessment in order to gain an understanding of the client’s likely response to treatment and level of insight.

The simplest method for assessing readiness to change is through direct questioning during the assessment interview.

Two questions that might prove useful are:

» ‘How interested are you in changing your AOD use now?’ and

» ‘Do you feel that you ought to change your AOD use, or do you really want to?’

The client may also be asked:

» ‘What would you be prepared to do to solve this AOD problem?’

» ‘How confident are you that you can achieve this?’

» ‘Are you prepared to attend the next appointment?’

Responses may vary from:

» ‘I’m happy with my [substance] use’, ‘I enjoy using [substance]’, ‘I’m not interested in stopping [substance]’; through to ‘I’m thinking about cutting down’, ‘I’m not sure if I’m ready at the moment’, ‘I’m interested in weighing up stopping’; or ‘The disadvantages are outweighing the advantages for me’
2. **Physical examination – conducted by psychiatrist, FACHAM or other medical practitioner.**

A general physical examination should be carried out, including vital signs, neurological observations, nutritional status, fluid balances, level of consciousness and signs of AOD intoxication or withdrawal.

Indicators of AOD use may be due to the pharmacological effects of the drug, the half-life or life of the drug, the route of administration, accidental injury or illness arising from concurrent use.

Signs of harmful AOD use may include:
- Flushed or ashen face
- Ascites
- Jaundice
- Hepatomegaly
- Spider naevi on face
- Injecting sites
- Cellulitis
- Phlebitis
- Skin abscesses
- Erosion or irritation around nostrils/septum
- Irritation or rash around nose and mouth
- Conjunctival infection
- Odour – breath, skin
- Unstable or abnormal gait
- Distended blood vessels along side of neck.

Specific signs of intoxication:
- Abnormal pupil size – constricted (opioids) or dilated (psychostimulants)
- Drowsiness or decreasing alertness
- Ataxia
- Slurred speech
- Pressured or rapid speech
- Mood swings
- Decreased concentration or erratic ability to concentrate
- Poor ability or inability to manage normal tasks (eg lacing up shoes, writing clearly).

Specific signs of withdrawal:
Withdrawal is a clinical feature of chronic substance use, and is part of substance dependence, occurring with reduction or cessation of use of a substance in the setting of neuroadaptation or tolerance. Characteristics of withdrawal syndromes vary in relation to the particular pharmacology of the drug and its half-life.

- Symptoms emerge with a significant drop in blood concentration or abrupt cessation of AOD use. This occurs in someone whose central nervous system has neuroadapted to maintain normal body function in response to his or her excessive and frequent (daily) use.
- A general guide is that the withdrawal syndrome will usually exhibit opposite signs to the acute drug affects (ie, CNS depressant alcohol withdrawal can produce increasing irritability, acute agitation, anxiety, tremor, sweating, nausea, headache, general physical and psychological discomfort). It can also progress to severe complications such as delirium tremens (DTs) and possibly death, if not managed effectively.

*Ref: Alcohol, Tobacco and Other Drugs Guidelines for Nurses: Clinical Guidelines version 2. 2003. Flinders University, South Australia. Re-produced for educational purposes with permission.*
3. Mental health – conducted by psychiatrist, FACHAM, or jointly by medical practitioner and AOD professional.

Alcohol and other psychoactive drugs affect cognition, emotions, moods and behaviour. A mental health assessment is an important part of the overall AOD assessment, and should include:

**Client’s mental health (current and past)**
- Establish whether there are any current problems in need of immediate attention/referral. Include where possible, history of condition, investigations and treatments. Ask about past relevant psychological history, symptoms relating to depression, anxiety or phobia. Enquire about medication doses, the prescriber, and the date and time of the last dose. Ask the client do they take the medication in accordance with the doctor’s instructions.

**Cognitive functioning**
- It is recommended that any client with an extensive history of alcohol or volatile substance use undergoes a short assessment, such as the Mini Mental State Examination (MMSE) reproduced in Section 3. Depending on the degree of severity of suspected cognitive damage you may wish to refer to a clinical psychologist for further assessment. A score of 24 or above on the MMSE is considered normal. A score of 18–23 indicates mild to moderate cognitive impairment. A score of 0–17 indicates severe cognitive impairment.

**Mental state**
- Note client’s general appearance and behaviour, observations about client’s affect and mood, and whether the client’s thoughts are ordered, reasonable, and realistic. Is the client experiencing hallucinations (visual, auditory, tactile), illusions, or perceptual distortions? Does the client demonstrate appropriate insight?

4. Psycho-social issues – conducted by psychiatrist, FACHAM, or AOD professional.

Exploration of these issues assists with understanding the client’s AOD use in context, and its function in the client’s life. Exploration also assists the client to make links between their AOD use and current position:

**Family history**
- Ask whether there are any particular family concerns, problems or special circumstances the client feels are relevant to their AOD use or this assessment. Include cultural/ethno-specific issues. Establish whether the client has family networks which encourage continuing problematic AOD use. Ask about the quality of various family relationships and the role of the family in convincing the client to seek help.

**Childhood experiences (including schooling)**
- Ask the client to describe their childhood — do they recall it being a happy or difficult time? For what reason(s)? What about their primary school experience? Did they regularly attend school? Did they have any difficulties at school (with learning, social relationships, teachers, etc)?

**Adolescent experiences (including schooling)**
- Ask the client to describe their adolescence — do they recall it being a happy or difficult time? For what reason(s)? What about their secondary school experience? Did they regularly attend school? What year did they leave school? Did they have any difficulties at school (with learning, social relationships, teachers, etc)?

**Occupational history**
- Ask the client about their work history — how long have they been in the workforce and in this job, what is it that they do, what were they doing before that (and before that, etc)? Do they enjoy their job? What is it that they like/dislike about their job?

**Sexual/relationship adjustment**
- Ask whether there are any particular sexual/relationship concerns, problems or special circumstances the client feels are relevant to their AOD use or this assessment. Ask the client how their AOD use might have affected relationships with their spouse or partner.
Legal issues—past or current convictions and engagement in criminality  - Ask the client whether they have any charges pending (include bail conditions). Explore any current offences, including the circumstances, attitude to the offence, and consequences. Establish the client’s legal history, including any past imprisonment. Are there any issues relating to Family Court, Children’s Court, or any current court orders (establish the conditions of the orders)?

  » Does the client have a history of violence or present a risk to others (includes assault, domestic violence, threats to kill, sexual offences, offences against other persons especially children, driving under the influence)?
  » Is there a current risk to the client from others?
  » Financial and housing information - Establish the client’s accommodation arrangements (where, with whom, etc.). Is this a stable situation? Is there problematic AOD use in the household? Does the client have financial concerns? What is the impact of AOD use on the client’s financial situation? Are there debt issues? Have any steps been taken to address these?

Leisure pursuits (past and present) - Ask the client how they spend their time away from work. What do they enjoy doing on weekends, in the evenings, during leave? Are there any activities that they used to do that they don’t do any more? Do they regret no longer doing these things? Would they like to take them up again? Is there anything that they have never tried that they think they might like to? Are any of the client’s leisure pursuits facilitating their AOD use? Consider hobbies, sports, gym, music, reading, fishing, clubs, motorsports, nightclubs, gambling, etc.

Risk-taking behaviours (including sexual and injecting drug use) - Is the client engaging in risk-taking behaviours? How are these linked to their AOD use (ie risk-taking only when intoxicated, risk-taking in order to finance AOD use, etc). Is the client concerned about this risk-taking? Has anyone else expressed concern?

Support networks - Ask the client about their support networks. These may include family members, friends, colleagues, neighbours, health/allied health and other service providers, and self-help groups. Different people offer different sorts of support. Ask the client what sort of support each can be relied upon to provide.

5. Brief medical and medication history – conducted by psychiatrist, FACHAM or other medical practitioner.

The patient may present with concurrent health conditions, which need to be assessed for and attended to. These may include liver disease, injuries (including head injuries), poor nutrition or hydration status, acute or chronic mental health problems.

Exploration of medical and medication history assists with understanding the development (causal or consequential) and possible self-medicating functions of AOD use. Co-existing illness will influence treatment protocol and may necessitate referral to an appropriate health/mental health service provider. The history also allows the clinician to collect information from the patient about current health problems or medications that may influence blood test results such as HCV, recent course of antibiotics, etc.

  » Establish whether there are any current problems in need of immediate attention/referral. Include, where possible, history of condition, investigations and treatments.
  » Ask the patient about past relevant medical history and general hospital admissions. Has the patient ever lost consciousness as a result of their AOD use? What happened?
  » Ask the patient about the impact of their AOD use on their general health, weight, appetite, nutrition, sleep pattern.
  » Enquire about current medication (including OTCs), dose, prescriber, and the date and time of the last dose. Ask the patient whether they take the medication in accordance with the doctor’s or pharmacist’s instructions.
6. Laboratory markers – conducted by psychiatrist, FACHAM or other medical practitioner

A number of blood tests can be used to screen for alcohol problems. However, they can be less sensitive and specific than questionnaires and are not a substitute for taking an adequate history.

These screening tests include:
» Full blood count, including MCV
» Liver function tests, including gamma GT
» Triglycerides.

Urine drug screening to detect alcohol, other drugs and/or metabolites, or breathalyser testing to detect the presence of alcohol may be considered useful and appropriate. Screening tests for drug use include:
» Full blood count, including white cell count
» Liver function tests
» Hepatitis B and C and HIV serology.

The following detailed information has been copied from the Assessment Guidelines for AOD Dependence in Drivers, prepared by Drug and Alcohol Services South Australian 2005:

**Liver Enzymes**

Gamma Glutamyl Transferase (GGT) is an inducible membrane-bound enzyme that is the most sensitive and reliable indicator (that is widely available) of alcohol consumption. It is more likely to be elevated when alcohol consumption is greater than 80 grams/day. It probably requires more than a week of heavy drinking for serum changes to occur.

Only 44 percent of males and 26 percent of females with an identified alcohol problem will have an elevated GGT. Further, among adolescents there is no relationship between serum GGT levels and alcohol consumption. There is also a poor correlation between serum GGT and alcohol consumption in individuals under 30 years of age.

In spite of poor specificity, 50-72 percent of elevated GGTs are explained by excessive alcohol consumption.

When the serum GGT has previously been elevated as a result of excessive alcohol consumption, the level should return to normal within three months of effectively controlled alcohol consumption.

GGT levels can be elevated through a variety of other causes (e.g., antibiotic or antidepressant use, some other drug use, a range of health conditions) and care should be exercised to exclude them. If in doubt, the biochemistry laboratory can help you to interpret the results of tests they have performed. Alanine Aminotransferase (ALT) and Aspartate Aminotransferase (AST) are more indicative markers of hepatocyte injury and less sensitive indicators of exposure to excessive alcohol consumption than GGT.

A useful pointer to help identify alcohol as a cause of liver enzyme abnormalities is a disproportionately large elevation of the GGT compared to AST and ALT levels. In alcoholic hepatitis, AST is more sensitive to liver damage than ALT.

Low albumin and increased globulins together with AST much greater than ALT, are suggestive of cirrhosis.

Serum GGT and AST levels are valuable markers of recovery in patients who have known alcohol-related liver disease. Reducing alcohol consumption, or abstinence, will usually result in a reduction in the serum levels of these enzymes. When the serum AST level is abnormally elevated, it is considered the more reliable indicator of recent consumption levels.

In the absence of raised GGT it should be remembered that a raised AST and/or ALT in isolation are commonly seen in cases of chronic hepatitis (e.g., Hepatitis C). Further investigation of these abnormal results may be warranted.
Haematology

Mean corpuscular volume (MCV) may be elevated in people who consume more than 60 grams of alcohol per day. The threshold for a relative macrocytosis is 96fl. Caution needs to be exercised as this lies in the normal range.

Only 33 percent of males and seventeen percent of females with acknowledged alcohol problems will have an elevated MCV. In general practice, heavy alcohol consumption has accounted for 89 percent of male and 56 percent of female raised MCV values.

MCV responds slowly to abstinence with 40 percent having a sustained elevation after three months of abstinence.

It should be remembered that there are alternative causes for a raised MCV. Among these are Vitamin B12/folate deficiency, suppurative lung disorders and abnormal thyroid metabolism.

Other

Carbohydrate deficient transferrin (CDT) has been shown to have high sensitivity (52-100 percent) and specificity (greater than 90 percent) for heavy alcohol consumption. Values start to rise after ten days of consuming greater than 60 grams of alcohol per day. CDT values also have reasonable correlation with self-reported consumption. Hence the test has application in both the identification of heavy drinkers and monitoring alcohol consumption. However, the sensitivity for detecting heavy drinking is reduced among younger drinkers.

In general, CDT levels are not influenced by non-alcohol related liver conditions with the exception of primary biliary cirrhosis. Pregnancy artificially elevates serum CDT.

CDT elevation returns to normal after two months abstinence from alcohol. The test is not yet available in an automated form and is conducted in specialist research laboratories.

Each laboratory maintains its own standard for CDT and although 2.3 is the average, medical practitioners should ensure they are aware of the laboratory standard prior to incorporating the information into their decision-making.

Joint assessment

Where an assessment is to be conducted jointly by a medical practitioner who is neither a psychiatrist nor a FACHAM, and an AOD professional, there is no strict protocol for allocation of various aspects of the assessment to each of the treatment providers, or for the order in which the aspects are to be addressed. However, to take advantage of the specific skill-sets and experience of each clinician, in most cases the most productive allocation of components of assessment is likely to be:

» the medical practitioner takes responsibility for the medical and medication history, the physical examination, and urine/blood collection; and

» the AOD professional takes responsibility for undertaking the assessment of signs of intoxication and withdrawal, AOD use career and psychological/psycho-social aspects.

The mental health assessment should both be performed by the medical practitioner and the AOD professional and throughout these guidelines, suggestions for allocation of assessment components occur. Where a joint assessment is conducted, it is likely that many aviation sector employees may prefer that their own general practitioner (GP) to conduct those components of the assessment that require medical qualifications. There are no barriers to this course of action within the CASA regulations.

Responsibility for locating and making an appointment with appropriately qualified clinicians, and for meeting the costs associated with the assessment, rests with the aviation sector employee.

A flowchart diagram demonstrating the process of joint assessment is included overleaf.
Joint assessment process

Aviation employee provides + AOD test, or is found to have interfered with integrity of a test, or refuses to provide a sample for testing

Aviation employee obtains Comprehensive Assessment Form and collects necessary documentation* prior to initial appointment with AOD professional and medical practitioner. Consent signed.

Aviation employee makes appointment to see (1st) AOD professional and (2nd) medical practitioner.

Appt 1: AOD professional
» Check consent
» Conducts parts 1, 2, 3, 5 and 6 of Comprehensive Assessment
» Discuss treatment options and identify treatment goals, pending medical practitioner feedback

AOD professional completes corresponding sections (1, 2, 3, 5 and 6) of Comprehensive Assessment Form.

AOD professional provides Comprehensive Assessment Form to medical practitioner (via fax, email or mail) for completion of parts 4, 5 and 6.

Appt 2: Medical practitioner
» Reviews notes by AOD professional on Comprehensive Assessment Form
» Conducts parts 4, 5 and 6 of Comprehensive Assessment

Medical practitioner completes corresponding sections (4, 5 and 6) of Comprehensive Assessment Form, and returns form to AOD professional (via fax, email or mail).

AOD professional determines category of AOD use and makes treatment recommendation, signs document and returns to medical practitioner for review, counter-sign and return.

AOD professional forwards completed Comprehensive Assessment Form and any attachments [reports, diagnostic instruments, etc] to identified medical review officer for consideration regarding intervention required and fitness for duty.
**Presentation to Medical Practitioner/AOD Professional**

At first contact, the medical practitioner or AOD professional should make it clear to the client/patient they will require a joint assessment. It is necessary to fulfil the requirements of the CASA regulations. The AOD professional or medical practitioner will need to determine whether the client/patient has a preferred clinician to assist in the joint assessment – for instance, the client/patient may present to an AOD professional and indicate a preference for the family GP to undertake the medical aspect of the assessment.

The name and contact details of the joint assessor will need to be obtained from the client/patient and it must be explained that information regarding their assessment will be passed between the assessors and then back to the MRO. The client/patient’s informed consent must be obtained prior to any information transfer. CASA has developed a *Comprehensive Assessment Form* for use by joint assessment teams and is included in Part 3 of these guidelines.

A checklist to assist medical practitioners and AOD professionals with the first presentation in a joint assessment appears below.

- **Has client/patient brought with them:**
  - a copy of their AOD test result and other documentation associated with the test, including the reason for the test?
  - a list of their duties and responsibilities (i.e., job statement)?
  - work history, including absenteeism, any performance management undertaken, and involvement in accidents or serious incidents?
  - previous results of AOD tests (positive or negative)?
  - letter from their treating doctor advising current medications and health status?
  - a copy of their pre-employment medical information?
  - a signed consent form for release of information to their employer?

- **Has client/patient identified a preferred joint assessor?** Obtain contact details and consent for transfer of information between joint assessors.

- **If no identified joint assessor, ensure client understands the requirement for joint assessment and provide your contact details to the client/patient to pass on to the joint assessor when presenting.** Obtain consent for transfer of information between joint assessors.
Steps for the AOD Professional

As previously stated in these guidelines, there is no strict protocol for allocation of various aspects of the assessment to either of the treatment providers, or for the order in which the aspects are to be addressed. Note that it is recommended that the mental health assessment is performed by both the medical practitioner and the AOD professional.

A prompt to assist AOD professionals with the first steps in a joint assessment appears below.

- If the client has already commenced the assessment process, determine whether a Comprehensive Assessment Form has been received from the assessing medical practitioner.
- Assess client for signs of intoxication or withdrawal.
- Determine client’s AOD use career, including age of initiation, current use patterns and route of administration, previous treatment episodes.
- Explore the client’s psycho-social aspects, including family history, childhood and adolescent experiences, schooling, occupational history, relationships, legal issues, financial issues, housing status, leisure pursuits, risk-taking behaviours and support networks.
- Assess client’s readiness to change.
- Discuss with the client treatment options and identify treatment goals.
- Complete Comprehensive Assessment Form for transfer to medical practitioner.
- If the comprehensive assessment process is now complete, make contact with the medical practitioner to finalise assessment report.

Steps for the Medical Practitioner

There is no strict protocol for allocation of various aspects of the assessment to either of the treatment providers, or for the order in which the aspects are to be addressed. The mental health assessment should be performed by both the medical practitioner and the AOD professional.

A prompt to assist medical practitioners with the first steps in a joint assessment appears below.

- If the patient has already commenced the assessment process, determine whether a Comprehensive Assessment Form has been received from the assessing AOD professional.
- Conduct a physical examination of patient, with particular attention to indicators of hazardous or harmful AOD use. Examination should include vital signs, neurological observations, nutritional status, fluid balance, level of consciousness and signs of AOD intoxication or withdrawal.
- Ask patient about concurrent health conditions, medical and medication history.
- Urine or blood collection for analysis.
- Mental health assessment of patient.
- Prepare brief summary of assessment for discussion with AOD professional.
- If the comprehensive assessment process is now complete, make contact with the AOD professional to finalise assessment report.
**File building and information sharing**

To aid the joint assessment process, CASA has developed a *Comprehensive Assessment Form* (see Part 3 of these guidelines). The form is a file cover sheet which facilitates the recording and transfer of information between the members of the joint assessment team.

It is envisaged that as the client/patient moves from the first to the second assessor, all original and comprehensive notes from their assessment will remain with the assessing clinician, but a summary of information will be transferred to aid the second assessor in their assessment.

Note: Use of the Comprehensive Assessment Form is not mandatory, and assessing clinicians may use alternative vehicles and media for transfer of information in accordance with all usual protocols.

**Communication between the assessment team**

Under the regulations, the CASA MRO requires the joint assessment team to categorise the employee’s AOD use and recommend a treatment plan. To do this, members of the joint assessment team will need to jointly discuss their findings and agree on the most appropriate treatment options for the client/patient.

Communication between members of the assessment team may be in writing (including electronic communication), via telephone or face-to-face.

**Finalising assessment**

Following communications between the members of the joint assessment team, the assessment can be finalised. To finalise this, the joint assessors must agree on:

- Categorisation of the client’s/patient’s AOD use (non-problematic, hazardous or problematic);

When agreement has been reached between the members of the joint assessment team, they should then prepare a report for the CASA MRO [see ‘Reporting to the CASA MRO’ section of these guidelines].
Specialist Assessment Process

A comprehensive assessment by a specialist (that is, a psychiatrist or FACHAM) may be conducted in a single session, or over several sessions and the elements addressed in any order, but all elements of the comprehensive assessment must be considered.

Treatment Planning – conducted by psychiatrist, FACHAM, or AOD professional

A comprehensive assessment should lead to the identification of negotiated treatment goals, and an agreed treatment plan based on the intervention or combination of interventions most likely to result in the best possible health outcome for the client/patient. There is evidence that offering choices about treatment goals and strategies produces better outcomes and improves treatment retention.

The treatment plan will set short, medium and long term goals for treatment. These will include health progress, lifestyle issues, educational and training needs and family involvement (where appropriate). The treatment plan emphasises the relevant aspects of the intervention as appropriate for the person’s readiness to change AOD use, level of motivation, level of commitment, skills and goals for treatment.

The treatment plan should also note review dates for renegotiation. Treatment plans may need to be reviewed and renegotiated by a specialist clinician.

Treatment planning will be affected the availability of services and the motivation of the client. It may be that the only available treatment service is also the one at which the assessing clinician is employed. There is no regulatory barrier to a client undertaking treatment at the assessing agency where it can be demonstrated that this is the most appropriate option.

Referral

Recommendations for referral to the most appropriate setting and service will depend on the outcome of the comprehensive assessment. In particular, issues such as the client/patient’s preference regarding treatment, the severity and longevity of their AOD problem, geographic location, timely availability of services and individual responsibilities (such as child care arrangements), will need to be considered.

The client/patient does not have to remain with the clinician or agency which conducted the comprehensive assessment. CASA has no specific requirements regarding referral options.

Overleaf is a table of factors which may assist in decision-making regarding referral has been reprinted for educational purposes with permission, from ‘Alcohol, Tobacco and Other Drugs Guidelines for Nurses: Clinical Guidelines version 2. 2003. Flinders University, SA’.

22 COMPREHENSIVE ASSESSMENT GUIDELINES
### Factors Assisting Decision-Making Regarding Referral

<table>
<thead>
<tr>
<th>Factors</th>
<th>Primary care setting</th>
<th>Specialist services</th>
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<tbody>
<tr>
<td><strong>AOD history</strong></td>
<td>Occasional use</td>
<td>Chaotic poly-drug use</td>
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<td></td>
<td>Recreational users</td>
<td>Dependence greater than one year</td>
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<td></td>
<td>Lower levels of hazardous use</td>
<td>Methadone or buprenorphine assessment and therapy</td>
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<td></td>
<td>Dependence less than one year</td>
<td>Person’s request/choice</td>
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<tr>
<td><strong>Complications</strong></td>
<td>Stable psychiatric conditions</td>
<td>Unstable psychiatric condition</td>
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<td></td>
<td>Co-existing medical problems (eg diabetes, hypertension, infection, injury, HIV, HBV, HCV, acute illness, injury)</td>
<td>Pregnant or at special risk</td>
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<td></td>
<td>History of chronic AOD relapse or unsuccessful AOD treatment episodes</td>
<td>History of recent self-harm</td>
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<td></td>
<td>Blood-borne virus infection may be a reason to involve specialist services if unstable, or requiring specialist treatment. Most HCV would not interfere with primary care management of SUD.</td>
<td>Some other medical comorbidities, eg, unstable or severe liver/cardiac/respiratory/endoctrine/renal disease may require specialist input</td>
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<td><strong>Previous AOD treatment episodes</strong></td>
<td>No previous attempts to cease or reduce AOD use</td>
<td>History of poor AOD treatment outcomes</td>
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<td></td>
<td>Strong motivation to undergo intervention including withdrawal management</td>
<td>Poor home or family support system</td>
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<td></td>
<td>Willingness to access other appropriate services</td>
<td>Multiple agency involvement</td>
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<td></td>
<td>Drug use already stabilised by specialist services or GP</td>
<td>Undertaking current AOD treatment, eg methadone, chronic pain management, co-management for mental health disorder</td>
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<td></td>
<td>Family/support network</td>
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<td><strong>Social</strong></td>
<td>Employment/study commitments</td>
<td>Child care and safety concerns</td>
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<td>Financial resources</td>
<td>Homeless/unstable social circumstances</td>
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<td></td>
<td>Family responsibilities</td>
<td>Poverty, unemployment, poor supports</td>
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<td></td>
<td>Family/social and effective supports in place</td>
<td>Must be acceptable to culture and gender</td>
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<td></td>
<td>Being a volunteer, carer, or parent</td>
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<td></td>
<td>Not acceptable to go to a specialist service for cultural/gender reasons</td>
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For CASA purposes, recommendations from the comprehensive assessment assist decision-making regarding the aviation sector employee’s participation in an agreed treatment program. This decision-making is the responsibility of the CASA medical review officers (MRO). CASA MRO staff are qualified and registered medical practitioners.

With the informed consent of the client/patient, the CASA MRO requires the following information, in writing, from the treating clinician/s or agency:

1. classification, according to the categories specified in this document, of the nature of the employee’s AOD use;
2. concurrent health or mental health information that may be of relevance to decision-making about the employee’s capacity to perform safety sensitive aviation activities;
3. an assessment of the employee’s readiness to change;
4. the agreed treatment plan;
5. courses, programs, treatment, therapy or other assistance completed; and
6. the employee’s ongoing progress against the agreed treatment intervention/s

A realistic recommendation regarding capacity to return to work, which follows on logically from facts presented, is to be included.

**Other Issues**

**Intoxicated client/patient**

Clients/patients may present for assessment in an intoxicated state. In mild intoxication, all or part of assessment may be able to be completed. When intoxication is severe enough to preclude a meaningful comprehensive assessment the aviation sector employee should be advised to reschedule the appointment.

**Hostile or aggressive client/patient**

The circumstances by which aviation sector employees present for comprehensive assessment may result in an elevated anxiety level or low-level hostility, because they are concerned about their job and dealing with their AOD issue. They may feel that they have been coerced or harassed into attending the appointment.

The clinician can reduce anxiety skilfully working with the client in a quiet, relaxed and confident manner. You should minimise the number of staff attending to the client/patient and reassure the client/patient about the assessment, clearly explaining how it will be conducted.

If the level of the client/patient’s hostility becomes unacceptable, or if they become aggressive, you should advise them that the assessment will not proceed and another appointment should be scheduled unless there are concerns for the safety of the clinician. In this case the client will have to find an alternative practitioner.
### Substance Use Summary

<table>
<thead>
<tr>
<th>Drug category</th>
<th>Age first used</th>
<th>No. days used in last 30 days</th>
<th>Current frequency of use</th>
<th>Average daily amount</th>
<th>Amount of money spent per day</th>
<th>Route of administration</th>
<th>Last used</th>
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<td>Alcohol</td>
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<td>Other opioids</td>
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<td>Ecstasy or other pills</td>
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<td>Anabolic androgenic steroids</td>
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</table>

**Principal drug of concern:**

**Route of administration:**

### Substances used in the last three days:

<table>
<thead>
<tr>
<th>Drug name</th>
<th>Amount used</th>
<th>Frequency</th>
<th>Route of administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Today:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Yesterday:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Day before:</td>
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</tbody>
</table>

**Longest period of abstinence since commencement of use:** yrs mths days
# Mini Mental State Examination

<table>
<thead>
<tr>
<th>Task</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Orientation</strong></td>
<td></td>
</tr>
<tr>
<td>Year, month, day, date ,season</td>
<td>/5</td>
</tr>
<tr>
<td>Country, state, town, suburb, street address</td>
<td>/5</td>
</tr>
<tr>
<td><strong>Registration</strong></td>
<td></td>
</tr>
<tr>
<td>Examiner states three objects [eg orange key ball]. Patient asked to repeat the three objects. Score one for each answer. Ask the patient to repeat all three names three times.</td>
<td>/3</td>
</tr>
<tr>
<td><strong>Attention</strong></td>
<td></td>
</tr>
<tr>
<td>Subtract 7 from 100 then repeat from result. Stop after 5: 93, 86, 79, 72, 65. If patient makes errors, spell ‘world’ backwards D L R 0 W. Score best performance on either task.</td>
<td>/5</td>
</tr>
<tr>
<td><strong>Recall</strong></td>
<td></td>
</tr>
<tr>
<td>Ask for the names of the objects learned earlier.</td>
<td>/3</td>
</tr>
<tr>
<td><strong>Language</strong></td>
<td></td>
</tr>
<tr>
<td>Name a pencil and a watch.</td>
<td>/2</td>
</tr>
<tr>
<td>Repeat ‘No ifs, ands, or buts’.</td>
<td>/1</td>
</tr>
<tr>
<td>Give a three-stage command. Score one for each stage [eg 'Take this piece of paper in your right hand, fold it in half and place on the chair next to you'].</td>
<td>/3</td>
</tr>
<tr>
<td>Ask patient to read and obey a written command on a piece of paper stating: 'Close your eyes'.</td>
<td>/1</td>
</tr>
<tr>
<td>Ask patient to write a sentence. Score correct if it is sensible and has a subject and a verb.</td>
<td>/1</td>
</tr>
<tr>
<td><strong>Copying</strong></td>
<td></td>
</tr>
<tr>
<td>Ask patient to copy intersecting pentagons [below]. Score as correct if they overlap and each has five sides.</td>
<td>/1</td>
</tr>
</tbody>
</table>

**Total Score** /30
Use this checklist to make sure you have the documents you need when you attend your Comprehensive Assessment Interviews.

You will need to take a copy of the following documents when you go to your AOD Professional and your Medical Practitioner.

- A copy of your AOD test result
- Any other documentation associated with the test, including the reason for the test
- A list of your duties and responsibilities (i.e. a job statement)
- Work history covering the following information:
  - dates of employment (i.e. from / to)
  - organisation
  - reason for leaving
  (Note: You can use page 2 of this checklist to record your work history)
- A report from your HR Manager or Supervisor covering details of any absenteeism, any performance management undertaken, and involvement in accidents or serious incidents
- Previous results of AOD tests (positive or negative)
- Letter from your GP advising current medications and health status
- A copy of your pre-employment medical information

Steps in the process — What you need to do...

Step 1 — Gather the documents you need to take to your interviews (as above).

  Note: You need to take a copy of your documents to both the AOD Professional and the Medical Practitioner when you attend your appointments.

Step 2 — Attend your appointment with the AOD Professional.

  The AOD Professional will discuss the steps in the process with you and ask you to complete a Consent to Release Information form.

  You will then have a discussion with the AOD Professional and be asked a series of questions.

Step 3 — Attend your appointment with the Medical Practitioner.

  The Medical Practitioner will conduct a physical examination, including a urine or blood sample, and discuss your health conditions, medical and medication history with you.

What happens next?

After you have attended the appointments with the AOD Professional and Medical Practitioner, they will prepare an assessment report and provide it to CASA’s Medical Review Officer for assessment.
<table>
<thead>
<tr>
<th>Dates of employment</th>
<th>Organisation</th>
<th>Reason for leaving / changing positions</th>
</tr>
</thead>
<tbody>
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</table>
### Comprehensive Assessment Guidelines

**AOD Professional’s Checklist**

<table>
<thead>
<tr>
<th>Safety worker’s name</th>
<th>Given name(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family name</td>
<td></td>
</tr>
<tr>
<td>Agency assigned ID</td>
<td></td>
</tr>
</tbody>
</table>

1. **On initial presentation to you the safety worker should bring with them:**
   - a copy of their AOD test result and other documentation associated with the test, including the reason for the test
   - a list of their duties and responsibilities (i.e. a job statement)
   - work history, including absenteeism, any performance management undertaken, and involvement in accidents or serious incidents
   - previous results of AOD tests (positive or negative)
   - letter from their treating doctor advising current medications and health status
   - a copy of their pre-employment medical information

2. **Establish whether the safety worker has identified a Medical Practitioner for joint assessment?**
   If not, ensure they understand the requirement for joint assessment and provide your contact details to the safety worker to pass on to the Medical Practitioner when presenting

3. **Obtain the safety worker’s consent for transfer of information between joint assessors using the Consent to Release Information (Form 1)**
   Also ask the safety worker to read the General Privacy Provisions

4. **Conduct assessment**
   - Assess safety worker for signs of intoxication or withdrawal
   - Assess their AOD use career, including age of initiation, current use patterns and route of administration, previous treatment episodes
   - Explore their psychosocial aspects, including family history, childhood and adolescent experiences, schooling, occupational history, relationships, legal issues, financial issues, housing status, leisure pursuits, risk-taking behaviours and support networks
   - Assess their readiness to change
   - Discuss with the safety worker treatment options and identify treatment goals

5. **Complete Part A of the Comprehensive Assessment Record (Form 2) and the Family History – Genogram (Form 3) and send Forms 1, 2 and 3 to the Medical Practitioner**
   - Form 1 sent / /
   - Form 2 sent / /
   - Form 3 sent / /
   - Fax ☐ Email ☐ Post ☐

6. **Receive Comprehensive Assessment Record (Form 2) from Medical Practitioner**
   - Form 2 received / /
   - Complete Part C of the Comprehensive Assessment Record (Form 2), sign and return to Medical Practitioner for signature
   - Form 2 returned / /
   - Fax ☐ Email ☐ Post ☐

7. **Receive Comprehensive Assessment Record (Form 2) from Medical Practitioner**
   - Form 2 received / /
   - Forward completed forms 1, 2 and 3 and any attachments (reports, diagnostic instruments etc) to identified Medical Review Officer
   - All to MRO / /
   - Fax ☐ Email ☐ Post ☐

### Design date 03/10
## Comprehensive Assessment

**Medical Practitioner’s Checklist**

### Safety worker’s name
- **Family name**
- **Given name(s)**
- **Agency assigned ID**

### 1. Receive the Consent to Release Information (Form 1), Comprehensive Assessment Record (Form 2) and Family History – Genogram (Form 3) from AOD Professional

<table>
<thead>
<tr>
<th>Form 1 received</th>
<th>Form 2 received</th>
<th>Form 3 received</th>
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<tbody>
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</table>

### 2. On initial presentation to you the safety worker should bring with them:

- a copy of their AOD test result and other documentation associated with the test, including the reason for the test
- a list of their duties and responsibilities (i.e. a job statement)
- work history, including absenteeism, any performance management undertaken, and involvement in accidents or serious incidents
- previous results of AOD tests (positive or negative)
- letter from their treating doctor advising current medications and health status
- a copy of their pre-employment medical information

### 3. Review Part A of the Comprehensive Assessment Record (Form 2) and conduct examination

- Complete Part B of Form 2 and return to the AOD Professional

<table>
<thead>
<tr>
<th>Form 2 returned</th>
<th>Fax</th>
<th>Email</th>
<th>Post</th>
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<tbody>
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</table>

### 4. Receive Comprehensive Assessment Record (Form 2) from AOD Practitioner

- Review Form 2, sign at Part C and return to the AOD Professional

<table>
<thead>
<tr>
<th>Form 2 returned</th>
<th>Fax</th>
<th>Email</th>
<th>Post</th>
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<tbody>
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</table>
General Privacy Provisions
Information you provide will be treated in the following way:
• identifiable information will not be divulged without your written consent, and
• the Civil Aviation Safety Authority and/or your employer may have access to your information after it is made identifiable.

Exceptions provided by Privacy Law
The exceptions to the laws concerning confidentiality are:
• child abuse/spouse abuse, and
• the life or safety of you or another person.

Consent to release information
Safety worker’s name
Family name
Given name(s)
Agency assigned ID

I, the undersigned, consent to the disclosure to all members of the assessment team, a DAMP organisation, a CASA medical review officer, and my treating clinician(s) of:
1. any medical or workplace information relating to me which is held by a registered medical practitioner, psychologist, alcohol and other drugs professional, hospital or other organisation.
2. any information about convictions for alcohol or substance abuse from any organisation who may hold such information.

In addition, I consent to the disclosure of information contained in my health records or other relevant personal information from any of the clinicians referred to above to my employer for the following purposes:
1. to enable my employer to make decisions about the timing of my return to safety sensitive work;
2. to ensure that my employer allocates me appropriate duties at work taking into account my medical situation;
3. to facilitate future treatment and rehabilitation, if necessary.

I understand this consent will remain valid until revoked by me in writing.

Signatures
Signature of safety worker

Date

Signature of witness

Full name
Position
Circumstances of positive test

State the circumstances surrounding the positive test

Occupational history

How long has the safety worker been in the aviation sector?

What is it that they do?

Do they enjoy their job and for what reasons?

Ask them to describe their work history — what were they doing before working in the aviation sector, and before that etc?
Family history

Are there any particular family concerns, problems or special circumstances that the safety worker feels are relevant to their AOD use or this Assessment, including cultural/ethno-specific issues?

No ☐ Yes ☐

Do they have family networks that encourage continuing problematic AOD use?

No ☐ Yes ☐

Ask about the quality of various family relationships and the role of the family in convincing them to seek help:

Complete the Family History — Genogram (Form 3).

Childhood experiences (including primary schooling)

Ask the safety worker to describe their childhood — do they recall it being a happy or difficult time and for what reasons?

What about their primary school experience

Did they regularly attend school?

No ☐ Yes ☐

Did they have any difficulties at school with learning, social relationships, teachers etc?

No ☐ Yes ☐
Adolescent experiences (including secondary schooling)

Ask the safety worker to describe their adolescence — do they recall it being a happy or difficult time and for what reasons?

What about their secondary school experience

Did they regularly attend school? No □ Yes □

When did they leave school?

Did they have any difficulties at school with learning, social relationships, teachers etc? No □ Yes □
Relationships

Are there any particular sexual/relationship concerns, problems or special circumstances that the safety worker feels are relevant to their AOD use or this Assessment?

No ☐ Yes ☐

Ask about how they feel their AOD use might have affected relationships with their spouse or partner:

Comments

Legal issues — past or current convictions and engagement in criminality

Are there any charges pending, or bail conditions, against the safety worker?

No ☐ Yes ☐ Explore any current offences, including the circumstances, attitude to the offence, and consequences

Ask about their legal history including any past imprisonment:

Are there any issues relating to Family Court, Children’s Court, or any Court Orders?

No ☐ Yes ☐ Establish the conditions of the Orders

Does the safety worker have a history of violence or present a risk to others (including assault, domestic violence, threats to kill, sexual offences, offences against other persons especially children, driving under the influence)?

No ☐ Yes ☐

Is there a current risk to the safety worker from others?

No ☐ Yes ☐
Financial and housing information

Establish the safety worker's accommodation arrangements (where, with whom, etc).

Is this a stable situation?  No ☐ Yes ☐
Is there problematic AOD use in the household?  No ☐ Yes ☐
Does the safety worker have financial concerns?  No ☐ Yes ☐
  What is the impact of AOD use on these concerns?

Are there any debt issues?  No ☐ Yes ☐
  What steps have been taken to address these?

Comments

Leisure pursuits (past and present)

Ask the safety worker how they spend their time away from work — what do they enjoy doing on weekends, in the evenings, during leave etc?

Are there any activities that they used to do that they can’t do anymore?  No ☐ Yes ☐
  What were they?
  Do they regret no longer doing these things?  No ☐ Yes ☐
  Would they like to take them up again?  No ☐ Yes ☐

- Medical in Confidence when filled -
Leisure pursuits continued

Is there anything they have never tried that they think they might like to try?
Yes/No □ □ □ What is it?

Are any of their leisure pursuits facilitating their AOD use?
Consider hobbies, sports, gym, music, reading, fishing, clubs, motor sports, nightclubs, gambling etc.
Yes/No □ □ □ Give details

Risk-taking behaviours (including sexual and IDU)
Is the safety worker engaged in risk-taking behaviours?
Yes/No □ □ □ How are these linked to their AOD use (e.g., risk-taking only when intoxicated, risk taking in order to finance AOD use)?

Are they concerned about this? Yes/No □ □ □
Has anyone else expressed concern? Yes/No □ □ □

Support networks
Ask the safety worker about their support networks. These may include family members, friends, colleagues, neighbours, health/social health and other service providers, and self-help groups. Different people offer different sorts of support.
Ask the safety worker what sort of support each can be relied upon to provide.

Family name and ID: ___________________________
Basic personality

Exploration of how the safety worker sees him or herself assists with ascertaining some indication of self-esteem and sociability, and can be used to help with achieving goals.

Current strengths (as described by the safety worker):

Clinician's assessment (only if clinician has known the safety worker prior to commencement of this Assessment):

Current weaknesses (as described by the safety worker):

Clinician's assessment (only if clinician has known the safety worker prior to commencement of this Assessment):
Mental health

Exploration of the safety worker's mental health and mental state assists with understanding the development (causal or consequential) and possible self-medicating functions of AOD use. Co-existing mental illness will influence treatment protocol and may necessitate referral to an appropriate mental health service provider.

Are there any current problems in need of immediate attention/referral?

No ☐ Yes ☐ Give details including, where possible, history of condition, investigations and treatments:

Is there a past relevant psychological history, or symptoms relating to depression, anxiety or phobia?

No ☐ Yes ☐ Give details:

Do they take any medication relevant to their mental health and mental state?

No ☐ Yes ☐ Give details including the name of the medication, doses, the prescriber and the date and time of the last dose:

Do they take the medication in accordance with the doctor's instructions?

No ☐ Yes ☐

Mental state

Note the safety worker's general appearance and behaviour, observations about their affect and mood, and whether their thoughts are ordered, reasonable, and realistic. Also note whether they are experiencing hallucinations (visual, auditory, tactile), illusions, or perceptual distortions, and whether they demonstrate appropriate insight.

General appearance and behaviour (allure, grooming, movements, speech, attitude to examiner):

Affect and mood (quality, range, appropriateness):

--- Medical in Confidence when filled ---
### Mental state continued

**Thought** (form, content, delusions, suicidal or homicidal ideas)

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
</tr>
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<tbody>
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</tbody>
</table>

**Perception** (hallucinations, illusions, perceptual distortions)

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
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</table>

**Insight**

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<th>Question</th>
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</table>

### Mini Mental State Examination

**Orientation** Year, Month, Day, Date, Season

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
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Country, State, Town, Suburb, Street address

<table>
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<tr>
<th>Question</th>
<th>Score</th>
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</table>

**Registration** Examiner states three objects (e.g., orange, key, ball). Safely worker asked to repeat the three objects. Score one for each answer. Then ask them to repeat all three names three times.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
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<tbody>
<tr>
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</tbody>
</table>

**Attention** Subtract 7 from 100 then repeat from result. Stop after 5: 90, 86, 79, 72, 65. If safety worker makes errors, spell ‘world’ backwards D L R O W. Score best performance on either task.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
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<tbody>
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</table>

**Recall** Ask for the names of the objects learned earlier

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
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</table>

**Language** Name a pencil and a watch

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
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</table>

Repeat ‘No ifs, ands, or buts’

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
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</table>

Give a three stage command (e.g., ‘Take this piece of paper in your right hand, fold it in half and place on the chair next to you’). Score one for each stage.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
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</table>

Ask safety worker to read and obey a written command on a piece of paper stating: ‘Close your eyes’

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
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</table>

Ask safety worker to write a sentence. Score correct if it is sensible and has a subject and a verb.

<table>
<thead>
<tr>
<th>Question</th>
<th>Score</th>
</tr>
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</table>

**Copying** Ask safety worker to copy intersecting pentagons (below). Score as correct if they overlap and each has five sides.

Total score /30

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*Medical in Confidence when filled*
<table>
<thead>
<tr>
<th>Drug category</th>
<th>Age first used</th>
<th>No. days used in last 30 days</th>
<th>Current frequency of use</th>
<th>Average daily amount</th>
<th>Amount of money spent per day</th>
<th>Route of administration</th>
<th>Last used</th>
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</thead>
<tbody>
<tr>
<td>Alcohol</td>
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<tr>
<td>Methadone or buprenorphine</td>
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<tr>
<td>Methadone or buprenorphine</td>
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<td>Other opioids</td>
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<tr>
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<td>Hallucinogens</td>
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<td>Ecstasy or other pills</td>
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<tr>
<td>Nicotine</td>
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<td>Anabolic androgenic steroids</td>
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<td>Anaesthetics</td>
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<td>Caffeine</td>
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<td>Volatile liquids</td>
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<td>Other</td>
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</tbody>
</table>

Principal drug of concern: [ ]
Route of administration: [ ]
Last used: [ ]
Amount: [ ]

Substances used in the last three days

<table>
<thead>
<tr>
<th>Day</th>
<th>Drug name</th>
<th>Amount used</th>
<th>Frequency of use</th>
<th>Route of administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Today</td>
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<tr>
<td>Yesterday</td>
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<td>Day before</td>
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</table>

Longest period of abstinence since commencement of AOD use: yrs, mins, days

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Medical in Confidence when filled

Page 11 of 19
**Clinician’s comments regarding AOD use career and previous treatment/support**
This section allows space for further information if required.
It is useful to record how previous treatment/support options worked or did not work for the safety worker.

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**Other issues pertaining to AOD use**
What is the safety worker’s usual place of AOD use, e.g. party, home, nightclub?

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Do they use alone or with others?      
- Alone [ ]  
- With others [ ]  
- Both [ ]

Explore with the safety worker the consequences of use — ask them to describe in terms of the four ‘Ls’: liver (health), lover (relationship), legal and lifestyle.

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**Readiness to change**

- **Precontemplation** [ ]: Safety workers in this stage are not interested in changing their AOD use. For some, the positives of continued use may vastly outweigh the negatives. Alternatively, for some the negatives of change outweigh the positives.

- **Contemplation** [ ]: Safety workers in this stage gain many benefits from their alcohol and drug use, however there are rising costs that prompt them to start thinking about change. They have not, though, made a firm decision to do so.

- **Preparation** [ ]: During this stage the safety worker has made a decision to change and is planning how to put it into effect. They will need to consider some of the actions they will take to change their behaviour as well as recognising those things that will tempt them to relapse.

- **Action** [ ]: Safety workers in this stage are changing their AOD use behaviour. They are generally putting a lot of energy into replacing the AOD using lifestyle by developing new interests and activities. They can get bored and disillusioned and can also feel very isolated, anxious and difficult to relate to the non-using world.

- **Maintenance** [ ]: During this stage the safety worker will have maintained changed behaviour for a period of six months and be focused on maintaining the positive change they have made to their lifestyle.
### Safety worker’s goals regarding AOD use and treatment

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<th>Comments</th>
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</table>
PART B — Medical Practitioner to complete (pages 14 — 19)

Medical history

Safety worker’s physical health (past and present)

Are there any current problems in need of immediate attention/referral (not including mental health conditions)?

No ☐ Yes ☐

Tick all that apply and give details including, where possible, history of condition, investigations and treatments:

- Allergies ☐
- Gastrointestinal problems ☐
- Cardiovascular problems ☐
- Diabetes ☐
- Seizures / fits / epilepsy ☐
- Cardiac problems ☐
- Pregnancy ☐
- Liver disease ☐
- Respiratory (e.g. asthma) ☐
- Information/Education ☐
- Dental ☐
- Chronic pain ☐
- Other — specify ☐
- Head injuries (including loss of consciousness from accidents, assaults, non-fatal overdose, past suicide attempts, nyctopia) ☐
- Organic Brain Syndrome ☐
- Skeletal injuries ☐

Ask about past relevant medical history

Have they ever been admitted to hospital (including ambulance attendances)?

No ☐ Yes ☐

Give details including date, hospital, reason for admission, length of stay

Have they ever lost consciousness as a result of their AOD use?

No ☐ Yes ☐

What happened?

— Medical in Confidence when filled —
Safety worker’s physical health (past and present) continued

Ask about the impact of their AOD use on their general health, weight, appetite, nutrition, sleep pattern:

Do they take any medication (including OTCs)?

No ☐ Yes ☑ Give details including the name of the medication, doses, the prescriber and the date and time of the last dose.

Do they take the medication in accordance with the doctor’s or pharmacist’s instructions?

No ☐ Yes ☑

Are they engaged in high-risk behaviour for BBV?

No ☐ Yes ☑ Have testing options been discussed?

No ☐ Yes ☑

How well do they sleep and has there been any recent change?

How is their appetite and has there been any recent change?

How is their licido and has there been any recent change?
### Physical Examination

<table>
<thead>
<tr>
<th>Parameter</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Height (cm)</td>
<td></td>
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<tr>
<td>Weight (kg)</td>
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<tr>
<td>Nutritional State</td>
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<tr>
<td>Skin</td>
<td>Scars [ ]</td>
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<td></td>
<td>Tattoos [ ]</td>
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<tr>
<td>Blood Pressure - Sitting (mmHg)</td>
<td>/</td>
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<tr>
<td>Pulse</td>
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<td>Respiration</td>
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<td>Temperature °C</td>
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<tr>
<td>BAC %</td>
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<tr>
<td>Pupil Size (mm)</td>
<td>1mm [ ]</td>
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<td></td>
<td>2mm [ ]</td>
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<td>3mm [ ]</td>
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<td>4mm [ ]</td>
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<td>5mm [ ]</td>
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<td>6mm (or more) [ ]</td>
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<tr>
<td>Injection Sites</td>
<td>Recent [ ]</td>
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<td></td>
<td>Chronic [ ]</td>
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<tr>
<td>Consistent with stated history?</td>
<td>No [ ]</td>
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<td></td>
<td>Yes [ ]</td>
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<tr>
<td>Alcohol Use</td>
<td>Signs of chronic liver disease? No [ ]</td>
</tr>
<tr>
<td></td>
<td>Yes [ ]</td>
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<tr>
<td>Liver Span (cm)</td>
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<tr>
<td>Neurological</td>
<td>Cerebellar ataxia [ ]</td>
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<td>Peripheral neuropathy [ ]</td>
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<td>Nystagmus [ ]</td>
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<td></td>
<td>Romberg's sign [ ]</td>
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<td>General Examination</td>
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<tr>
<td>Pregnancy</td>
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</tbody>
</table>

#### Do they appear to be intoxicated?

- Not intoxicated
- Moderately intoxicated
- Severely intoxicated

#### Do they appear to be in withdrawal?

- Not withdrawing
- Moderate withdrawal
- Severe withdrawal

### Other information relevant to the physical examination

### Blood and/or urine specimen analysis

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*Medical in Confidence when filled*
Mental health

Exploration of the safety worker’s mental health and mental state assists with understanding the development (causal or consequential) and possible self-medicating functions of AOD use. Co-existing mental illness will influence treatment protocol and may necessitate referral to an appropriate mental health service provider.

Are there any current problems in need of immediate attention/referral?

No ☐ Yes ☐ ▶ Give details including, where possible, history of condition, investigations and treatments.

Is there a past relevant psychological history, or symptoms relating to depression, anxiety or phobia?

No ☐ Yes ☐ ▶ Give details.

Do they take any medication relevant to their mental health and mental state?

No ☐ Yes ☐ ▶ Give details including the name of the medication, doses, the prescriber and the date and time of the last dose.

Do they take the medication in accordance with the doctor’s instructions? No ☐ Yes ☐

Mental state

Note the safety worker’s general appearance and behaviour, observations about their affect and mood, and whether their thoughts are ordered, reasonable, and realistic. Also note whether they are experiencing hallucinations (visual, auditory, tactile), illusions, or perceptual distortions, and whether they demonstrate appropriate insight.

General appearance and behaviour (attire, grooming, movements, speech, attitude to examiner)

Affect and mood (quality, range, appropriateness)
Comprehensive Assessment Guidelines

Mental state continued

Thought (form, content, delusions, suicidal or homicidal ideas)

Perception (hallucinations, illusions, perceptual distortions)

Insight

Mini Mental State Examination

**Orientation**
Year, Month, Day, Date, Season
Country, State, Town, Suburb, Street Address

**Registration**
Examiner states three objects (e.g., orange, key, ball). Safely worker asked to repeat the three objects. Score one for each answer. Then ask them to repeat all three names three times.

**Attention**
Subtract 7 from 100 then repeat from result. Stop after 5, 93, 86, 79, 72, 65.
If safely worker makes errors, spell 'world' backwards D L R O W.
Score best performance on either task

**Recall**
Ask for the names of the objects learned earlier

**Language**
Name a pencil and a watch
Repeat 'No ifs, ands, or buts.'
Give a three stage command (e.g., 'Take this piece of paper in your right hand, fold it in half and place on the chair next to you'). Score one for each stage.
Ask safely worker to read and obey a written command on a piece of paper stating: 'Close your eyes.'
Ask safely worker to write a sentence.
Score correct if it is sensible and has a subject and a verb.

**Copying**
Ask safely worker to copy intersecting pentagons (below).
Score as correct if they overlap and each has five sides.

Total score

[Medical in confidence when filled]
PART C — AOD Professional to complete after Parts A and B have been completed

Note: Part C should be completed by the AOD Professional and signed by the AOD Professional AND the Medical Practitioner.

**Categorisation of AOD use (mark one only)**  
Non-problematic  
Hazardous  
Problematic

**Treatment recommendation (activities as determined at assessment by the AOD professional)**

- Assessment only
- Information and education only
- Counseling
- Structured rehabilitation  
  - Residential  
  - Non-residential
- Withdrawal management  
  - Inpatient  
  - Outpatient  
  - Home
- Pharmacotherapy
- Specialist referral (including Neuropsychological / Psychiatric)
- Other  
  - Give details

**Treatment plan**

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**Signatures**

- Signature of AOD Professional
- Full name
- Signature of Medical Practitioner
- Full name

When returning this form to the MRO attach copies of any investigations undertaken and any screening or diagnostic instruments used.

---

- Medical in Confidence when filled —
Family History — Genogram

A genogram identifies the family relationships in a safety worker’s life through graphic representation. It is useful to include all members of their immediate family, and extended family members such as grandparents, where they are perceived as important by the safety worker.

- Female
- Male
- Marriage
- Separated
- Divorced
- De facto
- Children
- Twins
Attach copies of any investigations undertaken and any screening or diagnostic instruments used.

Screening instruments can be used during assessment of problematic AOD use to indicate the likelihood of a diagnosis or level of AOD problem. Other screening instruments are useful for detecting psychological disorders such as depression, anxiety and other mental health problems. The presence of co-existing psychiatric or psychological problems is likely to impact on the success of treatment services.

In a comprehensive review of diagnostic screening instruments for AOD use and other psychiatric disorders conducted jointly by the School of Applied Psychology Griffith University, Department of Psychiatry University of Queensland, National Drug and Alcohol Research Centre for the Commonwealth Department of Health and Ageing in August 2002, it is noted that ‘most screening instruments are sensitive to low-level misuse of a substance, but are less sensitive to determining a range of use and dependence (i.e., they have a ceiling effect). Therefore screening instruments are most suitable for research in the general population and for detecting the presence of potential abuse and dependence. Conversely, measures of severity of dependence are often insensitive to low-level use and are most appropriately used with clients with established dependence, and to monitor treatment outcomes.

Frequency/quantity measures are most useful clinically for diagnostic purposes and determining treatment goals. Biochemical measures are both expensive and often insensitive. However, there may be a role for their use if external validation of recent use is necessary. Quantity/quantity and biochemical measures provide measures of drug and alcohol use, but fail to provide information on negative psychological, occupational, social and physical consequences—information that is particularly important to treatment planning’.


SECTION 4: ATTACHMENTS