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INTRODUCTION

In December 2016, the Victorian Government Department of Health and Human Services engaged Turning Point to refresh the standard adult alcohol and drug screening and assessment tools developed in 2013. The project began with an initial sector wide online survey which informed an initial draft of the tools, which was further refined with sector consultation through a series of regional and metropolitan workshops. The **self-complete initial screen for AOD problems** tool has been replaced with a **Victorian AOD intake tool** and the **AOD comprehensive assessment** now includes **self-completion form**. These tools were rolled out mid-year 2017 with state-wide training in both metropolitan and regional locations.

The Department of Health and Human Services committed to regularly reviewing these tools, and this current version was released following feedback from the sector in August 2018.

**What is the purpose of this clinician guide?**

This is a guide to using the refreshed AOD intake and assessment tools with clients. It explains how the instrument was developed and why items have been included. It also has been developed to support intake and assessment workers collecting information from clients, offering guidance on how to elicit and capture some of the more sensitive information whilst maximising rapport.

**Why refresh the AOD screening and assessment instrument?**

The current screening tool and assessment (core module) used in AOD services were revised and refreshed to ensure tools:

1. are fit for purpose
2. accurately identify client needs and inform treatment planning
3. support clinician decision-making
4. support the changes announced in December 2016 in relation to the new intake and assessment process commencing 1 July 2017
5. are more appropriate for a range of clients, including Aboriginal and Torres Strait Islander people, Culturally and Linguistically Diverse (CALD), Lesbian, Gay, Bisexual, Trans and gender diverse, Intersex Queer/Questioning and Asexual (LGBTIQ) communities.
6. streamline information collection for services by integrating Victorian Alcohol and Other Drug Collection (VADC) screening and assessment data into the form

**The intake tool:**

The intake tool provides the necessary information (e.g. dependence, level of risk, harm etc.) to support your clinical judgement in making referrals to appropriate services. One function of intake is to engage the client and to discuss what they can expect from specialist AOD treatment. The refreshed intake tool has been designed to be more appropriate for a range of delivery settings including for clinicians to complete with clients over the phone.
The assessment tool:
The function of the compressive assessment is to provide further detail on the broader context of AOD use and to inform treatment planning. The assessment will also gather baseline data needed for performance management activity (i.e., client outcomes), for clients who are likely to need specialist AOD treatment.

Comprehensive assessment is used as to determine the level and type of treatment and support required by presenting clients. Those providing assessment use the department-endorsed comprehensive assessment tool and clinical judgement, with the support of clinical supervision.

Comprehensive assessment ensures that a client’s comprehensive treatment needs are adequately understood so that they can access the services most suitable to their needs. Optional assessment modules provide a detailed understanding of particular strengths, issues or experiences that may have been flagged intake or assessment, or that may require further consideration.

Practitioners providing assessment develop an initial treatment plan for all clients that forms part of a package of referral information provided to services engaged in the client’s treatment pathway.

Steps to treatment planning and review

There are two stages before treatment goals are set. This approach involves:

Step 1: The intake tool is administered by the clinician with the client. This may occur over the phone, or be face to face e.g. for drop-in clients. At the end of step 1, the clinician determines whether comprehensive assessment and additional treatment and support is necessary and/or if motivational interviewing or a brief intervention would be helpful in the interim.

Step 2: If further assessment is needed (i.e., the client has harmful or dependent AOD use, risk, and other complexity factors etc.), the client should undergo a comprehensive assessment. At the beginning of assessment, the client is required to fill in a self-completion form which includes baseline data for client outcome monitoring, including substance use, health and wellbeing, (ATOP, AUDIT, DUDIT, K10). If necessary, a clinician may assist in the completion of the self-completion form.

Following the completion of the self-completion form, comprehensive assessment is undertaken. This can only be completed by a specialist AOD clinician. It contains a 19-page core component comprising six sections including Alcohol and other Drugs, Psychosocial, Medical History, Mental Health, Current Prescribed Medications, Risk, and a Final Case Summary Sheet. Optional assessment modules are also included but are not compulsory for most clients. Optional Module 12 (Forensic) is required for forensic ‘diversion’ clients referred from courts or court support programs such as the Court Integrated Services Program (CISP).

The information gathered from Steps 1 and 2 is synthesised in a Final Case Summary Sheet, which can then be used to fill in your agency’s care planning form, and for the purpose of onward referral.
**Step 3:** Page 1 of the self-completion form and the K10 can be completed again after a minimum of four weeks after the assessment to see how the client is progressing compared to when they were first assessed. The information provided in this form is used to monitor client progress as part of performance management (and replaces the old review tool) and meets the data specification requirements for this activity.

Figure 1 provides a detailed picture of the main steps of the process and how it is envisaged that the process might work.
Figure 1: Detailed overview of process

**STEP 1**

1) **Intake tool**
   a) Administer intake tool, including questions on demographics, reason for call/visit, AOD use and risk.
   b) Decide if a comprehensive assessment is needed or if not, complete preliminary case summary sheet

Also consider providing:
- MI/BI
- Education/health promotion
- Linking/referring to community groups and/or other services
- Family support

**STEP 2**

2) **Comprehensive assessment (and self-complete)**
   a) Check and clarify information gathered in intake
   b) Client completes self-complete form (if necessary you may assist)
      includes: outcome monitoring questions ATOP, AUDIT, DUDIT, K10
   c) Clinician to check and score and include score in final case summary
   d) Complete core component of the assessment: AOD, mental health, medical history, psychosocial and risk
   e) Complete any optional modules as desired
   f) Complete final case summary sheet and use this to fill out your agency’s care plan

Also consider providing:
- Agency care-plan.
- Develop treatment goals
- Agree on goals
- Agree on review points
- Links and referrals to wraparound services

**STEP 3**

3) **Review**
   a) Repeat page 1 of the self-complete form and K10
   b) Compare with self-complete form prior to treatment
   c) Inform client of their progress
   d) Review and modify care plan accordingly

Minimum of 4 weeks after assessment or longer
How does the instrument fit into existing local service processes?
The instrument was designed as a core minimum, which can be built upon. This means that processes such as client consent to share information, risk assessment, or specific intake processes that your service has, will still be completed as usual. It also means that you can still use your agency’s preferred intake and assessment tools alongside this new instrument.

VADC Data collection requirements of DHHS have been embedded across all of the tools.

As each service is different and has their own processes and procedures, services are in the best position to decide how the instrument will fit with their own existing processes. However, you will find some guidance on implementation throughout this document.

DEVELOPMENT OF THE INSTRUMENT
Phase 1 of the project began with a sector wide survey to inform initial revisions of the tools. The survey gathered the opinions and experiences of intake and assessment workers and treatment providers. Particular emphasis was placed on any suggestions from clinicians on content and phrasing of items to ensure that the tool is appropriate for a diverse range of clients. The initial online survey garnered feedback from 37 services across Victoria. Feedback on the intake tool included:

- Needs to be shorter and more engaging
- Needs to be more ‘telephone friendly’
- Needs to draw on clinical judgement more
- Needs to provide more information in some areas (e.g. risk etc.)
- Phrasing needs to be a little more sensitive
- Desire for more open-ended approach

Feedback on the assessment tool included:

- Needs to be more engaging
- Remove any repetition between screen and assessment
- Add a ‘safety plan’ following suicide risk section
- Allow for a larger range of potential responses, include specific examples following Q’s
- Include a comprehensive clinician guide to lessen assessor burden
- Phrasing needs to be a little more sensitive and inclusive

This information informed initial revisions of current tools, which included significantly reducing the number of items at intake, eliminating duplicate questions, allowing greater flexibility in how information is elicited from the client, greater reliance on clinical judgement and moving standardised measures (ATOP, K10, AUDIT and DUDIT) to a self-completion form in assessment.

Phase 2 of the project involved nine workshops with over 114 attendees from 40 services across metropolitan and regional locations in Victoria. Consultation with specialist groups (including Victorian Aboriginal Community Control Health Organisation, Victorian AIDS Council, Family Violence, and the Victorian Alcohol & Drug Association) was sought to ensure tool was fit for a diverse range of clients.

Feedback from workshops was incorporated into the tools and presented to the following workshop, thereby building a more refined set of tools with each workshop.
In phase 3, the final draft of the tools underwent minor revisions following feedback from all workshop attendees, a review by experienced senior clinicians and DHHS to support alignment with VADC. Sector-wide training workshops in regional and metropolitan Victoria were held to present the new tools and to provide guidance in their administration. The training workshops also gathered input from workers on the content of this ‘clinician guide’.

**SUMMARY OF MAJOR FEATURES OF THE INSTRUMENT**

**Evidence based**
Standardised measures that have high reliability, validity and client acceptance have been included in the self-complete form (e.g. ATOP, AUDIT, DUDIT, K10) and as optional modules in the assessment (e.g. WHOQOL-BREF, Modified Mini Screen, PsyCheck, Problem Gambling Severity Index and others).

The intake and assessment tool also covers all the comprehensive assessment domains recommended in the National guidelines for the treatment of alcohol problems¹ (see table 1), which also resembles the assessment domains recommended by the National Institute of Health and Clinical Excellence's guidelines on drug misuse interventions in the UK.

**Shorter and telephone friendly intake tool**
The length of the intake tool was shortened (particularly the demographic section), removing duplication where possible between the tools, including only essential information required to inform the need for further assessment. The ATOP, AUDIT, DUDIT & K10 were moved to the self-completion form in the assessment. The intake form is designed to be telephone friendly; the question/answer format has been replaced with prompts so clinicians can collect items using a more open-ended, less structured approach, using language as they see fit.

**Greater emphasis on clinician judgement**
There is much greater emphasis of clinical judgement of the intake and assessment workers. Many clinicians felt that the screening tool with its multiple structured standardised questions was disengaging and difficult to administer over the phone. There was a clear need for a more natural, open-ended, conversational approach that will serve to engage clients, particularly at intake. This means that clinicians will need to make decisions about the need for further assessment based on their knowledge experience and skills combined with the information provided by the client regarding harm, risk, dependence and complexity.

**Strengths based**
The optional modules in the assessment incorporates strengths-based and motivational enhancement brief-intervention type modules in recognition of what clinicians told us – that intake and assessment can be used opportunistically to motivate and engage clients.

**Opportunity for outcome measurement**
Outcome measures (such as the AUDIT, DUDIT, ATOP and K-10 score as well as other individual items

assessing broader outcomes) are embedded in the self-completion form. This can form a baseline measure to gauge a clients’ progress if re-administrated during or following treatment.

**Flexibility to be used in a range of settings**

The format of the assessment tool (i.e. a core-component plus optional modules that could be completed as required), means that the assessment can be tailored to the individual needs of clients and agencies. Optional modules enable a detailed understanding of particular strengths, issues or experiences that may have been flagged during intake, in the self-completion form, or during assessment, or that require further consideration. For instance a clinician suspecting that a client may have an Acquired Brain Injury could use the ABI module to determine whether the client might need a referral for a neuropsychology assessment. In contrast, if gambling is not an issue for the client, then there is no need to follow-up on this further.

**Comprehensive and holistic**

Acknowledging the role of a range of factors on individuals AOD use, the instrument is holistic and incorporates questions and sections on psycho-social issues, mental health, and physical health among other things.

**Aligns with DHHS activity and outcome reporting requirements**

To streamline clinical workflow, the tools have been aligned with VADC data reporting requirements to reduce duplication of data entry into CMS, where CMS have the tools built in. As with all questions within this tool, data elements for VADC reporting should be collected with due consideration to whether collecting the information during the assessment will detrimentally impact treatment engagement with the service and clinician. The VADC inbuilt flexibility allows for a response of “Not Stated/Inadequately described” for data elements that are required for reporting but cannot be asked at that collection point in time, and can be reported once the question is able to be asked at a future collection point.
### Table 1: National guideline domains covered in the screening and assessment instrument

<table>
<thead>
<tr>
<th>Domains recommended in Australian national guidelines</th>
<th>Covered</th>
<th>Notes on where covered</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Presentation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Presenting problems</td>
<td>✓</td>
<td>The first page of the intake tool includes a question around reasons for presenting in client need section. There is also a section in the case summary sheet at the end of the assessment (goals/reasons for presenting) where clinicians can summarize presenting problems.</td>
</tr>
<tr>
<td>Role of drinking/drug use in presenting problems</td>
<td>✓</td>
<td>There is an initial question around evidence of harm from AOD use in the intake (AOD section). The case summary in assessment provides an opportunity to document and describe the role of AOD use in medical problems, mental health issues and other problems from the client and clinician perspective.</td>
</tr>
<tr>
<td>Motivation for presentation</td>
<td>✓</td>
<td>The first page of the intake tool has a prompt around reasons for presenting in the client need section. This provides an insight into clients’ motivation for presentation, and acts as a prompt for further discussion</td>
</tr>
<tr>
<td>Other concerns</td>
<td>✓</td>
<td>There is a specific section in the assessment (other key issues), where clients can identify other concerns or information they think is important.</td>
</tr>
<tr>
<td><strong>Alcohol and other drug use</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quantity, frequency, pattern of drinking and other drug use (tobacco, illicit drugs, pharmaceutical drugs, injecting drug use)</td>
<td>✓</td>
<td>The intake tool collects basic frequency of AOD use and associated harms, while the assessment builds on this to explore quantities and patterns of use.</td>
</tr>
<tr>
<td>Last use of alcohol and other drugs (time and amount)</td>
<td>✓</td>
<td>Last AOD use is collected in both the intake and assessment.</td>
</tr>
<tr>
<td>Duration of drug and alcohol problems and previous withdrawal complications (seizures, delirium, hallucinations)</td>
<td>✓</td>
<td>Duration of AOD problems is collected in the assessment.</td>
</tr>
<tr>
<td>Features of abuse or dependence. If dependent, assess likely withdrawal severity and previous withdrawal complications (seizures, delirium, hallucinations).</td>
<td>✓</td>
<td>Scores on AUDIT and DUDIT in the self-complete provide an indication of level of problematic use, and this is then expanded upon in the assessment.</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Medical and psychiatric comorbidity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical health problems (including liver, gastro-intestinal, trauma, cardiovascular, neurological, cognitive, endocrine)</td>
<td>✓</td>
<td>The intake collects significant physical health issues in Section 2: Risk, additionally there is a medical history section in the comprehensive assessment that enables the clinician to record more detailed history of these conditions using the table provided.</td>
</tr>
<tr>
<td>Mental health problems (depression, anxiety, psychosis, suicide risk)</td>
<td>✓</td>
<td>The intake contains a question on any current mental health issues. Furthermore in the self-completion package there is a question on self-reported satisfaction with psychological health, and the K10, which provides an indication of possible symptoms of anxiety or depression. There is a section in the core component of the assessment dedicated to mental health, and the Modified Mini Screen and PsyCheck that clinicians can complete.</td>
</tr>
<tr>
<td>Social circumstances</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social functioning (including relationship, employment, financial, housing, legal)</td>
<td>✓</td>
<td>The intake tool has basic questions employment and living arrangement. The core component of the comprehensive assessment builds on this in the psychosocial section, which includes space to record resources and supports, a genogram, family and social relationships, housing, finances, employment and training, current legal status, and harm to or from others. In addition there are several optional modules available related to psychosocial issues that can be used.</td>
</tr>
<tr>
<td>Examination (by suitably trained professionals)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical examination (general examination, signs of intoxication or withdrawal, nutritional assessment, neurological function, gastrointestinal,</td>
<td>✓</td>
<td>A physical examination module is included as an optional module that medically trained clinicians can complete.</td>
</tr>
<tr>
<td>Mental state examination (signs of intoxication or withdrawal, cognitive function, mood, motivation and insight)</td>
<td>✔</td>
<td>Mental state examination (with appropriate prompts) is included in the core part of the assessment.</td>
</tr>
<tr>
<td><strong>Motivation and treatment goals</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Goals of treatment (abstinence or reduced use, other health improvement)</td>
<td>✔</td>
<td>The intake asks about self-reported reasons for presenting, in which clients can detail their goals. In the final case summary sheet of the assessment there is prompts around goals and reason for presentation. There is also an optional module about goals that can be completed.</td>
</tr>
<tr>
<td>Involvement of other health and/or welfare professionals</td>
<td>✔</td>
<td>The intake tool contains a section where the client can record whether they have a GP and whether they use other AOD services, and/or other services. Clinicians can elaborate on this in the assessment and can record this on the case summary sheet. Child protection involvement is prompted for in the intake tool.</td>
</tr>
<tr>
<td>Clinical risks and risk management plan (harm to self/others, serious physical or mental illness, driving, child protection, domestic violence, occupational concerns)</td>
<td>✔</td>
<td>There is a section around risk in the intake tool which prompts clinicians around issues of harm to self/others, serious physical or mental illness, family violence and clinician concern around parenting which can be further expanded upon in the comprehensive assessment. In the AOD section of intake there are prompts around risky drug practices including driving under the influence.</td>
</tr>
<tr>
<td>Treatment plan (need for brief interventions, controlled drinking strategies, detoxification, relapse prevention strategies, management of comorbidities)</td>
<td>✔</td>
<td>The final case summary sheet provides a space for clinicians to formulate a summary of the client's problems, strengths and goals (based on optional module 7). The final case summary sheet also provides a space to document the treatment/s and referrals required and actions taken. This information can then be transferred across to an agency's treatment plan.</td>
</tr>
</tbody>
</table>
COMPLETING THE VICTORIAN ALCOHOL AND OTHER DRUG INTAKE TOOL

The following sections of the clinician guide provides step-by-step information about the AOD intake and assessment instrument.

Instructions:

1. Administer the AOD Intake tool with the client. The intake form layout may be used as a prompt to gather required information. It is not necessary to ask questions in the order in which they are presented, however it may help build rapport by gathering demographic information before asking about AOD and risk and complexity. It is expected that an enquiry in to the reason for their call or visit will initiate a conversation which provides much of the required information. The intake tool does not contain any questions to be read verbatim and so enables the clinician to elicit the required information as they see fit, using appropriate language and permitting a more engaging and conversational approach.

2. When the clinician and client have completed all that they can, check, clarify, and ask any unanswered questions.

3. After a clinical decision is reached in relation to “next-steps” refer on to an appropriate agency for comprehensive assessment or indicated support. Outline the support options available to the client, including bridging support offered by the organisation, and additional supports available, such as DirectLine.

Purpose:

- To accurately identify client needs, determine eligibility for AOD treatment and inform treatment planning
- To enable the clinician to make a preliminary determination about the client’s level of AOD problem severity, risk, harm, level of urgency for treatment and what treatment types might be suitable.
- To facilitate client engagement

Content:

1. Demographic Information
2. AOD use
3. Risk and complexity
4. Outcome of intake

How to enquire about potentially sensitive areas

As some items collected at intake are of sensitive nature, this guide has been created to inform intake workers on why the information is being collected, and how best to collect this information. Specific guidance around sensitive items has been prepared below to guide intake and assessment workers in this
process. However it is important that all intake and assessment workers explain the process of intake clearly and inform their client about the types of questions they will be asking and why it is important to gather such information. Disclosure will be impacted by a range of factors including the known context of the data collection; the level of privacy, anonymity and confidentiality perceived; and the knowledge of how and why the information will be used, along with other socio-cultural factors.

If an intake worker finds it difficult to ask particular item(s), the following preamble has been suggested to normalize the process before administering the tool or before particular questions:

“(Some of) the following question(s) I am going to ask can be quite personal, which you may or may not feel comfortable answering. It’s important to know that we ask all clients these questions because the information will assist in the planning and provision of appropriate and improved health care and services for yourself and others. If you do not wish to answer the questions, you do not have to.”

It is also important that a level of privacy is maintained during intake process to ensure client feels safe disclosing information. If intake is being conducted over the phone, ask the client if they are in a space where they feel comfortable disclosing personal information.

This guide has been based on a combination of best practices guidelines, population specific resources and advice of workers from consultation process. We acknowledge working with specific populations (such as Aboriginal and/or Torres Strait Islander, LGBTQ, CALD etc.) can add further complexity. Please refer to the guidelines below and Appendix 1 for a more detail list of resources and websites that may be used to support your work with specific populations.

**Page 1. DEMOGRAPHIC SECTION**

The demographic section is broadly divided into five sections. The first section captures name, pronoun and gender, the second captures contact details, the third captures cultural information, the fourth captures employment and family details and the final section captures GP and other service details.

**Name and pronoun**

As part of the demographic section there is a space for name and pronoun. Referring to the chosen name and pronoun affirms a client’s identity, and should take place throughout the intake process (including informal discussions with your client any written communication such as intake notes) [1]. Ask the client how they would like to be addressed, including their pronoun, name, how it is pronounced and word order. Avoid using gendered pronouns until this has been established.

If you are unsure of a clients preferred name/pronoun wait until you can politely and discreetly ask. For example, you could say:

“I want to make sure we address you properly, can I ask what your preferred name/pronoun is?”

**Gender and sex at birth identification**

When gathering this data it is important to recognise that a person’s gender refers to their internal “felt” sense of gender identity (a sociological construct) and may not reflect their sex at birth (physiological and biological characteristics identified at birth)[1].
The current option allows a client to self-identify as male, female or other- which may be used as a space to specify non-binary or other gender identity's that do not fall strictly into male or female (for example trans-male/transman, trans-female/trans-woman, gender queer etc.), importantly this space allows the client to best describe their gender.

Gender identification question is followed by sex at birth identification (male, female, intersex) which may or may not be the same as a client’s gender identity. Both sex and gender items have been added to better capture and understand complexities among gender diverse people, and identify transgender people, whilst validating a client’s identity (2).

Suggested wording for these items is:

"What gender do you identify as?
Followed by:

"What sex were you assigned at birth?"

It is important to recognise disclosure of gender identity can be a very personal decision and can be of special concern for trans and gender diverse consumers for a number of reasons as their identity documents may not match their gender and name (see FAQ), or they may be concerns around privacy, discrimination, or being treated insensitively or denied services (1,3). Therefore it is important that clients are made aware of how this information may be used and if the data may be shared with other organisations (3). Note the LGBTIQ community refers to people of diverse sex, sexuality and gender. This may include, but is not limited to people who identify as Lesbian, Gay, Bisexual, Trans and gender diverse, and Intersex.

Both gender and sex at birth are items included as part of the minimum dataset Victorian Alcohol and other Drug Collection (VADC), and therefore it is important that a response is recorded for both of these items.

**Lesbian Gay Bisexual (LGB) identification**

Disclosure of a person's sexual orientation is a very personal decision and many clients may be hesitant to disclose this information for fear of discrimination, negative past experiences and a range of socio-cultural factors (3). However it can be useful to note a clients' sexuality and gender identity as this can be important for informing culturally-inclusive care. It also enables healthcare services to plan and design services according to need and help understand the specific needs of LBGTI clients. A major barrier to disclosure of this information is a perceived lack of anonymity or confidentiality; therefore it is important that clinicians explain why the information is being collected and how it is used (3). Whilst clients may identify as belonging to the broader LGBTIQ community the VADC requirements are for recording LGB status separately, as trans and intersex will be recorded in gender and sex at birth items. However it may be beneficial to note if someone identifies as queer. Please indicate on the form whether the client identifies as lesbian, gay or bi-sexual as this can be useful for monitoring trends and patterns of drug use for specific populations and to inform appropriate service responses.

A suggestion wording is below:
Do you identify as LGB?  "If Yes please specify......?"

Disclosure is optional and clients have the option of choosing “prefer not to say” if a client does not wish to answer. Importantly this information may be valuable when discussing client preferences for specific services.

Aboriginal and/or Torres Strait Islander Identification
The Aboriginal and/or Torres Strait Islander or non-Indigenous status question should be asked of all clients irrespective of appearance, accent, country of birth or whether the clinician knows of the client or their family background (4). Clients may be hesitant to disclose Aboriginal and/or Torres Strait Islander status for many reasons including individual or family experiences of stigma, racism and trauma (5). Disclosure of status is voluntary and may change over time in response to a personal journey of identity or upon gaining trust with a service provider (5).

In line with best practice guidelines, the standardised wording for the question is (4):

‘Are you of Aboriginal or Torres Strait Islander origin?’

It is important to explain that this information is collected so that the client can access the most appropriate health care enabling. It enables health care services to plan and design services according to need, and also helps understand preferences of Aboriginal and Torres Strait Islander clients (4). Asking the question is a Victorian health policy requirement aiming to ‘Close the (health) Gap’ for Aboriginal and Torres Strait Islander.

Cultural background
There are various ways to make sense of a person’s cultural background; in the intake tool there are prompts around country of birth, cultural background and language. It’s important when collecting this information to enquire about how the client defines their ethnicity and cultural identity and not be guided by any assumptions as a great deal of diversity may exist within each specific community (6).

Collecting information around visa status can be difficult area, especially for clients who arrived as asylum seekers/refugees. Sensitively open this conversation emphasising client-worker confidentiality and steer away from undue disclosures of past trauma (6).

For clients with low English proficiency a professional interpreter may need to be engaged, this can be done via the Victorian Interpreting Translation Service.

Employment and living arrangements
These items open up a discussion around a client’s social functioning in particular their interactions, and abilities to fulfil their roles, within the work and family context.

Clients may be reluctant to discuss items such as ages of children, particularly if they have had negative past experiences with Child Protection services. Where possible normalise this conversation by incorporating it into a discussion around broader family/living circumstances and child care responsibilities. There is an opportunity to further probe around involvement with Child Protection services in the next section when inquiring about other services the client has been involved with.
This section requires the intake worker to document if the client is a caregiver for a child/children or dependant(s) (e.g. a person whom is unable to protect themselves from harm or exploitation due to personal capacity, such as mental or physical capacity, and current circumstances, such as social or financial hardship) and to note their ages.

This section also allows the intake worker to ask if a person is seeking treatment as a requirement of their child’s Family Reunification Order (FRO). Parents who must meet court-issued conditions to seek AOD treatment relating to their child’s FRO are supported by intake providers to access assessment and treatment as quickly as possible. This is due to changes in the Children, Youth and Families Act 2005 that mean that a child who is a subject to a FRO may be placed in permanent care if the parent fails to satisfy condition of the order within the time permitted (typically a maximum of 12 months, but potentially up to 24 months).

Service engagement:
At the end of the demographic page is a section where details relating to treatment and other services the client may be currently engaged with can be documented. This includes Medicare number and client health care card number. Please note the client may be hesitant to provide these details, however they can be important to assist agencies in managing clients as they move through the system, enabling agencies to match records and refer clients appropriately to further treatment. It is also a requirement of VADC that this information is collected. Please note that there is an opportunity to capture involvement with child protection services by asking if the client is involved in any other services and explicitly giving child protection, NDIS, housing, mental health, legal etc., as examples. It is particularly important here to record whether there is any legal or justice involvement and whether the client has an existing order as this may indicate that the client might be a forensic client.

Client Need
The prompt around reasons for presenting allows clinicians to start a conversation about the client’s concerns and priorities and provides an insight into clients’ motivation for presenting. It is important to document here whether the caller is concerned about their own AOD use or someone else’s AOD use (Other) and, if possible to note the relationship the concerned ‘other’ has to the person they are concerned about.

Page 2. SECTION 1: ALCOHOL AND OTHER DRUG USE SECTION
The items in this section capture information about AOD use patterns, risky and harmful use, problem severity and treatment history

Item 1: AOD use in the past year
The first item to be captured is AOD use in the past year. AOD use includes use of alcohol, illicit substances, non-prescribed medications and prescribed medications that are not taken as prescribed. If someone is using only tobacco but no other substance, it may be more appropriate to refer them to QuitLine.

Item 2: At risk of lapse/relapse
This item was added to the refreshed intake tool in response to concerns with the earlier version that clients who had not used in the past year were deemed ineligible for AOD treatment. It is recognised that a client may not have used AOD in the past year but may still require support or treatment from AOD services to prevent relapse. This can include clients who may be abstinent, clients who have experienced a ‘slip’ or
'lapse' as well as clients who are using AOD and are at risk of returning to/experiencing problematic/harmful pattern of use.

If the response to both items 1 and 2 is "No", it is unlikely the client will need specialist OD treatment in which case the rest of section 1 is skipped but section 2 on risk is then completed to identify potential need for other services.

Item 3: Primary drug of concern.
The drug grid which captures days of use in the past month for various substances no longer features in the intake tool as this was duplicated in the assessment. Whilst many clients may be using multiple substances, at intake the focus is on the substance which is causing them the most concern (i.e., is there Primary drug of concern (PDOC). The PDOC can be alcohol, tobacco, any illicit drug, non-prescribed drug or a prescribed drug that is not taken as instructed).

Item 4 concerns frequency of use of their PDOC which to be recorded as the number of days they have used that substance in the past month (e.g., daily use would be 28, weekly would be 4). Note: changes in PDOC days is an indicator of client progress so a baseline is required.

Item 5 concerns the quantity of their PDOC per day, i.e., the amount used each day they use it. For example, 2 bottles of wine would be 14 (amount) standard drinks (units), methamphetamine may be 1 (amount) bag (unit), or heroin may be 3 (amount) straws, or points (units), or 2 (amount) tablets (unit). Note if the dose of a tablet is known for example for Diazepam 3 (amount) x 5mg (unit), please record this with the unit (see appendix 2 alcohol conversion chart).

Item 6 concerns 'last use of the Primary drug of concern', record date.

Item 7 concerns usual route of administration of their PDOC. Note that more than one route of administration may be used (please tick all that apply).

Item 8 concerns 'other drugs of concern' that the client may have. Note that this does not simply mean other drugs that they use, unless they are drugs (or alcohol) that they are concerned about.

Item 9 concerns "recent injecting drug use" in the past 3 months and the number of days they have injected in the past month. Note: changes in IV days is an indicator of client progress so a baseline is required.

Item 10 concerns "history of drug overdose" and refers to both intentional and accidental drug overdose (e.g., heroin overdose, paracetamol overdose etc.). If the client indicates they have had a past overdose, note the drug and circumstances (e.g., paracetamol, intentional 10 years ago) on the line next to the tick box and include this in the summary.

Item 11 concerns 'risky drug use practices' in the past 3 months. This includes driving under the influence of alcohol or drugs, unsafe injecting practices (e.g., sharing or re-using needles and other IV equipment), using alone, engaging in unsafe sexual practices when drug affected etc. Please note the details in the space provided. This will flag harm reduction and psychoeducation opportunities (i.e., potential areas to target with brief interventions)
Item 12 concerns ‘evidence of harm from substance use’. Akin to DSM-IV abuse criteria, this includes interpersonal issues (i.e., relationship difficulties), financial problems, failing to fulfil major role obligations at work or home, a negative impact on occupational functioning, mental or physical health issues, and any other evidence that AOD use is having an adverse impact on the clients’ functioning. Please note the details in the space provided. This will flag harm reduction and psychoeducation opportunities (i.e., potential areas to target with brief interventions).

Item 13 concerns ‘evidence of dependence’ equivalent to DSM-V substance use disorder (moderate or severe), this includes having 4 or more of the following criteria:

1. Taking larger amounts and for longer than intended
2. Wanting to cut down or quit but not being able to do it
3. Spending a lot of time obtaining it
4. Craving or a strong desire to use
5. Repeatedly unable to carry out major obligations at work, school, or home due to use
6. Continued use despite persistent or recurring social or interpersonal problems caused/exacerbated by use
7. Stopping or reducing important social, occupational, or recreational activities due to use
8. Recurrent use in physically hazardous situations
9. Consistent use despite acknowledgment of persistent or recurrent physical or psychological difficulties from using
10. Tolerance as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount.
11. Withdrawal symptoms when ceasing use or when drug effects wear off. This includes psychological or physical symptoms, such as trouble sleeping, anxiety, shakiness, restlessness, nausea, sweating, racing heart, seizure, or sensing things that are not there

Item 14 concerns pharmacotherapy programs. Add details of the medication such as name and dose if known (e.g., suboxone 16mg daily, methadone 60mg)

Item 15 and 16 concerns previous AOD service use, add details on previous episodes.

Page 3. SECTION 2: RISK

The items in this section are indicators of related risks and complexity issues that often exist alongside AOD use. Information on these domains will indicate the need for AOD and non-AOD treatment. Item 17 concerns “current significant physical or medical issues” and refers to diagnosed conditions. A client with the conditions listed (e.g., history of seizures, liver disease) may be candidates for inpatient withdrawal services. A pregnant client may require urgent assessment for further treatment (high priority case). Other chronic physical illnesses which may be related to or exacerbated by changes in substance use (e.g., respiratory diseases) need to be flagged. If a client suspects they may have one of the conditions listed in this sector or other conditions that are not listed, please note this in the ‘summary of identified needs’ section on page 4). For example if a client suspects they may have an ABI because of a past head injury, you could also flag optional module 2 to be used at assessment and may note the need for referral to the neuropsychology services on page 4.

Item 18 concerns ‘current mental health issues’ and the focus here is on significant or unmanaged mental health conditions (e.g., schizophrenia, BPAD, major depression) that may be exacerbated by AOD use or driving ongoing AOD use (e.g., using substances to manage anxiety). One indicator of a significant mental health issue is having a case manager or a mental health plan with their GP. Past mental health conditions
can be noted here, however the focus in terms of assessing complexity is on current conditions that require medical attention. The assessment will explore past and current issues (including diagnoses) in more detail. Items 9-20 concern self-harm and suicide. If this information has not been self-disclosed by the client, it is recommended that you preface any questioning by re-iterating that you will be asking some personal or sensitive questions that we ask all clients [see earlier guidance on sensitive questioning Page 12]. Recent self-harm and suicide behaviours mean those that have occurred in the past 3-months. If such behaviours have occurred in the past please note when. If there is an indication of current self-harm or suicide thoughts refer to your services risk assessment processes. Note details of any existing safety plan or complete a safety plan and record details here. A safety plan is included in the comprehensive assessment, and you may like to refer to this.

Items 21-22 are also sensitive questions concerning family violence and harm to others. Refer to sensitive questioning guidance. However if you feel that asking this information will threaten rapport or client engagement then note that it was not asked so that it can be revisited at the assessment stage. Note details of any existing safety plan or complete a safety plan and record details here.

Item 23 is NOT to be asked directly, but provides a space for the clinician to record any initial concerns you may have about a client’s parenting capacity which could be examined at assessment. As per the protocol between Drug Treatment Services and Child Protection for Working with Parents with Alcohol and Other Drug Issues, please note that it is not appropriate for an AOD worker to complete an in-depth assessment of parenting capacity. Furthermore, initial concerns about parenting capacity may not necessarily require a report to child protection, but may do in some circumstances.

All professionals working with families share in the responsibility of protecting children who are being physically, sexually or emotionally abused or neglected. Under the Children, Youth and Families Act 2005, doctors, nurses, midwives, teachers and principals, and police are mandatory reporters. The Protocol between drug treatment services and child protection for working with parents with alcohol and other drug issues 2002 sets out the roles and responsibilities of workers, including those who are, and those who are not, required to report under mandatory reporting legislation.

A report to child protection should be made where a treatment service or worker holds a belief on reasonable grounds that a child may be in need of protection from significant harm or damage to their health or development. For example, this may occur in connection with:

- physical abuse, non-accidental or unexplained injury
- sexual abuse
- emotional abuse or ill treatment
- persistent neglect, poor care or lack of appropriate supervision
- persistent family violence, parental substance misuse or psychiatric illness, or intellectual disability
- a child’s actions or behaviour which places them at risk.

A report should also be made where a child appears to have been abandoned, or where the child’s parents are dead or incapacitated, and no other suitable person is willing and able to care for the child. Many cases may not neatly fit into these categories, and a variety of factors may influence your belief of the level and the nature of any risk. More information, including the protocol, is available at the child protection manual website <http://www.cpmanual.vic.gov.au/advice-and-protocols/protocols/education-
Items 24-26 provide opportunities to document the clients housing, employment, legal circumstances. For the latter you could ask “are you concerned about any legal issue?”. If a court or intervention orders is disclosed, then you should ask for details, especially in relation to pending court dates and family intervention orders.

Item 27 related to whether the client has any concerns about their gambling. You may wish to initially ask whether the client gambles, and if they do, then ask if they have any concerns about their gambling. The final section asks about medications. This is where all medications for mental and physical health conditions are to be recorded including medication name and dose (if known).

**Page 4. SUMMARY OF IDENTIFIED NEEDS**

The space here enables you to summarise the clients presenting concerns and need, the level of AOD problem severity (i.e., risky, harmful or dependent use) as well other risks and complexities that must be considered. You can also document here the need for AOD and other non-AOD services, as well as any literacy issues that may impact on the client’s ability to complete forms, such as the self-completion form, should they be referred on for further assessment.

**Outcome of intake**

The outcome of the intake process is based on the information provided by the client, clinical judgement and client preference. If further assessment is not required, please provide details and complete the “next steps” section. This can be an opportunity to provide a brief intervention, harm reduction or psychoeducation. If further assessment is required, please provide a preliminary indication of the treatment type for which the client must be assessed. This is particularly important if the indicated treatment is withdrawal, to ensure that the assessment is completed at an agency that can provide the indicated treatment.

**Prioritisation for assessment**

Prioritisation level must be completed and is an indicator of how urgently a client requires a comprehensive assessment (i.e., low, medium or high). Victorian Government-funded AOD treatment works on the principle that people who are most in need of treatment are prioritised for access. Providers have the discretion to assess who is most in need and who requires treatment based on clinical judgement, existing case load and the best management of client flow through different treatment streams. When considering how urgently a client needs assessment, consider AOD dependency, including frequency and amount of use and other risk/complexity factors such as being at risk of experiencing family violence, homelessness, or being required to attend treatment as a part of a court order or having dependant children who are reliant on them for their safety and wellbeing. Also consider protective factors and client preferences, as well as planned/allocated treatments (e.g., a allocated to a place in residential rehabilitation which may necessitate urgent prior withdrawal). Providers will work within catchments to provide timely access to assessments for priority cohorts. For more information on prioritisation, please see the Program Guidelines – Part 1 Section on 4.3.2 Priority access to treatment.
Any issues relating to the clients capacity to attend the assessment must be noted here (e.g., lack of transport, childcare responsibilities etc.). There is also an opportunity to flag any optional modules that might be useful during the comprehensive assessment (e.g., gambling, acquired brain injury, family violence). This may be particularly useful for sensitive issues that were not discussed at intake, and which may be better examined at assessment or treatment.

The section on “Next steps” is to be completed for all clients. Note referral needs and need for bridging support if there is likely to be a delay until assessment.

When making a decision about where to refer clients to ensure any preferences they have (e.g., female clinician) are considered and documented, however note that this is subject to availability. For example you could say “There are sometimes certain services that cater for particular individuals, such as youth, indigenous clients, LGBTIQ clients etc. are there any that you would prefer to be referred to if possible?”

Finally, if the client would like family members or significant others involved in their care or to receive information please document details.

**Consent to share information**

With consent, information about a client obtained through the intake process will be passed on to assessment and treatment providers to support a client’s treatment journey. In doing so, this reduces the likelihood of a person needing to repeat their details and re-tell their story as they are referred to supports, and will assist treatment providers to deliver individualised evidence-based treatment.

Intake providers are required to discuss the sharing of a client’s information with each client and arrange for a client to sign the organisation’s consent to share information form. It is important that a client knows why their information is collected, what information will go and to whom, as well as their rights and obligations in relation to providing (and later accessing) their information.

De-identified information provided through the intake tool is collected by the Victorian Alcohol and Drug Collection. This information is used by the Department of Health and Human Services to develop a better understanding of how clients travel through treatment services, assess system performance and client trends and ultimately to improve the service system.

Further information about consent and information sharing can be found in the Frequently Asked Questions (FAQ) section of this Clinician Guide on page 57.
SELF COMPLETION FORM

Instructions:
1) Provide client with self-complete form or administer with client where appropriate. Instructions for clients how to fill out the self-complete questionnaire are included with the instrument.

2) When the client has completed all that they can, you can check, clarify, and ask any unanswered questions.

3) Score screen results and provide feedback on scores to client (if appropriate). Enter these scores into the final case summary sheet of the comprehensive assessment.

4) Begin comprehensive assessment.

5) Repeat ATOP and K10 at least four weeks after first completed to track progress.

6) Repeat all tools at the completion of treatment to track progress.

Purpose:

1. Provide an indication of AOD problem severity, psychological distress, health and wellbeing and risk factors. This acts as baseline data against which client progress can be assessed.

2. To track a client’s progress in treatment and monitor outcomes of the services provided. These fields are captured in the Victorian Alcohol and Drug Collection.

Structure:
The four screening instruments in the self-complete form will provide an indication of AOD use and any psychological distress (ATOP, AUDIT, DUDIT and K10). For each, clinicians should record score in final case summary sheet for the AOD Comprehensive Assessment and assist in development of an integrated treatment plan. Please note that while the self-completion form was designed so that it could be self-completed, in instances where English is not the client’s preferred language, or where the client has literacy issues or prefers not to self-complete the form it may be more appropriate for the clinician to administer the form. In the case where English is not the client’s preferred language, an interpreter may be required.

Instruments were selected on the basis of a review of relevant screening instruments conducted in 2011. Instruments needed to be valid, reliable, brief and easy to use (including able to be self-completed), and had to be able to be used in a number of population groups. Table 2 summarises the evidence for the four screening instruments. A gold star indicates that instruments have proven reliability, validity and that are widely used – “gold star” instruments – according to the Alcohol and Drug Abuse Institute’s extensive instrument database (see appendix 3 Table 2).
1. ATOP

The Australian Treatment Outcomes Profile (ATOP) is an outcome monitoring tool, which provides a clinically relevant picture of client progress and will enable policy makers and funders to monitor the effectiveness of AOD treatment services, and support improvement where necessary. The ATOP was developed on the basis of the Treatment Outcomes Profile (TOP), which is now routinely administered as part of outcome monitoring in the UK.

The first section of the form relates to substance use. It provides space to record the average daily quantities of substances used, and the number of days used in the past four weeks. If the client is struggling to remember quantities of substances used one month prior you can record this on a week by week basis, starting with the number of days used in the most recent week, and work backwards. You may also like to use a calendar as a prompt to help the client think about the past four weeks. If the client was in hospital/rehab or incarcerated (i.e., in a situation where they were unable to use alcohol or drugs) in the previous month, they should report their alcohol use in the four weeks before that period.

Section 2 relates to health and wellbeing in the past four weeks. It includes work status and asks a series of tick-box answer questions about a range of experiences related to housing and homelessness, caring for children, legal issues, and violence in the past four weeks. The form then concludes with the client being asked to rate their psychological and physical health status, and overall quality of life on three 0-10 rating scales.

In order for this form to be useful, it needs to be readministered in at least 4 weeks after it was first completed and this will provide an indication of progress.

Alcohol use (AUDIT)

The AUDIT (Alcohol Use Disorders Identification Test) was developed by the World Health Organisation (WHO) as a simple method of screening for excessive drinking and to assist in brief assessment.

Scoring the AUDIT

The AUDIT responses are each denoted a score found at the top of the AUDIT table in the screen (e.g. 'Never' = 0, 'less than monthly' = 1, '2-4 times a month' = 2 and so on). The total AUDIT score is determined by adding the score of all of the responses. The maximum score is 40. Total AUDIT scores of 8 and above indicate hazardous and harmful alcohol use and possible alcohol dependence. The higher the total AUDIT score, the greater the need for treatment.

Interpretation of scores

When using the AUDIT to screen for excessive alcohol consumption, the interpretations in table 3 are suggested.²

Table 3: Suggested interpretation for the AUDIT overall score

² NB: These guidelines should be considered tentative, subject to clinical judgement that takes into account the client’s medical condition, psychosocial situation, family history of alcohol problems and perceived honesty in responding to the AUDIT questions.
### Table 4: Meaning of questions in the AUDIT

<table>
<thead>
<tr>
<th>Domains</th>
<th>Question Number</th>
<th>Item Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hazardous alcohol use</td>
<td>1</td>
<td>Frequency of drinking</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Typical quantity</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Frequency of heavy drinking</td>
</tr>
<tr>
<td>Dependence Symptoms</td>
<td>4</td>
<td>Impaired control over drinking</td>
</tr>
<tr>
<td>Harmful Alcohol Use</td>
<td>5</td>
<td>Increased salience of drinking</td>
</tr>
<tr>
<td></td>
<td>6</td>
<td>Morning drinking</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Guilt after drinking</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>Blackouts</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>Alcohol-related injuries</td>
</tr>
<tr>
<td></td>
<td>10</td>
<td>Others concerned about drinking</td>
</tr>
</tbody>
</table>

In sample B, the person has scored 22, which indicates that dependence may be likely. When interpreting the results of any screener, it is important not only to review the total score, but also to examine the responses to individual questions and the story that these begin to tell when viewed together as part of a larger narrative. For instance in the following sample, the person has indicated that they don’t drink very often (2-4 times a month), but when they do, they drink lots (10 or more), indicating a potential binge-drinking pattern of use. When we scan down the screener, we find that the client has indicated some signs of dependence (impaired control over drinking & increased salience of drinking in particular) and also some signs of harmful use (guilt after drinking in particular). We also learn that the client’s drinking in the past has caused harm to themselves or to others and that others have been concerned about their drinking in the past. This means that this person warrants further diagnostic evaluation for alcohol dependence.

A detailed interpretation of a client’s AUDIT score may be obtained by considering individual items where scores are assigned. Table 4 details what each question relates to.
is likely to have had a problem with alcohol in the past, and may or may not have sought help. It also means that in the last year, the client’s drinking has not caused injury and other has not been concerned about their drinking. As a clinician you may interpret this as a sign of improvement and may like to draw on this as strength or something to build upon. Even so, you would probably want to found out more information and complete a comprehensive assessment with a client with this score profile.

It is also important to interpret the results of screeners in the context of a person's broader psychosocial situation. For instance, a score in the low risk of harmful use category could be considered harmful if a person is pregnant, or in the case where operating heavy machinery as part of their work, or where they are using alcohol in conjunction with other drugs, or where someone has a medical condition.

Sample B: AUDIT

<table>
<thead>
<tr>
<th>Score</th>
<th>Level of Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-7</td>
<td>Low risk of harm</td>
</tr>
<tr>
<td>8-15</td>
<td>Moderate risk of harm</td>
</tr>
<tr>
<td>16-19</td>
<td>High-risk or harmful level</td>
</tr>
<tr>
<td>20+</td>
<td>Dependence likely</td>
</tr>
</tbody>
</table>

3. Use of drugs other than alcohol (DUDIT)
The DUDIT, the Drug Use Disorders Identification Test, was developed as a parallel instrument to the AUDIT for identification of individuals with drug-related problems. The following provides details on how to interpret the scores and the appropriate intervention to deliver.

Scoring the DUDIT
The DUDIT responses are each denoted a score found at the top of the DUDIT table in the screen (e.g. 'Never' = 0, 'monthly or less' = 1, '2-4 times a month' = 2 and so on). The total DUDIT score is determined by adding the score of all of the responses. The maximum score is 44. The cut off scores for DUDIT are low indicating that any drug use is hazardous to health. A score above 24 is indicative of drug dependence requiring further comprehensive assessment.
Interpretation of scores

Table 5 provides guidance on interpreting scores on the DUDIT.

**Table 5: Suggested interpretation of the DUDIT overall score**

<table>
<thead>
<tr>
<th>Score</th>
<th>Sex</th>
<th>Interpretation</th>
<th>Drug problem</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-24</td>
<td>♂</td>
<td>Sign of problematic drug use that is harmful to health but the client may not necessarily be dependent *</td>
<td>Harmful use/substance abuse</td>
<td>Warrants comprehensive assessment of drug dependence</td>
</tr>
<tr>
<td>5-24</td>
<td>♂</td>
<td>Sign of problematic drug use that is harmful to health but the client may not necessarily be dependent *</td>
<td>Harmful use/substance abuse</td>
<td></td>
</tr>
<tr>
<td>25+</td>
<td>♂ and ♂</td>
<td>Most likely heavily dependent on drugs</td>
<td>Substance dependence/Dependency syndrome</td>
<td></td>
</tr>
</tbody>
</table>

*For clients that score 1-24, the individuals are more likely to have drug-related problems; i.e., risky or harmful drug habits that might be diagnosed as substance abuse/harmful use or even dependence.

A more detailed interpretation of a client's DUDIT score may be obtained by determining on which questions points were scored. As outlined in the table 6, Q1-4 are about consumption, Q5-7 are about dependence symptoms, and Q 8 to 11 relate to consequences as a result of drug use:

**Table 6: Meaning of questions in the DUDIT**

<table>
<thead>
<tr>
<th>Question</th>
<th>Focus</th>
<th>Question</th>
<th>Focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Frequency of use per week or month</td>
<td>7</td>
<td>Prioritisation of drug use</td>
</tr>
<tr>
<td>2</td>
<td>Polydrug use</td>
<td>8</td>
<td>‘Eye opener’</td>
</tr>
<tr>
<td>3</td>
<td>Frequency of use per day</td>
<td>9</td>
<td>Guilt feelings</td>
</tr>
<tr>
<td>4</td>
<td>Heavy use</td>
<td>10</td>
<td>Harmful use</td>
</tr>
<tr>
<td>5</td>
<td>Craving</td>
<td>11</td>
<td>Concern from others</td>
</tr>
<tr>
<td>6</td>
<td>Loss of control</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The overall DUDIT score in sample C is 33, which indicates that the person is likely to be dependent. When we look at the individual responses to questions, it is evident that this person uses frequently and regularly, and is a polydrug user, which immediately indicates a pattern of heavy use. This person has also indicated regular symptoms of dependence, and has reported that their drug use has been mentally or physically harmful to themselves or others in the past year. Other people have been concerned about this persons drug use. Interpreted together the results from this screen indicate a need for further comprehensive assessment and possible intervention.

**Sample C: DUDIT**
Score - 33

Potentially harmful use:
>1 and the client is female
>5 and the client is male
0-24 dependence unlikely

>24 dependence likely

After the DUDIT there is a single question to indicate whether the client has injected in the past four weeks. This can form the basis of a discussion about injecting practices in the comprehensive assessment.

4. How have you been feeling during the past 30 days? (K10)
The Kessler 10 (K10) is a measure of psychological distress that first should be considered at face value. Higher scores are indicative of greater psychological distress, whatever the cause. The K10 is predominantly used in the identification of depression and anxiety disorders.
Scoring the K10
Each response in the K10 grid is denoted a score (i.e., ‘none of the time’ = 1, ‘a little of the time’ = 2, ‘some of the time’ = 3, most of the time’ = 4 and ‘all of the time’ = 5). The Total score is determined by adding the score for all responses. The maximum score is 50.

Interpretation of scores
There are a number of cut-off systems used to interpret the K10 total score. The one that is used in this instrument was developed by the Clinical Research Unit for Anxiety and Depression in NSW for use in specialist mental health service settings. This has slightly higher cut-off ranges than other ways of categorising K10 scores in the general population, and thus was more relevant for use in specialist AOD services, where clients are more likely to present with psychological distress. Table 7 provides an indication of what overall total scores mean, and what actions might be taken.

Table 7: Suggested interpretation of the K10 overall score

<table>
<thead>
<tr>
<th>Score</th>
<th>Interpretation</th>
<th>Intervention</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-19</td>
<td>This score indicates that the client may currently not be experiencing significant feelings of distress.</td>
<td>No action or simple advice and/or self help reading material.</td>
</tr>
<tr>
<td>20-24</td>
<td>The client may be experiencing mild levels of distress consistent with a diagnosis of a mild depression and/or anxiety disorder.</td>
<td>Simple advice and/or self help reading material. Might like to administer optional modules on mental health in the comprehensive assessment. Provide support as required.</td>
</tr>
<tr>
<td>25-29</td>
<td>The client may be experiencing moderate levels of distress consistent with a diagnosis of a moderate depression and/or anxiety disorder.</td>
<td>Discuss issues with the client and administer optional modules on mental health in the comprehensive assessment. Provide support as required.</td>
</tr>
<tr>
<td>30+</td>
<td>The client may be experiencing severe levels of distress consistent with a diagnosis of a severe depression and/or anxiety disorder.</td>
<td>Discuss issues, assess suicide risk and administer optional modules on mental health in the comprehensive assessment. Provide support and/or referral if required.</td>
</tr>
</tbody>
</table>

A more detailed interpretation of a client's K10 score may be obtained by determining on which questions points were scored. Six questions relate to anxiety and four questions relate to depression (see table 8).

Table 8: Meaning of questions in the K10

<table>
<thead>
<tr>
<th>Q</th>
<th>Anxiety</th>
<th>Q</th>
<th>Depression</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>tired</td>
<td>4</td>
<td>hopeless</td>
</tr>
<tr>
<td>2</td>
<td>nervous</td>
<td>7</td>
<td>depressed</td>
</tr>
<tr>
<td>3</td>
<td>so nervous that nothing could calm you down</td>
<td>8</td>
<td>so depressed that nothing could cheer you up</td>
</tr>
<tr>
<td>5</td>
<td>restless or fidgety</td>
<td>10</td>
<td>worthless</td>
</tr>
<tr>
<td>6</td>
<td>so restless that you could not sit still</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>everything was an effort</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The overall K10 score on sample D is 26, which indicates that this person may be experiencing moderate levels of psychological distress. This may indicate that the client may have moderate depression or anxiety. When looking at the individual items, there does not seem to be clear pattern in terms of whether this person might...
be experiencing depression or anxiety, with responses. This along with the person's score would suggest a need for further assessment, and possibly some more immediate support as required. It is particularly important to interpret the K10 in the context of the other information in the self-complete initial screen to try and understand potential sources of psychological distress. Scores on the K10 may be high due to symptoms of withdrawal or other AOD related issues, and generally people with AOD often score high on the K10. Other contextual issues such as housing, legal, family and employment issues may also be influential in feelings of psychological distress and vice versa.

Sample D: K10

<table>
<thead>
<tr>
<th>During the past 30 days, how often did you feel:</th>
<th>None of the time</th>
<th>A little of the time</th>
<th>Some of the time</th>
<th>Most of the time</th>
<th>All of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ...tired for no good reason?</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>![Checkmark]</td>
</tr>
<tr>
<td>2. ...nervous?</td>
<td></td>
<td>![Checkmark]</td>
<td></td>
<td></td>
<td>![Checkmark]</td>
</tr>
<tr>
<td>3. ...so nervous that nothing could calm you down?</td>
<td>![Checkmark]</td>
<td></td>
<td></td>
<td></td>
<td>![Checkmark]</td>
</tr>
<tr>
<td>4. ...hopeless?</td>
<td>![Checkmark]</td>
<td></td>
<td></td>
<td></td>
<td>![Checkmark]</td>
</tr>
<tr>
<td>5. ...restless or fidgety?</td>
<td></td>
<td>![Checkmark]</td>
<td></td>
<td></td>
<td>![Checkmark]</td>
</tr>
<tr>
<td>6. ...so restless that you could not sit still?</td>
<td></td>
<td>![Checkmark]</td>
<td></td>
<td></td>
<td>![Checkmark]</td>
</tr>
<tr>
<td>7. ...depressed?</td>
<td>![Checkmark]</td>
<td></td>
<td></td>
<td></td>
<td>![Checkmark]</td>
</tr>
<tr>
<td>8. ...so depressed that nothing could cheer you up?</td>
<td>![Checkmark]</td>
<td></td>
<td></td>
<td></td>
<td>![Checkmark]</td>
</tr>
<tr>
<td>9. ...that everything was an effort?</td>
<td>![Checkmark]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. ...worthless?</td>
<td>![Checkmark]</td>
<td></td>
<td></td>
<td></td>
<td>![Checkmark]</td>
</tr>
</tbody>
</table>

Score – 26

Level of psychological distress

10-19  Low psychological distress

20-24  Mild psychological distress

25-29  Moderate psychological distress

30-50  High level of psychological distress
AOD COMPREHENSIVE ASSESSMENT

This section provides information about the AOD Comprehensive Assessment (referred to interchangeably throughout this document as “comprehensive assessment” and “assessment”).

Instructions

1. Use the intake tool and self-completion form as starting points that you can refer back to and build on
2. Complete the core part of the assessment
3. Complete any Optional Modules as appropriate or if desired

Complete final case summary sheet and your agency’s care plan,

Purpose

- To ensure that the client’s comprehensive treatment needs are adequately assessed and recorded so they can access the services most suitable to their needs.
- Provide MI/BI if required and/or complete any immediate referrals.
- To allow specialist AOD clinicians to coordinate treatment placements effectively.

Structure

The AOD Comprehensive Assessment contains a core component (pages 1 to 18) of largely open-ended items, and additional optional modules, which can be completed if required or desired. It culminates in a Final Case Summary Sheet, which enables you to synthesise all the information gathered during intake and assessment before completing a care plan. It is not intended that items are read out verbatim in a formulaic and mechanical manner. Rather the items act as prompts and reminders and provide space for you to record information provided throughout the course of discussion with the client.

The Comprehensive Assessment builds on the intake tool, and as such there are in-built links to the intake tool in the form of alerts. These alerts indicate information that the client has already provided in the intake tool and therefore that you can record in the assessment without having to repeat it. In some instances information provided in the intake tool can act as prompts that elicit further information and clarification. For instance, basic psychosocial information is recorded on the intake tool. When discussing psychosocial information in the assessment you might like to draw upon intake tool information to stimulate further discussion.

The intake tool also acts as a point of reference to ensure that vital information is recorded in the assessment correctly. For instance, if during the course of an assessment, the client mentions that they only use alcohol, but on the intake tool, they have reported that they have also used cannabis, then this might be something that needs to be clarified.

Similarly alerts also indicate where optional modules are available for completion as required or desired. These do not necessarily have to be completed right away but may be completed over time as appropriate.
Content
The core component of the assessment contains the following sections:

1. Alcohol and other drugs (AOD)
2. Psychosocial
3. Medical history
4. Mental health
5. Current prescribed medications
6. Risk
7. Final case summary sheet

1. Alcohol and other drugs (AOD)
The alcohol and other drugs (AOD) section is a place to record detailed information related to alcohol and drug use and associated harms and experiences.

1a) contains a drug grid, which enables you to succinctly record details relating to each substance used. These include age at first use, age of regular use, route of use, average quantity used, days used in the past week, days used in the past four weeks, days injected in the past four weeks (as this can be a particularly important flag of risk), a clients' last use, and whether a client is seeking help for each substance used. The substance categories listed in the first column correspond with the substance categories used in the self-completion form so that in some instances you can transfer the details over. There is space in each row to record where a client mentions using more than one substance in a substance category (e.g., they use both speed and Ice, which are included in the “Methamphetamines” category). Given the high rates of cigarette smoking amongst AOD clients, a prompt around whether smoking cessation support is desired has been included, along with the Quitline number for those that would like smoking cessation support.

1b) provides a space to record details about a client’s current drug use state, including signs of intoxication or withdrawal and for BAC where appropriate.

1c) enables you to record a client’s AOD use history and behaviours. The first two of these relate to periods of abstinence, and past treatment history. The remainder relate to hospitalisations/ED presentations as a result of AOD use, overdoses and awareness of naloxone, withdrawal or related complications (e.g., seizures, delirium and hallucinations etc.), risky injecting practices, whether people use AOD alone, drives while intoxicated (and ever been caught/lost licence), and harm to self and others as a result of AOD use (which can be transposed from the intake tool). For each item you can record whether this occurred within the last four weeks (current), and/or in the past, or if the experience has never occurred at all. There is also space for you to record further details about each experience. Together this information may provide a potential indication of problem severity and risk, and conversely strengths and resources; if for instance, the client has had periods of successful treatment completion in the past. It also provides an opportunity for harm-reduction responses such as raising awareness of naloxone where relevant.

There is also space at the bottom of 1c) to record and synthesis any notes or actions, or any patterns of use and AOD experiences that are apparent.
2. Psychosocial

Often AOD issues are influenced by or influence the psychosocial context in which people live their lives. Clients also readily report a desire for help in addressing these issues as part of a holistic response. Therefore it is important to assess pertinent psychosocial issues and strengths. In the assessment document, the psychosocial section contains prompts on: resources and supports; a genogram; prompts for family, children and social relationships; finances, employment and training; and a client's current legal status. This section also contains a range of optional modules for further exploration if desired, including OPTIONAL MODULE 5: QUALITY OF LIFE, OPTIONAL MODULE 6: GAMBLING, AND OPTIONAL MODULE 7: GOALS, OPTIONAL MODULE 8: ASSESSMENT OF RECOVERY CAPITAL; and OPTIONAL MODULE 9: STRENGTHS. You may like to consider completing OPTIONAL MODULE 6: GAMBLING if in the intake tool, the client indicated gambling was a concern. Similarly, OPTIONAL MODULE 12: FORENSIC is also available if potential legal issues are flagged. Aside from these two optional modules, the other optional modules included in this section all have a strengths focus and could be used as therapeutic tools as well as assessment tools.

2a) this section enables you to detail resources, supports and strengths that the client can draw upon to meet their treatment goals. These may include informal resources such as participation in meaningful activities, groups, employment and training or supportive family members, friends, social networks, and past successful experiences in overcoming challenges. This section also includes space to record formal supports such as engagement with other services and health professionals. One way to think about resources and supports is in terms of recovery capital, which relates to the internal and external resources that a person can draw upon to initiate and sustain recovery. Optional Module 8: Assessment of Recovery Capital, and Optional Module 9: Strengths are available to explore this in further detail.

2b) provides space for a genogram, ecomap or socio-gram, in which you can map out family and other important relationships to get a sense of the client's social networks and environments and how their AOD use affects or is affected by their social networks and environments. Given that clinician’s may have preferences around how they visually represent a client’s social networks and worlds, clinicians may choose to complete a genogram, ecomap or sociogram as desired. Similarly, they may also choose simply to record information about social relationships in written form. As there are a variety of resources available and different techniques for completing a genogram/ecomap/sociogram these are only briefly described here.

A genogram is a visual representation of family relationships, which uses symbols to provide an indication of the type and quality of relationships within a family. Additional symbols can be included to include AOD and/or other health problems. While clinicians may have their own styles in completing genograms, Figure X (from dovetail.org.au) provides an example of basic symbols:

---

Figure X: Genogram symbols (dovetail.org.au)

Basic symbols

<table>
<thead>
<tr>
<th>Male</th>
<th>Female</th>
<th>Transgender</th>
<th>Birth Date</th>
<th>Age</th>
<th>Death Date</th>
<th>Death = X</th>
</tr>
</thead>
<tbody>
<tr>
<td>![Male Symbol]</td>
<td>![Female Symbol]</td>
<td>![Transgender Symbol]</td>
<td>![Birth Date Symbol]</td>
<td>![Age Symbol]</td>
<td>![Death Date Symbol]</td>
<td>![Death Symbol]</td>
</tr>
</tbody>
</table>

- female to male
- male to female
- written above left of symbol
- written inside symbol
- written above right of symbol

Marriage

De-facto Relationship

Lesbian Couple

Gay Couple

- Two people who are married or de-facto are connected by lines that go down and across.

Separation

Divorce

Getting back together after divorce

Children: List in birth order beginning with oldest on the left

Symbols denoting interactional patterns between people

Close

Distant

Fused

Focused On

- Cutoff
- Hostile
- Physical Abuse
- Sexual Abuse

Symbols Denoting Alcohol and Other Drug (AOD) and/or Mental / Physical Problems

<table>
<thead>
<tr>
<th>Alcohol or Other Drug Problem</th>
<th>Suspected AOD Problem</th>
<th>Previous AOD Problem</th>
<th>Mental Health or Physical Problem</th>
<th>AOD Problem and Mental Health or Physical Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>![Alcohol or Other Drug Problem Symbol]</td>
<td>![Suspected AOD Problem Symbol]</td>
<td>![Previous AOD Problem Symbol]</td>
<td>![Mental Health or Physical Problem Symbol]</td>
<td>![AOD Problem and Mental Health or Physical Problem Symbol]</td>
</tr>
</tbody>
</table>
A sociogram is similar to a genogram but enables you to map out not only family relationships but also other people in a client's social network, providing an indication of the size, composition, and nature of relationships within a social network. An ecogram is similar to a sociogram but it can also include groups and other sources of support, such as support groups or services that the client is engaged with. You may also like to incorporate details on the genogram, sociogram or ecomap about the strength of connections (or how important/supportive they are) and whether people in the map are active AOD users or non-users.

Figure 3: Example of a sociogram and ecomap

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2c) can be used to record important details of the discussion on family, children/dependents and social relationships prompted by the genogram/ecomap/sociogram in 5b). Among other things, you might record information on responsibilities for children/dependants, their ages, the impact of substance use on these, whether they are vulnerable, have child protection involvement and responsibility for pets. It also contains a prompt to record information about the safety of dependants/children.

2d) enables you to build on the information gained in the intake tool about a client’s housing situation and whether the client has current housing support or whether any further housing support is required.
2e) also refers to a client’s finances, employment and training situation. You will be able to transpose, clarify and build on information collected in the intake tool. You may also like to consider the client’s main income source such as benefits or employment and whether the client needs financial counselling.

2f) is about a client’s current legal status and history. This is an opportunity to build on information from the intake tool, and to understand whether the client currently has any criminal justice involvement. There is also space to record any charges pending, offences, and legal history. This could include information about a client’s next court date, previous convictions, involvement with sheriff, and their correction officer’s details if they have one. **OPTIONAL MODULE 12: FORENSIC** is also available if potential legal issues are identified in this section.

3. **Medical history**

Excessive AOD use can exacerbate or result in a range of physical health issues, and medications for physical conditions may interact with other substances used. This section provides a place to record any medical issues that the client may be or may have experienced. Near the title at the beginning of the module, there is an alert that says “**OPTIONAL MODULE 1: PHYSICAL EXAMINATION** available”. This optional module that can be completed by qualified medical and nursing staff.

3a) enables you to record any medical problems, conditions or experiences that a client has. This can be done by ticking the corresponding box/es and recording information about the history of the condition, details of hospital admissions, past and needed investigations/actions, or treatments where appropriate. There is an alert to an optional module that can be completed if you think your client may have a potential Acquired Brain Injury – **OPTIONAL MODULE 2: ABI REFERRAL TOOL** available. This section also contains a prompts around whether the client would like to be tested for STIs. Given the legal and other sensitivities around Blood Borne Viruses it is not appropriate to ask whether a client has these. However this section does include prompts to explore whether the client has been tested or would like to be tested or whether the client would like information around current treatments and preventative medications such as Pre exposure prophylaxis (PreP).

4. **Mental health**

Given that mental health and AOD issues may co-occur, it is important to record information about any mental health issues a client may be experiencing. This section includes a table of diagnosed mental health conditions, space to record a client’s mental health history and assess their mental state, and additional space to record any notes and actions. There are also two optional assessment modules that can be completed to follow-up on any suspected mental health issues as indicated by the client’s K10 score in the self-completion form. These include **OPTIONAL MODULE 3: MENTAL HEALTH (MODIFIED MINI SCREEN)** or **OPTIONAL MODULE 4: PSYCHECK**.

4a) begins with a table to record current diagnosed conditions that the client may have talked to you about. Conditions are grouped according to the disorder type and in each category there is also another box, to enable you to record diagnosed conditions that do not appear on the form. In the column next to each diagnosed condition there is space to record the history of each mental health condition, who diagnosed it and when, as well as details about investigations and treatments where appropriate.

Underneath the table, there is also space to record details about whether the client has a mental health case manager or mental health worker, a mental health care plan from a GP or whether there are any current undiagnosed mental health concerns. Here you might also document the results of the K10 or Optional Module 3 or Optional Module 4 in order to further explore potential undiagnosed mental health concerns.
4b) is a common mental state examination, which provides an opportunity to document a client’s appearance, behaviour, speech, mood, thought form, thought content, perception, cognition and insight/judgement. Further prompts in the document are provided for each of these to assist with this. The results of the mental state examination might inform your evaluation of risks, and ongoing treatment planning. Further information about conducting a mental state examination can be found here: https://www.mhc.wa.gov.au/media/1178/aod-counselling-guidelines.pdf

5. Current prescribed medications
This section enables you to table the client’s current prescribed medications. This includes methadone, psychotropic medication, over-the-counter-drugs, and complementary medicines. There may be some overlap here with the drug grid in 1a), in which case you can transpose this over, and record any additional prescribed medications taken, prescribed dose and duration of treatment, reasons for prescription/use, whether the medication is taken as prescribed and details of the prescriber/pharmacy and pick up arrangements. This section culminates with the space to note down any further relevant information and/or actions.

6. Risk
This section reminds you to complete your agency’s current risk assessment. An example of a suicide and self-harm risk assessment is included and space to record risks to self and others.

6a) is an example of a suicide and self-harm risk assessment – based upon the Suicide Assessment Five-step Evaluation and Triage (SAFE-T approach) – is included for your reference and in case your agency doesn’t have a risk assessment. This was developed by the Suicide Prevention Resource Centre in the United States and involves:

   i. Identifying risk factors, noting those that can be modified to reduce risk
   ii. Conducting suicidal (and self-harm) inquiry: suicidal thoughts, plans, behaviour and intent
   iii. Identifying protective factors, noting those that can be enhanced
   iv. Determine level of risk and choose appropriate intervention to address and reduce the risk
   v. Document the assessment of risk, rationale, intervention and follow-up and follow up instructions

One of the positive features of this suicide and self-harm risk assessment is that it also draws attention to protective factors – something which traditional risk assessments have sometimes overlooked. It is important to note that the prompts included in the table are not intended to be asked out loud as they appear, but are instead places where you can record information that is discussed over the course of the assessment conversation.

Determining level of risk is based on the information you’ve recorded in relation to risk, suicidal enquiry, protective factors etc. and your clinical judgement.
The following table from the developers of the SAFE-T approach might also provide an indicative guide:

<table>
<thead>
<tr>
<th>RISK LEVEL</th>
<th>RISK/PROTECTIVE FACTORS</th>
<th>SUICIDALITY</th>
<th>POSSIBLE INTERVENTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGH</td>
<td>Psychiatric disorders with severe symptoms, or acute precipitating event</td>
<td>Potentially lethal suicide attempt or persistent ideation with strong intent or rehearsal</td>
<td>Admission generally indicated unless a significant change reduces risk. Suicide precautions</td>
</tr>
<tr>
<td>MODERATE</td>
<td>Multiple risk factors, few protective factors</td>
<td>Suicidal ideation with plan, but no intent or behaviour</td>
<td>Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers</td>
</tr>
<tr>
<td>LOW</td>
<td>Modifiable risk factors, strong protective factors</td>
<td>Thoughts of death, no plan, intent or behaviour</td>
<td>Outpatient referral, symptom reduction. Give emergency/crisis numbers</td>
</tr>
</tbody>
</table>

Further information about the SAFE-T approach can be found here: [https://www.porticonetwork.ca/documents/366159/1073220/Suicide+Assessment+Five-Step+Evaluation+and+Triage+%28SAFE-T%29+Booklet/00b209ca-3078-45db-a175-6983c6962166](https://www.porticonetwork.ca/documents/366159/1073220/Suicide+Assessment+Five-Step+Evaluation+and+Triage+%28SAFE-T%29+Booklet/00b209ca-3078-45db-a175-6983c6962166)

6b) enables you to record harms that the client has inflicted upon others or that they have experienced from others. These could include things like a history of violence to or from others including assaults, family violence, the presence of children, threats to kill, and sexual abuse/assault. You could also record how harm to or from others may be associated with AOD use. It also invites you to document whether the client feels safe. OPTIONAL MODULE 10: FAMILY VIOLENCE (DHS IDENTIFYING FAMILY VIOLENCE RECORDING TEMPLATE) is also available should you need to record any family violence issues.

Please note that the data specification requirements around maltreatment require a distinction between a history of neglect/abandonment, physical abuse, sexual abuse, psychological abuse, and otherwise not specified e.g. financial. It will also require the perpetrator to be identified as spouse/domestic partner, parent, other family member, friend/acquaintance, official authorities, person unknown to the victim, multiple persons unknown to the victim or other/not stated. Importantly it is not necessary (and in some cases not appropriate) to directly inquire about history of maltreatment. However if the client self discloses during the assessment or treatment, the above details should be noted for data collection purposes. For guidance on how to sensitively ask and record family issues, dependant vulnerability, and child protection issues please refer to the guidance provided in the section on Optional Module 10 (Page 49).

**Safety Plan**

This section also includes a safety plan template that can be completed with the client if any risk of suicide, self-harm or violence is identified. The safety plan can be given to the client to help them work through any suicidal thoughts or feelings of distress as they arise. It contains space to record people that the client can call when they are feeling distressed, and actions they can take to help them cope with and get through the suicidal or distressing thoughts. It also includes the Lifeline and Directline numbers for immediate support. Ideally, a copy of the safety plan will be given to the client, and potentially other family members, supports or health professionals as desired.
More safety planning resources can be found here: https://www.beyondblue.org.au/get-support/beyondnow-suicide-safety-planning

Another option is to give the client a copy of the K10 to self-monitor their psychological distress so that they can implement their safety plan when the K10 exceeds an agreed score e.g. the baseline score that has been recorded in the self-completion form.

7. Final Case Summary Sheet
The final section of the comprehensive assessment provides space to synthesise and summarise the key presenting concerns and issues identified across the intake and assessment process in preparation for care planning.

Goals and reasons for presentation
As well as recording any allergies identified, there is space to synthesise the client’s goals and reasons for presentation, in which you might include some contextual information about client demographics as well.

Substance use and mental health
The next section then enables you to narratively synthesise information about the client’s substance use and any mental health issues. It also includes space to record the client’s main substances of concern, and boxes to record their AUDIT, DUDIT and K10 score from the self-completion form. As per the DHHS data specification requirements, it also provides a box to record the client's Tier. Note Tiers are NOT used to determine treatment plan but can be useful in assisting services to monitor client groups in terms of complexity and assist service planning activity. As well as using your clinical judgement, tiers can be determined by:

1. Looking at the client’s AUDIT/DUDIT score to see whether they are indicated as being in the “dependence likely” category
2. Tallying up how many of the following complexity factors the client has:

<table>
<thead>
<tr>
<th>Complexity factor</th>
<th>Definition</th>
<th>Where to find the information?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poor mental health</td>
<td>• K10 score of 30 or above or Presence of serious Mental Health diagnoses (e.g., Bipolar disorder, Schizophrenia, Borderline personality disorder etc.)</td>
<td>• Self-completion form (Page 4)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Comprehensive assessment (K10 score in final case summary)</td>
</tr>
<tr>
<td>Lack of meaningful activity</td>
<td>• Unemployed and not studying or performing home duties</td>
<td>• Self-completion form (Page 2, section 2)</td>
</tr>
<tr>
<td>Housing insecurity</td>
<td>• Homeless or at risk of eviction</td>
<td>• Intake tool (Page 3, Q24)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Self-completion form (Page 2 Section 2)</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>• Pregnant</td>
<td>• Intake tool (Page 3, Q17)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Comprehensive assessment (Page 8, Medical Section)</td>
</tr>
<tr>
<td>Serious criminal justice</td>
<td>• (i.e., on a court order or on)</td>
<td>• Intake tool (Page 3, Q26)</td>
</tr>
</tbody>
</table>
involvement parole

Multiple previous AOD treatment episodes
- More than 5 AOD treatment episodes (lifetime)

Children potentially unsafe
- Clinician concern about parenting capacity or
- Children unsafe

Significant/serious physical health issue
- Serious physical illness (e.g. liver, cardiovascular, respiratory, neurological disease) that significantly impacts on well-being/functioning

3. Clients can be placed in Tier as per the following table:

<table>
<thead>
<tr>
<th>Tier</th>
<th>Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Not dependent and no complexity factors</td>
</tr>
<tr>
<td>2</td>
<td>Not dependent and complexity factors</td>
</tr>
<tr>
<td>3</td>
<td>Dependent and 0-1 complexity factors</td>
</tr>
<tr>
<td>4</td>
<td>Dependent and 2-3 complexity factors</td>
</tr>
<tr>
<td>5</td>
<td>Dependent and 4+ complexity factors</td>
</tr>
</tbody>
</table>

**Risk to self, children or others**
This section enables you to summarise any of the risks to self, children and others recorded and consistent with the DHHS data specifications, provides a space to rate on a scale of 0 to 3 whether you think the risks to self and risk to others is: 0 = None, 1 = Low, 2 = Medium, 3 = High. This section also provides space to document what, if any, safety plan actions were taken.

**Other key issues**
This provides a space for you to synthesise any medical, and psychosocial issues and needs that may have become apparent through the assessment process.

**Brief case formulation**
This section provides you with space to integrate all the information gathered throughout the assessment process to provide a brief explanation and formulation of what factors are contributing to and perpetuating the clients presenting issues, which you’ve documented in the other parts of the Final Case Summary Sheet.

The Brief Case Formulation contains the 4P's headings, including:
- "Predisposing factors: These are issues in the client's childhood, adolescence and adulthood that predispose them towards experiencing AOD, mental health and other current difficulties."
• Precipitating factors: These are the factors that have brought the client's difficulties to a head and resulted in them seeking treatment.
• Perpetuating factors: These are the factors in the client's life, behaviour, beliefs and psychological state that maintain the presenting issues.
• Protective factors: These are the client's strengths and resources.” (AOD counselling guidelines)
• See appendix 4 for the tool

According to the AOD counselling guidelines:
• “Assessment results should be presented to clients in the form of the case formulation so as to help them make sense of their difficulties. A case formulation diagram can be useful.
• Clients should be encouraged to provide feedback on the case formulation and it should be adjusted in response to this feedback.
• The case formulation should be linked to a treatment plan that addresses the factors that are perpetuating the client's difficulties.” (AOD counselling guidelines)


**Treatment type/s required**
The final case summary sheet culminates with a table that enables you to record the treatment types that the client might require. For each treatment type required, you can also document the agreed actions, which could include referrals and noting the where, why, and to whom a referral is sent, as well as a referral date and appointment time and date. Finally, as per the DHHS data collection requirement, you will need to record the date the assessment was completed, the number of sessions it took to complete the assessment, the number of assessment sessions where the client did not attend and the setting where the assessment was completed. While the final case summary is not meant to replace your agency's care plan, it can be sent to another agency if onward referral is required.

**8. Consent to share information**
With consent, information about a client obtained through the assessment process will be passed on to intake and treatment providers to support a client's treatment journey. In doing so, this reduces the likelihood of a person needing to repeat their details and re-tell their story as they are referred to supports, and will assist treatment providers to deliver individualised evidence-based treatment.

Assessment providers are required to discuss the sharing of a client's information with each client and arrange for a client to sign the organisation's consent to share information form. It is important that a client knows why their information is collected, what information will go and to whom, as well as their rights and obligations in relation to providing (and later accessing) their information.

Upon the completion of an assessment, the assessment provider will collaborate with the intake service to share information about client movement and treatment types referred to. This assists the intake provider to understand service demand, capacity and availability. Assessors should obtain consent from a client for this purpose.

De-identified information provided through the assessment tool, including the self-assessment, is collected by the Victorian Alcohol and Drug Collection. This information is used by the Department of Health and Human
Services to develop a better understanding of how clients travel through treatment services, assess system performance and client trends and ultimately to improve the service system.

Further information about consent and information sharing can be found in the Frequently Asked Questions (FAQ) section of this Clinician Guide on page 57.
OPTIONAL ASSESSMENT MODULES

The optional assessment modules are not compulsory but provide clinicians with tools to gather further detailed information in relation to specific issues or areas as desired. The use of additional optional modules is likely to vary according to your agency and its focus and also on the client’s needs. If a client indicates that gambling is not a problem for them in the intake tool, then there is no need to complete Optional Module 6: Gambling. The optional modules are predominantly standardised instruments and are detailed below.

Each optional module begins with a brief explanation of the purpose of the module and who can administer the module, a suggested introduction for the client, and instructions. Please note that the introduction is simply a prompt for you as the clinician to explain what the module is about. Like any prompt in the assessment document, you would articulate it in a way that you see is appropriate in the context of your interaction with a particular client.

**Optional module 1: Physical examination**

This module is to be completed by a medical doctor or nurse only, and will enable the clinician to determine the physical impact of AOD issues on a person’s health. Information collected in this module is routinely collected by medical doctors and nurses when undertaking a physical examination of clients with AOD issues. It is a generic examination that was developed in consultation with an addiction medicine specialist. It includes systems that may be involved in any drug use, and some prompts that are specific for injecting and alcohol, but not to the exclusion of other drug use. It contains ample space for a clinician to formulate responses and note actions to be taken.

**Optional module 2: ABI referral tool for neuropsychology assessment**

This module can be completed if you suspect that the client may have symptoms of an ABI or require further neuropsychology assessment. The module was developed in collaboration with Turning Point’s Neuropsychology service, as a way of ascertaining whether referral for further neuropsychology assessment is required. This module is to be completed by you as the clinician based upon discussion with the client and information gathered during assessment. The module enables you to record in simple tick box form whether the client has a history of factors which may put them at greater risk of having an ABI or other neuropsychological difficulties. These include a history of head injury, brain surgery, diagnosed neurological disorder, learning difficulties, mental illness, or chronic heavy AOD use over a period of greater than five years among others. Then the form asks you to record whether any current concerns about a client’s cognitive functioning are present. These include factors such as memory issues, attentional problems, difficulties in reasoning or problem solving, a lack of insight, disinhibited or inappropriate behaviour, or poor orientation to place, day, month or year. You may have detected some of these issues when recording a client’s mental state in the comprehensive assessment. If there is at least one historical factor and one current concern present, then you might consider referring the client on to an ABI-AOD clinician at your agency or if you are unsure, you can contact the Statewide Neuropsychological Service to discuss a potential referral.
Optional Module 3: Mental health (Modified Mini Screen)

The Modified MINI Screen provides comprehensive screening of psychological and psychiatric disorders. The questions in the screen are based upon gateway questions used in the Diagnostic and Statistical Manual IV (DSM-IV), the Structured Clinical Interview for Diagnosis (SCID) and the Mini International Neuropsychiatric Interview (MINI). This means that it can be readily linked to diagnosis (although diagnosis can’t be inferred from screen results). It has also been found to have good client acceptability, and is easily administered. It involves the clinician asking the client 22 questions related to symptoms of mental health issues. Questions 1 to 6 relate to mood disorders, questions 7 to 15 relate to anxiety disorders, and questions 16-22 relate to psychotic disorders. These questions are based upon gateway questions used in the Diagnostic and Statistical Manual IV (DSM-IV), the Structured Clinical Interview for Diagnosis (SCID) and the Mini International Neuropsychiatric Interview (MINI).

Tallying up the total number of Yes responses yields a score and this can be compared against established cut-offs, which are provided at the end of the module. A score of 10 or above indicates that the client has a high likelihood of mental illness and that further diagnostic assessment by a trained mental health clinician is warranted. Any intervention you might be able to provide might also be useful here. For clients that score between 6 and 9, indicating a moderate likelihood of mental illness, clinical judgement will need to be applied as to whether the client is referred for further diagnostic assessment.

If the client answers “yes” to question 4 “In the past month, did you think that you would be better off dead or wish you were dead?” you would need to present, apply appropriate suicide risk measures. The Modified MINI Screen developers recommended that further assessment is required if a client says “yes” to question 4, irrespective of their overall score. They also recommend further assessment if the client responds “yes” to both question 14 and question 15, which relate to symptoms of Post Traumatic Stress Disorder. Further information can be found in the Modified Mini Screen user guide:


Optional Module 4: Psycheck

The Self Reporting Questionnaire (SRQ) component of Psycheck was initially developed by the World Health Organization and modified to screen for symptoms of the more common mental health problems, such as anxiety and depression, among alcohol and drug clients in AOD clinical settings. There are 20 questions related to common symptoms of depression, anxiety and somatic complaints (such as sleep problems, headaches and digestive problems). The client is first asked to tick any symptoms that they have experienced in the past 30 days. Second, for every ‘Yes’ answer, the client is asked to tick whether they have experienced that problem when they were not using alcohol or other drugs. The clinician then counts the total number of ticks in the circles and places the score at the bottom of the page. Interpreting the score is a matter of comparing the total number of ticks to cut-offs as outlined at the end of the module. The PsyCheck Screening Tool is the basis of a stepped care model in which the treatment response is determined by the initial PsyCheck Screening Tool score. The PsyCheck Screening Tool is designed to be used in conjunction with the PsyCheck Clinical Treatment Guidelines. Further information can be found at the Psycheck website: www.psycheck.org.au
Optional module 5: Quality of life
This module contains the World Health Organization Quality of Life-BREF (WHOQOL-BREF). This assesses a person's perceived quality of life in relation to their goals and expectations. It covers four major facets of quality of life: physical health, psychological health, social relationships and environment – and asks questions that clients may not have been asked before. Quality of life is one of the areas that has been neglected in the area of addictions but one that is considered important to clients.

This module can either be self-completed or clinician-administered and contains 26 questions that the client responds to using a 5-point Likert scale.

It is possible to derive four domain scores from the WHOQOL-BREF. The four domain scores denote an individual's perception of quality of life in each particular domain. Calculating domain scores involves two steps

Step 1
Calculate raw scores for each domain using the guidance in table 9.

\[
\begin{align*}
\text{Domain} & \quad \text{Equation for computing domain scores} & \text{Raw score} \\
1. \text{Physical Health} & \quad (6 \cdot Q3) + (6 \cdot Q4) + Q10 + Q15 + Q16 + Q17 + Q18 & = \\
2. \text{Psychological} & \quad Q5 + Q6 + Q7 + Q11 + Q19 + (6 \cdot Q26) & = \\
3. \text{Social relationships} & \quad Q20 + Q21 + Q22 & = \\
4. \text{Environment} & \quad Q8 + Q9 + Q12 + Q13 + Q14 + Q23 + Q24 + Q25 & = 
\end{align*}
\]

For instance to calculate the Physical Health domain raw score, note down the client’s responses to each of the relevant questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Clients response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question 3</td>
<td>Very much = 4</td>
</tr>
<tr>
<td>Question 4</td>
<td>A moderate amount = 3</td>
</tr>
<tr>
<td>Question 10</td>
<td>A little = 2</td>
</tr>
<tr>
<td>Question 15</td>
<td>Poor = 2</td>
</tr>
<tr>
<td>Question 16</td>
<td>Satisfied = 4</td>
</tr>
<tr>
<td>Question 17</td>
<td>Satisfied = 4</td>
</tr>
</tbody>
</table>


Then add these responses into the equation in the table above. For example:

<table>
<thead>
<tr>
<th>Physical health domain raw score</th>
<th>= (6 - 4) + (6 - 3) + 2 + 2 + 4 + 4 + 5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>= 2 + 3 + 2 + 2 + 4 + 4 + 5</td>
</tr>
<tr>
<td></td>
<td>= 22</td>
</tr>
</tbody>
</table>

**Step 2**

Convert raw scores to a transformed scores (on a 0-100 scale) using table 10 for each domain on the next page (e.g. if a client's raw score on the Physical Health domain is 22 then their transformed score will be 56).
### Domain 1: Physical Health

<table>
<thead>
<tr>
<th>Raw score</th>
<th>Transformed Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>9</td>
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<tr>
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</tr>
<tr>
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<tr>
<td>12</td>
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<tr>
<td>21</td>
<td>50</td>
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<td>22</td>
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<td>63</td>
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<td>25</td>
<td>63</td>
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<tr>
<td>26</td>
<td>69</td>
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<tr>
<td>27</td>
<td>69</td>
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<td>29</td>
<td>81</td>
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<tr>
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<td>81</td>
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<td>34</td>
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<td>35</td>
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### Domain 2: Psychological

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<td>38</td>
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<td>27</td>
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<td>94</td>
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<td>29</td>
<td>94</td>
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<tr>
<td>30</td>
<td>100</td>
</tr>
</tbody>
</table>

### Domain 3: Social relationships

<table>
<thead>
<tr>
<th>Raw score</th>
<th>Transformed score</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
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<td>6</td>
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<td>81</td>
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<tr>
<td>14</td>
<td>94</td>
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<tr>
<td>15</td>
<td>100</td>
</tr>
</tbody>
</table>

### Domain 4: Environment

<table>
<thead>
<tr>
<th>Raw score</th>
<th>Transformed score</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>0</td>
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<tr>
<td>39</td>
<td>94</td>
</tr>
<tr>
<td>40</td>
<td>100</td>
</tr>
</tbody>
</table>

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Table 10: Conversion table
There are no cut-off scores for the WHOQOL-BREF but higher transformed scores on each of the domains indicate a higher quality of life in that particular area (e.g. someone who scores 75 on the Social relationships domain has a higher perceived quality of life in relation to Social Relationships than someone who scores 25). The WHOQOL-BREF is potentially a really useful indicator of progress and can be readministered in two weeks after the completion of the module (at the very least). If re-administered it is likely to be helpful to tell the client how they have been progressing as this may encourage and motivate them to continue progressing, or to do things slightly differently to maximise progress. Further information on the WHOQOL-BREF can be found in the WHOQOL-BREF user guide here: [http://www.who.int/mental_health/media/en/76.pdf](http://www.who.int/mental_health/media/en/76.pdf)

Optional Module 6: Gambling

This module is from the *Problem Gambling Severity Index (PGSI)*. The PGSI is a standardised 9-item gambling scale that is based upon DSM-IV criteria and is easy to administer. It enables you to identify the severity of a client's gambling issue. The PGSI was designed to be self-administered but can also be administered by a clinician.

Each of the questions in the PGSI ask the client to respond on a scale of 0 (never) to 3 (sometimes) about issues in the past year. These responses are then tallied up to provide an overall score of 0 to 27. A score from 8 to 27 indicates that the client is likely to be a problem gambler, and may experience negative consequences as a result of this, including and a possible loss of control.

As well as the overall score, it is also possible to assess the answers to individual items to obtain a better understanding of a person's gambling. Questions 1 to 4 relate to problem gambling behaviours and questions 5 to 9 relate to adverse consequences of gambling. Table 11 details the specific content of each question:

<table>
<thead>
<tr>
<th>Domains</th>
<th>Question Number</th>
<th>Item Content</th>
</tr>
</thead>
<tbody>
<tr>
<td>Problem gambling</td>
<td>1</td>
<td>Bet</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>Tolerance</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>Chase</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>Borrowed</td>
</tr>
<tr>
<td>Adverse consequences</td>
<td>5</td>
<td>Felt problem</td>
</tr>
<tr>
<td>of gambling</td>
<td>6</td>
<td>Criticised</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>Felt guilty</td>
</tr>
<tr>
<td></td>
<td>8</td>
<td>Health problem</td>
</tr>
<tr>
<td></td>
<td>9</td>
<td>Financial problem</td>
</tr>
</tbody>
</table>

Further information about the PGSI can be found in the following article:

Optional Module 7: Goals
The goal planner is another optional brief intervention form. It builds on client's self-reported assessment of needs to determine the client’s priorities. This may not only enhance motivation for treatment but may also build client's ownership and involvement in their treatment journey. Together with results from standardised screeners and your own clinical judgement, this form can provide a strong indication of the client's needs. You may like to give the client a copy of this to take home, as an everyday reminder of what they are aiming to achieve.

Optional Module 8: Assessment of Recovery Capital
Using the Assessment of Recovery Capital (ARC), this module enables you to identify internal and external resources and strengths that individuals can draw upon to help them meet their recovery and treatment goals. The 50-item ARC measures recovery capital on ten domains including: 1) Substance use and sobriety, 2) Global psychological health, 3) Global physical health, 4) Citizenship and community involvement, 5) Social support, 6) Meaningful activities, 7) Housing and safety, 8) Risk-taking, 9) Coping and life functioning, 10) Recovery experiences.

Each domain has a score out of 5, with higher scores indicating more strengths and resources. Like the WHOQOL-BREF, there are no cut off scores for the ARC, but it will illustrate areas of strengths and possibly areas for improvement. For instance, if a client scores 5 (out of 5) on the social support domain, but scores 1 (out of 5) on the meaningful activities domain, then this might indicate that the client is doing really well in terms of social support but may not be engaged in many meaningful activities. This might be an area that the client might like to work on.

Like most of the standardised instruments, feedback on the results of the ARC might be helpful to the client in terms of motivating clients to continue with their progress. This module may be particularly suitable for clients whose goal is recovery but also might be applicable broadly, as many of the domains it measures are likely to be important to any client, irrespective of their treatment goals. Further information on the ARC can be found in the following article:


Optional Module 9: Strengths
This is a motivational enhancement module that flows on from optional module 8: assessment of recovery capital to map a client’s strengths. This module asks clients to reflect on their strengths in six areas of their life including: social relationships, health and physical, problem solving/coping, values and beliefs, work/skills, and emotions/temperament. These strengths can be drawn upon in devising care plans and goals. This module can be completed by the client with the clinician assisting through prompts that draw attention to strengths that the client may have missed. If the client is struggling to think of any strengths, you might like to draw their attention to strengths outlined in optional module 8. Even if their scores on domains in optional module 8 aren't high, there might be some areas that stand out relative to others. Like optional module 9, you may like to give the client a copy of this to take home, as an everyday reminder of their strengths.
Optional Module 10: Identifying family violence

This module enables you to record experiences of family violence that the client might have disclosed. Under the *Department of Human Services Family Violence: Risk Assessment and Risk Management* framework document, there are three levels of family violence assessment:

1. Identifying Family Violence using the Identifying Family Violence Recording Template, which can be completed by mainstream professionals (including AOD workers).
2. Preliminary assessment that can be completed by professionals including police and court staff, members of community legal centres, members of community health centres, and disability and housing services workers.
3. Comprehensive assessment designed to be completed by specialist family violence professionals.

This module includes only the first tier of family violence assessment – identifying family violence. As a clinician you may have expertise in the area of family violence and may feel confident completing the preliminary or comprehensive assessment components of the assessment. If so you can find these here along with other helpful information about family violence:


If you are interested in participating in training on identifying family violence, information on training dates and materials can be found here:


This module involves:

1. Assessing whether any possible indicators of family violence have been mentioned
2. Ask prompting questions (in a conversational style rather than one by one in a survey style)
3. Fill out recording template and refer to a family violence worker or service as appropriate. If trained in family violence assessment, consider completing the preliminary assessment found here: http://www.tafe.swinburne.edu.au/CRAF/resources/CRAF%20manual%202012.PDF

Please note that the following content is reproduced from the *Department of Human Services Family Violence: Risk Assessment and Risk Management Manual* (2012) document.
1. Indicators of Family Violence

**Indicators of family violence in an adult can include:**

- appear nervous, ashamed or evasive
- describe their partner as controlling or prone to anger
- seem uncomfortable or anxious in the presence of their partner
- be accompanied by their partner, who does most of the talking
- give an unconvincing explanation of injuries that they or their child has sustained
- have recently separated or divorced
- be reluctant to follow advice
- suffer anxiety, panic attacks, stress and/or depression
- have a stress-related illness
- have a drug abuse problem including dependency on tranquillisers or alcohol
- have chronic headaches, asthma and/or vague aches and pains
- have abdominal pain and/or chronic diarrhoea
- report sexual dysfunction
- have joint and/or muscle pain
- have sleeping and/or eating disorders
- have attempted suicide and/or have a psychiatric illness
- have gynaecological problems and/or chronic pelvic pain, and/or have suffered miscarriages
- have physical signs of violence such as bruising on the chest and abdomen, multiple injuries, minor cuts, injuries during pregnancy and/or ruptured eardrums
- have delayed seeking medical attention
- present with patterns of repeated injury or signs of neglect
Indicators of family violence in a child or young person can include:
- bruises, burns, sprains, dislocations, bites, cuts
- fractured bones, especially in an infant where a fracture is unlikely to have occurred accidentally
- poisoning
- internal injuries
- showing wariness or distrust of adults
- wearing long-sleeved clothes on hot days in an attempt to hide bruising or other injury
- demonstrating fear of parents and of going home
- becoming fearful when other children cry or shout
- being excessively friendly to strangers
- being very passive and compliant.

Indicators of sexual abuse of a child or young person:
- telling someone that sexual abuse has occurred
- complaining of headaches or stomach pains
- experiencing problems with schoolwork
- displaying sexual behaviour or knowledge unusual for the child’s age
- displaying maladaptive behaviour such as frequent rocking, sucking and biting
- experiencing difficulties in sleeping
- having difficulties relating to adults and peers

Indicators of emotional abuse of a child or young person:
- displaying low self-esteem
- tending to be withdrawn, passive and/or tearful
- displaying aggressive and/or demanding behaviour
- being highly anxious
- showing delayed speech
- acting like a much younger child, for example, soiling and/or wetting pants
- displaying difficulties relating to adults and peers

Indicators of possible neglect of a child or young person:
- being frequently hungry
- being poorly nourished
- having poor hygiene
- wearing inappropriate clothing, for example, wearing summer clothes winter
- being unsupervised for long periods
- not having their medical needs attended to
- being abandoned by their parents
- stealing food
- staying at school outside school hours
- often being tired and/or falling asleep in class
- abusing alcohol or drugs
- displaying aggressive behaviour
- not getting on well with peers.

8. Prompting questions for adults

Questioning about possible family violence should begin with an explanation that sets the context for such personal probing. For example:

- *I am a little concerned about you because (list family violence indicators that are present). I would like to ask you some questions about how things are at home. Is that okay with you?*

Once the client has indicated a willingness to talk, you can ask the prompting questions below. These are quite direct, because research indicates that victims are more likely to accurately answer direct questions.

- *Are you ever afraid of someone in your family or household? If so, who?*
• Has someone in your family or household ever put you down, humiliated you or tried to control what you can or cannot do?
• Has someone in your family or household ever threatened to hurt you?
• Has someone in your family or household ever pushed, hit, kicked, punched or otherwise hurt you?
• Are you worried about your children or someone else in your family or your household?
• Would you like help with any of this now?

Prompting questions for adults about violence their child might be experiencing
Children and young people can be affected by family violence even if they do not hear or see it. This means you should always ask the adult about what any children or young people who reside with them (or who have contact with the suspected perpetrator) are experiencing.

If you hold concerns for children, questioning should be appropriate to the developmental stage of the child. If infants are suspected of being at risk from family violence, a thorough assessment must occur. This assessment will need to occur with the mother (or non-abusive parent) present. Referral to Child Protection or to a service with expertise in infant development may be appropriate.

• Is there anyone else in the family who is experiencing or witnessing these things?
• Are you worried about the children?
• How is this affecting the children?

Questions to ask children
Of the following questions, only ask those that you judge to be appropriate to the child’s developmental stage.

• Tell me about the good things at home
• Are there things at home you wish you could change?
• What don’t you like about home?
• Tell me about the ways mum/dad look after you?
• What happens in your house if people have an argument?
• Do you worry about your mum/dad/ brothers/sisters for any reason?

3. Filling out the recording template and making appropriate referrals.
The recording template provides space to record basic information about the victim of family violence, information about the perpetrator, and any children in the family.

Next steps
If it seems family violence is not occurring
If responses to the prompting questions indicate that family violence is not occurring, you must respect this. The person might be experiencing family violence, but either not yet ready to talk about it, or not comfortable talking to you about it. Of course, it is also possible that they are not experiencing family violence. The person should be thanked for answering the questions and informed about the help that is available should they ever experience family violence.
If family violence is occurring

If the person’s responses indicate that they are experiencing family violence:
- start by asking the person how the violence is affecting them, perhaps by simply asking, ‘How is the violence affecting you?’
- acknowledge any challenges and difficulties they have spoken of and validate their efforts to protect themselves and their family members
- state clearly that the violence is not their fault, and that all people have a right to be and feel safe
- briefly (in a few sentences) note that there are many different services and options open to people who experience family violence
- ask whether they would like your help.

You might need to contact several services or authorities in response to a disclosure of family violence. Figure 4 over the page outlines your referral options. If family violence is occurring but the victim declines assistance

If a victim indicates they do not want assistance:
- provide them with contact details for a specialist family violence service
- consider discussing the idea of safety planning (see page 90 of Department of Human Services Family Violence: Risk Assessment and Risk Management Manual (2012) document)
- try to arrange ongoing opportunities to monitor and discuss the violence, perhaps by scheduling future appointments
- continue to engage with the victim and encourage them to accept a referral for their own safety and wellbeing
- determine an appropriate course of action to address the safety and wellbeing of any children or young people who are also victims of the violence:
  - if the child or young person is at risk of physical, emotional or other types of harm and neglect, you should report to Child Protection
  - if you have significant concerns for the wellbeing of the child or young person in the present or future, you could make a referral to your local Child FIRST agency and discuss appropriate options.

Special considerations

If a crime might have been committed
If you consider that a crime might have been committed, carefully set aside evidence such as weapons or torn or blood-stained clothing and contact police. Make notes about your conversation with the victim and about your observations of the victim as soon as possible. This information may be required to help police investigate the possible crime.

If the person identifies as Aboriginal or Torres Strait Islander
Aboriginal or Torres Strait Islander people must be offered a clear choice about whether to use a mainstream or Aboriginal service, and this choice must be respected. Where an Aboriginal-specific service response is not available, consultation with an Aboriginal organisation will support culturally respectful service provision.

The figure on the next page provides a summary of response options for the identification of family violence.
Figure 4: Response options for mainstream services in the identification of family violence

Person in contact with mainstream service

- Indicators of family violence present?
  - YES
    - Ask questions to detect family violence
  - NO
    - No action required

- Person discloses family violence?
  - YES
    - Respect person’s answers and provide information about help that is available if they ever find themselves in a family violence situation
  - NO
    - If in immediate danger and person is willing to receive assistance, refer to Police and/or Specialist Family Violence Service for full assessment
    - If not in immediate danger and person is willing to receive assistance, refer to Specialist Family Violence Service for full assessment
    - If in immediate danger but person NOT willing to receive assistance, consider referral to Police
    - If not in immediate danger and person NOT willing to receive assistance, provide information about help that is available, and monitor closely

- Are children also involved?
  - YES
    - Are children at risk of significant harm?
      - YES
        - Refer to Child Protection
      - NO
        - Are there concerns for child’s wellbeing?
          - YES
            - Refer to Child FIRST
          - NO
            - Monitor situation
    - NO
      - No other action required
Optional Module 11: Impact of AOD use on family member (Significant Other Survey)
This module is based upon the Significant Other Survey and was designed to be used with family members affected by a loved one’s substance use. This is a validated and standardised measure that explores emotional, relationship, family, legal, financial, health, and violence issues faced by family members as a consequence of another person’s AOD use. It was written at a 7th grade reading level and can be self-completed by clients in 10-15 minutes or can be administered by clinicians. It asks the family member about a number of difficulties that are sometimes reported by people with a loved one who may have an alcohol or other drug problem. It then asks the family member to indicate how often they have experienced a particular difficulty (if at all), and how much the problem has bothered them in the past 30 days.

By looking at responses you as the clinician can identify problems/difficulties that occur frequently and/or that the client is particularly bothered by. For instance, if a family member reports frequent emotional difficulties as a consequence of another person’s AOD use and are quite bothered by these, then this is likely to indicate this is a particular problem area. This information can be used to inform care planning, and to make referrals to family support services/groups as required. This module can be re-administered at a minimum of 30 days after it was first completed to monitor changes in the frequency of particular problems and how bothered the client is by these over time. Further information about the Significant Other Survey can be found in the following article: Benishek LA, Carter M, Clements NT, et al. (2012) Psychometric assessment of a self-administered version of the Significant Other Survey. *Psychology of Addictive Behaviors*, 26(4):986-993.

Optional Module 12: Forensic
This module can be completed by you if the client reports a current or past legal history and offending behaviours. The module is required for forensic ‘diversion’ clients referred from courts or court support programs such as the Court Integrated Services Program (CISP).

The module was designed by ACSO's DUETS (Developing Understanding, Expertise, Treatment, and Systems in Dual Diagnosis) team to assist alcohol and other drug assessment providers to obtain a comprehensive history of a client’s contact with the criminal justice system. As the clinician, you can complete this based upon discussion with the client and information gathered during assessment, along with any collaborating and additional information. The questions are not designed to be completed verbatim however you can use them to guide your collection of information. When used in conjunction with a treatment readiness assessment, this module can help you to develop an understanding of the individual's treatment readiness. The module consists of a suite of prompts to guide the collection of additional information pertinent to a client’s past, current or pending offending behaviours initially identified in the legal section of the: AOD (Alcohol and Other Drug) Comprehensive Assessment. Further, the module assists you to explore the relationship between client’s offending, AOD use, and/or mental health issues. The information gathered can inform treatment planning tailored to the client’s needs, as well as to inform the development of a forensic report. This module is not a risk assessment tool.
Frequently asked Questions (FAQ)

How have family violence issues been explored in the tool?
Questions potentially related to family violence are posed in the following parts of the tool:

Intake tool
- Page 1 under the GP/services section asks provides an opportunity to note any child protection involvement
- Q22 on page 2 prompts the clinician to explore if the client Concerned about harm from others/family violence and to note the details of their safety plan

Self-completion section
- Question 9 of the AUDIT and question 10 of the DUDIT are about harms to self and others as a consequence of substance use

Comprehensive Assessment
- Section 2C: experiences of family violence may be explored in: family, children, dependants and social relationships
- Section 2F: current legal status relevant orders such as family violence intervention order, child protection custody orders can be explored and information documented here
- Section 6b: HARM TO OR FROM OTHERS is where information relating to history of violence to, or from others including assaults (e.g., sexual), family violence, whether or not children were present, threats to kill, and its relationship to AOD use can be recorded.
- Family violence may also be documented under the Risk to Self, Children and Others heading in the final case summary sheet

Optional Assessment Modules
- Section 7 in Optional module 8: assessment of recovery capital relates to housing and safety
- Optional module 10: identifying family violence provides an opportunity to systematically record family violence
- Optional module 11: impact of substance use on family member contains a section on experiences of physical violence.

Information sharing
Sharing of information between relevant staff and organisations plays an important role in providing seamless and continuity of care to a person on their recovery journey. Information must however be shared within legislative requirements. AOD treatment providers in Victoria are required to comply with both the Privacy and Data Protection Act 2014 and the Health Records Act 2001. Your organisations policies and procedures should reflect these legislative requirements. If you are unsure of your obligations please speak with your manager and/or supervisor.
For more information about these legislative requirements, a number of fact sheets and guidelines are also available through the Office of the Victoria Information Commissioner and the Health Complaints Commissioner. These include:

- The Guidelines to the IPPs, containing some thorough explanations of each IPP, as well as some useful examples and applications.
- The Guidelines for sharing personal information which provides guidance on how organisations can go about sharing personal information.
- The Department of Health and Human Services also released the Privacy and information security guidelines for funded agency staff in September 2017. This resource is available online at: [https://dhhs.vic.gov.au/privacy-and-information-security-guideline-funded-agency-staff](https://dhhs.vic.gov.au/privacy-and-information-security-guideline-funded-agency-staff)

Changes in 2018: The Child Information Sharing (CIS) Scheme and the Family Violence Information Sharing (FVIS)

The Family Violence Protection Amendment (Information Sharing) Act 2017 prescribes certain organisations to comply with the Family Violence Information Sharing Scheme (the scheme). The scheme is designed to enable safe information sharing between professionals in a timely and effective manner to assist with preventing or reducing family violence.

From 26 February 2018, community based child protection practitioners located within Support and Safety Hubs (Hubs), and workers delegated to represent the child protection program on Risk Assessment and Management Panels (RAMPs) will be required to comply with the scheme.

From September 2018, AOD services will be prescribed to comply with the scheme.

From 3 September 2018, AOD organisations will be required to comply with the Child Information Sharing (CIS) Scheme. This scheme will allow information sharing between authorised and trained professionals specifically to promote children’s wellbeing and safety. All Victorian children and young people from 0 to under 18 years of age will be covered by the new scheme.
The Department of Health and Human Services are in the process of developing further advice on what these changes will involve and how they will impact the AOD sector. Please check with your organisation for further advice.

Further information can be found at:


**Can I add other screens or modules to the assessment?**
Yes, the assessment was designed as the core minimum that can be built upon. This means that you can add your preferred or favourite instruments as desired. For instance, if you would like to conduct an assessment of parenting style/skills you can complete this.

**Do I need to complete all or any of the optional assessment modules?**
Optional Module 12 (Forensic) is required for forensic ‘diversion’ clients referred from courts or court support programs such as the Court Integrated Services Program (CISP).

In all other circumstances, the modules are optional and can be completed if desired, or as indicated, by the comprehensive assessment.

**Can I complete optional assessment modules over time?**
Yes. You can draw upon the optional assessment modules when and as needed. Some of the optional assessment modules (e.g. strengths, goals etc.) may be beneficial from a therapeutic perspective, and may be completed as part of a brief or ongoing intervention.

**What are my obligations for dependant children?**
If any concerns are raised about the welfare of children, consult with child protection if you suspect children are placed at risk (see below list of contacts) and other relevant services.

<table>
<thead>
<tr>
<th>After Hours</th>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child Protection After Hours Service</td>
<td>131 278</td>
</tr>
</tbody>
</table>

**DHS Regions**

<table>
<thead>
<tr>
<th>Telephone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eastern</td>
</tr>
<tr>
<td>Southern</td>
</tr>
<tr>
<td>Northern &amp; Western</td>
</tr>
<tr>
<td>Barwon South Western</td>
</tr>
</tbody>
</table>
After Hours
Child Protection After Hours Service 131 278

DHS Regions Telephone
Gippsland 1800 020 202
Grampians 1800 000 551
Hume 1800 650 227
Loddon Mallee 1800 675 598

For immediate help
To report concerns that are life threatening call Victoria Police 000.
To report concerns about the immediate safety of a child within their family unit, call the Child Protection Crisis Line 13 12 78 (24 hours, 7 days a week, toll free within Victoria).
Note: this is an emergency service for weekends and after hours only and will pass on cases to the relevant regions the following working day.

Further information on child protection issues and reporting can be found here:

Appendix 1. List of resources
CALD
Australian Drug Foundation (ADF) – factsheet series on working with CALD communities from an AOD perspective. Available from: www.druginfo.adf.org.au
Centre for Culture, Ethnicity and Health (CEH) – information sheets on enhancing health literacy, culturally appropriate health assessment and providing language service support. Available from: www.ceh.org.au
Centre for Multicultural Youth (CMY) – factsheets and other information on working with CALD youth. Available from: www.cmy.net.au
Drug and Alcohol Multicultural Education Centre (DAMEC) – resources on culturally appropriate AOD treatment and responding to access issues for CALD communities. Available from: www.damec.org.au
VAADA, Cultural cues: working with cultural diversity in AOD and intake settings
ABORIGINAL AND/OR TORRES STRAIT ISLANDER
Victorian Aboriginal Community Controlled Health Organisation http://www.vaccho.org.au/

LGBTIQ
Victorian AIDS Council and VADDA, 2016 Recommendations have been guided by Policy and practice recommendations for Alcohol and Other Drugs Service Providers supporting the Trans and Gender Diverse (TDG) Community
Thorneharbour health (formerly VAC) https://thorneharbour.org/
Transgender Victoria www.transgendervictoria.com
YGENDER www.ygender.org.au
Rainbow Network www.rainbownetwork.com.au
Touchbase www.touchbase.org.au
GLHV www.glhv.org.au
Appendix 2 Alcohol conversion chart
There are only an approximate number of standard drinks. Always read the container for the exact number of standard drinks.

NUMBER OF STANDARD DRINKS – WINE

- Wine
  - Bottle of White Wine: 750ml, 11.5% Alc. Vol.
  - Bottle of Port: 750ml, 17.5% Alc. Vol.

- Restaurant Serving
  - Average: 150ml, 13% Alc. Vol.

- Standard Serve
  - 100ml, 13% Alc. Vol.

- Standard Serving
  - 100ml, 12.5% Alc. Vol.
There are only an approximate number of standard drinks. Always read the container for the exact number of standard drinks.

**NUMBER OF STANDARD DRINKS - SPIRITS**

1. **1.2**
   - 30ml High Strength Spirit
   - 700ml High Strength Bottle of Spirit
   - 40% Alc. Vol

2. **1.5**
   - 375ml Pre-mix Spirits
   - 5% Alc. Vol

3. **1.5**
   - 400ml Pre-mix Spirits
   - 5% Alc. Vol

4. **1.7**
   - 500ml High Strength Pre-mix Spirits
   - 7% - 10% Alc. Vol

5. **1.4 - 1.9**
   - 300ml High Strength Pre-mix Spirits
   - 7% Alc. Vol

6. **1.6**
   - 375ml High Strength Pre-mix Spirits
   - 7% Alc. Vol

7. **1.9**
   - 400ml High Strength Pre-mix Spirits
   - 7% Alc. Vol

8. **2.1**
   - 440ml High Strength Pre-mix Spirits
   - 7% Alc. Vol

9. **2.4**
   - 440ml High Strength Pre-mix Spirits
   - 7% Alc. Vol

10. **3.6**
    - 330ml High Strength RTD
    - 7% Alc. Vol

* Ready-to-Drink
### Table 2: Summary of the four measures included in the initial screen

<table>
<thead>
<tr>
<th>Screening instrument</th>
<th>Items and time</th>
<th>Administration</th>
<th>Areas covered</th>
<th>Psychometrics</th>
<th>Key References</th>
</tr>
</thead>
<tbody>
<tr>
<td>ATOP</td>
<td>26 items</td>
<td>Self or clinician</td>
<td>1. Substance use (including injecting behaviours) 2. Health and Wellbeing (Bio/Psycho/Social model) – Global ratings 0 – 10 – Housing, employment &amp; study, violence, legal issues, child protection</td>
<td>Studies of reliability Yes ☑ No ☐  Studies of validity Yes 1No0</td>
<td>SOURCE Ryan A; Holmes J; Hunt V. Dunlop A; Mammen K; Holland R; Sutton Y; Sindhusake H, Rivas G &amp; Lintzeris (2014) Validation and implementation of the Australian Treatment Outcomes Profile in specialist drug and alcohol settings Drug and Alcohol Review 33: 33-42</td>
</tr>
<tr>
<td>Alcohol Use Disorders Identification Test (AUDIT)</td>
<td>10 items, that takes 2 minutes to complete and 1 min to score</td>
<td>Self or clinician</td>
<td>1. Amount and frequency of drinking (3 questions) 2. Alcohol dependence (3 questions) 3. Problems caused by alcohol (3 questions)</td>
<td>Studies of reliability Yes ☑ No ☐  Studies of validity Yes ☑ No ☐  Tested in a variety of settings and populations Yes ☑ No ☐  Although the AUDIT performs well in most populations, it's performs less well when used in older adults populations.</td>
<td>SOURCE Saunders, J.B., Aasland, O.G., Babor, T.F., de la Fuente, J.R. &amp; Grant, M. (1993). Development of the Alcohol Use Disorders Screening Test (AUDIT). WHO collaborative project on early detection of persons with harmful alcohol consumption. II. Addiction 88, 791-804.  SUPPORTING Reinert, D. F. and Allen, J. P. (2007), The Alcohol Use Disorders Identification Test: An Update of Research Findings. Alcoholism: Clinical and Experimental Research, 31: 185–199.</td>
</tr>
<tr>
<td>Test</td>
<td>Items</td>
<td>Completion Time</td>
<td>Format</td>
<td>Level of Drug Use</td>
<td>Selected Criteria for Substance Abuse/Harmful Use and Dependence</td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>-------</td>
<td>----------------</td>
<td>----------------</td>
<td>-------------------</td>
<td>-----------------------------------------------------------------</td>
</tr>
<tr>
<td>Drug Use Disorders Identification Test (DUDIT)</td>
<td>11</td>
<td>Less than 5 minutes</td>
<td>Self</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Kessler Psychological Distress Scale (K10)</td>
<td>10</td>
<td>2 minutes</td>
<td>Self or Clinician</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**SOURCE**


Kessler RC; Andrews G; Colpe LJ; Hiripi E; Mroczek DK; Normand SL; et al. Short screening scales to monitor population prevalences and trends in non-specific psychological distress. *Psychological Medicine 2002;32:959-976.*

Arnaud B; Malet L; Teissedre F; Izaute M; Moustafa F; Geneste J; Schmidt J; Llorca P; Brousse G. Validity study of Kessler’s psychological distress scales conducted among patients admitted to French emergency department for alcohol consumption-related disorders. *Alcoholism: Clinical and Experimental Research 2010; 34(7):1235-1245.*
Appendix 4

**HOW DID THE PROBLEM DEVELOP?**

What made me susceptible in the first place? (Predisposing)

Triggers for the most recent episode (Precipitating)

The problem (Presenting problem)

Things that keep the problem going (Perpetuating)

Things that motivate me to cease (Future goals)

Things that reduce the risk of me doing it again (Protective)