CLINICIAN GUIDE

TO THE VICTORIAN AOD INTAKE & ASSESSMENT TOOLS

APRIL 2021

INTRODUCTION

What is the purpose of this clinician guide?

This is a guide to using the refreshed alcohol and other drug (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:

- are fit for purpose
- accurately identify client needs and inform treatment planning
- support clinician decision-making
- are more appropriate for a range of clients, including Aboriginal and/or Torres Strait Islander people, Culturally and Linguistically Diverse (CALD), Lesbian, Gay, Bisexual, Trans and gender diverse, Intersex Queer/Questioning and Asexual (LGBTIQA+) communities.
- streamline information collection for services by integrating Victorian Alcohol and Other Drug Collection (VADC) screening and assessment data into the form
- align to the Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM) in respect of victim survivors. (**NOTE:** responding to people using family violence will be included in updates when new perpetrator-focused practice guides are available in 2021).

The AOD Intake Tool

The AOD 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. It also now includes prompts to screen for family violence and to take appropriate actions in responding to family violence where immediate risk is identified.

The AOD Comprehensive Assessment tool

The function of the AOD Comprehensive 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. It has most recently been updated to align with the MARAM framework, for victim survivor screening. It now includes embedded questions and prompts, with reminders to complete a separate MARAM Intermediate Risk Assessment (victim survivor), and an embedded MARAM aligned basic safety plan template.

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

AOD 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. It embeds mental health, suicide risk and family violence as critical co-psychosocial factors. Optional assessment modules provide a detailed understanding of other particular strengths, issues or experiences that may have been flagged at 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.

The tools are available here: https://www2.health.vic.gov.au/alcohol-and-drugs/aod-treatment-services/pathways-into-aod-treatment/intake-assessment-for-aod-treatment

Steps to treatment planning and review

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

Step 1: The AOD Intake Tool is administered by the clinician with the client. This may occur over the phone, or face to face e.g. for drop-in clients. At the end of step 1, the clinician determines whether AOD Comprehensive Assessment and additional treatment and support is necessary and/or if motivational interviewing (MI) or a brief intervention (BI) would be helpful in the interim.

Step 2: If further AOD assessment is needed (i.e. the client has harmful or dependent AOD use, risk, and other complexity factors etc.), the client should undergo an AOD 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 (part of the AOD Comprehensive Assessment process), an AOD Comprehensive Assessment is undertaken. This can only be completed by a specialist AOD clinician. It contains an 18-page core component comprising eight sections including Alcohol and Other Drugs, Psychosocial, Medical History, Mental Health, Current Prescribed Medications, Suicide and Self-Harm Risk, Family Violence 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). **NOTE:** as at April 2021 optional module 10 in respect of family violence has been removed and replaced by the MARAM framework and tools.

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

CONTACT POINT 1 or 2

Minimum of 4 weeks after assessment

Step 1 – Intake Tool

- Administer intake tool, including questions on demographics reason for call/visit, AOD use and risk
- Decide if a comprehensive assessment is needed or if not, complete preliminary case summary sheet
- If a family violence victim survivor has been identified screen for immediate risk.

Step 2 – Comprehensive Assessment (and self-complete)

- Check and clarify information gathered in intake
- Client completes self- complete form (if necessary you may assist) includes: outcome monitoring questions ATOP, AUDIT, DUDIT, K10
- Clinician to check and score and include score in final case summary
- Complete core component of the assessment: AOD, mental health, medical history, psychosocial and risk
- Victims of Family violence require MARAM Intermediate Risk Assessment and may require a safety plan
- Complete any optional modules as desired
- Complete final case summary sheet and use this to fill out your agency's care plan

Step 3 – Review

- Repeat page 1 of the self-complete form and K10
- Compare with self-complete form prior to treatment
- Inform client of their progress
- Review and modify care accordingly

Also consider providing:

- MI/BI
- Education/health promotion
- Linking/referring to community groups and/or other services
- Family support
- Family Violence service

Also consider providing:

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

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 questions in these state-wide tools must be asked, however 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 means that you can still use your agency's preferred Intake and Assessment tools alongside this instrument.

VADC Data collection requirements of 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 the questions
- 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 Controlled 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 the Victorian Government 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'.

Phase 4 of the project involved updates commencing in 2020 to align the tools to the Family Violence Multi-Agency Risk Assessment Management Framework (MARAM). The Intake Tool and the AOD Comprehensive Assessment tool have been updated to prompt screening for victims of family violence and assist in determining whether any urgent action is required to mitigate immediate family violence risk to victim survivors. A MARAM Intermediate Risk Assessment (victim survivor) should be completed at intake or during the AOD Comprehensive Assessment when a client is identified as experiencing family violence and a safety plan completed where needed. The MARAM framework and tools replaces Optional Module 10 in the AOD Comprehensive Assessment tool, and the tool now embeds a victim survivor family violence safety plan alongside AOD and suicide risk safety planning. For information about MARAM, refer to https://www.vic.gov.au/family-violence-multi-agency-risk-assessment-and-management

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 tools also cover all the comprehensive assessment domains recommended in the National guidelines for the treatment of alcohol problems[1] (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 appropriate and safe language as indicated in guidance.

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

[1] Haber et al. (2009). Guidelines for the Treatment of Alcohol Problems. Canberra: Australian Government Department of Health and Ageing

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 (ABI) 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, family violence and physical health among other things.

Aligns with activity and outcome reporting requirements- VADC

To streamline clinical workflow, the tools have been aligned with VADC data reporting requirements to reduce duplication of data entry into Client Management System (CMS), where CMS have the tools built in. 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 should be reported once the question is able to be asked at a future collection point.

As of 1 July 2021, VADC specifications will require agencies to report whether a client is a victim survivor or perpetrator (person who uses family violence), if known, and whether MARAM was used in any way.

Note - current Intake and Assessment funded activities including brief intervention, bridging support, and family single session (as per the *Alcohol and other drugs program guideline Part 3: quality, reporting and performance management* https://www2.health.vic.gov.au/alcohol-and-drugs/aod-service-standards-guidelines/aod-program-guidelines) incorporate all Intake and Assessment functions, including screening for and responding to family violence.

Ensure case notes record family violence record risk and how it was managed.

Aligns with the MARAM Framework

The Family Violence Multi-Agency Risk Assessment and Management Framework (MARAM) has been designed to increase the safety and wellbeing of Victorians by supporting prescribed services to identify, assess and manage family violence risk effectively. MARAM sets out key principles and pillars that should be embedded into an organisation's policies, procedures, practice guidance and tools. MARAM also identifies the responsibilities of organisations and staff across the system.

MARAM has been established in law under a new Part 11 of the ***Family Violence Protection Act 2008***. It creates a shared responsibility between prescribed services and sectors. This collaborative approach provides more options to keep victim survivors safe and it supports a more coordinated approach to keep perpetrators in view and accountable for their actions.

Everyone has a role to play in assessing and managing family violence risk. Your role will be dependent on the nature of your work and contact with those experiencing family violence. Identification, assessment, and management of family violence risk is a shared responsibility across a broad range of services, organisations, and sectors. Leaders will also hold MARAM responsibilities and have a role to play in ensuring the MARAM reforms are appropriately implemented in the organisations.

MARAM is being rolled out with the Child Information Sharing Scheme and Family Violence Information Sharing Scheme. Information sharing is a key enabler of the MARAM reforms. More information and Ministerial Guidelines regarding the Schemes are available on the Victorian Government website (https://www.vic.gov.au/information-sharing-schemes-and-the-maram-framework).

The benefits of MARAM are:

- All parts of the service system will have a shared understanding of family violence, risk assessment and management.
- Clinicians have evidence-based tools to guide assessment and appropriate risk management action.
- There is a clear understanding of the responsibilities of other parts of the system to coordinate and implement safety and accountability planning.
- Ensure the broad range of experiences across the spectrum of seriousness and presentations of risk are represented for Aboriginal and/or Torres Strait Islander peoples in a way that promotes self-determination for the individual/family, and works in alignment with trauma informed practice.
- Ensure the broad range of experiences across the spectrum of seriousness and presentations of risk are represented, including for culturally and linguistically diverse communities, children, young people and older people, across identities, and family and relationship types.
- Help support people experiencing family violence and keep people who use family violence in view and accountable.

Meaning of family violence and links to AOD context

Family violence can include a range of behaviours. It may present as a single event but can often be part of a pattern of ongoing coercive and controlling behaviours. As described under the MARAM Framework, which is guided by Victoria's definition of family violence under the *Family Violence Protection Act 2008 (Vic)* (FVPA), family violence is behaviour that controls or dominates a family member and causes them to fear for their own or another person's safety of wellbeing, and includes exposing a child to those behaviours. Family violence is defined at section 5 of the FVPA and includes physical, sexual, emotional, psychological and economic abuse, as well as coercive and threatening behaviour. See the MARAM Framework and MARAM *Foundation Knowledge Guide* for more detail - https://www.vic.gov.au/maram-practice-guides-and-resources .

Coercive and controlling family violence behaviours may present in particular ways in the context of substance use. Warshaw (2018) has explored coercive control specifically in the context of substance use, defining

substance use coercion as:[2]

'Abusive tactics targeted towards a partner's substance use as part of a broader pattern of abuse and control. This often involves the use of force, threats, or manipulation and can include forcing a survivor to use substances or to use more than they want, using a survivor's substance use to undermine and discredit them with sources of protection and support, leveraging a survivor's substance use to manipulate police or influence child custody decisions, deliberately sabotaging a survivor's recovery efforts or access to treatment, and/or engaging substance use stigma to make a survivor think that no one will believe them, forcing a partner into withdrawal, among many other tactics.'

Sensitively exploring the experience of our clients who seek AOD treatment may indeed uncover elements of coercive control, thus leading to better treatment outcomes and opportunities to assess and manage family violence risk concurrently.

Overview of MARAM Expectations for AOD Intake and Assessment – Victim Survivors

MARAM Framework responsibilities have been mapped and embedded within the Intake and Assessment tools for the AOD sector. Importantly, this revision of the Intake and Assessment tools applies to victim survivors only. Guidance for working with people who use family violence will be available later in 2021. *In addition to guidance below, please note that further practice-based information on the MARAM can be found in Appendix 5.*

During intake, AOD clinicians are required to screen for clients experiencing family violence and take appropriate safety planning steps. Accordingly, questions/prompts have been added to the Intake Tool to identify possible family violence including coercive control behaviours, culminating in asking the client about immediate safety concerns. Asking about the details of a Family Violence Intervention Order (FVIO) has also been included. If family violence has been identified or disclosed by the client it is recommended that the Intake clinician should undertake the MARAM Intermediate Risk Assessment (victim survivor). If it is not safe, or you or the client is short on time, you should complete a MARAM Brief Risk Assessment. If you cannot complete a MARAM Intermediate or Brief Assessment you should recommend this is completed during the AOD Comprehensive Assessment. Complete a safety plan with the client at Intake if there is not a safety plan in place already.

Similarly, during AOD Comprehensive Assessment, prompts about family violence have been added in the domains of AOD use, housing, finances, and legal status (e.g. FVIO details). In section 2G, there are three specific questions asking about safety which may in turn lead to identifying family violence. If family violence is identified or disclosed by the client, and a MARAM Risk Assessment has not been completed at Intake, the Assessment clinician should undertake a MARAM Intermediate Risk Assessment (victim survivor). If it is not safe, or you or the client are short on time, you should complete a MARAM Brief Risk Assessment. Complete a safety plan with the client if needed.

If you are concerned about the immediate safety of your client in relation to family violence – escalate to your supervisor, call Safe Steps on 1800 015 118 or police if necessary. Immediate risk as determined by the MARAM is when the person has let you know they are experiencing an immediate threat to their life, health,

[2] Warshaw C., Tinnon E (2018) Coercion related to mental health and substance use in the context of intimate partner violence, National Centre on Domestic Violence, Trauma and Mental Health. US DHHS

safety or welfare, or you have determined this based on their answers to the screening questions. For further information about immediate risk see - https://www.vic.gov.au/maram-practice-guides-and-resources

(If you have been unable to access MARAM training– see advice below).

Post Assessment: While MARAM responsibilities have been mapped to AOD Intake and Assessment functions, it should be noted that risk assessment and management is an ongoing process which should continue post-assessment and throughout an AOD treatment episode. Importantly, risk assessment and management must be guided by the views of the victim survivor. MARAM family violence risk assessment should also be undertaken at any stage of treatment where family violence is disclosed or identified, particularly with the understanding that risk is dynamic and can change over time.

Further practice guidance relating to foundational knowledge about family violence, identifying, screening and assessing for family violence can be found in these documents:

Topic	Description	Link
Foundational knowledge	Describes information which explains key elements of the MARAM Framework	https://www.vic.gov.au/sites/default/files/2020-05/Foundation%20Knowledge%20guide.pdf
Sensitive and safe engagement	This guide helps to create a respectful, sensitive and safe environment for people who may be experiencing family violence	https://www.vic.gov.au/sites/default/files/2020-05/PG%20Responsibility%201_0.pdf
Identification of family violence risk	This guide enables you to identify if family violence is present and undertake screening.	https://www.vic.gov.au/sites/default/files/2020-05/PG%20Responsibility%202.pdf
Intermediate risk assessment	This guide assists in assessing the 'seriousness' of family violence risk.	https://www.vic.gov.au/sites/default/files/2020-05/PG%20Responsibility%203.pdf

MARAM training

AOD staff not trained in MARAM are not expected to use the MARAM Risk Assessment tools until trained and should request support when commencing the work. Workers who have not completed MARAM training may use the embedded screening questions and safety planning aspects within the AOD Intake and Assessment tools, with support from experienced staff and team leaders, specialist family violence secondary consultation and support from local area Specialist Family Violence Advisors (SFVAs). MARAM and family violence assessment capacity and capability building support should be provided via agency managers and clinical AOD staff are to be supported to attend any MARAM training they require.

The tools also reference two information sharing schemes:

- The ***Family Violence Information Sharing Scheme (FVISS)*** which promotes sharing information between AOD agencies and other bodies designated as information sharing entities for family violence risk assessment and management purposes.
- The ***Child Information Sharing Scheme (CISS)*** which promotes sharing information between AOD agencies and other prescribed bodies to promote child safety and wellbeing, which goes beyond family violence.

Consideration of opportunities to request or proactively share information when the clinician is completing

their work with the client are present on the tool. Links to more information on the information sharing schemes can be found here: https://www.vic.gov.au/guides-templates-tools-for-information-sharing .

Also refer to the section '*Information Sharing'* in Appendix 5 for more information.

How to safely enquire about potentially sensitive areas using MARAM

This guidance refers to people who have experienced family violence as 'victim survivors', a term that is intended to acknowledge the strength and resilience shown by people who have experienced or currently live with family violence. Not every person who has experienced family violence identifies with this term.

The term 'perpetrator' should not be used in a practice context. This is because in a practice context using the term 'perpetrator' de-emphasises the person's agency for change and may make them more resistant to engagement. It can also limit practitioners' own capacity to understand or recognise the person in their context and broader identity or experience, including use of intersectional and trauma-informed approaches (where appropriate). The term person who uses violence is to be used in a practice context.

Speaking about family violence can be difficult for victim survivors. Subsequently, respectful, sensitive and safe engagement (MARAM Responsibility 1) is an important foundation for family violence response work. 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 and Assessment 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.

Only ask questions of victim survivors

When it is suspected or identified that a client is using family violence, **do not** ask questions designed for use with victim survivors. However, all clients can safely be asked a conversational opener like: 'How are things at home?'

The following preamble has been suggested to normalise the process before administering the Intake or assessment tool or before particular questions:

"(Some of) the following question(s) I am going to ask can be quite personal, and 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 health care and services for yourself and others. If you do not wish to answer the questions, you do not have to."

The following sections give some initial guidance in a range of topics related to family violence and relevant to both AOD Intake and Assessment. Also consult the MARAM Practice guides for more information.

Clinicians should exercise their professional judgement to determine whether family violence perpetration may be occurring.

Practitioners may believe a person is **using family violence** because of: The person's words or behaviour towards family members in the context of service delivery.

This could include:

- narratives of minimisation, denial or blame in relation to coercive and controlling behaviours
- attempts to manipulate clinicians and invite collusion with narratives or views about the victim survivor
- speaking disparagingly about family members and denigrating them based on their identity/identities (this might include making statements that indicate sexist, misogynistic, homophobic, transphobic, ableist, ageist or racist beliefs)
- verbalising expectations of how their family member should behave including narratives of entitlement or about 'respect'
- making comments which reflect the presence of coercive control: e.g. 'She knows I don't like her talking to other men'
- You should also be aware that minimisation narratives suggested through disclosures of 'heated arguments' or the client being 'angry' or 'aggressive' may indicate that the client is using violence.
- Disclosures from the client
- Disclosures from family members
- Reports through another source of information
- Identification of Intervention Orders naming the client as the respondent, Community Corrections Orders or other involvement with the justice system

If behaviours are identified which indicate risk to a victim survivor, clinicians need to consider options for risk management, including information sharing and seeking secondary consultation in discussion with their supervisor. Clinicians should not engage directly with people who are using violence about their use of violence but to contribute to collaborative risk management with specialist services. Clinicians can seek secondary consultation from an AOD Specialist Family Violence Advisor, or alternatively a local specialist family violence service provider, Men's Referral Service (1300 766 491) or Rainbow Door (1800 729 367) for LGBTIQA+ clients. In cases where a client is identified as using family violence, escalate this for review via your organisation's clinical governance structure.

Clinicians should also be mindful that some people who use violence present themselves as victims of family violence. Clients who use violence may also present as calm, articulate and friendly. These presentations should not influence an assessment of risk or safety for victim survivors. Ensure you seek support around identifying and responding to collusion when you suspect a client is using family violence. Ahead of the release of upcoming MARAM Practice Guidance and assessment tools focused on people who use violence, please see the *MARAM Foundation Knowledge Guide*, which provides advice on responding to people who use violence. (https://www.vic.gov.au/maram-practice-guides-and-resources).

Adolescents who use violence

Distinction should be made between adults who use violence and adolescents who use violence. Adolescents should receive a response that considers their age, developmental stage, therapeutic needs, and overall circumstances, including that they may also be victim survivors. For further guidance around Adolescents who use violence, refer to the *MARAM Foundation Knowledge Guide.*

Check for safety to ask about family violence

It is also important that a level of privacy is maintained during the Intake process to ensure the 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. It is also important to consider how the communication

modality you use to assess clients can affect safety assessment.

In instances where the client may be a victim of family violence, it is critical that you do not ask questions in the presence of the person using violence (or that you suspect may be using violence whether they are an adult or adolescent). Doing so may increase the risk to the victim survivor and any child victim survivors in their care. Therefore, we must also ask if the client calling is safe to speak openly. If they seem unsure or answer that they don't feel safe, always reschedule the call or ask the client to call back when they are alone and able to speak openly. If it sounds like the client has you on speaker phone, do not ask if they are safe to speak openly. First of all, you should ask whether you are on speaker phone, and if so, request that the client takes you off speaker phone. Once safety is established, the client can place you on speaker phone once more if that is their preference.

When seeking permission to send mail to a client or leaving a voicemail or text message, consider that if they live with someone who uses violence, this could put the client at risk. Where family violence is identified, you should consult the client about whether it is safe to send them mail, email, text messages or voicemail, and if so, what is safe to send.

Preamble to asking about family violence

To begin the screening conversation, you can begin with broad, prompting statements, such as "*Tell me a bit about your family / home life – are things ok at home?*" You can also frame the questions around family violence as part of the routine process used in the AOD Intake Tool such as "*In our organisation it is common that we ask questions about family violence so that we can connect people with appropriate support. Is it ok if I ask you a few questions about how things are going at home / in your relationship?*" You could start by asking if there is anyone in the family that is making the individual or the children/ other family member feel unsafe or afraid and where they indicate this is an issue, go on to ask what that person/s is/are doing. Remember to inquire very sensitively, given that it can be intimidating to be asked these questions.

When partner is present

Many clinicians have experiences where partners of clients have insisted on coming into the clinical space uninvited. Do not ask family violence questions at this point. Asking questions about family violence in front of someone who is a person that uses violence can increase the risk to the victim survivor. This is unlikely to be apparent when the client is present during the assessment but is more likely to occur in private or when the client and their partner return home. In these instances, you should try and have the partner of your client wait outside. This can be positioned as an organisational policy and procedure so there is no suspicion from the partner. If this is not possible or safe for you or the client, make a follow up time with the client to be able to ask these questions in private.

Respecting disclosures

When asking about sensitive topics, emphasise the person's right to choose how much they disclose. We must all work to increase the emotional safety and promote the agency of victim survivors.

Do not push for disclosures from your client. Respect their decision and reiterate that you support them. Remember that many victim survivors may have had poor experiences when they have disclosed in the past and carry guilt and shame around their experiences. These factors will influence their choice to disclose. Additionally, many clients are concerned about the implications of disclosure for Child Protection involvement.

Confidentiality

You must explain any limitations to confidentiality/your reporting obligations to clients before engaging in screening. For a victim survivor, that you will only share information with their consent or if there is a serious risk of harm. For a child victim survivor that you do not require consent to share information but will inform the victim survivor first and discuss this with them. You may wish to emphasise that your role is to partner with victim survivors and that you recognise where Child Protection concerns arise from family violence as a result of the perpetrator's behaviour and choices, not the victim survivor's parenting capacity. Refer to Appendix 5 for further details on information sharing.

Exploring further

You may have already identified indicators or evidence-based risk factors of family violence in other sections of the Intake or assessment tool. For example, sections of the Intake Tool which explore medical issues, housing etc. all provide opportunities to identify family violence. In these instances, you can also begin screening by inquiring further about the indicators you have identified. For example, if you had identified the client has become homeless after a recent break up, you might ask: 'You mentioned that you left your home after your breakup. If it's ok, could you tell me about what led to your breakup?'

Exploring Controlling Behaviours

The presence of controlling behaviours of one partner over the other can indicate the presence of family violence. Some examples present in the Intake and Assessment tools are:

- Being injected by the partner
- The partner controlling the finances
- Needing to stay in emergency accommodation

Exploring how this situation came about may result in the client disclosing they may have little influence in the decision-making process. In fact, victim survivors may state they are afraid to ask about these issues as their partner/family member may become abusive. If that is the case, then **controlling behaviours** is one of the high-risk indicators in the evidence base for people experiencing family violence. High risk factors are those evidence-based risk factors that correlate highly with a victim being killed or seriously injured. Therefore, it is important to reflect back to the client that you have noted this, and it is an important opportunity to ask if there are any other ways that they feel controlled by their partner/family member. It is important to use both direct and open-ended questions to explore the presence of additional controlling behaviours. For example, if a client tells you they would be afraid to ask their partner to stop injecting them, you could ask: "can you tell me why you are afraid to ask them?" This can then open the conversation and lead to identification of additional controlling behaviours. You may also ask direct questions, such as: "is there anything else they do that makes you feel scared?" Be mindful to avoid professional jargon where possible.

Evidence-based risk factors

The tool prompts you to record details of any **controlling behaviours, threats and physical harm** that you have identified. Refer to the evidence-based risk factors in Appendix 5 which may help you identify behaviours; it will also help you identify those risk factors which indicate an increased risk of the victim survivor being killed or almost killed. If the client indicates that these behaviours are happening more frequently or escalating in severity, this indicates that they are at **increased risk**.

Victim survivor sense of safety

If you have confirmed that family violence risk is present, the second part of the tool asks you to consider any immediate concerns about safety. You can do this by asking the client if they feel safe at home today or if they have any immediate concerns. Victim survivors will have a variety of views regarding their own risk, safety and support needs. If you have concerns about the immediate safety of your client, escalate to your supervisor, call Safe Steps or call the police.

Where immediate danger is not an issue, you should discuss options for support with the client. This may include a referral to specialist family violence services and consent to share information. If the client does not consent, then offer to provide details of appropriate services. Please note that male victim survivors can be referred to the Mens Referral Service (1300 766 491), Victims of Crime Helpline (1800 819 817) or Rainbow Door (1800 729 367) for LGBTIQA+ clients.

Safety plan

You should also ask the client whether they have a safety plan. If they do not, ask them if they would like to develop one together. Please see Section 7, page 15 of the AOD Comprehensive Assessment for a family violence safety plan template which can be used to prompt your conversation.

Use of MARAM Brief or Intermediate Risk Assessment tool

If it is identified that a client is experiencing family violence, clinicians should use the intermediate MARAM Risk Assessment (victim survivor) tool to determine the level of risk present. The victim survivor brief risk assessment tool may be used in short term crisis situations, or where there is a brief window of engagement (the brief risk assessment tool is a subset of questions from the intermediate risk assessment tool).

MARAM Intermediate Risk Assessment tool

A MARAM Intermediate Risk assessment should be completed in conversation with victim survivors. It is important that a 'tick box' approach is avoided. The tool contains detailed questions about family violence risk. After assessing risk, safety planning and support options should be discussed with the victim survivor.

The following comments come from consumer feedback on asking questions about family violence:

"*If the questions are asked in a supportive manner and the consumer does not feel it is only a tick box approach, they may feel supported and safe to answer the questions even as they become more difficult*"

"If it is seen as only superficial and a tick box, the [person] is less likely to elaborate"

The purpose of the MARAM Intermediate Risk Assessment Tool is to:

- Identify the range of family violence behaviours being experienced by asking questions based on risk factors
- Consider the information gained through the assessment and apply the MARAM Structured Professional Judgement model to determine the level of risk. Refer Appendix 5 for a description of the Structured Professional Judgement Model.
- Understand the level of risk at a point in time or changes in risk over time.

Questions in the MARAM Intermediate Risk Assessment are grouped according to:

- Risk-related behaviour being used by a person who uses violence against an adult, child or young person
- Self-assessment of level of risk (adult victim survivor)

- Questions about imminence (change and escalation)

MARAM and Children

As an Intake and Assessment practitioner you will not have direct contact with children. However, children are to be recognised as victim survivors in their own right where family violence is identified as an issue.

When assessing an adult victim survivor who has the care of children, you are also required to use the Child Assessment Tool so the risk to each child can be assessed through asking questions of the client.
The Child Assessment Tool contains questions directed to a parent/carer about risk experienced by the child.

Introducing a MARAM Risk Assessment (victim survivor)

You can start a MARAM Risk Assessment (victim survivor) conversation by providing context to why you are asking the questions, your role and the role of your organisation. You can then use prompting and open-ended questions to support the victim survivor to tell their story in their own words, before moving on to ask specific questions in an assessment to draw out important information about risk factors.

Keep in mind that risk assessment involves asking highly sensitive questions which can be experienced as invasive and confronting. It is important that you have created an appropriate level of rapport and emotional safety before assessing risk.

You could lead into risk assessment questions by describing the assessment structure, with a statement such as:

- "You have let me know that you are experiencing family violence from [name of person/relationship]. Risk assessment is the next step we take in this organisation"
- "It sounds like you are really worried about (adolescents/ person who uses violence) behaviour and the impact it is having on you and/or other children/family members. It's important to understand the risks of this behaviour. I'd like to ask you some questions to understand this better"

Key prompting questions to ask prior to introducing the risk assessment tool that will open the conversation, build rapport and trust, and elicit important information relevant to risk, include:

- "Could you tell me about the most recent incident?"
- "How long has this been going on?"
- "In your view, is the situation getting worse?"
- "What is the most serious thing that has happened?"
- "We have talked about the last incident. Can you tell me more about previous incidents? Have you noticed a pattern to their behaviour?"
- "What do they do that hurts / scares / controls you or your children?"
- "What do they do that gets in the way of your relationship with your children / the way you parent them?"
- "What do they do that makes you afraid for yourself, (if an adolescent) your other children, or themselves (in the case of self-directed violence, for example, including self-harm or threats to suicide)?"

If you have already identified the presence of certain evidence-based risk factors in the client's narrative, you do not need to ask about these risk factors again. However, if further information about these risk factors is needed, you could ask additional questions. For example, if the victim survivor has mentioned that the perpetrator has breached their Family Violence Intervention Order (see below), you might ask when this occurred, whether this

was reported to police and whether there have been other breaches.

Family Violence Intervention Orders (FVIO)

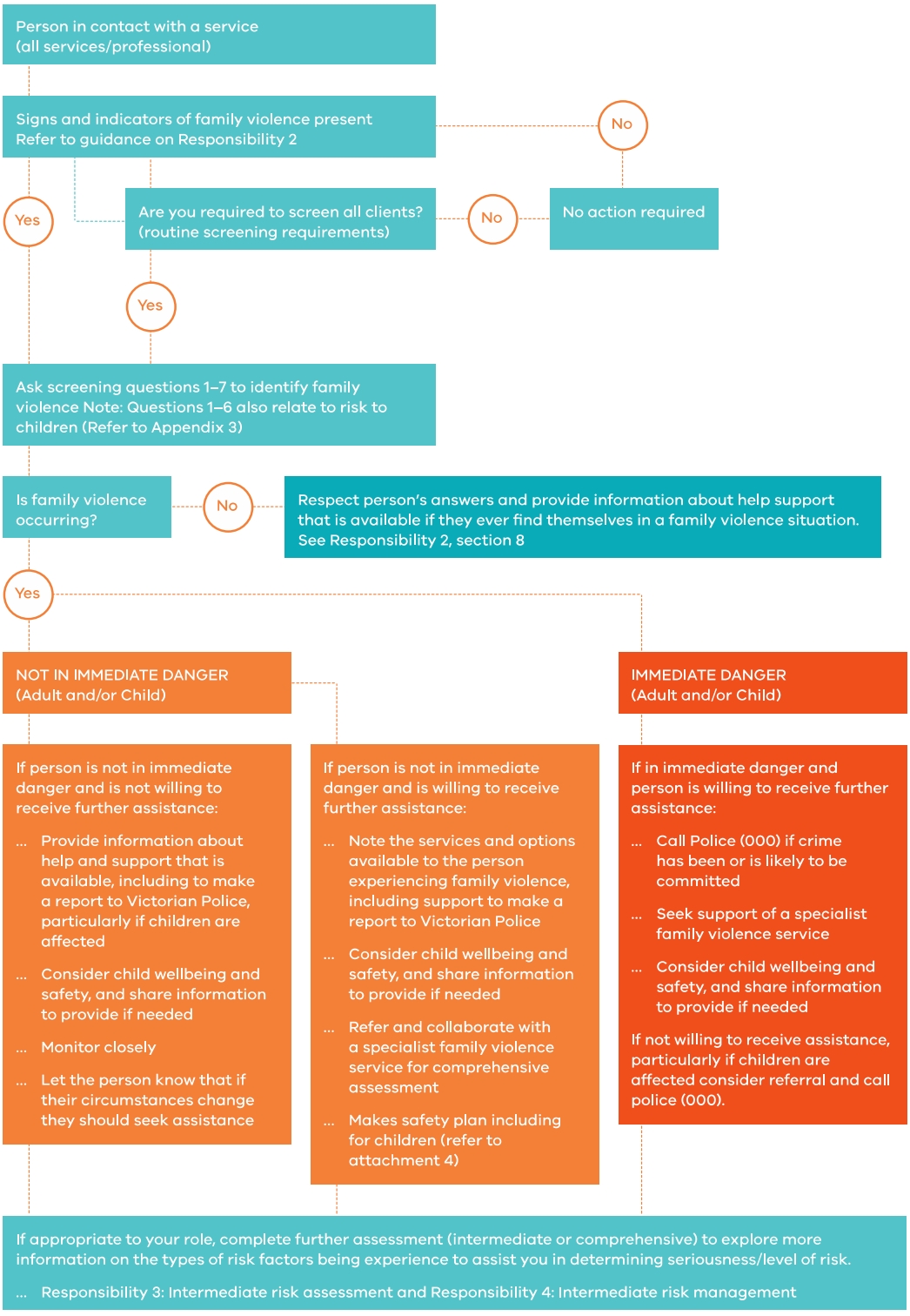
The updated tools include expanded options to prompt discussion around engagement with the justice system, including if the client has a Family Violence Intervention Order (FVIO). If the person has taken out an Intervention Order to help protect them from a family member then they are known in the court and police system as the Affected Family Member (AFM). If they have had an intervention order served against them to protect someone else from them, they are called the Respondent and they will have restrictions that they must adhere to by law.

It's also helpful to understand the implications of an FVIO so there is space to take down the details of the intervention order and if children are listed on the order. This will mean that the respondent is likely limited in how and when they can have access with children. If a respondent breaks the conditions of an FVIO the police can charge them with a criminal offence. This is called a breach. The court takes breaches of FVIO's very seriously. If the court finds the respondent guilty, they can be given a prison sentence and they will also have a criminal record.

You can find further information about FVIOs at https://www.mcv.vic.gov.au/family-matters/family-violence-intervention-orders-fvio .

Basic flowchart addressing Family Violence response

The following MARAM flowchart describes the basic response options when family violence is identified. Both AOD Intake and Assessment processes are guided by these responses.



Further information about this flow chart can be found in MARAM Practice Guide, responsibility 2
https://www.vic.gov.au/sites/default/files/2020-05/PG%20Responsibility%202.pdf

Consent to Share Information

With consent, information about a client obtained through the AOD Intake and Comprehensive Assessment processes will be passed on to AOD 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.

AOD Intake and Comprehensive 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 AOD assessment, the assessment provider with consent, 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.

De-identified information provided through the AOD Intake and Comprehensive Assessment tool, including the self-assessment, is collected by the Victorian Alcohol and Drug Collection. This information is used 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.

It is important to note that with the introduction of the Family Violence Information Sharing Scheme (FVISS) and Child Information Sharing Scheme (CISS), there are now additional considerations that need to be discussed with clients when explaining privacy and confidentiality provisions.

State-funded AOD treatment providers are prescribed under both FVISS and CISS as Information Sharing Entities (ISEs). ISEs have obligations to share information with other ISEs if they receive a request for information that meets the thresholds of the schemes. As ISEs, prescribed AOD treatment providers can also request information and proactively share information with other ISEs in line with the scheme's requirements. In some instances, this will involve sharing information without client consent.

You should follow your organisation's policy and procedure regarding information sharing under FVISS and CISS. However, at a minimum, you should be aware of the changes to consent the schemes have introduced and ensure this is included in your discussions with clients. Please note, although you should inform all clients about legislative limitations to confidentiality, it is important you do not notify perpetrators of family violence when you have shared their information under FVISS. Doing so may escalate risk to the victim.

See page 87 in Appendix 5 for further details of the schemes and consent.

Table 1: National guideline domains covered in the screening and assessment instrument

Domains recommended in Australian national guidelines	**Covered**	**Notes on where covered**
Presentation		
Presenting problems	✓	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 summarise presenting problems.
Role of drinking/drug use in presenting problems	✓	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.
Motivation for presentation	✓	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
Other concerns	✓	There is a specific section in the assessment (other key issues), where clients can identify other concerns or information, they think is important.
Alcohol and other drug use		
Quantity, frequency, pattern of drinking and other drug use (tobacco, illicit drugs, pharmaceutical drugs, injecting drug use)	✓	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.
Last use of alcohol and other drugs (time and amount)	✓	Last AOD use is collected in both the Intake and Assessment.
Duration of drug and alcohol problems and previous withdrawal complications (e.g. seizures, delirium, hallucinations).	✓	Duration of AOD problems is collected in the assessment.

Features of abuse or dependence. If dependent, assess likely withdrawal severity and previous withdrawal complications (seizures, delirium, hallucinations).	✓	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.
Medical and psychiatric comorbidity		
Physical health problems (including liver, gastro-intestinal, trauma, cardiovascular, neurological, cognitive, endocrine)	✓	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.
Mental health problems (e.g. depression, anxiety, psychosis, suicide risk)	✓	The Intake contains a question on about 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.
Social circumstances		
Social functioning (including relationship, employment, financial, housing, legal)	✓	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.
Examination (by suitably trained professionals)		
Physical examination (general examination, signs of intoxication or	✓	A physical examination module is included as an optional module that medically trained clinicians can complete.

withdrawal, nutritional assessment, neurological function, gastrointestinal, cardiovascular)		
Mental state examination (signs of intoxication or withdrawal, cognitive function, mood, motivation and insight)	✓	Mental state examination (with appropriate prompts) is included in the core part of the assessment.
Motivation and treatment goals		
Goals of treatment (abstinence or reduced use, other health improvement)	✓	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.
Involvement of other health and/or welfare professionals	✓	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.
Clinical risks and risk management plan (harm to self/others, serious physical or mental illness, driving, Child Protection, family violence, occupational concerns)	✓	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.
Treatment plan (need for brief interventions, controlled drinking strategies, detoxification, relapse prevention strategies, management of comorbidities)	✓	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.

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 tools.

Instructions:

- 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 risk and complexity. It is expected that an enquiry into 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.
- When the clinician and client have completed all that they can, check, clarify, and ask any unanswered questions if appropriate.
- After a clinical decision is reached in relation to 'next steps' refer on to an appropriate agency for AOD 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, and family violence support where applicable.

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:

- Demographic Information
- AOD use
- Risk and complexity
- Outcome of Intake

This guide has been based on a combination of best practices guidelines, population specific resources and advice of workers from consultation process. You may need to tailor your approach to communication and assessment when working with specific populations (such as Aboriginal and/or Torres Strait Islander communities, LGBTIQA+ communities, people from CALD communities) to assist with overcoming service access barriers and particular fears and barriers affecting disclosure of family violence . The MARAM *Foundation Knowledge Guide* and victim survivor focused Practice Guide for MARAM Responsibility 1 in particular can assist you with responding to these barriers and presentations of family violence risk across the community using an intersectional approach.[3] Please refer to the guidelines below and Appendix 1 for a more detailed list of resources and websites that may be used to

[3] Intersectionality, or intersectional analysis, is a theoretical approach recognising the interconnected nature of social categorisations, identity and experience. Many people's experience is shaped by multiple identities, circumstances or situations. Applying an intersectional lens means considering a person's whole, multi-layered identity and life experience, and reflecting on one's own bias to be able to respond safely and appropriately in practice (MARAM *Foundation Knowledge Guide* p.32).

support your work with specific populations.

Screening for family violence has now been embedded throughout the Intake Tool notably with respect to:

- Connection with Child Protection
- Connection with Specialist Family Violence Service
- Item 11 – risky drug practices where substance use coercion may be experienced
- Item 12 – harm from substance use where 'relationship issues' may indicate family violence
- Item 22 – homelessness
- Item 23 – employment status
- Item 27 – Family Violence Intervention Orders
- Item 28 – immediate safety concerns

MARAM and family violence response expectations

All clinicians should undertake the MARAM Brief and Intermediate level training. Other workers in AOD services such as peer workers and non-clinical staff are required to undertake the MARAM Screening and Identification training in line with their MARAM responsibilities.
Refer to https://www.vic.gov.au/training-for-information-sharing-and-maram for more information.

Each of these domains may give rise to the disclosure of MARAM Evidence Based Risk Factors which may indicate the presence of family violence. If family violence is indicated, then the role of the Intake worker is to:

- Check for immediate risk
- If family violence has been identified or disclosed – it is recommended that you should complete a MARAM Intermediate Risk Assessment– and complete a safety plan if a safety plan is not in place. If it is not safe, or you or the client are short on time, you should complete a MARAM Brief Risk Assessment.
- Use Structured Professional Judgement to determine risk level (see Appendix 5)
- Consider information sharing needs under FVISS and CISS
- Provide information about services
- Offer referral to a specialist family violence service where a further assessment may be made.

The table at item 28 provides a greater level of detail as how to respond based on how the client wishes to proceed.

NOTE:

- Guidance embedded within the tool is only relevant for victim survivors of family violence, not for people using family violence
- Further guidance relating to specific aspects of the Intake Tool are embedded within the sections below.

PAGE 1: DEMOGRAPHIC SECTION

The demographic section is broadly divided into five sections. The first section captures name/s, pronoun/s, gender identification and identification as LGBTIQA+. 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 (he/she/they). Some clients may indicate that they have one name that they use (their preferred name) and a different name that appears on their legal documents. If possible, collect both names but indicate which is which, and continue to call the client by their preferred name during Intake. Consultation with the LGBTIQA+ community has indicated that a client's identity is affirmed by the use of their correct name and pronoun. For this reason, do not make assumptions about a client's pronoun but ask them what this is, and then continue to use this throughout the Intake process. Please also note that the examples offered on the Intake form (she/he/they) are just for clarification of the prompt and are examples that can be offered for anyone who does not understand the question.

If you are unsure of how to ask the question about pronouns you could try something like the following:

"It's important to me that we address you correctly, I use the pronouns (e.g she/her/hers) - can I ask what your name/pronoun is?"

Gender When gathering this information, it is important to recognise that a person's gender refers to their internal 'felt' sense of gender identity (a sociological construct), rather than their biological sex.

It is important to recognise disclosure of gender identity can be a very personal decision and can be of special concern for transgender and gender diverse clients for a number of reasons as their identity documents may not match their gender and name (see FAQ), or they may have 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*: In the previous iteration of the Intake process, the gender identification question was followed by a prompt for sex at birth identification (male, female, intersex etc.). This question may be discriminatory or harmful to some people (i.e., transgender peoples) and therefore the prompt has been removed.* ***Please note that sex at birth is still a VADC data element for the time being.***

LGBTIQA+ The acronym is intended to describe those who identify as a member of LGBTIQA+ communities. LGBTIQA+ includes both gender and sexuality (Lesbian, Gay, Bisexual, Transgender, Intersex, Queer/Questioning, Asexual/Aromantic or '+' identities not captured within this acronym and those that would but have other culturally specific titles). Disclosure of a person's sexual orientation can be a very personal decision for some people and many clients may be hesitant to disclose this information for fear of discrimination, negative past experiences and a range of other socio-cultural factors (3). Disclosure is therefore optional, and clients have the option of choosing 'prefer not to say'.

However, it can also be useful information as it can be important for informing inclusive and non-discriminatory care. It also enables healthcare services to plan and design services according to need and helps us to understand the specific needs of LGBTIQA+ clients. If a client identifies as a gender or sexuality not identified within the LGBTIQA+ acronym, then be sure to write it in the section provided under 'Other'. Further, professionals should be mindful of not homogenising people as 'LGBTIQA+' and be aware of the diversity of experiences, needs and identities across LGBTIQA+ communities.

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. This section can be read together with the section on 'asking about identity' on p.76 the Practice Guide for MARAM Responsibility 1: Respectful, sensitive and save engagement.

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 regardless of observations or information you have about them. (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):

"Do you identify as Aboriginal and/or Torres Strait Islander?"

For Aboriginal people, structural inequality, discrimination, the effects of colonisation and dispossession, and past and present policies and practices, have resulted in deep mistrust of people who offer services based on concepts of protection or best interest. Clinicians should hold an awareness of this, emphasising that the question is asked of all clients and is aimed at understanding client needs and ensuring the most appropriate and safe response can be provided. 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 Islanders.

Cultural Background: There are various ways to address 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 a 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 and Translation Service (VITS) (03) 9280 1955.

A question concerning whether the client has a disability has been added to capture those who identify as having a disability and help to highlight any specific needs and adjustments to ensure that appropriate services are offered to the client.

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.

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.

Questions/prompts concerning changes to parenting arrangements and/or parenting orders has been added to facilitate a dialogue around potential changes in the family unit, especially for children. In cases of family violence, threats of taking or not returning children can be used by perpetrators as a way to maintain control of their partners. Consequently, you should be mindful of exploring this, particularly if family violence indicators are identified.

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* explicitly Child Protection, NDIS, housing, mental health, family violence support services, men's behaviour change programs etc. 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.
If the client indicates that they are engaged with family violence support services as a victim survivor of family violence, record the service name and location if possible. Similarly, if they are engaged with an intervention service for people who use violence you should record these details. You can also ask if the client self-referred or was mandated to attend the program. This will indicate if the client has engagement with the courts regarding family violence.

PAGE 2: SECTION 1: ALCOHOL AND OTHER DRUG USE

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, 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 AOD 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) 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, but rather 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 AOD, 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).

To help in the identification of family violence, it is important to also ask if the client injects for themselves or if they are being injected by a partner, friend or family member. If a client responds that their partner or family

member always injects them, consider asking:

'What would happen if you told your partner that you no longer want them to inject you?'

If the client states that they are afraid to ask or that their partner/family member would become abusive in response to this kind of request, make a note in this section and also at Question 28. (pg. 3) as it may be an indication of family violence.

Item 12: concerns *'evidence of harm from substance use'*. Akin to DSM-5abuse 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-5 substance use disorder (moderate or severe), this includes having 2 or more of the following 11 criteria:

- Taking larger amounts and for longer than intended
- Wanting to cut down or quit but not being able to do it
- Spending a lot of time obtaining it
- Craving or a strong desire to use
- Repeatedly unable to carry out major obligations at work, school, or home due to use
- Continued use despite persistent or recurring social or interpersonal problems caused/exacerbated by use
- Stopping or reducing important social, occupational, or recreational activities due to use
- Recurrent use in physically hazardous situations
- Consistent use despite acknowledgment of persistent or recurrent physical or psychological difficulties from using
- 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.
- 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) as well as prescriber details if known.

Items 15 and 16: concern previous AOD service use - add details on previous episodes.

PAGE 3: SECTION 2: RISK AND COMPLEXITY

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, bipolar affective disorder, major depressive disorder) 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, the most significant indicator is when the client is subject to a Community Treatment Order (CTO). 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.

Item 19: concerns '*current medications for managing mental health issues'*. Please note any medications taken by the client to manage their mental health issues.

Items 20 & 21: 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. Recent self-harm and suicide behaviours means 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 AOD Comprehensive Assessment, and you may like to refer to this.

Items 22-26: provide opportunities to document the client's housing, employment, gambling and legal circumstances.
In regard to 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
In regard to legal concerns you could ask *"are you concerned about any legal issue?".* If court orders are disclosed, then you should ask for details.

Item 27: concerns Family Violence Intervention Orders (FVIO). The client may be the Affected Family Member (AFM – the person who is protected by the order), or the Respondent (the person to whom the order applies).If an FVIO is present, also ask the client if there are children on the order and if they are aware of the conditions on the order.

If an FVIO is present, then consult with your manager/supervisor to discuss if using FVISS/CISS to obtain a copy of the order may assist with managing the safety of the client, or in making those who use violence more accountable and visible.

Item 28: concerns '*family violence*' for a victim survivor. If family violence has been indicated or identified up to this point and the client is a victim survivor, you would check 'yes'. There is also space to note any controlling

behaviours identified, and/or physical assaults or threats mentioned by the client. To screen for immediate risk where family violence has been identified, and if safe to do so, ask

Do you have any immediate concerns about your safety?

If your client disclosed to you that they are experiencing family violence:

- Follow the advice above in 'MARAM and family violence response expectations' on page 29
- Provide validation and confirm that the violence is not their fault.
- Acknowledge any challenges and difficulties and validate efforts to protect themselves and their family members.
- Ask whether they would like help.
- Engage their local level supports
- Seek secondary consultation
- Case note the risk and risk management

When handing over family violence risk for the AOD Comprehensive Assessment, consider the skillset of the AOD assessor, clearly flagging risks and actions so far.

PAGE 4. SUMMARY OF IDENTIFIED NEEDS

The space here enables you to summarise the client's presenting concerns and needs, 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 an AOD 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 dependent 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 client's 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 AOD Comprehensive Assessment (e.g., gambling, acquired brain injury). This may be particularly useful for sensitive issues that were not discussed at Intake, and which may be better examined at assessment or treatment. Also note any recommendation to complete a MARAM Risk Assessment.

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. With respect to 'family violence service', make a note here regarding the status of any action taken or what may need handing over to the AOD Comprehensive Assessment stage.

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 communities, such as youth, Aboriginal or First Nations clients, LGBTIQA+ clients etc. are there any that you would prefer to be referred to if possible?"*

Agency consent to share form AOD 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. For further information, refer to 'Consent to Share Information' earlier in this guide.

COMPLETING THE SELF-COMPLETION FORM

A self-completion form is part of the comprehensive assessment and review process.

Instructions:

- 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
- When the client has completed all that they can, you can check, clarify, and ask any unanswered questions
- Score screen results and provide feedback on scores to client (if appropriate). Enter these scores into the final case summary sheet of the AOD Comprehensive Assessment
- Begin AOD Comprehensive Assessment
- Repeat ATOP and K10 at least four weeks after first completed to track progress.
- Repeat all tools at the completion of treatment to track progress.

Purpose:

- 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.
- To track a client's progress in treatment and monitor outcomes of the services provided. These fields are captured in the VADC.

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.

2 Alcohol Use Disorders Identification Test (AUDIT)

The AUDIT was developed by the World Health Organization (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]

[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 3: Suggested interpretation for the AUDIT overall score

Score	Risk level	Drinking pattern	Intervention	Delivery
0-7	Low	Non-drinker	Simple advice	These clients could be reminded of the benefits of low risk drinking/abstinence and advised to avoid drinking in certain circumstances: • When operating machinery/vehicle; • When pregnant or considering pregnancy; • If contraindicated medical condition present; • When using certain medications such as analgesics, sedatives and selected anti-hypertensives
8-15	Medium	Hazardous	Simple advice focussed on the reduction of hazardous drinking	A brief intervention using simple advice and client education materials is likely to be an appropriate course of action
16-19	High	Harmful	Brief counselling and continued monitoring	Harmful and hazardous drinking can be managed by a combination of simple advice, brief counselling and continued monitoring, with further diagnostic evaluation indicated if the client fails to respond or is suspected of possible alcohol dependence.
20+	Very high	Dependent	Warrants further diagnostic evaluation for alcohol dependence	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.

Table 4: Meaning of questions in the AUDIT

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

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 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 find out more information and complete an AOD 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

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

Score - 22

Level of Risk

0-7	Low risk of harm
8-15	Moderate risk of harm
16-19	High-risk or harmful level
20 or more	Dependence likely

3 Drug Use Disorders Identification Test (DUDIT)

The DUDIT 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

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

*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

Question	Focus	Question	Focus
1	Frequency of use per week or month	7	Prioritisation of drug use
2	Polydrug use	8	'Eye opener'
3	Frequency of use per day	9	Guilt feelings
4	Heavy use	10	Harmful use
5	Craving	11	Concern from others
6	Loss of control		

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 person's drug use. Interpreted together the results from this screen indicate a need for further comprehensive assessment and possible intervention.

Sample C: DUDIT

	DUDIT	0	1	2	3	4
1	How often do you use drugs other than alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
2	How often do you use more than one drug on the same occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
3	How many times do you take drugs on a typical day when you use drugs?	0	1 or 2	3 or 4	5 or 6	7 or more
4	How often are you influenced heavily by drugs?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5	Over the past year, have you felt your longing for drugs was so strong that you could not resist it?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6	Has it happened, over the past year that you have not been able to stop taking drugs once you started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7	How often over the past year have you taken drugs and then neglected to do something you should have done?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8	How often over the past year have you needed to take a drug the morning after heavy drug use the day before?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9	How often over the past year have you had guilt feelings or a bad conscience because you used drugs?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
10	Have you or anyone else been hurt (mentally or physically) because you used drugs?	No		Yes, but not in the last year		Yes, during the last year
11	Has a relative or a friend, a doctor or a nurse, or anyone else been worried about your drug use or said to you that you should stop using drugs?	No		Yes, but not in the last year		Yes, during the last year
	Total score = 33					

Score - 33

Potentially harmful use:

>1 and the client is female

>5 and the client is male

0-24 dependence unlikely

> 24 dependency 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

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

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*

Q	Anxiety	Q	Depression
1	tired	4	hopeless
2	nervous	7	depressed

3	so nervous that nothing could calm you down	8	so depressed that nothing could cheer you up
5	restless or fidgety	10	worthless
6	so restless that you could not sit still		
9	everything was an effort		

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

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

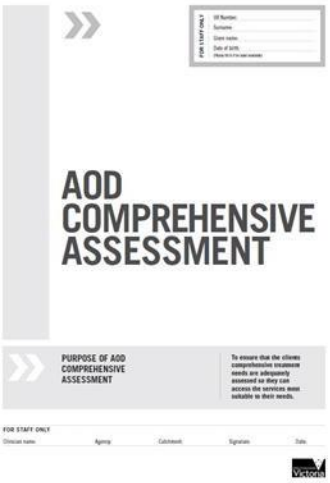
Score – 26
Level of psychological distress
10-19 Low psychological distress
20-24 Mild psychological distress

25-29 Moderate psychological distress

30-50 High level of psychological distress

COMPLETING THE AOD COMPREHENSIVE ASSESSMENT

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



Instructions

- Use the Intake tool and self-completion form as starting points that you can refer back to and build on
- Complete the core part of the assessment
- Complete any Optional Modules as appropriate or if desired Complete final case summary sheet and your agency's care plan,
- If it is noted on the Intake Tool that family violence is present or family violence is indicated through this assessment, the MARAM Intermediate Risk Assessment (victim survivor) tool should be completed if not completed at Intake (noting Optional Module 10 is now obsolete)

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.
- To assess any risk to the client's safety or the safety of any children in the family
- 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 AOD 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.

MARAM and family violence response expectations:

All clinicians should undertake the MARAM Brief and Intermediate level training. Other workers in AOD services such as peer workers and non-clinical staff are required to undertake the MARAM Screening and Identification training in line with their MARAM responsibilities. Refer to https://www.vic.gov.au/training-for-information-sharing-and-maram for more information

Each domain within the AOD Comprehensive Assessment tool may give rise to the disclosure of evidence-based risk factors which may indicate the presence of family violence. **If family violence is indicated**, then the role of the assessor is to:

- Check for immediate risk
- If not completed at Intake – you should complete a MARAM Intermediate Risk Assessment (If it is not safe, or you or the client are short on time, you should complete a MARAM Brief Risk Assessment.) and complete a safety plan with the client, if a safety plan is not in place
- Use Structured Professional Judgement to determine risk level (see Appendix 5)
- Consider information sharing under FVISS and CISS
- Provide information about services

Offer referral to a specialist family violence service where a further assessment may be made.

NOTE: Guidance embedded within the tool is only relevant for victim survivors of family violence, not for people using family violence

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. Suicide & Self Harm Risk
7. Family Violence – Basic MARAM Aligned Safety Plan
8. 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 has been amended to include if the client is being injected by another. This is to capture the physical harms and inability to control dose that occur with being injected by another as well as the evidence that indicates a relationship between clients who are injected by another and family violence/intimate partner violence. If a person responds that a partner/family member always injects them, consider asking the hypothetical question:

"What would happen if you asked your partner/family member no longer to inject you?"

If the client states that they are afraid to ask or that their partner/family member would become abusive in response to this kind of request, make a note in this section and also at Section 2G FAMILY VIOLENCE (pg. 6) as it may be an indication of family violence. **NOTE**: this topic may already have been discussed during Intake.

Other behaviours present include whether people use AOD alone, drive 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, risk and strengths. In the assessment document, the

psychosocial section contains prompts on resources and supports; a genogram; prompts for family, children and social relationships; housing, finances, employment and training; and a client's current legal status and family violence. 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 strength-based focus and could be used as therapeutic tools as well as assessment tools.

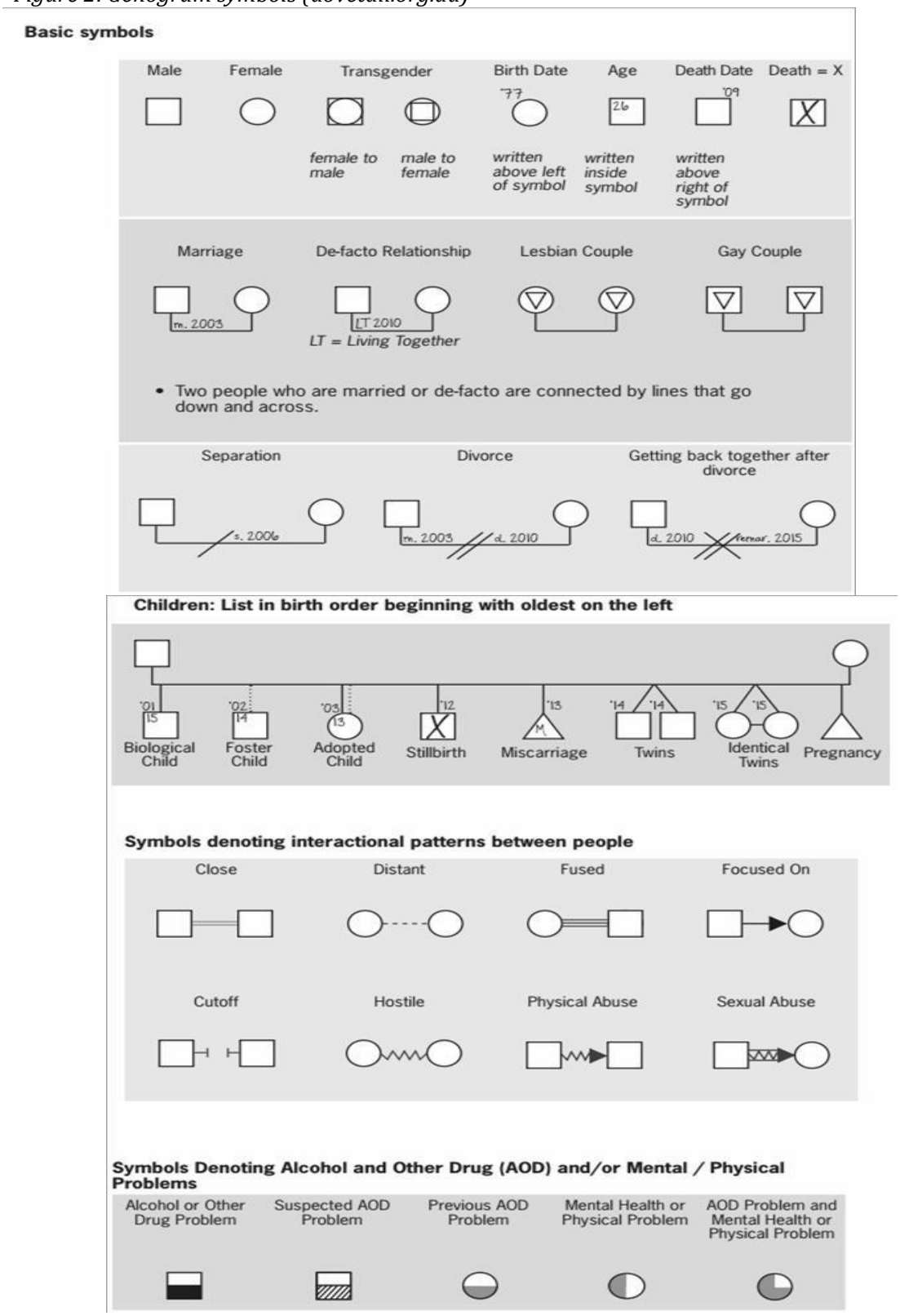
2a) enables you to detail resources, supports and strengths that the client can draw upon to meet their treatment goals. These may include informal resources such as participation in meaningful activities, groups, employment and training or supportive family members, friends, social networks, and past 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 is 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. The MARAM Framework also includes examples of ecomaps and genograms to assist with family violence risk assessment and management including safety planning, though these are more likely to be used by professionals engaged in comprehensive risk assessment and management. Given that clinicians 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.

It is important to note that many people's family relationships are the source of trauma, including violence and abuse. Taking this into consideration, move through this section with sensitivity and care, taking note of any relationships that cause significant stress or emotion and of course taking breaks if the client needs.

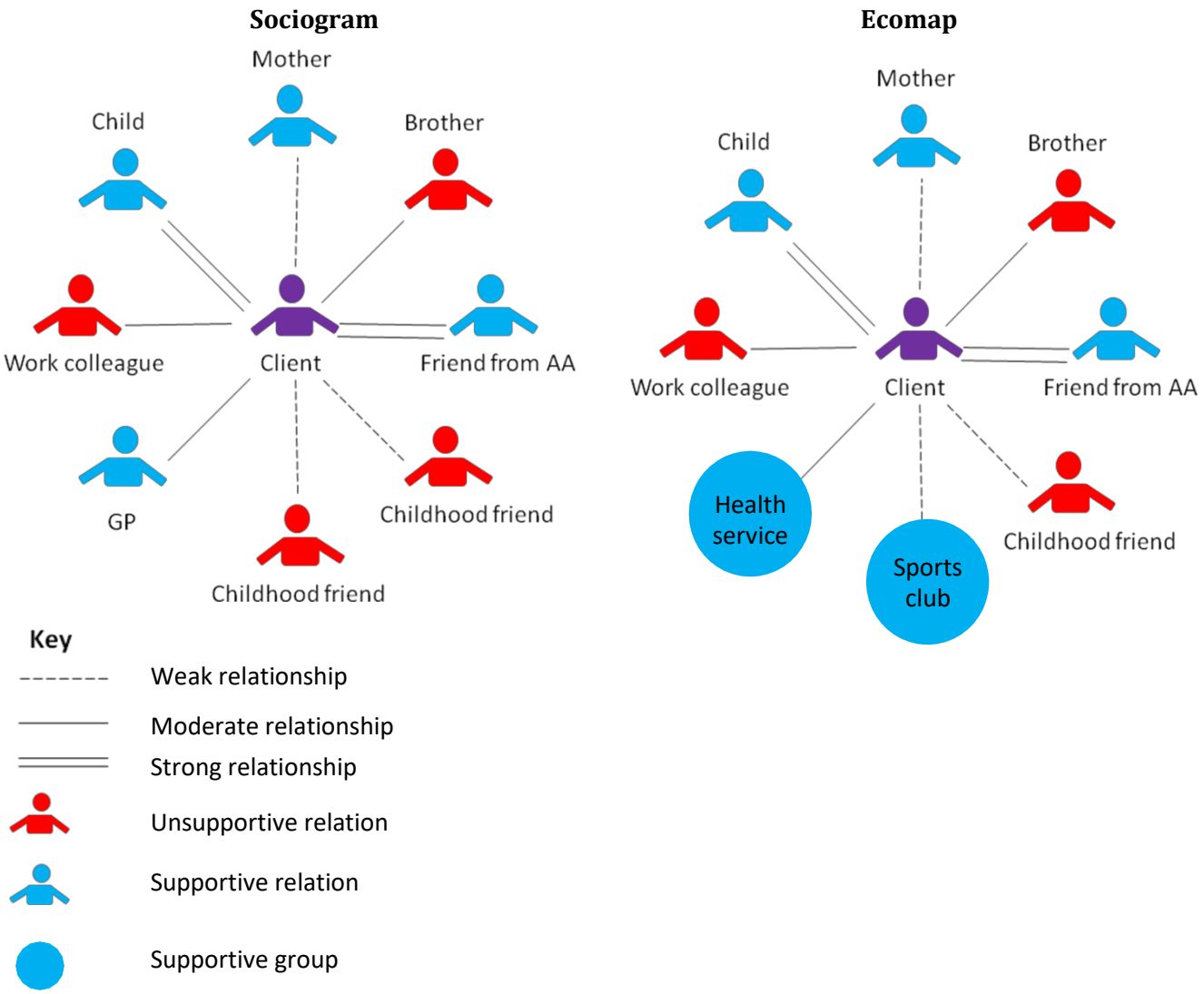
A genogram is a visual representation of family relationships, which uses symbols to provide an indication of the type and quality of relationships within a family. Additional symbols can be included to include AOD and/or other health problems. While clinicians may have their own styles in completing genograms, Figure 2 (from dovetail.org.au) provides an example of basic symbols:

Figure 2: Genogram symbols (dovetail.org.au)



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



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 2b). 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. Due to legislative changes and the introduction of the Child Information Sharing Scheme, clinicians may be contacted with requests for information regarding the safety and wellbeing of children. For this reason, the updated assessment tool contains more space to record information as it pertains to children, including Child Protection) involvement, children's names and

dates of birth.

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. In the updated assessment, a prompt has been included to enquire if a client has been made homeless due to being forced out of housing by a partner or family member. This is derived from the evidence base around coercive behaviour of people who use family violence. People using violence may exclude partners/family members from the home or threaten to do so as a way to control them. Additionally, many victim/survivors are made homeless when they flee their home to get away from a person who uses family violence. You could normalise this line of questioning by using the following preamble:

"*many people end up homeless or at risk of being homeless because of needing to escape abuse/family violence in the home. Have you ever been forced out of housing due to a partner or family member's abusive behaviour?*"

Any responses indicating that the person has needed to flee their home due to family violence needs to be noted in section 2G FAMILY VIOLENCE (pg. 6). If family violence is identified, a MARAM Intermediate Risk Assessment (victim survivor) should be completed to assess the level of risk and safety needs of the client (If it is not safe, or you or the client are short on time, you should complete a MARAM Brief Risk Assessment.)

If you identify the client is perpetrating family violence, ensure you record this. However, you should not ask direct questions about or engage directly with the person about their use of violence, as this can increase risk for the victim survivor. Instead, you should consider possible information sharing activities, secondary consultation and referral to specialist organisations involved in MARAM Comprehensive Assessment of people using violence. You should not ask the client any of the victim survivor screening or assessment questions embedded in section 2G.

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. The updated assessment also includes a question about financial control.

"Does anyone have access to your bank account or control your finances?"

Evidence shows that many victim survivors of family violence experience financial control. This may be indicated by a partner/family member controlling most or all finances (i.e., controlling cash and ATM cards, bank accounts in their name) and/or requiring the client to comply with a strict budget set out for them by the partner/family member. If you identify that a family member has control over a client's finances, it is important to explore this further to determine if this is family violence. You can do so by asking:

- *How did you decide that they would control your money?*
- *Are you happy with this arrangement?*

- *If you wanted to change this, how do you think they would react?*

If it appears that there is equality in decision making present and the client does not disclose behaviour consistent with coercive control, you do not need to note this as family violence. Family violence is indicated when a client discloses things such as:

- Their family member made the decision to control their finances for them, without their consent or without consulting them
- They are unhappy with this arrangement or that this arrangement is negatively impacting them
- They would feel afraid to discuss changing this arrangement or indicate their family member would react angrily, aggressively or violently if this were to be mentioned

Keep in mind that financial abuse aligns with the serious evidence-based risk factor of controlling behaviour (**serious risk factors** are those which may indicate an increased risk of the victim being killed or almost killed). Consequently, where there is financial abuse/controlling behaviour the level of risk may be 'elevated' or 'serious' (see p.82 of this guide for detailed information on determining levels of risk). All of this information should culminate in section 2G FAMILY VIOLENCE where all indicators of family violence should be recorded. Following this, a MARAM Intermediate Risk Assessment (victim survivor) should be completed to assess the level of risk and safety needs of the client. If it is not safe, or you or the client are short on time, you should complete a MARAM Brief Risk Assessment.

If you identify the client is exercising financial control over family members, you should also note this as it may indicate the client is using family violence. This is particularly important if you have also observed that the client has a sense of entitlement over family members, speaks disparagingly about family members or talks about themselves as becoming 'aggressive'.

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.

The updated assessment includes expanded options to prompt discussion around engagement with the justice system, including if the client has a Family Violence Intervention Order (FVIO).

Your client may be the Affected Family Member (AFM) – the person who is protected by the order), or the Respondent (the person to whom the order applies). If an FVIO is present, also ask the client if there are children on the order and if they are aware of the conditions on the order. **NOTE**: this information may have been provided at Intake.

If an FVIO is present, then consult with your manager/supervisor to discuss if using FVISS/CISS to obtain a copy of the order may assist with managing the safety of the client, or in making perpetrators more accountable and visible.

OPTIONAL MODULE 12: FORENSIC is also available if potential legal issues are identified in this section.

2g): is about family violence for victim survivors.

Consider the family violence information provided at Intake and obtained throughout the earlier part of your comprehensive assessment and use your professional judgement about whether screening needs to take place, or whether you should move straight to a MARAM Intermediate Risk Assessment.

There are three family violence screening questions in the AOD Comprehensive Assessment tool :

1. *Is there a partner or family member(s) who does things that make you or your children unsafe?*

2. *Do you have concerns about your immediate safety?*

3. *Do you and your children feel unsafe when you leave here today?*

NOTE: if you have concerns about the immediate safety of your client, escalate to your supervisor, call Safe Steps or call the police.

If family violence is disclosed or identified, and a MARAM Intermediate Risk Assessment has not been completed at Intake, the Assessment clinician should undertake MARAM Intermediate Risk Assessment. If it is not safe, or you or the client are short on time, you should complete a MARAM Brief Risk Assessment.
Also if needed, use the MARAM safety plan or the MARAM aligned basic family violence safety plan in the assessment tool in section 7, page 15.

Guidance on completing the MARAM Intermediate Risk Assessment can be found at page 20

If you are new to family violence screening and /or assessment, you should seek support from your supervisor to undertake training and/or supervision. It is expected that you may also seek secondary consultation from the Specialist Family Violence service for your region and/or from a Specialist Family Violence Advisor. For a list of advisors refer to https://www.vaada.org.au/victorian-specialist-family-violence-advisors/ .

NOTE: if you suspect the client is using family violence or you have identified that they are using family violence, you should not ask these screening questions as they are designed to be used with victim survivors.

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 prompt 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).

You should also keep in mind that the client may be experiencing physical health issues as a result of family violence. Family violence can result in ABIs, gynaecological problems, skeletal injuries etc. You should note if a client has any medical issues resulting from family violence.

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 SUICIDE & SELF-HARM 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:

- Identifying risk factors, noting those that can be modified to reduce risk
- Conducting suicidal (and self-harm) inquiry: suicidal thoughts, plans, behaviour and intent
- Identifying protective factors, noting those that can be enhanced
- Determine level of risk and choose appropriate intervention to address and reduce the risk
- 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:

RISK LEVEL	RISK/PROTECTIVE FACTORS	SUICIDALITY	POSSIBLE INTERVENTIONS
HIGH	Psychiatric disorders with severe symptoms, or acute precipitating event	Potentially lethal suicide attempt or persistent ideation with strong intent or rehearsal	Admission generally indicated unless a significant change reduces risk. Suicide precautions
MODERATE	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behaviour	Admission may be necessary depending on risk factors. Develop crisis plan. Give emergency/crisis numbers

LOW	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behaviour.	Outpatient referral, symptom reduction. Give emergency/crisis numbers

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%20Booklet/00b209ca-3078-45db-a175-6983c6962166

Safety Plan: This section also includes a safety plan template that can be completed with the client if any risk of suicide, self- harm 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 FAMILY VIOLENCE – BASIC MARAM ALIGNED SAFETY PLAN

This section will need completing where family violence has been identified and the client does not already have a plan in place, or requires an updated safety plan. If the client has already created a safety plan for themselves or with another service, you should ask if they are comfortable to share it with you and if there is any way your service can provide support within the existing plan.

A safety plan must be current, relevant, and adaptable and kept up to date in response to change in circumstances, escalation or other changes to the level of risk.

Where family violence risk has been identified, all victim survivors, including children and young people, benefit from having a safety plan. All risk management must involve safety planning, and it's key that the victim survivor leads this process. Where you are working with a parent who is a victim survivor you need to work with them to develop a safety plan for each child in the family affected by family violence. This can be recorded in the adult's safety plan.

Protective Factors: Be sure to ask the client about any protective factors for them or the child(ren). Protective factors alone do not remove risk. However, if protective factors are present these can help to mitigate or reduce risk and promote stabilisation and recovery from violence. Where protective factors are identified, they must be confirmed before assessing if they mitigate or reduce the identified risks or their impacts (short or long-term).

Accepting what a parent/carer describes as a protective action should be explored to ensure it is an effective protection.

A prompt to commence the discovery of protective factors is provided in the tool as:

"What is currently working to keep you/you and your children safe?"

For reference, the following list of factors for adults and children is provided:
Systems intervention:

- Person who uses violence is incarcerated or prevented from contact
- Victim survivor is on the Victims Register for notification of pending release of perpetrator from incarceration
- Court dates relating to family law, family violence or other matters involving perpetrator or victim survivor
- Intervention order is in place and being adhered to
- Person who uses violence is actively linked to a support program.

Practical/environmental:

- Safe housing
- Financial security (access to money or employment)
- Health (including mental health)
- Immigration status
- Food security
- Transport
- Communication safety (including via phone, online etc)
- Ability to access community
- Connection to advocacy/professional/therapeutic services
- Positive and friendly care environment (particularly for children and young people).

Strengths-based (Identity / Relationships / Community):

- Social networks (family, friends, informal social networks)
- Healthy relationships
- Connection/sense of belonging to community
- Culture and identity
- Agency of victim survivor
- An individual's personal skills and emotional resilience

Safety Plan: The victim survivor may not be ready to have this conversation and may have strategies they are already using to keep themselves safe. Safety planning discussions can be postponed if the victim survivor prefers. If safety planning is not discussed, ensure this is flagged for follow up and that the client is given crisis support contacts, such as Safe Steps or other specialist family violence services. Preface this by explaining you are providing these details so that they can access support in future if needed. Ensure you explain the type of support that these services offer.
Keep in mind that safety planning can be explored throughout the AOD Comprehensive Assessment, particularly

when you touch on other topics like finances and housing. For example, if family violence has already been identified at these points, you can include discussions around how the client might access money in emergencies.

Safety planning should always be completed in conversation style. Consumer feedback suggests that if risk assessment and safety planning is seen as superficial and a 'tick-box', the person is less likely to elaborate. You might consider:

- Beginning your conversation by explicitly responding to key concerns the victim survivor has raised/identified risks. E.g. if the victim survivor is separated from the person who uses violence and has expressed concern that person may attempt to contact them or (if applicable) any children during a school drop off, you could discuss strategies to mitigate this risk. This may include things like using alternative entry/exit points instead of the usual drop-off area, ensuring the school has copies of any IVOs etc. You should also discuss how you can support any of these actions as appropriate.
- Tailoring your plan to the client's individual circumstances, including whether they want to remain in the relationship/continue contact with the person using violence, or if they want to leave/cease contact.
- Considering actions and strategies beyond crisis contacts and professional supports. While these are essential to consider, you should also think about community supports and other strategies the client may use to support their safety. E.g. if the client wants to stay in the relationship and there is an identified safe family friend/contact who provides support, you might consider how this person can be utilised in their safety plan. Further, you can consider tailored supports and connection to specialist organisations working with diverse community groups (See Appendix 1 of this guide) . Clients who identify as Aboriginal and/or Torres Strait Islander may also prefer to connect with an Aboriginal community controlled organisation – you should, however, **offer choice** rather than presuming the person will want to connect with an Aboriginal community organisation, as the person may prefer a mainstream service due confidentiality or other concerns.

The safety plan within the comprehensive tool contains key prompts and considerations to discuss.

What *resources do you currently have? Eg. Cash, phone with safe sim, car, Myki card, important documents/scripts are hidden away in safe place*

Who *are the safe people in your life who could support you at this point in time?*

Who *else do you need to consider on your safety plan eg. Children, pets?*

How *would you get to safety if you needed to leave your home quickly?*

Where *If you needed to leave where could you go to be safe?*

When *If you needed to leave, when would be a good time or opportunity?*

Is Technology safety required Turn off Find my Phone, change social media settings, new sim, access to safe Internet?

You can also consider the following:

- List emergency contact numbers
- List the contact numbers for a specialist family violence organisation, including if an Aboriginal organisation or other culturally appropriate service is being engaged
- Identify a safe place for the victim survivor to go if they are in danger, and how to get there

- Reflect protective factors, incorporated from what the victim survivor has discussed with you
- Identify a friend, family member or neighbour who can assist in an emergency, and how to contact them
- Identify a way for the victim survivor to get access to money in an emergency
- List what to include in an 'escape bag' or identify a place to store valuables, so that the victim survivor can access them when needed. An escape bag at a minimum should include:
- Phone/communication devices
- Keys (house, car, office, etc.)
- Money (cash and coins), bank cards (if the account is not shared with a perpetrator)
- Medications/scripts and important documents (or copies)
- Clothing for themselves and any children or person in their care.
- Identify ways to safely use technology, including e-safety strategies, and the limitations of devices used, including children's devices
- Specifically address any barriers to the victim survivor implementing the safety plan (for example, access to funds, access to vehicles, leaving a pet behind, or having mobility or communication difficulties)
- Explore necessary ties to community, such as caring responsibilities, access to medical care, education (particularly for children and young people), access to cultural organisations or faith places, or requirements to contact justice services (e.g. parole officer)
- Consider support needs: disability including NDIS support, medical care, translation, systems literacy (such as being primary person engaging with Medicare, banks and Centrelink), financial literacy or access (if usually provided by the person using violence).

For more information about Safety Planning, refer to Responsibility 4 in the MARAM Practice Guides https://www.vic.gov.au/sites/default/files/2020-05/PG%20Responsibility%204.pdf

8 FINAL CASE SUMMARY SHEET

The final section of the AOD 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 Victorian Government 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:

- Looking at the client's AUDIT/DUDIT score to see whether they are indicated as being in the 'dependence likely' category
- Tallying up how many of the following complexity factors the client has:

Complexity factor	Definition	Where to find the information?
Poor mental health	• K10 score of 30 or above or • Presence of serious Mental Health diagnoses (e.g., Bipolar disorder, Schizophrenia, Borderline personality disorder etc.)	• Self-completion form (Page 4) • Comprehensive assessment (K10 score in final case summary)
Lack of meaningful activity	• Unemployed and not studying or performing home duties	• Self-completion form (Page 2, section 2)
Housing insecurity	• Homeless or at risk of eviction	• Intake tool • Self-completion form
Pregnancy	• Pregnant	• Intake tool • Comprehensive assessment
Serious criminal justice involvement	• (i.e., on a court order or on parole)	• Intake tool • Comprehensive assessment
Multiple previous AOD treatment episodes	• More than 5 AOD treatment episodes (lifetime)	• Intake tool • Comprehensive assessment Section 1C)
Children potentially unsafe	• Clinician concern about parenting capacity or • Children unsafe	• Intake tool • Comprehensive assessment
Significant/serious physical health issue	• Serious physical illness (e.g. liver, cardiovascular, respiratory, neurological disease) that significantly impacts on well-being/functioning	• Intake tool • Comprehensive assessment

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

Tier	Definition

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

Risk

*Suicide, Self-Harm Risk & Harm to others***:** This section is a summary of any risk assessment and safety planning that you may have completed with the client. Any specific safety actions that require follow up should also be noted here.

*Family Violence***:** This section enables you to summarise if there was family violence identified. There is a tick box to indicate if a MARAM Risk Assessment (victim survivor) has been completed, and what the outcome was. There is also a tick box to indicate if any information has been received or requested under the Family Violence Information Sharing Scheme (FVISS) or Child Information Sharing Scheme (CISS). Any ongoing safety needs discussed with the client should be included in the details section. This section also provides space to document if any future safety plan actions will be required.
If you have identified the client is using violence, you should also document this. If required, clinicians can seek secondary consultation from local specialist family violence service providers to be supported in how best to respond to users of violence. Key services for this kind of secondary consultation include, Men's Referral Service (1300 766 491) or Rainbow Door (1800 729 367) for LGBTIQA+ clients.

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 client's 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, adulthood and including, background (e.g. genetic factors, lived experience, modelling) 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 brief case formulation 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)

More information on case formulation can be found here: https://www.mhc.wa.gov.au/media/1178/aod-counselling-guidelines.pdf

Treatment type/s required

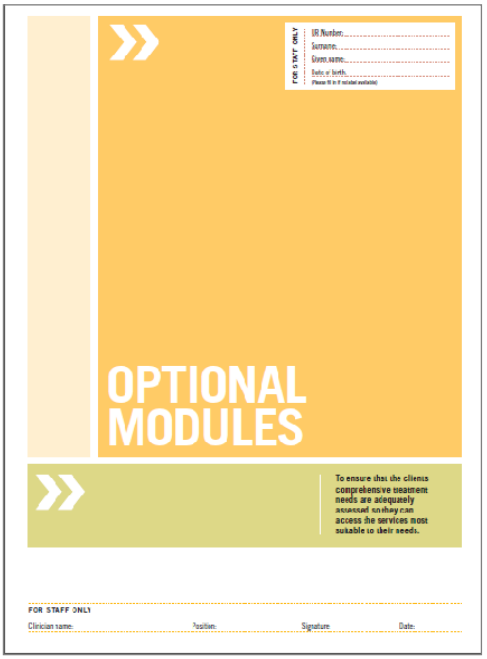
The final case summary sheet culminates with a table that enables you to record the treatment types that the client might require. For each treatment type required, you can also document the agreed actions, which could include referrals and noting the where, why, and to whom a referral is sent, as well as a referral date and appointment time and date. Finally, as per the VADC 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.

Agency consent to share form

AOD 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. For further information, refer to 'Consent to Share Information' earlier in this guide.

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 AOD 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 question 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, question 7 to 15 relate to anxiety disorders, and questions 16-22 relate to psychotic disorders.

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:
OASAS. (2005). *Screening for Co-occurring Disorders: User Guide for the Modified MINI Screen (MMS)* Albany, NY: NYS Practice Improvement Collective.

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).[4] 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.[5]

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.

Table 9: Equations for calculating raw scores

Domain	**Equation for computing domain scores**	**Raw score**
1. Physical Health	(6-Q3) + (6-Q4) + Q10 + Q15 +Q16 + Q17 + Q18 ☐ + ☐ + ☐ + ☐ + ☐ + ☐ + ☐	=
2. Psychological	Q5 + Q6 + Q7 + Q11 + Q19 + (6-Q26) ☐ + ☐ + ☐ + ☐ + ☐ + ☐	=
3. Social relationships	Q20 + Q21 + Q22 + +	=
4. Environment	Q8 + Q9 + Q12 + Q13 + Q14 + Q23 + Q24 + Q25 + + + + + + +	=
	☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	

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

Question	**Clients response**
Question 3	Very much = 4
Question 4	A moderate amount = 3
Question 10	A little = 2
Question 15	Poor = 2
Question 16	Satisfied = 4
Question 17	Satisfied = 4
Question 18	Very Satisfied = 5

[4] Skevington SM, Lotfy M, O'Connell KA. The World Health Organization's WHOQOL-BREF quality of life assessment: psychometric properties and results of the international field trial. A report from the WHOQOL group. *Qual Life Res* 2004;13:299–310.

[5] See: Laudet, A.B. (2011). The case for considering quality of life in addiction research and clinical practice. *Addiction Science and Clinical Practice*, 6(1), 44-55.

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

Physical health domain raw score = (6 - 4) + (6 - 3) +2 + 2 + 4 + 4 + 5

= 2 +3 +2 + 2+ 4 + 4 + 5

= 22

Step 2 Convert raw scores to a transformed score (on a 0-100 scale) using table 10 for each domain (e.g. if a client's raw score on the Physical Health domain is 22 then their transformed score will be 56).

Table 10: Conversion Table

Domain 1: Physical Health		**Domain 2 : Psychological**		**Domain 3: Social Relationships**		**Domain 4: Environment**	
Raw score	**Transformed Score**	**Raw score**	**Transformed score**	**Raw score**	**Transformed scores**	**Raw score**	**Transformed score**
7	0	6	0	3	0	8	0
8	6	7	6	4	6	9	6
9	6	8	6	5	19	10	6
10	13	9	13	6	25	11	13
11	13	10	19	7	31	12	13
12	19	11	19	8	44	13	19
13	19	12	25	9	50	14	19
14	25	13	31	10	56	15	25
15	31	14	31	11	69	16	25
16	31	15	38	12	75	17	31
17	38	16	44	13	81	18	31
18	38	17	44	14	94	19	38
19	44	18	50	15	100	20	38
20	44	19	56			21	44
21	50	20	56			22	44
22	56	21	63			23	50
23	56	22	69			24	50
24	63	23	69			25	56
25	63	24	75			26	56
26	69	25	81			27	63
27	69	26	81			28	63
28	75	27	88			29	69
29	81	28	94			30	69
30	81	29	94			31	75
31	88	30	100			32	75
32	88					33	81
33	94					34	81
34	94					35	88
35	100					36	88
						37	94
						38	94
						39	100
						40	100

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

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 11: Meaning of questions in the PGSI

Domains	Question Number	Item Content
Problem gambling behaviours	1	Bet
	2	Tolerance
	3	Chase
	4	Borrowed
Adverse consequences of gambling	5	Felt problem
	6	Criticised
	7	Felt guilty
	8	Health problem
	9	Financial problem

Further information about the PGSI can be found in the following article:
Holtgraves, T. (2009). Evaluating the problem gambling severity index. *Journal of gambling studies*, *25*(1), 105- 120.

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:
Groshkova T, Best D, White, W. The Assessment of Recovery Capital: Properties and psychometrics of a measure of addiction recovery strengths. *Drug and Alcohol Review* 2012 (in press).

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 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 problems 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 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)

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 assess 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 AOD 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 to children? If you have immediate and life-threatening concerns for a child contact Victoria Police – 000.

If you think a child is in need of protection make a report to a Child Protection Intake or after hours service (out of business hours).

For Child Protection contacts: https://services.dhhs.vic.gov.au/child-protection-contacts
For information about how to make a report: https://providers.dhhs.vic.gov.au/making-report-child-protection

If you have significant concerns about the wellbeing of a child but do not believe they are in need of protection, a referral should be made to Child FIRST or The Orange Door –

ChildFirst; https://providers.dhhs.vic.gov.au/making-referral-child-first
Orange Door: https://orangedoor.vic.gov.au/

For reporting to Child Protection, please consult section in Appendix 5 and online at https://services.dhhs.vic.gov.au/child-protection

If you know your client has a child who is a Child Protection client, liaise with the Child Protection practitioner for the child regularly about the parent's treatment. If you have any concerns for the safety of the child, contact their Child Protection practitioner.

What are my obligations about sharing client information? 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 the *Privacy and Data Protection Act 2014,* the *Health Records Act 2001,* the *Family Violence Information Sharing Scheme* (FVISS) and *Child Information Sharing Scheme* (CISS). 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. Refer to Appendix 5 'Information Sharing' for further information.

Where can I find regulations and guidelines for sharing information? For more information about these legislative requirements, a number of fact sheets and guidelines are also available. These include:

- The Guidelines to the IPPS containing some thorough explanations of each Information Privacy Principle (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.
- Health Complaints Commissioner: Health records information and online training: https://hcc.vic.gov.au/providers/health-records
- Office for the Victorian Information Commissioner (OVIC) Information Sheet - The Information Privacy Principles and the Health Privacy Principles
  https://ovic.vic.gov.au/privacy/for-agencies/information-privacy-principles/
- OVIC Information Sheet - Drafting a Privacy Policy
  https://ovic.vic.gov.au/resource/drafting-a-privacy-policy/
- OVIC Information Sheet – Collection notes
  https://ovic.vic.gov.au/resource/collection-notices/
- The Victorian Government 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
- VAADA FVISS and CISS navigator
  https://www.vaada.org.au/navigator/
- FVISS Ministerial Guidelines
  https://www.vic.gov.au/guides-templates-tools-for-information-sharing
- CISS Ministerial Guidelines
  https://www.vic.gov.au/guides-templates-tools-for-information-sharing

APPENDICES

APPENDIX 1: LIST OF RESOURCES

Culturally and Linguistically Diverse communities:

- Australian Drug Foundation (ADF) – factsheet series on working with CALD communities from an AOD perspective. Available from: www.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 https://www.vaada.org.au/wp-content/uploads/2018/05/RES_CALD-AOD-Project-tip-sheet-AOD-Counselling_13112015.pdf
- Victorian Refugee Health Network – 2012 desktop guide on caring for refugee patients in general practice. Available from: www.refugeehealthnetwork.org.au
- InTouch – Multicultural Centre Against Family Violence intouch.org.au

ABORIGINAL AND/OR TORRES STRAIT ISLANDER communities:

- Victorian Aboriginal Community Controlled Health Organisation http://www.vaccho.org.au/
- Djirra – for Aboriginal people experiencing family violence http://djirra.org.au/
- Boorndawan Willam Aboriginal Healing Service (BWAHS) http://bwahs.com.au/
- Victorian Aboriginal Legal Service (VALS) https://www.vals.org.au
- Australian Drug Foundation (ADF) indigenous resources https://adf.org.au/programs/indigenous-resources/

People with disabilities

- Women with a Disability Victoria**:** www.wdv.org.au
- Disability Worker Commission**:** www.vdwc.vic.gov.au
- Office of the public advocate**:** www.publicadvocate.vic.gov.au

  The Victorian Office of the Public Advocate (OPA) promotes the rights, interests and dignity of people with disability (specifically intellectual impairment, mental illness, brain injury, physical disability or dementia) living in Victoria.
- Yooralla: www.yooralla.com.au

LGBTIQA+ communities

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

- Department of Health and Human Services Rainbow eQuality guide: https://www2.health.vic.gov.au/rainbowequality/
- Thorne Harbour Health (formerly VAC) thorneharbour.org/
- Transgender Victoria www.tgv.org.au
- Youth Projects www.youthprojects.org.au/Pages/Category/drug-safety
- YGENDER www.ygender.org.au/
- Rainbow Network www.rainbownetwork.com.au
- Rainbow Door www.rainbowdoor.org.au
- Touchbase www.touchbase.org.au
- GLHV www.glhv.org.au
- QLife qlife.org.au/

  Provides Australia-wide anonymous, LGBTIQA+ peer support and referral for people wanting to talk about a range of issues including sexuality, identity, gender, bodies, feelings or relationships

Older people

- Seniors Rights Victoria: seniorsrights.org.au
  Seniors Rights Victoria provides information, support, advice and education to help prevent elder abuse and safeguard the rights, dignity and independence of older people.
- Council on the Ageing: www.cotavic.org.au
  Council on the Ageing (COTA) Victoria is the leading not-for-profit organisation representing the interests and rights of people aged 50+ in Victoria.. Their focus is on promoting opportunities for, and protecting the rights of, older Victorians.
- Elders Rights Advocacy: www.era.asn.au
  Elder Rights Advocacy supports older people, their families and representatives in Victoria address issues related to Commonwealth funded aged care services. Their service is free, independent and confidential.
- Better Place Australia: www.betterplaceaustralia.com.au
  Better Place Australia provides a range of services for the enhancement of family relationships and the prevention, management and resolution of family conflict, including but not limited to family mediation, conciliation, arbitration, counselling, child counselling, family therapy, elder abuse prevention, relationship education which is: community based; and easily accessible to all members of the community in need of benevolent relief.

APPENDIX 2: ALCOHOL CONVERSION CHART

NUMBER OF STANDARD DRINKS – WINE

1.5
150ml
Average
Restaurant Serving
of Red Wine
13% Alc. Vol

1
100ml
Standard Serve
of Red Wine
13% Alc. Vol

0.8
60ml
Standard Serve
of Port
17.5% Alc. Vol

1.4
150ml
Average
Restaurant Serving
of White Wine
11.5% Alc. Vol

0.9
100ml
Standard Serve
of White Wine
11.5% Alc. Vol

1.4
150ml
Average Restaurant
Serve of Champagne
12% Alc. Vol

7.1
750ml
Bottle of Champagne
12% Alc. Vol

7.7
750ml
Bottle of Red Wine
13% Alc. Vol

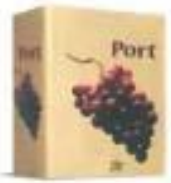
41
4 Litres
Cask Red Wine
13% Alc. Vol

21
2 Litres
Cask Red Wine
13% Alc. Vol

6.8
750ml
Bottle of White Wine
11.5% Alc. Vol

36
4 Litres
Cask White Wine
11.5% Alc. Vol

18
2 Litres
Cask White Wine
11.5% Alc. Vol



28
2 Litres
Cask of Port
17.5% Alc. Vol

These 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
30ml
High Strength
Spirit Nip
40% Alc. Vol

22
700ml
High Strength
Bottle of Spirits
40% Alc. Vol

1.1
275ml
Full Strength
RTD*
5% Alc. Vol

1.2
330ml
Full Strength
RTD*
5% Alc. Vol

2.6
660ml
Full Strength
RTD*
5% Alc. Vol

1.5
275ml
High Strength
RTD*
7% Alc. Vol

1.8
330ml
High Strength
RTD*
7% Alc. Vol

3.6
660ml
High Strength
RTD*
7% Alc. Vol

1
250ml
Full Strength
Pre-mix Spirits
5% Alc. Vol

1.2
300ml
Full Strength
Pre-mix Spirits
5% Alc. Vol

1.5
375ml
Full Strength
Pre-mix Spirits
5% Alc. Vol

1.7
440ml
Full Strength
Pre-mix Spirits
5% Alc. Vol

1.4 – 1.9
250ml
High Strength
Pre-mix Spirits
7% – 10% Alc. Vol

1.6
300ml
High Strength
Pre-mix Spirits
7% Alc. Vol

2.1
375ml
High Strength
Pre-mix Spirits
7% Alc. Vol

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

These are only an approximate number of standard drinks. Always read the container for the exact number of standard drinks.

* Ready-to-Drink

APPENDIX 3: SUMMARY OF THE FOUR MEASURES INCLUDED IN THE INITIAL SCREEN

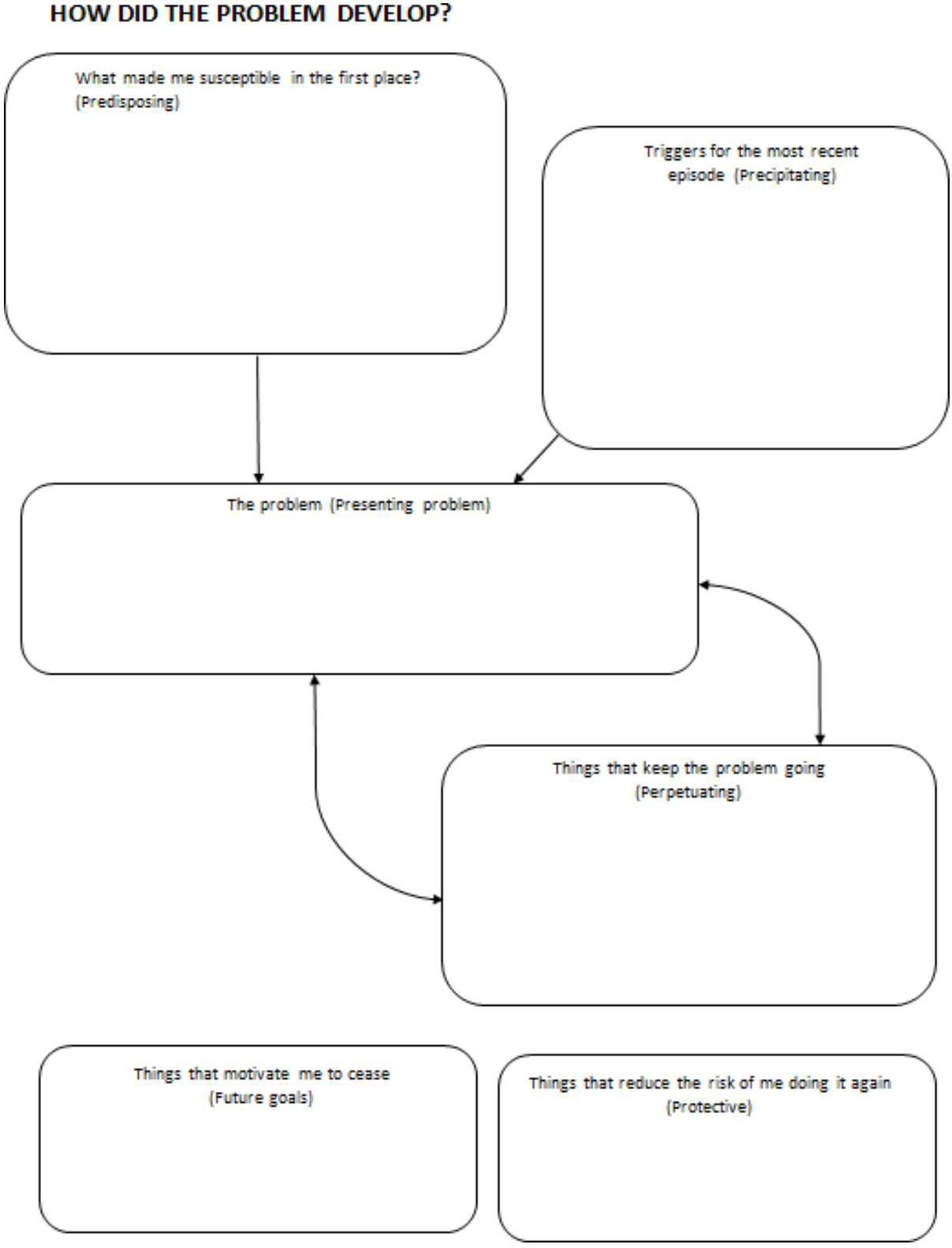
Appendix 3

Table 2: Summary of the four measures included in the initial screen

Screening instrument	Items and time	Administration	Areas covered	Psychometrics	Key References
ATOP	26 items	Self or clinician	1. Substance use (including injecting behaviours) 2. Health and Wellbeing (Bio/Psycho/Social model) – Global ratings 0 – 10 – Housing, employment & study, violence, legal issues, child protection	Studies of reliability Yes ☒ No☐ Studies of validity Yes 1 No0	SOURCE Ryan A; Holmes J; Hunt V. Dunlop A; Mammen K; Holland R; Sutton Y; Sindhusake H, Rivas G & Lintzeris (2014) Validation and implementation of the Australian Treatment Outcomes Profile in specialist drug and alcohol settings *Drug and Alcohol Review* 33: 33-42
Alcohol Use Disorders Identification Test (AUDIT) ★	10 items, that takes 2 minutes to complete and 1min to score	Self or clinician	1. Amount and frequency of drinking (3 questions) 2.Alcohol dependence (3 questions) 3. Problems caused by alcohol (3 questions)	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.	SOURCE Saunders, J.B., Aasland, O.G., Babor, T.F., de la Fuente, J.R. & 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.

Drug Use Disorders Identification Test (DUDIT)	11 items that takes less than 5 minutes to complete	Self	• Level of drug use • Selected criteria for substance abuse /harmful use and dependence according to the ICD-10 and DSM-4 diagnostic systems	Studies of reliability Yes ☒ No ☐ Studies of validity Yes ☒ No ☐ Tested in a variety of settings and populations Yes ☒ No ☐	SOURCE Berman AH; Bergman H; Palmstierna T; Schlyter F. (2005) Evaluation of the Drug Use Disorders Identification Test (DUDIT) in criminal justice and detoxification settings in a Swedish population sample. *European Addiction Research,* 11(10):22-31. SUPPORTING Berman AH; Palmstierna T; Kallmen H; Bergman H. (2007). The self-report Drug Use Disorders Identification Test-Extended (DUDIT-E): Reliability, validity, and motivational index. *J Subst Abuse Treat*, 32(4):357-36.
Kessler Psychological Distress Scale (K10)	10 items that takes 2 minutes to complete	Self or Clinician	Frequency of symptoms of generalized psychological distress	Studies of reliability Yes ☒ No ☐ Studies of validity Yes ☒ No ☐ Tested in a variety of settings and populations Yes ☒ No ☐	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. SUPPORTING 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: BRIEF CASE FORMULATION TOOL



APPENDIX 5: OVERVIEW: MARAM FAMILY VIOLENCE RISK ASSESSMENT & MANAGEMENT – FURTHER GUIDANCE

The purpose of the MARAM Brief and Intermediate Risk Assessment tools is to determine the patterns of family violence behaviour being perpetrated, identify evidence-based risk factors and assess the level of risk present. Family violence risk assessment focuses on determining the likelihood that a victim survivor/s will be killed or seriously injured.

The **Intermediate Assessment Tool** includes questions about a broad range of evidence-based risk factors experienced by adults and questions about risk to children. This tool can be used if engagement is short or long-term and allows time for more detailed assessment and holistic management.

The Brief Assessment Tool reflects high-risk factors only and should be used in place of the full intermediate assessment tool in time-critical interventions. This assessment can be used to inform a full intermediate assessment at a later point when time or the situation allows

The Child Assessment Tool is used to assess family violence risk to children. It contains a summary of adult risk factors, questions for an adult about a child's risk and a separate set of questions for direct assessment of an older child or young person. While the risk level of a carer who is a victim survivor is highly relevant to the risk level of any child victim survivors, it is important that, wherever possible, you conduct a specific and individual risk assessment for each child or young person in a family.

Key elements which MARAM brings to the AOD clinical space relevant to AOD Intake and Assessment clinicians are:

- a shared understanding of Family Violence
- Using the Structured Professional Judgement Model in the determination of family violence risk
- The range of Evidence Based Risk Factors
- The use of Family Violence and Child Information Sharing Schemes (FVISS/CISS)

The following sections summarise these elements

Shared Understanding of Family Violence MARAM seeks to ensure all professionals have a shared understanding of family violence. This enables a more consistent approach to risk assessment and management across the service system and helps keep perpetrators in view and accountable and victim survivors safe. According to Victorian law, family violence is behaviour by a person towards a family member that is physically, sexually, economically, emotionally or psychologically abusive. It includes behaviour that is threatening or coercive or that controls or dominates the family member and causes them to feel fear for their own safety or wellbeing or that of another family member or person. This includes behaviour that causes a child to hear or witness, or otherwise be exposed to the effects of such abuse. MARAM outlines key understandings of family violence that should underpin the work of all prescribed services including:

- Family violence is a behaviour that controls or dominates a family member and causes them to fear for their own or another person's safety or wellbeing.

- Family violence is a choice by a perpetrator to use behaviours for the purposes of power and control. Perpetrators use coercive tactics and violent controlling behaviour to gain power over one or more victim survivors. Responsibility for the use of violence rests solely with the perpetrator.
- Family violence is deeply gendered and rooted in structural inequalities. While both men and women can be perpetrators or victim survivors of family violence, overwhelmingly, perpetrators are men, who largely perpetrate violence against women (who are their current or former partner) and children.
- Family violence can occur in a range of ways across different relationship types and communities, including but not limited to the following:
  - Children and young people as victim survivors in their own right who have unique experiences, vulnerabilities and needs
  - Older peoples' experiences of family violence, often described as elder abuse, from intimate partners, adult children or carers, or extended family members
  - The experiences of family violence may vary across communities and people from Aboriginal or diverse backgrounds may additionally experience structural inequalities.

For further information, refer to the MARAM Foundation Knowledge Guide

Structured Professional Judgement Model MARAM incorporates a ***Structured Professional Judgement*** model which enables professionals to assess information to determine the level or seriousness of risk. It is an opportunity to ask the victim survivor about their self-assessment of their risk, fear and safety and to explore if family violence risk factors are present. Observing signs of trauma can also provide evidence of family violence- see page 87

The Structured Professional Judgement model consists of four key components combined in the assessment of risk:

1. **victim self-assessment**
2. **evidence-based risk factors**
3. **information sharing**
4. **professional judgement and intersectional analysis**.

Victim self-assessment

Risk assessment relies on you or another professional ascertaining:

- a victim survivor's self-assessment of their level of risk, fear and safety
- identifying the family violence risk factors that are present.

You can gather information to inform this approach from a variety of sources, including:

- interviewing or 'assessing' the victim survivor directly, and/or
- requesting or sharing, as authorised under applicable legislative Information Sharing Schemes, with other organisations about the risk factors present or other family violence risk relevant information about a victim or perpetrator's circumstances.

You should consider this information and apply your professional judgement to each of the elements; analysing and interpreting information to determine the level of risk. Risk assessment is a point-in-time assessment of the level of risk. Risk is dynamic and can change over time, which means that risk should be regularly reviewed, and any changes should inform future assessment. Your assessment of the level or seriousness of risk, as well as appropriate risk management approaches, must be informed by an intersectional analysis (detailed below).

Evidence-based risk factors All MARAM tools and resources are underpinned by the same evidence-based family violence risk factors to ensure that there is a consistent approach to family violence risk assessment across sectors and promotes collaborative practice. The MARAM family violence risk factors are presented below. Some of these factors may be new to you if you are familiar with using the Common Risk Assessment Framework (CRAF) indicated by # symbol. Risk factors in **bold** indicate increased risk of the victim being killed or almost killed (serious risk factors).

Risk factors for adult or child victims caused by perpetrator behaviours	**Risk factors relevant to adult victim circumstances**
• **Controlling behaviours** • **Access to weapons** • **Use of weapon in most recent event** • Has ever harmed or threatened to harm victim or family members • **Has ever tried to strangle or choke the victim** • **Has ever threatened to kill victim** • **Has ever harmed or threatened to harm or kill pets or other animals** • **Has ever threatened or tried to self-harm or suicide** • **Stalking of victim** • **Sexual assault of victim** • Previous or current breach of court orders/Intervention Order • History of family violence # • History of violent behaviour (not family violence) • **Obsession/jealous behaviour towards victim** • **Unemployed/Disengaged from education** • **Drug and/or alcohol misuse** • Mental illness/Depression • Isolation • Physical harm # • Emotional abuse # • Property damage #	• **Physical assault whilst pregnant/following birth** • Self-assessed level of risk # • **Planning to leave or recent separation** • **Escalation – increase in severity and/or frequency of violence** • Financial abuse/difficulties (including property damage) • Imminence # **Risk factors specific to children caused by perpetrator** • Exposure to family violence # • Sexualised behaviours towards a child by the perpetrator # • Child intervention in violence # • Behaviour indicating non-return of child # • Undermining the child-parent relationship # • Professional and statutory intervention # **Risk factors specific to children's circumstances** • History of professional involvement and/or statutory intervention # • Change in behaviour not explained by other causes # • Child as victim in other forms of harm #

It is important to note the following when you review the family violence risk factors:

- They are not weighted. Some are associated with an increased risk of the victim being killed or almost killed (in bold in the graphic above).
- The evidence base upon which the risk factors have been drawn are primarily based on reports of family violence incidents in heterosexual intimate partner relationships.
- The risk factors are relevant to family violence risk in Aboriginal communities, diverse communities and at-risk age groups, including children, young people and older people.
- The risk factors are described in gender-neutral language, where appropriate, to support further collection and understanding of the presentation of family violence risk factors across all communities and relationships and continuing development of the evidence base.
- The assessment of individual child experiences of risk should be undertaken with an understanding of the risk being experienced by any adult victim in the family as well as the child specific risk factors.

Intersectional Analysis: Applying an intersectional lens means considering a person's whole, multi-layered identity and life experience, and reflecting on one's own bias to be able to respond safely and appropriately in practice. Structural inequality and discrimination create and amplify barriers and risk which continue to exacerbate systemic marginalisation, power imbalance and social inequality for those experiencing family violence.

Intersectional analysis gives due weight to service users' identities and experience and understanding of risk. It is a theoretical approach to recognise the interconnected nature of social categorisations, identity and experience. Intersectional analysis reflects on an individual's age, gender identity, sexual orientation, ethnicity, cultural background, language, religion, visa status, class, socioeconomic status, ability (including physical, neurological, cognitive, sensory, intellectual or psychosocial impairment and/or disability) or geographic location.

Gender and the drivers of family violence are critical to informing your understanding of intersectional analysis in the family violence practice context.

To provide further information about how to apply professional judgement and intersectional analysis to your practice**,** refer to the MARAM Foundation Knowledge Guide https://www.vic.gov.au/sites/default/files/2020-05/Foundation%20Knowledge%20guide.pdf and Responsibilities 3: Intermediate risk assessments Practice Guide https://www.vic.gov.au/sites/default/files/2020-05/PG%20Responsibility%203.pdf

Risk Assessment and action: The following guidance provides a summary of the MARAM different levels of risk and the recommended action to take for each level.

There are four recognised levels of risk which denote 'seriousness':

- at risk
- elevated risk
- serious risk
- serious risk and requires immediate protection.

Risk levels can change and escalate over time, making ongoing monitoring and updated risk assessment important.

At risk:

- High-risk factors are not present.
- Some other recognised family violence risk factors are present.
- Protective factors and risk management strategies, such as advocacy, information and victim survivor support and referral, are in place to lessen or remove (manage) the risk from the perpetrator.
- Victim survivor's self-assessed level of fear and risk is low, and safety is high.

Action to take includes:

- Completing the safety plan. If the victim survivor has a child/ren, a safety plan should also be completed for each child
- Considering proactive information sharing and making a request to support risk assessment
- Monitoring the safety plan and any changes to the level of risk with the victim-survivor over time
- Considering and discussing with the victim survivor appropriate referrals to support them including in relation to risk management or protective factors required to support stabilisation (such as housing) - and broader supports beyond specialist family violence services, including those with specialist expertise in working with Aboriginal communities and diverse communities (generally and in the context of family violence)

Elevated risk:

- A number of risk factors are present, including some high-risk factors.
- Risk is likely to continue if risk management is not initiated/increased.
- The likelihood of a serious outcome is not high. However, the impact of risk from the perpetrator is affecting the victim survivor's day-to-day functioning.
- Victim survivor's self-assessed level of fear and risk is elevated, and safety is medium.

Action to take includes:

- Completing the safety plan. If the victim survivor has a child/ren, a safety plan should also be completed for each child.
- Consider proactive information sharing and making a request to support risk assessment
- Monitoring the safety plan and any changes to the level of risk with the victim-survivor over time
- Considering appropriate referrals to support the victim-survivor including a referral to a specialist family violence service for an urgent MARAM comprehensive assessment

Serious risk:

- A number of high-risk factors are present.
- Frequency or severity of risk factors may have changed/ escalated.
- Serious outcomes may have occurred from current violence and it is indicated further serious outcomes from the use of violence by the perpetrator is likely and may be imminent.
- Immediate risk management is required to lessen the level of risk or prevent a serious outcome from the identified threat posed by the perpetrator.
- Statutory and non-statutory service responses are required and coordinated, and collaborative risk management and action planning may be required.

- Victim survivor's self-assessed level of fear and risk is high to extremely high and safety is low.
- Most serious risk cases can be managed by standard responses (including by providing crisis or emergency responses by statutory and non-statutory (e.g. specialist family violence) services. There are some cases where serious risk cases cannot be managed by standard responses and require formally convened crisis responses.

Action to take includes:

- Making an immediate referral to Safe Steps, The Orange Door or other local specialist family violence services
- Considering proactive information sharing and making a request to support risk assessment
- If necessary, make a safety plan with the client pending Safe Steps accepting the referral with consultation with your Specialist Family Violence Advisor or a specialist family violence service. If the victim survivor has a child/ren, a safety plan should also be completed for each child.
- Considering appropriate referrals relevant to risk management or protective factors required to support stabilisation (such as housing) to support the victim-survivor beyond specialist family violence services, including those with specialist expertise in working with Aboriginal communities and diverse communities generally and in the context of family violence
- Supporting a referral for services, including legal services such as an intervention order (in consultation with the victim survivor if possible – however, consent is not needed where there is a serious threat to the life, health, safety or welfare of a person which includes situations where MARAM Risk Assessment determines a level of 'serious risk' or 'serious risk and requirement immediate protection')

Serious risk and requires immediate protection:

In addition to serious risk, as outlined above:

- Previous strategies for risk management have been unsuccessful.
- Escalation of severity of violence has occurred/is likely to occur.
- Formally structured coordination and collaboration of service and agency responses is required.
- Involvement from statutory and non-statutory crisis response services is required (including possible referral for a Risk Assessment and Management Panel (RAMP) response) for risk assessment and management planning and intervention to lessen or remove serious risk that is likely to result in lethality or serious physical or sexual violence.
- Victim survivor self-assessed level of fear and risk is high to extremely high and safety is extremely low.

Action to take:

- Contacting the police in crisis situations where an immediate response is required
- Making an immediate referral to Safe Steps
- If necessary, making a safety plan with the client pending Safe Steps accepting the referral with consultation with your Specialist Family Violence Advisor or a specialist family violence service. If the victim survivor has a child'ren, a safety plan should also be completed for each child.
- Supporting a referral for legal services such as an intervention order (in consultation with the victim survivor if possible – however, consent is not needed where there is a serious threat to the life, health, safety or welfare of a person which includes situations where a MARAM Risk Assessment determines a

level of 'serious risk' or 'serious risk and requirement immediate protection')

- Contributing to collaborative, coordinated risk management activities (secondary consultation, referral, monitoring and coordination – see MARAM Responsibilities 5-6, 9-10)

Observable signs of trauma in adult victims

Form	Signs of trauma that may indicate family violence is occurring for adult victims	
Physical	• bruising • fractures • chronic pain (neck, back) • fresh scars or minor cuts • terminations of pregnancy	• complications during pregnancy • gastrointestinal disorders • sexually transmitted diseases • strangulation
Psychological	• depression • anxiety • self-harming behaviour • eating disorders • phobias • somatic disorders	• sleep problems • impaired concentration • harmful alcohol use • licit and illicit drug use • physical exhaustion • suicide attempts
Emotional	• fear • shame • anger • no support networks	• feelings of worthlessness and hopelessness • feeling disassociated and emotionally numb
Social/financial	• homelessness • unemployment • financial debt	• no friends or family support • isolation • parenting difficulties
Demeanour	• unconvincing explanations of any injuries • describe a partner as controlling or prone to anger • be accompanied by their partner, who does most of the talking	• anxiety in the presence of a partner • recent separation or divorce • needing to be back home by a certain time and becoming stressed about this • reluctance to follow advice

A list of observable signs of trauma is also available for children and young people: https://www.vic.gov.au/sites/default/files/2020-05/APPENDIX%201.docx

Information Sharing

AOD services are able to share information with other services in accordance with the following schemes – the Family Violence Information Sharing Scheme and the Child Information Sharing Scheme. These schemes are described below.

Family Violence Information Sharing Scheme

The Family Violence Information Sharing Scheme (FVISS) prescribes AOD services as ISEs that are required on request and permitted to voluntarily share relevant information with other ISEs to assess and manage family violence risk with other ISEs. FVISS will improve professionals' and services' ability to help keep victim survivors safe and hold perpetrators in view and accountable for their actions and behaviours.

A key component of FVISS is that information about an alleged perpetrator or perpetrator can be shared without their consent, as can information about any person to assess or manage a risk to a child victim survivor. Consent is required for an adult victim survivor, unless a child is at risk or sharing is necessary to lessen or prevent a serious threat to the life, health, safety or welfare of a person.

There are two purposes for which ISEs can share information with each other under FVISS:

- A family violence assessment purpose (to establish and assess risk): The primary focus of a family violence assessment is on establishing whether a risk of family violence is present, assessing the level of risk the alleged perpetrator or perpetrator poses to the victim survivor, and correctly identifying the parties as the perpetrator or victim survivor. Information can only be shared for this purpose with a subset of ISEs, known as Risk Assessment Entities.

- A family violence protection purpose (to manage the risk, including through ongoing risk assessment) The family violence protection purpose means managing the risk of the perpetrator committing family violence, or the risk of the victim survivor being subjected to family violence. Information can be shared for this purpose when the presence of risk is known. Managing risk involves removing, reducing or preventing the escalation of risk.

As risk is dynamic and can change over time, information can be shared for ongoing risk assessment to monitor risk and escalation. For example, any ISE can request and share information from other ISEs to inform ongoing risk assessment and update risk management and safety plans with the victim survivor.

Child Information Sharing Scheme

The Child Information Sharing Scheme (CISS) allows authorised organisations to share and request information to support child wellbeing or safety. As a prescribed **Information Sharing Entity (ISE)**, CISS allows AOD organisations to share information with other prescribed entities such as Child Protection, Youth Justice, Maternal and Child Health, and Victoria Police. This ensures that professionals working with children can gain a complete view of the children they work with, making it easier to identify wellbeing or safety needs earlier, and to act on them sooner. This includes promoting the broader wellbeing and safety of children who experience family violence.

AOD organisations can share confidential information with other ISEs under CISS if:

1. The ISE is requesting or disclosing confidential information about any person for the purpose of promoting the wellbeing or safety of a child or group of children; and
2. The disclosing ISE reasonably believes that sharing the confidential information may assist the receiving ISE to carry out one or more of the following activities:
    i. making a decision, an assessment or a plan relating to a child or group of children
    ii. initiating or conducting an investigation relating to a child or group of children
    iii. providing a service relating to a child or group of children
    iv. managing any risk to a child or group of children; and

3. The information being disclosed or requested is not known to be 'excluded information' under Part 6A of the Child Wellbeing and Safety Act (and is not restricted from sharing by another law).

Consent is not required under CISS, though you should seek and take into account the views of the child and the child's relevant family members, if it is appropriate, safe and reasonable to do so.

For a decision tree regarding FVISS/CISS, refer to the Must/May model located at https://www.vaada.org.au/wp-content/uploads/2019/10/RES_Must-May-Model-Flowchart_30102019.pdf

Information Sharing Entities

For a full list of organisations prescribed as ISEs under CISS and FVISS, visit the ISE List at https://iselist.www.vic.gov.au/ise/list/ .

Child Protection Reporting

All professionals working with families share in the responsibility of protecting children as does everyone in the community.

Non-mandatory reporting

A non-mandatory report to Child Protection should be made where a person, including an AOD treatment service or worker, has formed a belief that a child has suffered or is likely to suffer significant harm as a result of abuse or neglect, and that their parent has not protected or is unlikely to protect the child from harm of that type. 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.

However, if a worker has significant concerns about the wellbeing of a child but does not believe they are in need of protection, a referral should be made to Child FIRST or The Orange Door.

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 is available at: https://providers.dhhs.vic.gov.au/making-report-child-protection

Parents whose children are subject to family reunification orders, where there is a condition attached for the parent to engage in alcohol or drug treatment, are eligible to be seen immediately, through particular service providers. The objective of this initiative is to engage parents requiring assessment and treatment in a timely manner in order to maximise the likelihood of safely reunifying with their child within the timeframes of a family reunification order.

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

For further information see:

https://www.cpmanual.vic.gov.au/advice-and-protocols/advice/health-and-medical/drug-and-alcohol-assessments

https://www.cpmanual.vic.gov.au/sites/default/files/CP%20fact%20sheet%20-%20AOD%20and%20FRO%20initiative%20v1.pdf

Mandatory reporting

Under the *Children, Youth and Families Act 2005*, registered medical practitioners, nurses, midwives, registered teachers and early childhood teachers, school principals, school counsellors, police officers, out of home care workers (excluding voluntary foster and kinship carers), early childhood workers, youth justice workers, registered psychologists and people in religious ministry are **mandatory** reporters. Mandatory reporters **must** make a report to Child Protection if they form a belief on reasonable grounds that a child is in need of protection from physical injury or sexual abuse.

Further information about mandatory reporting can be found on the Victorian Government website - https://providers.dhhs.vic.gov.au/mandatory-reporting
A presentation about how to report to Child Protection has been developed and is available for the community to use via the Child Protection manual - https://www.cpmanual.vic.gov.au/our-approach/community-education/community-education

Privacy Legislation

Under the Victorian *Freedom of Information Act 1982*, people can request access to documents held by Victorian public sector agencies – this **may** include documents held by AOD funded agencies, depending on the AOD agency service agreement and whether a particular AOD is attached to a health service. Access is subject to exceptions and exemptions, and sensitive information – such as family violence information – is carefully considered and **will often be protected from release**. **In processing an FOI request, the Department of Health's FOI team or other relevant FOI team** will consult with agencies or organisations about sensitive information prior to release, particularly regarding any family violence risk to victim survivors, staff, or others. Additionally, if a document contains personal information about a third party (not the requestor), **the FOI team** must consult with that third party to obtain their views on release of the information.

For further information see: https://ovic.vic.gov.au/freedom-of-information/for-the-public/make-a-freedom-of-information-request/

AOD funded agencies which are not subject to the *Freedom of Information Act 1982* may release information administratively in accordance with the *Privacy and Data Protection Act 2014*.

If you would like to consult with the Department of Health's Freedom of Information team to discuss clients' access to documents, you can contact: FOI@health.vic.gov.au