IN THE MATTER OF THE ROYAL COMMISSION INTO FAMILY VIOLENCE

ATTACHMENT JA-18 TO STATEMENT OF JUDITH DORENE ABBOTT

Date of document: 14 July 2015
Filed on behalf of: State of Victoria
Prepared by:
Victorian Government Solicitor's Office
Level 33
80 Collins Street
Melbourne VIC 3000

[redacted]

This is the attachment marked "**JA-18**" produced and shown to **JUDITH DORENE ABBOTT** at the time of signing her Statement on 14 July 2015.

[redacted]

Melbourne VIC 3000
An Australian Legal Practitioner within the meaning of the Legal Profession Uniform Law (Victoria)

The Adult AOD Screening and Assessment Instrument: Clinician Guide

June 2013

State Government Victoria

Table of Contents

Glossary of terms

Triage: Undertaken at the first contact with the client as part of intake procedures in order to make an initial judgement about the urgency of the problem, and to facilitate the client's pathway to an appropriate clinician and/or service.

Screening: Screening is the initial part of the assessment process and helps determine whether a particular condition or disorder is present. It also enables signposting for treatment and enables brief interventions to be conducted where appropriate.

Assessment: A positive screen triggers a detailed assessment, aimed at clarifying the presence of the condition, and at informing care planning.

Care planning: Care planning is the process of setting goals and interventions based on the needs identified by an assessment and then planning how to achieve those goals with the client.

Review: Process of gauging a client's progress against treatment goals. These may include reduced substance use (and/or harms associated with) or abstinence, and/or may also include improved functioning, improvements to other areas of life (i.e. employment, housing etc.) and general quality of life. Care plans may need to be altered to take into account a clients' progress.

INTRODUCTION

As part of the reform agenda the Department of Health has commissioned the development of a new, evidence based Alcohol and Other Drug (AOD) screening and assessment instrument for AOD clients. The project began in 2011 with an initial pilot of the screening and assessment instrument. A second phase of piloting concluded in December 2012 and culminated in the development of a final instrument, which will be implemented across the AOD sector.

What is the purpose of this clinician guide?

This is your guide to using the AOD screening and assessment instrument with your clients. It discusses how the instrument was developed. It contains a section by section description of the instrument, with 'frequently asked questions' addressed along the way.

Why develop a new AOD screening and assessment instrument?

In the first phase of the project in 2011, we conducted a state-wide online survey, a policy analysis and systematic literature review of screening and assessment instruments and found that:

- Existing instruments can be too long, which can be detrimental to developing a therapeutic relationship
- There is a perceived lack of mental health assessment in current instruments
- There are a number of service types, and they do screening and assessment differently
- A state-wide instrument needs to balance comprehensiveness with the flexibility to be used in a variety of settings

The need to introduce a common screening and assessment instrument has been recognised in the *New directions for alcohol and drug treatment services: a roadmap* released by the Department of Health in 2012. According to the roadmap "Introducing common screening and assessment tools in specialist alcohol and drug treatment services... (Pg 5)" is a key reform action.

Who will be required to use the new adult AOD screening and assessment instrument?

The new adult AOD screening and assessment tool will form part of the AOD recommissioning framework. All funded adult AOD services will be required to utilise the tool under new service agreements to be implemented in 2014.

The Department will mandate use of the following:

- Step 1: Initial Screen
- Step 2: Comprehensive Assessment

Use of the 11 Optional Modules and a Review is discretionary.

Services will be encouraged to prepare for the transition to the new AOD screening and assessment tools by accessing training and adopting the tool during 2013.

What does the new instrument look like?

The instrument is based on the assumption that after triage, there are typically two stages before treatment goals are set. This two-step approach involves:

Step 1: A basic screening process which will be a mix of client and clinician administered components. At the end of step 1 clinicians determine whether comprehensive assessment is necessary and/or if motivational interviewing or a brief intervention would be helpful. In some services Step 1 will follow the completion of Service Coordination Tool Template (SCTT): Single Page Screener for Health and Social Need, which may trigger the screen if AOD issues are identified.

Step 2: If further assessment is needed, the client receives a comprehensive assessment. This can only be completed by a specialist AOD clinician. It contains a 10-page core component comprising six sections including Alcohol and other Drugs, Medical History, Mental Health, Risk, Psychosocial, and a Final Case Summary Sheet. Optional assessment modules are also included. These are not compulsory but can be completed if desired.

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: Is a review form that can be completed a minimum of four weeks after the assessment to see how the client is progressing compared to when they were first assessed.

Each step builds upon and informs the next. The screen forms the basis of the assessment, and the information gathered from both forms a baseline, which can then be used to gauge progress at review.

Figure 1: Overview of steps

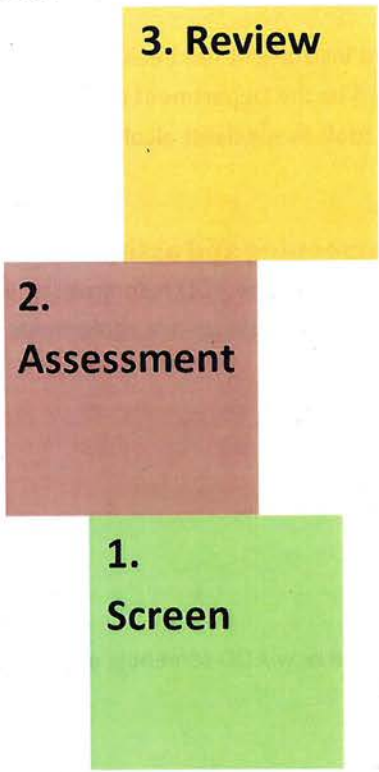
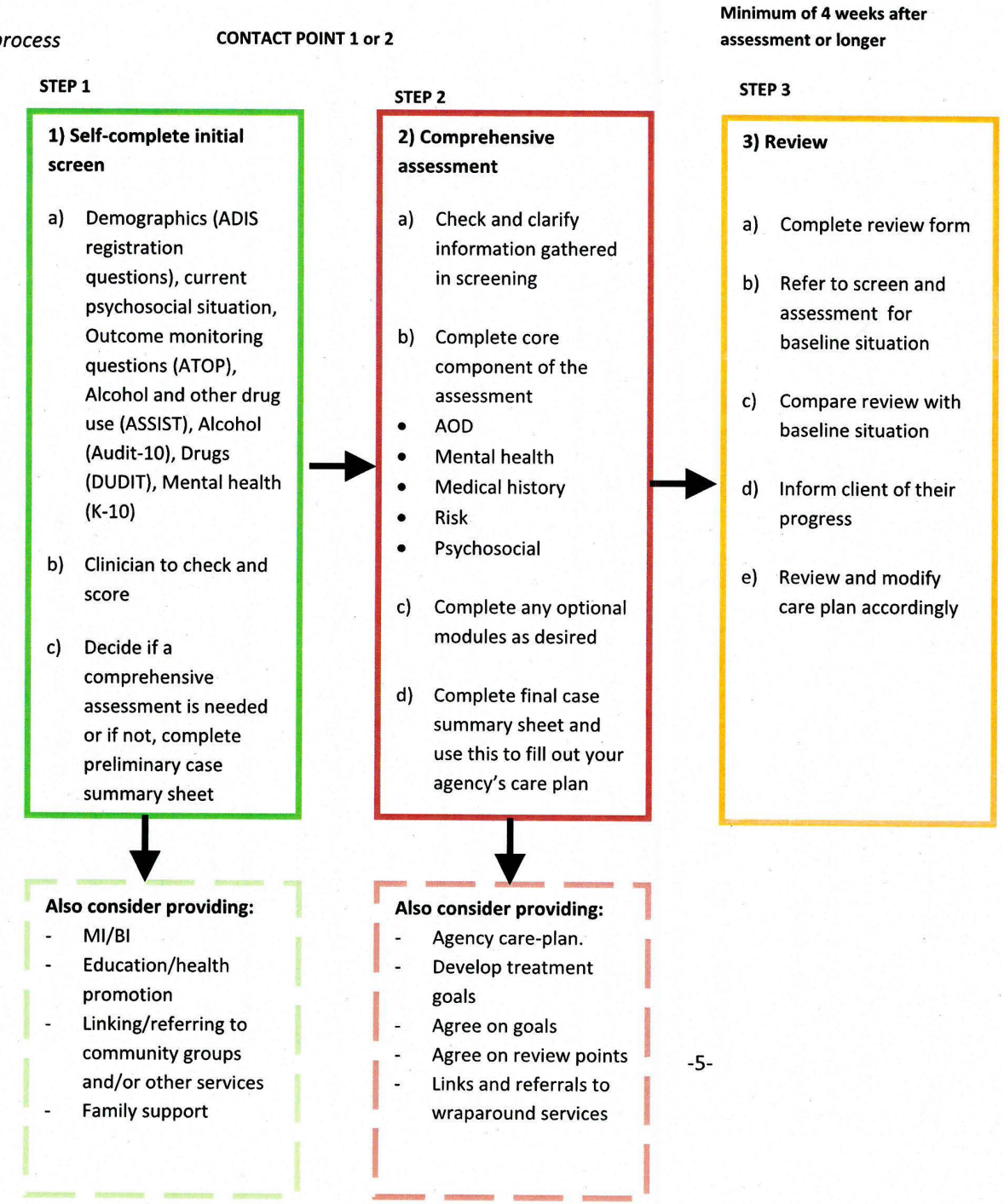


Figure 2 provides a detailed picture of the main steps of the process and how it is envisaged that the process might work.

Figure 2: Detailed overview of process



How does the instrument fit into existing local service processes?

The instrument was designed as a core minimum, which can be built upon. This means that processes such as client consent to share information, risk assessment, or specific intake processes that your service has, will still be completed as usual. It also means that you can still use your agency's preferred screening and assessment tools alongside this new instrument.

Questions to enable Alcohol Drug Information Service (ADIS) registration have been embedded in Step 1: self-complete initial screen. This may be administered or built in to triage and intake processes to meet the needs of your clients.

In time, the idea is that your service will build a single document that contains this core set of validated measures and those additional measures that are necessary in your service.

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

Findings from an initial online survey of, along with additional consultation and engagement with the AOD Sector, and guidance from an expert advisory group informed the development of a draft instrument in 2011. In this first phase of the project, the instrument was initially piloted in 5 specialist AOD agencies over 8 weeks. Feedback and findings from the evaluation then led to the development of a revised instrument, which was piloted on a broader scale in 2012.

This second phase of the project involved eight specialist AOD agencies, over 70 clinicians, and resulted in over 400 instances of screening and assessment being initiated. The major preliminary findings from the pilot were that:

- Around two thirds of clients completed the screen by themselves – mostly in the waiting rooms of services.
- Over 90% of clients said that the questions in the screen and the length of time taken to complete the screen were acceptable to them.
- The average time taken to complete the screen was around 20 minutes, although it took longer when clinicians administered the screen.
- In many cases clinicians reported that the screen provided enough information to: obtain a preliminary snapshot of the client's needs (84%) and goals (64.4%); make a preliminary determination about a client's level of risk (65.5%); make a determination about the urgency with which comprehensive assessment is required (70%); determine suitable treatment types (75%).
- On average the comprehensive assessment took around one hour to complete.
- Clinicians perceived the time taken to complete the assessment to be acceptable in 79% of cases, and in 80% of cases, clinicians reported that they felt comfortable administering the assessment.
- Over two thirds of clinicians reported that the instrument allowed the opportunity to develop a therapeutic relationship with clients.

- In many cases clinicians reported that the assessment provided enough information to: obtain a detailed understanding of the client's needs (84%) and goals (82%); make a preliminary determination about a client's level of risk (92%); make a determination of the urgency with which comprehensive assessment is required (92%); determine suitable treatment types (93%); make appropriate referrals (87%).
- There were some areas of both the screen and assessment that could be improved, including in relation to both psychosocial issues and legal status.

The instrument was then refined and modified to take into account the feedback and findings from the second phase of the pilot.

SUMMARY OF MAJOR FEATURES OF THE INSTRUMENT

Evidence based

We reviewed the evidence and selected standardised measures that had high reliability, validity and client acceptance and included these in the screen (e.g. ASSIST, 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 screening and assessment instrument also covers 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.

Short and user friendly

Our instrument needed to be short and user friendly, and so we created links between the screen and assessment to minimise repetition. This means that clinicians can build their assessment from the screen. We also incorporated design elements like a navigation system and colour coding to simplify navigation.

Ability for screen to be used in non-AOD services

Recognising that people with AOD problems sometimes access non-AOD services for help, we designed the screen part of our instrument so that it could be used in non-AOD services. A number of non-AOD services including mental health, child protection, and housing services are piloting the screen currently, and initial indications appear positive. When the screen is completed in non-AOD services, this can streamline referral and intake at specialist AOD agencies if clients are referred on.

Compatibility with service coordination tool templates

Many community services use the Service Coordination Tool Templates (SCTT). The initial screen was designed with this in mind. The SCTT single page screener acts as a flag for a number of issues, including potential AOD problems. If AOD issues are identified on the SCTT single page screener, this can act as a trigger for the completion of the self-complete initial screen in services using the SCTT.

Ability for screen to be self-completed

The screen was designed so that it could be self-completed, which would offer clients the option of actively engaging

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

and taking responsibility in their treatment journey from day 1. In the first phase of the pilot, clients were asked about their treatment motivation before and after self-completing the screen and we found that self-completion did not appear to have any adverse affect on the client's motivation for treatment, and can have a positive effect in some cases. Furthermore, people may report more accurately when they are able to self-complete forms.

Strengths based

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

Opportunity for outcome measurement

Outcome measures were embedded into the instrument to form a baseline measurement that can be compared against review results to gauge clients' progress.

Flexibility to be used in a range of settings

The format of the assessment instrument – with a core-component, and optional modules that could be completed if desired – means that the instrument can be tailored to the individual needs of clients and agencies. For instance a particular agency might have a focus on Acquired Brain Injury, and may choose to use the ABI module for every client. In contrast, if gambling is not an issue for the client, then there is no need to follow-up on this further.

Comprehensive and holistic

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

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 screen asks about self-reported reasons for presenting. There is also a section in the case summary sheet at the end of the assessment called "reasons for presenting" where clinicians can summarize presenting problems.
Role of drinking/drug use in presenting problems	✓	The assessment contains prompts for clinicians to explore the role of AOD use in medical problems, mental health issues and other problems.
Motivation for presentation	✓	The question "What is your reason for coming here today?" in the screen provides an insight into clients' motivation for presentation, and acts as a prompt for further discussion of motivation for presentation.
Other concerns	✓	There is a specific section in the screen 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 screen 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 the assessment.
Duration of drug and alcohol problems and previous withdrawal complications (seizures, delirium, hallucinations).	✓	Collected in the assessment.
Features of abuse or dependence. If dependent, assess likely withdrawal severity and previous withdrawal complications (seizures, delirium, hallucinations).	✓	Screen scores on AUDIT and DUDIT 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 screen asks one question on self-reported satisfaction with physical health, while there is a section in the comprehensive assessment that enables the clinician to record common physical health problems.
Mental health problems (depression, anxiety, psychosis, suicide risk)	✓	The screen contains a question on self-reported satisfaction with psychological health, and includes 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 if desired.
Social circumstances		
Social functioning (including relationship, employment, financial, housing, legal)	✓	The screen basic questions on social functioning, and quality of life. 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 clinicians can use if desired.
Examination (by suitably trained professionals)		
Physical examination (general examination, signs of intoxication or withdrawal, nutritional assessment, neurological function, gastrointestinal, cardiovascular)	✓	A physical examination module is included as an optional module that medically trained clinicians can complete if desired.
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 versus reduced drinking, other health concerns)	✓	The screen asks about self-reported reasons for presenting, in which clients can detail their goals, and both preliminary and final case summary sheet contain space for clinicians to record a client's goals and reasons for

		presenting. There is also an optional module about goals that can be completed if desired.
Involvement of other health and/or welfare professionals	✓	The initial screen 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 in the comprehensive assessment.
Clinical risks and risk management plan (harm to self/others, serious physical or mental illness, driving, child protection, domestic violence, occupational concerns)	✓	There is a section on suicide risk in the assessment, and a prompt for clinicians to complete their agencies own risk assessment form. In the psychosocial section of the assessment there is a prompt about harm to self and others, as well as family violence issues. Serious physical and mental illness are covered by the physical and mental health sections respectively.
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. It 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.

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

The following sections of the clinician's guide provides step by step information about the AOD screening and assessment instrument as well as answers to frequently asked questions (FAQs). This begins with the Self-complete Initial Screen for alcohol and other drug problems, which is also referred to in this document as Step 1. The terms "initial screen" and "screen" are sometimes used throughout this document interchangeably to refer to this component of the instrument. Completion of Step 1 will be required under new service agreements from 2014.

General instructions for completing Step 1: Initial Screen

1. Provide client with self-complete screen or administer with client. Instructions for clients on how to fill out the self-complete questionnaire are included with the instrument.
2. When the client has completed all that they can, you can check, clarify, and ask any unanswered questions.
3. Score screen results and provide feedback on scores.
4. If needed complete comprehensive assessment, using information from the screen to prompt discussion. If not needed or if it's unlikely that the client will return fill out preliminary case summary form.

Purpose

- To obtain a preliminary snapshot of the client's needs and goals.
- To enable the clinician to make a preliminary determination about the client's level of risk, level of urgency and about what treatment types might be suitable.
- To facilitate client involvement and ownership in the process.

Content

1. About you
2. Who to contact in case of emergency
3. Doctor's details Previous AOD treatment
4. More information

This section also includes four screening instruments

1. Alcohol and Other Drug use (ASSIST)
2. Alcohol Use (AUDIT)
3. Use of Other Drugs Other than Alcohol (DUDIT)
4. How Have You Been Feeling During the Past 30 Days? (K10)

The first two pages of the screen

The first page of the screen section will appear similar to any client registration form, and contains questions to enable client registration on ADIS. This includes demographic details, contact information, Aboriginal and Torres Strait Islander Status, cultural and linguistically diverse status, and whether the client has any allergies. It also contains information on emergency contact details, doctor's details and other services the client is involved with. The final section on the first page asks about previous AOD treatment, referral source and importantly also asks about clients reason for presenting. This question provides clients with the opportunity to articulate their goals and reason for presenting in their own words. If your agency already has a client registration form that collects this information, you can simply transpose the information from the client registration form onto the screen, or vice versa.

The second page of the screen asks the client for more information about their life situation. It is included on the premise that a clients AOD use is affected by, and effects, a range of psychosocial issues and a client's quality of life. Research has found that unmet social needs in relation to employment, education and housing are important reasons clients drop out of outpatient AOD treatment, suggesting that broader life issues and quality of life are important to clients[2]. Specifically this section asks about client's experience of employment, education, accommodation and housing, legal issues, gambling and the ages of children clients are responsible for caring for. These questions may be prompts that can be built upon in the assessment and flags for risk. For instance, if the client indicates that they are pregnant, or are responsible for caring for children, or are experiencing homelessness (and aren't receiving support for any housing issues), then these might indicate the need for an urgent or particular kind of response.

If the client is responsible for caring for children, then you can explore the impacts of substance use on children in the risk and psychosocial sections of the comprehensive assessment. If any concerns are raised about the welfare of children, consult with child protection if you suspect children are placed at risk (see FAQs related to the comprehensive assessment) and other relevant services.

This section also contains a question on gambling. The client is also asked to indicate whether they are currently receiving support for gambling, legal, or housing issues. This means that if a client indicates that they are concerned about their gambling for example and aren't currently receiving support for this, then this may be a trigger to complete the gambling optional module in comprehensive assessment.

At the end of this page, the client is asked to rate their physical, psychological health and overall quality of life in the past four weeks. Many of the questions refer to a four week time frame. These questions are embedded outcome monitoring questions, which are from the Australian Treatment Outcomes Profile – a recently developed Australian outcome monitoring tool. The answers to these questions form the basis of a baseline indication of a client's psychosocial functioning. Then at the time of review, these same questions can be asked again and are included in the Review form to gauge a client's progress and how effective their treatment has been.

The four screening instruments in the initial screen

[2] Laudet, A., Stanick, V., & Sands, B. (2009). What could the program have done differently? A qualitative examination of reasons for leaving outpatient treatment. *Journal of Substance Abuse Treatment*, 37(2), 182–190.

The four screening instruments in the Self Complete Initial Screen will provide an indication AOD use and any psychological distress. Positive screens should trigger a detailed assessment (Step 2 AOD Comprehensive Assessment) and assist in development of an integrated treatment plan.

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.

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

Screening instrument	**Items and time**	**Administration**	**Areas covered**	**Psychometrics**	**Key References**
Alcohol, Tobacco & Substance Involvement Screening Test (ASSIST) ★	8 items that takes 10-20 minutes, although the one part included would only take 2 minutes	Clinician, although the one part of the ASSIST used in the initial screen could be self-administered	1. Substances ever used (lifetime use) 2. Substance used in past 3 months 3. Problems related to Substance use 4. Risk of harm (current or future) 5. Dependence 6. IV use	Studies of reliability Yes ☒ No ☐ Studies of validity Yes ☒ No ☐ Tested in a variety of settings and populations Yes ☒ No ☐	SOURCE WHO ASSIST Working Group. (2002). The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST): development, reliability and feasibility. *Addiction,* 97, 1183-1194. SUPPORTING Humeniuk R, Ali R, Babor TF, Farrell M, Formigoni ML, Jittiwutikam J, de Lacerda RB, Ling W, Marsden J, Monteiro M, Nhiwatiwa S, Pal H, Poznyak V, Simon S (2008). Validation of the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST). *Addiction*, 103(6), 1039-47.
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.

1. Alcohol and other drug use (ASSIST)

The ASSIST Alcohol, Smoking, & Substance Involvement, Screening Test is a questionnaire developed by the World Health Organisation and screens for all levels of problem or risky substance use in adults. The full ASSIST (V3.1 or V3.0) consists of eight questions covering tobacco, alcohol, cannabis, cocaine, amphetamine-type stimulants (including ecstasy) inhalants, sedatives, hallucinogens, opiates and 'other drugs'. The version used in the Self Complete Initial Screen only includes question 2 of the full version to determine the type and frequency of substances used in the past month. Used in this way, the ASSIST is not to be scored but simply provides an indication of the main substance/s the client uses and other substances used (see sample A), which you can then enter into the preliminary case summary sheet. Please note that the full ASSIST is included in SCTT 2012 for those agencies currently using it.

Sample A: ASSIST

		Never	Once or twice	Monthly	Weekly	Daily
a)	Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	✓				
b)	Alcoholic beverages (beer, wine, spirits, etc.)					✓
c)	Cannabis (marijuana, pot, grass, hash, etc.)			✓		
d)	Cocaine (coke, crack, etc.)	✓				
e)	Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	✓				
f)	Inhalants (nitrous, glue, petrol, paint thinner, etc.)	✓				
g)	Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)		✓			
h)	Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	✓				
i)	Opioids (heroin, morphine, methadone, codeine, etc.)	✓				
j)	Other – please specify:	✓				

Substances used

1. Alcoholic beverages = Main Substance used
2 .Cannabis = Other substance used
3. Sedatives = Other substance used

No score required

2. Alcohol use (AUDIT)

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

Scoring the AUDIT

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

Interpretation of scores

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

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;

[3] 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.

				When using certain medications such as analgesics, sedatives and selected anti-hypertensive's
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 determining on which questions points were scored. 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 him/her-self or to others and that others have been concerned about his 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 his drinking. As a clinician you may interpret this as a sign of improvement and may like to draw on this as strength or something to build upon. Even so, you would probably want to found out more information and complete a comprehensive assessment with a client with this score profile.

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

Sample B: AUDIT

	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. Use of drugs other than alcohol (DUDIT)

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

Scoring the DUDIT

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

Interpretation of scores

Table 5 provides guidance on interpreting scores on the DUDIT.

Table 5: Suggested interpretation of the DUDIT overall score

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 persons 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 dependence likely

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

4. How have you been feeling during the past 30 days? (K10)

The Kessler 10 (K10) is a measure of psychological distress that first should be considered at face value. Higher scores are indicative of greater psychological distress, whatever the cause. The K10 is predominantly used in the identification of depression and anxiety disorders, and is also available in SCTT 2012. If your agency is using SCTT 2012 and a K10 has already been completed, you can transpose this information into Step 1: Self complete initial screen.

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 persons 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

FAQs about Step 1: Self-Complete Initial Screen for AOD Problems

What if the client is intoxicated, can't read English, and/or doesn't want to complete the self-complete initial screen?

Don't worry if the client cannot complete all the questions, or if the client prefers not to complete it at all. Where possible, the clinician should administer it with the client at the next possible opportunity. For clients who do not speak English, use your usual processes for accessing an interpreter.

What if the client does not understand a question or does not fill in the self-complete form correctly?

This is not a problem. Once the client has completed the *Self-complete initial screen* to the best of their ability, the clinician will then be able to run through and check the client's responses. This offers the client the opportunity to ask questions or to elaborate on any responses.

How long will it take for the client to complete?

According to data from the pilot, the *Screen* takes 20 minutes on average, but may take longer than this for some clients. It takes slightly longer if the screen is administered by a clinician.

When will the client's screen results be scored?

Clinicians will score the standardised screeners once they have been completed by clients. Cut-off levels are provided in the preliminary and final case summary sheets

Why screen for AOD problems when we know that someone has a problem, otherwise they wouldn't have come to a specialist AOD service in the first place?

Screening provides an initial understanding of the severity and complexity of a client's issues and indicates whether a full assessment is needed. In doing so screening provides a systematic way of gauging the urgency with which any individuals need to be assessed.

What if clients just want to talk and receive some advice in the first session?

Engagement is really important and so is your clinical judgement. And if you or the client doesn't feel it is appropriate to screen immediately then this can be done later at another session.

Do I have to use the screening instruments provided in Step 1 or can I use the ones I prefer?

The screening instruments in step 1 need to be completed. However, you can also use other instruments in addition to the screeners provided.

Is there an online version of the screen?

Yes. The link to the online version is: http://www.turningpoint.org.au/Treatment/Online-Self-Assessment.aspx
At present the online screen is an abridged version that contains all four screeners and some basic demographic information. Agencies may wish to collect further client registration data if using the online modality as this is currently not included in the online version of the screen. Despite this, doing it online may be an option for some clients and agencies. At the moment, the only way to print results is to do a print screen for each page completed. However, further improvements to the online screen will be made to ensure that the results can be easily printed or extracted.

Can I post the screen out to clients prior to seeing them, or give them the screen to do as part of a homework-type exercise?

The experience from the pilot indicates that posting the screen out to clients doesn't always work that well. Some clients might feel uneasy about completing the screen without having physically attended a service. Some might not return, or might return having forgotten to complete the screen. Introducing the screen as a homework-type exercise after having engaged with the client might be desirable for some clients.

The screen looks great in colour but my agency doesn't have a colour printer?

That's OK, you can print the screen out in black and white and this has little effect on its legibility.

How will the screen fit with triage?

You may like to use parts of the screen as part of triage. For instance the first page of the screen (which is a basic client registration form) could fit quite nicely into triage, and the remainder of the screen could be completed by the client in the waiting room or with the clinician in the consulting room of your agency. Each agency might opt to do implement the screen in differently so that it fit best within their processes.

I've only got an hour for assessment. If the screen takes about thirty minutes when it is clinician administered, that only leaves around half an hour for assessment?

In these circumstances, the screen works best when it is completed prior to the assessment session with the clinician. Some pilot agencies asked clients to come into their service 20 minutes prior to their appointment time, to provide time for them to complete the initial screen in the waiting room. For walk-in clients, you may like to ask them to complete as much as possible of the screen while they are waiting to be seen. Keep in mind that because the screen and assessment are linked you have already made progress towards completing the assessment.

How do I provide personalised feedback to clients on their scores from Step 1?

Having scored each of the standardised instruments, it is good practice to discuss these with the client. This is known as providing personalised feedback. Not only can screening and personalised feedback form part of a brief intervention, it is also a way of offering something therapeutic early on in the client's treatment journey. Providing personalised feedback on scores involves three simple steps:

1. Telling the client what they scored on each of the standardised instruments in Step 1: Self-complete Initial Screen and what their pattern of responses indicates
2. Explaining where this puts clients in relation to established cut offs (i.e. Low risk, moderate risk, high risk etc.)
3. Asking clients if they are aware that they were at the risk level they are, and discussing how they might change this.

Personalised feedback on a client's AUDIT scores, for instance may look like this:

"Thanks for completing these forms. You scored 17 on the AUDIT, which lets me know that over the past year there have been times when you had quite a bit to drink and with some unwanted consequences. This means that you are drinking at levels considered to be harmful, and you may be experiencing some symptoms of dependence. Does this sound right to you? I'm wondering if you have been thinking about this prior to completing the questionnaire. Have you thought about changing your drinking? If so the next steps for us will be to explore how to go about this."

What to do next?

Referred by a GP: Hugo arrives at the AOD service after being referred by his GP. He brings with him a brief referral letter.

Ask Hugo to complete Step 1 the Self Completes Initial Screen.

This should take around 20 minutes to complete. If Hugo is unable to complete the screening section you can come back to this at a later date.

Offer brief intervention as needed and/or reschedule for full assessment.

Referred by a non-AOD service: Hugo has been referred by a mental health service and arrives with the initial screen completed.

Check if Self Complete Initial Screen completed some time ago check if there have been any changes.

No re-screening required if Step 1 Initial Screen has just been completed.

Offer feedback on scores if this has not already been discussed, and complete Step 2: Comprehensive Assessment if required.

Drop in: Hugo arrives without an appointment and is new to your service, but has printed his results after completing the online screen.

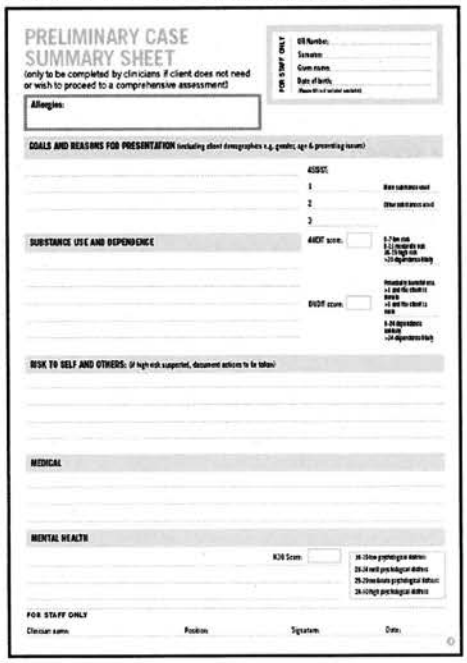
Hugo will only need to complete the 'About you' section of the Initial Self Screen.

Check if there have been any changes since Hugo completed the online screeners.

Discuss scores and offer feedback.

Provide brief intervention as needed or schedule for full assessment.

STEP 1: PRELIMINARY CASE SUMMARY SHEET



PRELIMINARY CASE SUMMARY SHEET

(only to be completed by clinicians if client does not need or wish to proceed to a comprehensive assessment)

Allergies:

FOR STAFF ONLY

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

ASSIST:

SUBSTANCE USE AND DEPENDENCE

AUDIT score:

DUDIT score:

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

MEDICAL

MENTAL HEALTH

K10 Score:

FOR STAFF ONLY

Clinician name: Position: Signature: Date:

Purpose

- To record any information gathered during the initial screen for clients who do not proceed to a comprehensive assessment
- Synthesis and initial summary of the client's needs
- Record any actions/referrals

Content

Space to record:

- Allergies
- Goals and reasons for presentation
- Substance use and dependence
- Risk to self, children and others
- Medical issues
- Mental health issues
- Psychosocial (family, children and social relationships, housing, employment and training, legal history)
- Brief case formulation
- Treatment types and referrals required
- Worker/agency actions

The preliminary case summary sheet is primarily for clients who do not need or wish to proceed to a full assessment. This serves the purpose of recording information gathered and actions taken during screening. If such clients return to the service at a later stage wanting or needing a full assessment, the preliminary case summary sheet (together with the screen) also acts as a starting point, which means that the client will not necessarily need to repeat their story over again. The preliminary case summary sheet together with the screen can also be used to make urgent referrals as required.

It can be completed at the end of a session with clients and it does not matter if there are blank spaces on the page. It is simply a way to record what you are aware of, based on what a client has told you, or reported when filling out each of the screeners.

FAQs about the Preliminary Case Summary Sheet

Do I complete the preliminary case summary if the client completed the initial screen, is booked for assessment but fails to attend?

Yes, you might like to complete the preliminary case summary if the client fails to attend their booked assessment session. This will enable you to synthesise a case summary, which may be a helpful record if the client does eventually return for an assessment.

Should I just complete the preliminary case summary even if I think the client will attend?

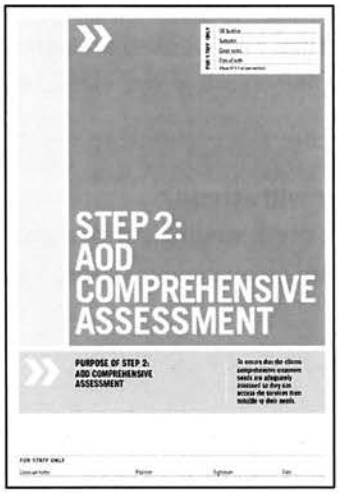
Although completing the preliminary case summary sheet is optional, you can complete it routinely if desired. In cases where screening and assessment processes are spread over time, the preliminary case summary sheet might provide a useful initial reference point.

STEP 2: AOD COMPREHENSIVE ASSESSMENT

This section provides information about Step 2: AOD Comprehensive Assessment (referred to interchangeably throughout this document as "step 2", "comprehensive assessment" and "assessment"). Completion of Step 2 will be required under new service agreements from 2014.

General instructions for completing Step 2: AOD Comprehensive Assessment

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



Purpose

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

Structure

The AOD Comprehensive Assessment contains a core component (pages 1 to 12) 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 screening and assessment before completing a care plan.

The Comprehensive Assessment builds on the Initial Screen, and as such there are in-built links to the initial screen in the form of alerts. These alerts indicate information that the client has already provided in the initial screen and therefore that you can record in the assessment without having to repeat it. In some instances information provided in the screen can act as prompts that elicit further information and clarification. For instance, basic psychosocial information is recorded on the initial screen. When discussing psychosocial information in the assessment you might like to draw upon screen information to stimulate further discussion. For example you could say to a client: "You mentioned in the screen that you don't feel safe where you are living. Would you like to tell me a little more about that?" Completing the screen, therefore contributes to completing the assessment.

The screen 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 screen, they have reported that they have also used cannabis, then this might be something that needs to be clarified.

Similarly alerts also indicate where optional modules are available for completion as required or desired. These do not necessarily have to be completed right away but may be completed over time as appropriate.

Content

The core component of the assessment contains the following sections:

1. Alcohol and other drugs
2. Medical history
3. Mental health
4. Risk
5. Psychosocial
6. Final case summary sheet

1. Alcohol and other drugs

The first two pages of the comprehensive assessment enable the recording of 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), and a clients' last use. The substance categories listed in the first column correspond with the substance categories used in the ASSIST in the initial screen so that in some instances you can refer back to the screen for further information.

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, withdrawal or related complications, risky injecting practices, drives while intoxicated (or under the influence), and harm to self and others as a result of AOD use (which can be transposed from the screen). 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 abstinence in the past.

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. 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 and how these interact with a client's AOD issues. 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.

2a) 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 then detailing any important information about the history of conditions, and any relevant investigations and treatments that have been undertaken. 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.

2b) provides space to record both you and your client's perceptions of the role of AOD use in any medical issues. This is about making connections and links, in order to inform care planning.

2c) is the final part of this section, and 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, reasons for prescription, and prescribers' details.

This section culminates with the space to note down any further relevant information and/or actions.

3. Mental health

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-complete initial screen. These include OPTIONAL MODULE 3: MENTAL HEALTH (MODIFIED MINI SCREEN) or OPTIONAL MODULE 4: PSYCHECK.

3a) begins with a simple tick box of known current diagnosed conditions that the client may have talked to you about. The most prevalent mental health conditions are included in the tick boxes as well as an option to record "other" conditions not listed. Underneath each of the boxes, there is space to record the history of the mental health conditions identified, history of trauma, and the treatments and outcomes (current diagnosis, community treatment order, past diagnosis, hospitalisations) related to these. Here you might also document the results of Optional module 3 or Optional Module 4, and the possibility of any undiagnosed mental health issues.

3b) 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 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.

3c) provides space to record any notes that you may wish to record. These might be about how a client's mental health issues affect or are affected by a clients AOD issues, or might be about any actions that you think might be helpful.

4. 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.

4a) is an example of a suicide and self-harm risk assessment – based upon the Suicide Assessment Five-step Evaluation and Triage (SAFE-T approach) – is included for your reference and in case your agency doesn't have a risk assessment. This was developed by the Suicide Prevention Resource Centre in the United States and involves:

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

One of the positive features of this suicide and self-harm risk assessment is that it also draws attention to protective factors – something which traditional risk assessments have sometimes overlooked.

4b) enables you to record and explore harms that the client has inflicted upon others or that they have experienced from others. These could include things like a history of violence to or from others including assaults, family violence, threats to kill, and sexual abuse/assault. The first part invites you to document harms to and from others in the past four weeks to obtain a current snapshot. These also form part of the baseline measures that enables you to measure any progress in this area at the point of review. It also invites you to document whether dependent children appear to be safe. The open space below the tick boxes provides you with room to expand on any current or past history of harm to or from others, and the impact of this on dependent children. OPTIONAL MODULE 10: FAMILY VIOLENCE (DHS IDENTIFYING FAMILY VIOLENCE RECORDING TEMPLATE) is also available should you need to record any family violence issues that the client may wish to talk about.

5. Psychosocial

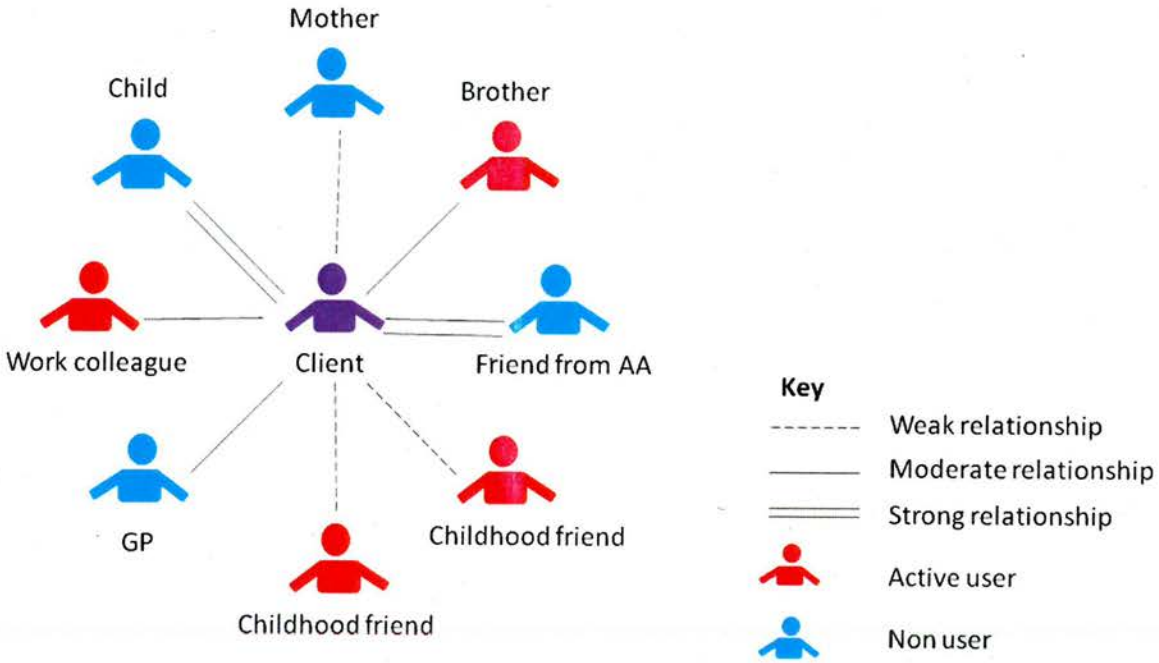
Often AOD issues are influenced by or influence the psychosocial context in which people live their lives. Clients also readily report a desire for help in addressing these issues as part of a holistic response. Therefore it is important to assess pertinent psychosocial issues and strengths. In the assessment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

5a) this section enables you to detail resources, supports and strengths that the client can draw upon to meet their treatment goals. These may include participation in meaningful activities, groups, employment and training or supportive family members, friends, social networks, and past successful experiences in overcoming challenges. 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[4] . Optional Module 8: Assessment of Recovery Capital, and Optional Module 9: Strengths are available to explore this is in further detail.

5b) provides space for a genogram or an ecomap, in which you can map out family and other important relationships to get a sense of the client's social networks and how their AOD use affects or is affected by other people in their social networks. An ecomap 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 function of people in the client's social environment. By referring to the initial screen, you may already have some sense of the number of children a person cares for. You may also like to incorporate details on the genogram 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 provides an example of an ecomap.

[4] Cloud, W., & Granfield, W. (2009). Conceptualising recovery capital: Expansion of a theoretical construct. *Substance Use and Misuse*, 42, 12/13, 1971-1986.

Figure 3: Example of an ecomap



5c) can be used to record important details of the discussion on family, children and social relationships prompted by the genogram /ecomap in 5b). Among other things, you might record information on child care responsibilities and impact of substance use on these, and any child protection involvement. In particular you might like to ask a client who cares for children to consider the child's perception of a caregiver's substance use and their perception of impacts.

5d) enables you to build on the information gained in the screen about a clients housing situation and whether any housing support is required.

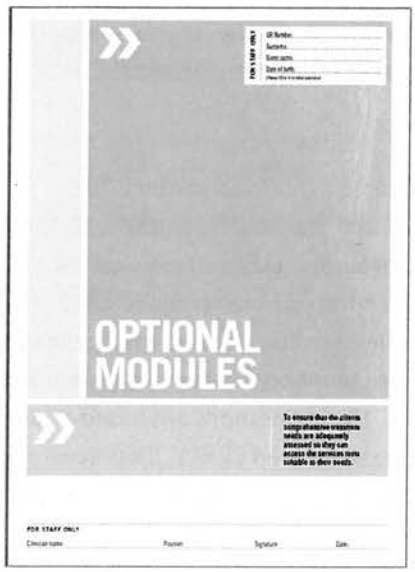
5e) also refers to a client's' finances, employment and training situation. You will be able to transpose, clarify and build on information collected in the initial screen.

5f) is about a client's current legal status and history. This is an opportunity to build on information from the screen, 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.

6. Final Case Summary Sheet

This final case summary sheet has headings for the major sections covered in the initial screen and the comprehensive assessment and is almost identical to the preliminary case summary sheet. The brief case formulation heading enables you to synthesise all the information you have gathered in preparation for care planning. It also contains space to record the treatment types which the client might require, and any worker or agency actions undertaken. It also reminds you to fill out your agency's detailed care plan and to consider completing Step 3: Review at a later date to monitor a client's progress. 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.

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 initial screen, 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 clients cognitive functioning are present. These include factors such as memory issues, attentional problems, difficulties in reasoning or problem solving, a lack of insight, disinhibited or inappropriate

behaviour, or poor orientation to place, day, month or year. You may have detected some of these issues when recording a client's mental state in the comprehensive assessment. If there is at least one historical factor and one current concern present, then you might consider referring the client on to an ABI-AOD clinician at you 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 (M.I.N.I.). 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. These questions are based upon gateway questions used in the Diagnostic and Statistical Manual IV (DSM-IV), the Structured Clinical Interview for Diagnosis (SCID) and the Mini International Neuropsychiatric Interview (M.I.N.I.).

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-occuring 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).[5] 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.[6]

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

[5] 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.

[6] 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.

Question 17	Satisfied = 4
Question 18	Very Satisfied = 5

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

Table 10: Conversion table

Domain 1: Physical Health

Raw score	Transformed Score
7	0
8	6
9	6
10	13
11	13
12	19
13	19
14	25
15	31
16	31
17	38
18	38
19	44
20	44
21	50
22	56
23	56
24	63
25	63
26	69
27	69
28	75
29	81
30	81
31	88
32	88
33	94
34	94
35	100

Domain 2: Psychological

Raw score	Transformed score
6	0
7	6
8	6
9	13
10	19
11	19
12	25
13	31
14	31
15	38
16	44
17	44
18	50
19	56
20	56
21	63
22	69
23	69
24	75
25	81
26	81
27	88
28	94
29	94
30	100

Domain 3: Social relationships

Raw score	Transformed scores
3	0
4	6
5	19
6	25
7	31
8	44
9	50
10	56
11	69
12	75
13	81
14	94
15	100

Domain 4: Environment

Raw score	Transformed score
8	0
9	6
10	6
11	13
12	13
13	19
14	19
15	25
16	25
17	31
18	31
19	38
20	38
21	44
22	44
23	50
24	50
25	56
26	56
27	63
28	63
29	69
30	69
31	75
32	75
33	81
34	81
35	88
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 10: Identifying family violence

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

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

This module includes only the first tier of family violence assessment – identifying family violence. As a clinician you may have expertise in the area of family violence and may feel confident completing the preliminary or comprehensive assessment components of the assessment. If so you can find these here along with other helpful information about family violence:
http://www.dhs.vic.gov.au/for-service-providers/workforce,-careers-and-training/workforce-training/child,-youth-and-family-services-workforce/family-violence-and-risk-assessment,-and-risk-management-training/family-violence-risk-assessment-risk-management-framework-manual

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

http://www.tafe.swinburne.edu.au/CRAF/index.htm

This module involves:

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

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

1. Indicators of Family Violence

Indicators of family violence in an adult can include:

- appear nervous, ashamed or evasive
- describe their partner as controlling or prone to anger
- seem uncomfortable or anxious in the presence of their partner
- be accompanied by their partner, who does most of the talking
- give an unconvincing explanation of injuries that they or their child has sustained
- have recently separated or divorced
- be reluctant to follow advice
- suffer anxiety, panic attacks, stress and/or depression
- have a stress-related illness
- have a drug abuse problem including dependency on tranquillisers or alcohol
- have chronic headaches, asthma and/or vague aches and pains
- have abdominal pain and/or chronic diarrhoea
- report sexual dysfunction
- have joint and/or muscle pain
- have sleeping and/or eating disorders
- have attempted suicide and/or have a psychiatric illness
- have gynaecological problems and/or chronic pelvic pain, and/or have suffere miscarriages
- have physical signs of violence such as bruising on the chest and abdomen, multiple injuries, minor cuts, injuries during pregnancy and/or ruptured eardr
- have delayed seeking medical attention
- present with patterns of repeated injury or signs of neglect

Indicators of family violence in a child or young person can include:

- bruises, burns, sprains, dislocations, bites, cuts
- fractured bones, especially in an infant where a fracture is unlikely to have occurred accidentally
- poisoning
- internal injuries
- showing wariness or distrust of adults
- wearing long-sleeved clothes on hot days in an attempt to hide bruising or other injury
- demonstrating fear of parents and of going home
- becoming fearful when other children cry or shout
- being excessively friendly to strangers
- being very passive and compliant.

Indicators of sexual abuse of a child or young person:

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

Indicators of emotional abuse of a child or young person:

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

Indicators of possible neglect of a child or young person:

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

2. Prompting questions for adults

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

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

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

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

Prompting questions for adults about violence their child might be experiencing

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

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

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

Questions to ask children

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

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

3. Filling out the recording template and making appropriate referrals.

The recording template provides space to record basic information about the victim of family violence, information about the perpetrator, and any children in the family.

Next steps

If it seems family violence is not occurring

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

If family violence is occurring

If the person's responses indicate that they are experiencing family violence:

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

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

If a victim indicates they do not want assistance:

- provide them with contact details for a specialist family violence service
- consider discussing the idea of safety planning (see page 90 of *Department of Human Services Family Violence: Risk Assessment and Risk Management Manual (2012)* document)
- try to arrange ongoing opportunities to monitor and discuss the violence, perhaps by scheduling future appointments
- continue to engage with the victim and encourage them to accept a referral for their own safety and wellbeing
- determine an appropriate course of action to address the safety and wellbeing of any children or young people who are also victims of the violence:
  - if the child or young person is at risk of physical, emotional or other types of harm and neglect, you should report to Child Protection
  - if you have significant concerns for the wellbeing of the child or young person in the present or future, you could make a referral to your local Child FIRST agency and discuss appropriate options.

Special considerations

If a crime might have been committed

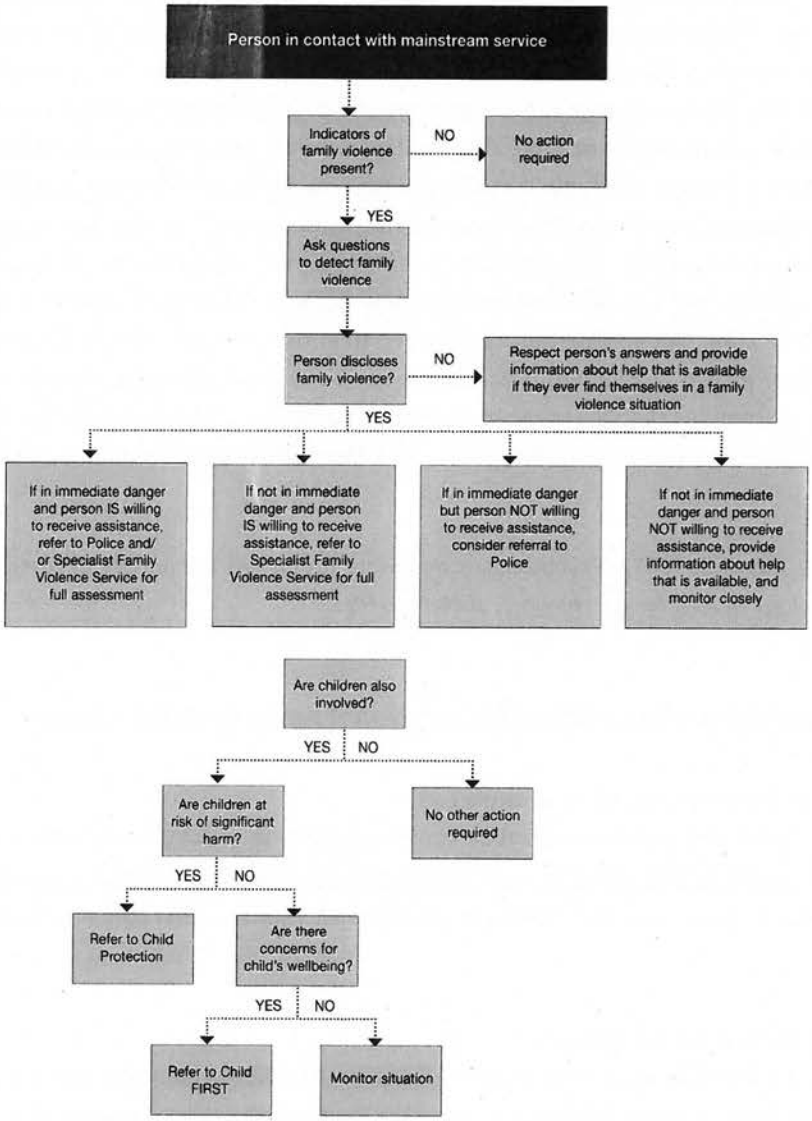
If you consider that a crime might have been committed, carefully set aside evidence such as weapons or torn or blood-stained clothing and contact police. Make notes about your conversation with the victim and about your observations of the victim as soon as possible. This information may be required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

If the person identifies as Aboriginal or Torres Strait Islander

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

The figure on the next page provides a summary of response options for the identification of family violence.

Figure 4: Response options for mainstream services in the identification of family violence



Optional Module 11: Impact of AOD use on family member (Significant Other Survey)

This module is based upon the Significant Other Survey and was designed to be used with family members affected by a loved one's substance use. This is a validated and standardised measure that explores emotional, relationship, family, legal, financial, health, and violence issues faced by family members as a consequence of another person's AOD use. It was written at a 7th grade reading level and can be self-completed by clients in 10-15 minutes or can be administered by clinicians. It asks the family member about a number of difficulties that are sometimes reported by people with a loved one who may have an alcohol or other drug problem. It then asks the family member to indicate how often they have experienced a particular difficulty (if at all), and how much the problem has bothered them In the past 30 days. By looking at responses you as the clinician can identify problems/difficulties that occur frequently and/or that the client is particularly bothered by. For instance, if a family member reports frequent emotional difficulties as a consequence of another person's AOD use and are quite bothered by these, then this is likely to indicate this is a particular problem area. This information can be used to inform care planning, and to make referrals to family support services/ groups as required. This module can be re-administered at a minimum of 30 days after it was first completed to monitor changes in the frequency of particular problems and how bothered the client is by these over time. Further information about the Significant Other Survey can be found in the following article:

Benishek LA, Carter M, Clements NT, et al. (2012) Psychometric assessment of a self-administered version of the Significant Other Survey. *Psychology of Addictive Behaviors*, 26(4):986-993.

FAQs about Step 2: Comprehensive Assessment and Optional Assessment Modules

When should the comprehensive assessment be completed?

It is recommended that Step 2: Comprehensive assessment be completed after Step 1b: Clinician administered screen and only for clients that require it. Depending on your usual processes, the comprehensive assessment may take place in the same appointment as the Step 1b: Clinician administered screen (i.e. first contact), or at another appointment.

How long will the comprehensive assessment take?

This will differ for each client and depending upon how many modules are completed but data from the pilot indicates that it may take around an hour for some clients. It may take longer with more complex clients.

Who can administer the comprehensive assessment screen?

It is recommended that *Step 2: Comprehensive assessment* be administered by staff trained in assessment. This means assessment staff in specialist AOD settings, and those with appropriate training and accreditation who are based in other services.

Why is there no risk assessment included?

As there is variation in risk assessments and agency requirements around this, no comprehensive risk assessment has been included. We recommend that you complete your agency's risk assessment as normal, but have provided an example of a Suicide and self-harm risk assessment that you can complete if your agency doesn't have a standard risk assessment form.

Why is the case summary sheet included at the end of the comprehensive assessment when it is already at the end of the initial screen?

The preliminary case summary sheet is optional but can be used as a live document that is added to as the client moves from screening to assessment. The clinicians who complete step 1 and step 2 may be different (i.e. a referring clinician who does the initial screen and an AOD clinician who does the comprehensive assessment etc.), which means that it needs to be included twice. It's also a reminder that a final case summary and care plan need to be completed.

Why is there no standard care planning form included?

There is a diversity of care-planning processes amongst service providers and some organisations have particular requirements about this. In acknowledgement of this, the *Final Case Summary Sheet* was designed so that it could help to inform these usual practices rather than replace them. Future research and development of the instrument may help to inform a more uniform structured care-planning process.

How could the assessment be used when working with families?

Optional Module 11: Impact of AOD use on family member (Significant Other Survey) was included specifically for the purpose of working with families or family members who are seeking help due to another person's AOD use. In addition there are a number of sections of the form that may be useful when working with family members:. Table 12 documents how different sections of the forms might be useful when working with families.

Table 12: Summary of how the screening and assessment forms might be used when working with a family member or friend affected by another person's AOD use.

Section of the instrument	**Potential usefulness in working with family or friends affected by another person's AOD use**
Step 1: Initial Screen	
Second page of screen	The second page of the screen provides a snapshot of a person's life situation. It might be useful for family and friends affected by another person's AOD use, to complete the three rating scales (physical health, psychological health, and quality of life). Information about the person's housing situation and children they care for or live with may also be important, particularly if the person is living with someone with an AOD problem or is a spouse or mother/father of children who live with someone with an AOD problem.
K10	Could be administered to a family member, to ascertain their level of psychological distress, which may or may not be affected by another person's AOD use.

Preliminary Case Summary Sheet	Could be used to record any information about the impact of a family member or friend's AOD use on the person presenting.
Step 2: Comprehensive Assessment	
Medical history	It might be appropriate to document any medical issues in the Medical History section of the assessment, especially if any of these are related to harms experienced as a consequence of another person's drinking.
Mental health	It might be appropriate to record any mental health issues that the person may be experiencing, and to explore the role of another person's AOD use might be playing in this.
Risk	It might be appropriate to record any harms experienced as a result of another person's AOD use in the section entitled 4b) Harm to or from others.
Psychosocial	The entire psychosocial section is likely to be useful – particularly 5a) Resources and Supports; 5b) Genogram/Ecomap; 5c) Family, children and social relationships. This is where you might record information about the relationship between the person presenting, and the person whose AOD use they are affected by.
Final Case Summary Sheet	Synthesise all the information gathered.
Optional Module 3: Mental Health (Modified Mini Optional Module 4: Psycheck	If a potential mental health problem is suspected or indicated by a high K10 score then, optional module 3 or optional module 4 might be appropriate.
Optional Module 5: Quality of life (WHOQOL-BREF)	This module might be a helpful way to understand the impact of another person's AOD use on the presenting family member/friend's quality of life.
Optional Module 8: Strengths Optional Module 9: Goals	Both of these modules could be useful. Optional Module 8 might draw out strengths and coping abilities. Optional Module 9 might be useful in exploring the presenting person's goals.
Optional Module 10: Family violence (DHS identifying family violence recording template)	If the person presenting has personally experienced, or if her/his children has experienced family violence, this module provides an opportunity to record this.

How have family violence issues been explored in the tool?

Questions potentially related to family violence are posed in the following parts of the tool:

Step 1: Initial Screen

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

Preliminary screen

- Family violence may be documented under the *Risk to Self, Children and Others* heading

Step 2: Comprehensive Assessment

- Section *1C: AOD use history and experiences* includes a question on harms to self or others.
- Question *4b: history of violence to or from others including assaults, family violence, children present, threats to kill, sexual)* may elicit experiences of family violence
- Experiences of family violence may be explored in *5c: family, children and social relationships*
- Family violence may be documented under the *Risk to Self, Children and Others* heading in the final case summary sheet

Optional Assessment Modules

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

Step 3: Review

- Questions g) and h) in section 2: health and wellbeing are about family violence and will enable you to monitor change in family violence over time

Can I add other screens or modules to the assessment?

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

Do I need to complete all or any of the optional assessment modules?

No, these are optional, and can be completed if desired or as indicated by the comprehensive assessment.

Can I complete optional assessment modules over time?

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

What are my obligations for dependent children?

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

After Hours	Telephone
Child Protection After Hours Service	131 278

DHS Regions	Telephone
Eastern	1300 360 391
Southern	1300 655 795
Northern & Western	1300 664 977
Barwon South Western	1800 075 599
Gippsland	1800 020 202
Grampians	1800 000 551
Hume	1800 650 227
Loddon Mallee	1800 675 598

For immediate help

To report concerns that are life threatening call Victoria Police 000.

To report concerns about the immediate safety of a child within their family unit, call the Child Protection Crisis Line 13 12 78 (24 hours, 7 days a week, toll free within Victoria)

Note: this is an emergency service for weekends and after hours only and will pass on cases to the relevant regions the following working day.

Further information on child protection issues and reporting can be found here:
http://www.dhs.vic.gov.au/for-individuals/children,-families-and-young-people/child-protection/about-child-abuse

STEP 3: REVIEW

General instructions for completing Step 3: Review

1. Record all information as instructed in the form.
2. You may like to use a simple calendar as a prompt to help the client think about the past four weeks.
3. Once the form is completed, compare results with information gathered during assessment (remembering that the Australian Treatment Outcome Profile questions were embedded in Step1: Initial screen and Step2: Comprehensive assessment).
4. Provide the client with feedback on their progress

This is a clinician administered module and can be administered at a minimum of four weeks after treatment to monitor and review client progress. It can also be administered at other time points (i.e. 3 month review) as long as they are at least four weeks apart. The questions in this module are from the Australian Treatment Outcomes Profile (ATOP). The ATOP is new 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.

At the beginning of Section 1 of this module, there is a tick box option to indicate the treatment stage at which the module was administered. Completion of the Step 1: Initial Screen and Step 2: AOD Comprehensive Assessment means you have already completed a baseline ATOP measure. This is because ATOP questions are embedded within the documents. So in most instances, you will need to tick one of the other treatment stage options – "Progress Review", "Discharge", or Post Discharge" – depending upon when you administer the module. You may, however, like to collate information from the screen and assessment into this form immediately after completion of the assessment, to make referring back to the baseline information easier. If this is the case, you can tick the start of service episode box, and then print of a blank form to complete at a progress review point.

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. 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. This same approach can be used to answer the question about the number of days a client injected in the past four weeks. Section 1 concludes with a tick-box answer question about whether the client has shared injecting equipment in the past four weeks.

Section 2 relates to health and wellbeing in the past four weeks. It asks about the number of days of paid work and the number of days at school, tertiary education, vocational training in the past four weeks. And then 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 compared with a client's baseline answers to each of the questions asked in the form. To find these you can look through the client's completed Step 1: Initial Screen and Step 2:

Comprehensive assessment. Table 13 highlights where each of the ATOP questions are embedded to help you locate these.

Table 13: Location of ATOP questions in the initial screen and comprehensive assessment.

ATOP question	Location in screening and assessment documents
SECTION 1: SUBSTANCE USE	
a) Number of days alcohol was used in the past four weeks. Average quantity used per day in the past four weeks.	Days used in the past four weeks and average quantities used per day are recorded in columns in item *1A) Current levels of AOD use* in *Step 2: Comprehensive Assessment*.
b) Number of days cannabis was used in the past four weeks. Average quantity used per day in the past four weeks.	As per a).
c) Number of days amphetamine-type stimulants were used in the past four weeks. Average quantity used per day in the past four weeks.	As per a).
d) Number of days benzodiazepines (prescribed & illicit) were used in the past four weeks. Average quantity used per day in the past four weeks.	As per a). However, benzodiazepine use is covered under the Sedatives and Sleeping Pills category in *1A) Current levels of AOD use* in *Step 2: Comprehensive Assessment*.
e) Number of days heroin was used in past four weeks. Average quantity used per day in the past four weeks.	As per a). However, heroin use is covered under the opioids category in *1A) Current levels of AOD use* in *Step 2: Comprehensive Assessment*.
f) Number of days other opioids were used in past four weeks. Average quantity used per day in the past four weeks.	As per a). However, other opioid use is covered under the opioids category in *1A) Current levels of AOD use* in *Step 2: Comprehensive Assessment*.
g) Number of days cocaine was used in the past four weeks. Average quantity used per day in the past four weeks.	As per a). However, cocaine use is covered under the Other category in *1A) Current levels of AOD use* in *Step 2: Comprehensive Assessment*.
h) Number of days another problem substance was used in the past four weeks. Average quantity used per day in the past four weeks.	As per a).
i) Daily tobacco use	As per a).
j) Number of days injected in the past four weeks	Days injected in the past four weeks are recorded for each substance in a column in *1A) Current levels of AOD use* in *Step 2: Comprehensive Assessment*. You

	will need to add these up to obtain an indication of the total number of days injected in the past four weeks. As a client may inject multiple substances on one day, you may need to clarify this.
k) Injected with equipment used by someone else in the past four weeks?	This can be found in item 1C) *AOD Related Experiences* in *Step 2: Comprehensive Assessment* under the heading "Risky injecting practices."
SECTION 2: HEALTH AND WELLBEING	
a) Days of paid work in the past four weeks	This can be found in the *Some More Information About You* section of *the Step 1: Self-complete Initial Screen*.
b) Days of school, tertiary education, vocational training in the past four weeks	As per a).
c) Have you been homeless in the past four weeks?	As per a).
d) Have you been at risk of eviction in the past four weeks?	As per a).
e) Have you, at any time in the past four weeks, been a primary caregiver for or living with any child/children? i) Under 5yo ii) 5-15yo	As per a). However in the *Some More Information About You* section of *the Step 1: Self-complete Initial Screen* the exact ages of children the client cares for or lives with are provided. This means that you can deduce whether the children are i) under 5yo or ii) 5-15yo.
f) Have you been arrested in the past four weeks?	As per a).
g) Have you been violent (incl. domestic violence) towards someone?	This information is recorded in 4b) Harm to or From Others in Step 2 *Step 2: Comprehensive Assessment.*
h) Has anyone been violent (incl. domestic violence) towards you?	As per g).
i) Client's rating of psychological health status (anxiety, depression and problem emotions and feelings)	As per a).
j) Client's rating of physical health status (extent of physical symptoms and bothered by illness)	As per a).
K) Client's rating of overall quality of life (e.g. able to enjoy life, gets on well with family and partner, satisfied with living conditions)	As per a).

Once you've had a chance to compare the results of the review with baseline measures, it may be helpful to communicate progress to the client. This may motivate clients to maintain their progress and validate the action they have taken, and may also highlight areas that they might like to work on further. The results of the review may also alert you to the need to modify the client's care plan.

FAQs about Step 3: Review

I want to administer the review six months after assessment instead of four weeks after?

The review can be administered at any time point as long as it is a minimum of four weeks after the assessment. This means you can administer it at three months, six months, four weeks, a year but not two weeks after.

APPENDIX A: USEFUL DEFINITIONS

	Defined by DSM-IVR	Defined by ICD-10
Substance abuse	Drug use has occurred at least once per month over a period of 12 months and at least one of the following negative consequences has occurred: 1. Legal consequences; 2. Persisting drug use despite obvious harm; 3. Inability to perform daily tasks; 4. Repeated risky behaviour	
Harmful use		Drug use has lasted for at least one month and mental and/or physical harm has occurred
Substance dependence	Drug use has occurred at least once per month for a period of 12 months and at least three of the following seven signs are present: 1. Loss of control – inability to stop using drugs in general; 2. Loss of control – uncontrolled use on single occasion; 3. Drugs are the highest priority; 4. Drug use requires considerable time to acquire, use and recover; 5. Development of tolerance; 6. Persisting drug use despite physical/mental harm; 7. Drug use in order to eliminate/relieve withdrawal symptoms	
Dependency syndrome		Drug use has lasted for at least one month and at least three of the following six signs occur at the same time: 1. Craving, desire; 2. Loss of control (unspecified); 3. Inability to perform daily duties, giving drugs highest priority and spending time obtaining, using and recovering from drugs; 4. Development of tolerance; 5. Persisting drug use despite physical/mental harm; 6. Withdrawal symptoms and drug intake in order to eliminate/relieve withdrawal symptoms

	Defined by DSM-IVR	Defined by ICD-10
Depressive disorder	Symptoms can cause clinically significant stress, or impairment in social, occupational or other important areas of functioning. Depression occurs for most of the day, nearly every day for at least 2 weeks. 5 or more of the following symptoms occur where at least one symptom is either depressed mood or loss of pleasure/interest: **1.** Depressed mood **2.** Loss of interest; **3.** Significant weight loss/gain/decrease or increase in appetite **4.** Insomnia/hypersomnia **5.** Psychomotor agitation/retardation; **6.** Fatigue or loss of energy **7.** Feelings of worthlessness or excessive guilt **8.** Diminished ability to concentrate/think or indecisive **9.** Recurrent thoughts of death/suicidal ideation without a specific plan or suicide attempt/specific plan	Some difficulty in continuing ordinary work and social activities, but will probably not cease function completely in mild depressive episodes. Considerable difficulty in continuing social, work or domestic activities in moderate depressive episode; considerable distress or agitation and unlikely to continue with social, work or domestic activities, except to a very limited extent in severe depressive episode. Depression occurs for at least 2 weeks for all three grades of severity Symptoms include depressed mood, loss of interest and enjoyment, and reduced energy leading to increased fatigability and diminished activity in typical depressive episodes. Other common symptoms: 1. Reduced concentration and attention 2. Reduced self esteem and self confidence 3. Ideas of guilt and unworthiness (even in mild episodes) 4. Bleak and pessimistic views of future 5. Ideas or acts of self harm/suicide 6. Disturbed sleep 7. Diminished appetite

Anxiety Disorders

Anxiety disorders categorise a large array of disorders where the primary feature is abnormal/inappropriate anxiety. Symptoms include increased heart rate, tensed muscles, and possibly an acute sense of focus without any reason for them. Anxiety disorders also include: acute stress disorder, agoraphobia, generalised anxiety disorder, obsessive-compulsive disorder (OCD), panic disorder (with or without agoraphobia), phobias (including social phobia) and posttraumatic stress disorder (PTSD).