

Indigenous Risk Impact Screen (IRIS)

Client name: _____

Date: _____

Worker name: _____

Time: _____

Alcohol and Other Drug Risk

1	In the last 6 months have you needed to drink or use drugs more to get the effects you want?	No <input type="checkbox"/> 1 Yes, a bit more <input type="checkbox"/> 2 Yes, a lot more <input type="checkbox"/> 3
2	When you have cut down or stopped drinking or using drugs in the past, have you experienced any symptoms, such as sweating, shaking, feeling sick in the tummy/ vomiting, diarrhoea, feeling really down or worried, problems sleeping, aches and pains?	Never <input type="checkbox"/> 1 Sometimes when I stop <input type="checkbox"/> 2 Yes, every time <input type="checkbox"/> 3
3	How often do you feel that you end up drinking or using drugs much more than you expected?	Never/Hardly ever <input type="checkbox"/> 1 Once a month <input type="checkbox"/> 2 Once a fortnight <input type="checkbox"/> 3 Once a week <input type="checkbox"/> 4 More than once a week <input type="checkbox"/> 5 Most days/Every day <input type="checkbox"/> 6
4	Do you ever feel out of control with your drinking or drug use?	Never/Hardly ever <input type="checkbox"/> 1 Sometimes <input type="checkbox"/> 2 Often <input type="checkbox"/> 3 Most days/Every day <input type="checkbox"/> 4
5	How difficult would it be to stop or cut down on your drinking or drug use?	Not difficult at all <input type="checkbox"/> 1 Fairly easy <input type="checkbox"/> 2 Difficult <input type="checkbox"/> 3 I couldn't stop or cut down <input type="checkbox"/> 4
6	What time of the day do you usually start drinking or using drugs?	At night <input type="checkbox"/> 1 In the afternoon <input type="checkbox"/> 2 Sometimes in the morning <input type="checkbox"/> 3 As soon as I wake up <input type="checkbox"/> 4
7	How often do you find that your whole day has involved drinking or using drugs?	Never/Hardly ever <input type="checkbox"/> 1 Sometimes <input type="checkbox"/> 2 Often <input type="checkbox"/> 3 Most days/Every day <input type="checkbox"/> 4

Alcohol and Other Drug Risk Score (Questions 1 – 7)

Emotional Wellbeing Risk (Mental Health Risk)

8	How often do you feel down-in-the-dumps, sad or slack?	Never/Hardly ever <input type="checkbox"/> 1 Sometimes <input type="checkbox"/> 2 Most days/Every day <input type="checkbox"/> 3
9	How often have you felt that life is hopeless?	Never/Hardly ever <input type="checkbox"/> 1 Sometimes <input type="checkbox"/> 2 Most days/Every day <input type="checkbox"/> 3
10	How often do you feel nervous or scared?	Never/Hardly ever <input type="checkbox"/> 1 Sometimes <input type="checkbox"/> 2 Most days/Every day <input type="checkbox"/> 3
11	Do you worry much?	Never/Hardly ever <input type="checkbox"/> 1 Sometimes <input type="checkbox"/> 2 Most days/Every day <input type="checkbox"/> 3
12	How often do you feel restless and that you can't sit still?	Never/Hardly ever <input type="checkbox"/> 1 Sometimes <input type="checkbox"/> 2 Most days/Every day <input type="checkbox"/> 3
13	Do past events in your family still affect your wellbeing today (such as being taken away from family)?	Never/Hardly ever <input type="checkbox"/> 1 Sometimes <input type="checkbox"/> 2 Most days/Every day <input type="checkbox"/> 3

Emotional Wellbeing Risk Score (Questions 8 – 13)

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IRIS Response Alternatives and Score

Instructions for scoring

1. Calculate the scores from the IRIS Screen Instrument pertaining to each risk
2. Compare the client's scores against the risk cut-off scores below
3. Proceed to Brief Intervention if indicated.

Risk	Calculating the score	Risk cut-off score
Alcohol and Other Drug Risk	Add scores for questions 1-7 Total Score: <input type="text"/>	Cut off Score = 10 Note: If client falls above risk cut-off scores proceed to Brief Intervention.
Mental Health and Emotional Wellbeing Risk	Add scores for questions 8-13 Total Score: <input type="text"/>	Cut off Score = 11 Note: If client falls above risk cut-off scores proceed to Brief Intervention.

Risk Card

