Criminal justice evaluation and performance monitoring

Guideline 3: Client characteristics

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Acronyms

ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
AIHW	Australian Institute of Health and Welfare
ANU	Australian National University
AOD	Alcohol or drug use
ATOP	Australian Treatment Outcomes Profile
CALD	Culturally and linguistically diverse
CJS	Criminal justice system
ICS	Inspector of Corrective Services
IRIS	Indigenous Risk Impact Screen
LGBTIQ+	Lesbian, gay, bisexual, trans and gender diverse, intersex and queer people
MD	Minimum Dataset
TTM	Trans-theoretical model of change

Contents

Introduction

This Guideline discusses the elements of good data collection and provides guidance and definitions for a recommended Minimum Dataset (MD) which includes information about:

- client characteristics (covered in this Guideline), and
- activities and outputs delivered by your program (Guideline 4)

An example data collection tool (spreadsheet) is provided at Attachment A. The tool should be read and used alongside the detailed definitions and guidance provided in this Guideline from pages 7 to 30.

For client data to be useful, it must be:

- **Consistent** – Defined and recorded the same way by all service providers.
- **Easy to analyse** – Collected in a format suitable for data analysis.
- **Accessible** – Stored in a way that evaluators with consent can access it (see Guideline 2).

This guideline provides practical steps for collecting, recording, and using client data while ensuring consistency and security.

Information security and privacy

Information that is collected about clients should be protected from disclosure, loss, unauthorised access and unauthorised uses. Your organisation or agency may have obligations under legislation, such as:

- *Information Privacy Act 2014* (ACT) and Territory Privacy Principles
- *Privacy Act 1988* (Cth) and the Australian Privacy Principles
- *Health Records (Privacy and Access) Act 1997* (ACT).

There may also be requirements about information security and Privacy under contractual arrangements such as Grant Guidelines, or within your organisation or agency's own policies and procedures.

Regardless of whether legislation or policies apply, good privacy practice will reduce the risk of harm to your entity, staff and clients that might result from a data breach.

It is important therefore to ensure your service only collects personal information you need, stores the information securely and deletes the information when it is no longer required.

Why collect detailed information about clients?

Collecting information about the clients you are working with (e.g., age, gender, employment status) helps services to evaluate their work and makes it possible to assess their impact and improve your practices. Collecting this information will also help you to understand the needs of different people (e.g., different ages, genders, living in different locations) and what programs (or program aspects) work better or worse for different groups. It also enables more fine-grained understanding of individual clients (i.e., change over time or between programs).

As such, it is important that service providers routinely collect data about their clients[1] and are supported to see the value in these administrative activities. If carefully designed and implemented, collecting information about clients can help – not hinder – practitioners' engagement with clients.

For example, regularly collecting information about a client's mental health can provide an opportunity to engage with the client about what factors have contributed to changes over time. In this way, **collecting data for monitoring and evaluation purposes should not be seen as taking away from time spent with clients – rather, it can complement and support it.**

What types of information should services be collecting?

Services are being asked to collect information across a range of domains to better understand who is accessing support and to contribute to evaluation and performance monitoring. These domains include:

- age,
- gender and sexuality,
- health status (including disability, mental health and substance use),
- cultural and linguistic diversity,
- Indigenous status,
- housing status,
- education level,
- employment status,
- carer responsibilities,
- veteran status, and
- readiness to change.

This list is not exhaustive—other data may also be relevant depending on the service or client population. Where possible, sensitive information should be collected in a way that is respectful, voluntary, and timed appropriately within the service journey.

When should client information be collected?

The timing of data collection depends on the question being asked.

Client information should be collected at the start of their engagement with the service. This allows providers to:

- adjust services to meet client needs,
- inform case planning and referrals, and

[1] A Moo et al. (2021). *Best Practices for Person-Centred Case Management: A Literature Review*. Institute for Safety, Compensation and Recovery Research.

- update client details as needed over time.

However, not all information needs to be collected at the same time. Some data—like a client's health and wellbeing, or housing situation—should be collected early, so that any changes can be measured later on. But other information, especially more sensitive questions (such as sexual orientation or past trauma), might be better asked once trust has been built. This is called *iterative data collection*, and it means collecting some information now, and other information later, when the timing feels right. This approach can support better-quality data and help service users feel more comfortable and respected.

How should services be recording and storing information?

Many services already have case management systems that centralise client information and streamline reporting. These systems can generate reports summarising client characteristics during a specific period, making it easier to meet funding requirements.

However, some important client details—such as gender identity or sexual orientation—may not have dedicated fields in these systems. Instead, staff may record them in free-text case notes on an ad-hoc basis, making data extraction difficult and inconsistent. Ideally, systems should be updated to include fields for these details, but this can be costly.

If updating the system is not an option, services may:

- continue recording the information in case notes,
- create a separate data collection form to standardise responses, or
- work with software providers to incorporate essential fields in future updates.

For services that may be looking to invest in case management software for the first time (or upgrading/changing what they already have) there are several software packages to assist with this.[2] This may include visual tools that can be used in case management with clients (e.g., 'we're seeing a lot of orange lights here and even a red light. What can we do to get you back to the green lights we were seeing a few months ago, when things were going a bit better for you?'). For these services, this guideline (and Guidelines 4, 5 and 6) can be useful for communicating to the software designers what your data collection needs are.

For services that are not looking to invest in case management software any time soon, we have provided a simple excel spreadsheet (Attachment A), which can be used on an ongoing basis to collect the information we have outlined in this guideline (a similar spreadsheet has been developed for **Guideline 4: Collecting data about activities and outputs**). It is essential that all staff use the spreadsheet consistently and adhere to the same definitions to ensure data accuracy.

How can services ensure that information is being collected consistently?

Since multiple staff members record client information, there is a risk of inconsistency which can lead to inaccurate data reporting. Some may use different definitions or enter data in different

[2] Capterra (2024). '*Human Services Software*'. https://www.capterra.com.au/directory/30660/human-services/software.

ways. Having a centralised system reduces this issue, but services using spreadsheets or manual records may face challenges.

To avoid inconsistencies:

- Make sure all staff understand how to collect and record client information correctly.
- Provide clear definitions for key terms for staff to follow, to ensure everyone is on the same page (See Attachment A).
- Assign one team member to train staff and answer any questions about data collection.
- Assign one staff member primary responsibility for inputting data.
- Conduct regular 'checks' of data collection processes to make sure that information is being collected consistently by all staff members.
- Assign a member of staff to reconcile the data against other records/sources of information to pick up data errors.

A structured approach helps ensure that client data is accurate, reliable, and useful for evaluation and service improvement.

What are some next steps services can take?

Data items and definitions in the MD for client characteristics

This section provides key advice about data items and counting rules for the MD. The data collection spreadsheet should be read alongside this information.

There is further information (including alternative approaches and tips) provided in the Additional Resources section. This can help refine your approach to collecting this data.

Client characteristic: Age

Why collect this information?

- Age is one of the basic core demographic variables and is commonly used to distinguish between populations.
- Knowing a client's (approximate) age has important implications for service planning and delivery.
- Ensuring that services are responsive to clients' age and stage of life will improve service delivery.

Additional Resources

See the additional resources section for more information about:

- how to ask about client age, and
- other options for collecting this information

Table 1: Age - Data items and definitions

Variable	Question text	Response categories / options
Date of birth	What is your date of birth?	DD-MM-YYYY

Client Characteristic: Gender and sexual identity

Why collect this information?

- To increase visibility of health and social wellbeing disparities within LGBTIQ+ communities, relative to the non-LGBTIQ+ community
- To improve service delivery and outcomes for LGBTIQ+ communities
- LGBTIQ+ communities believe that collecting information about sexuality and gender is important
- Misgendering a client who is trans, even unintentionally, can be psychologically harmful and contribute to gender dysphoria and be experienced as another form of victimisation
- LGBTIQ+ clients who disclose their sexual and/or gender identity to service providers are overall more satisfied with their service experience.[3]

Sexual identity – preamble to help with disclosure of sensitive information

Using a preamble may increase disclosure by clients by increasing transparency and feelings of safety. Here is an example of a preamble:

> *We'd like to ask you about your gender identity and sexual identity. You do not have to answer these questions, if you do not want to. We are asking for this information, so that we can better understand the characteristics of our clients, as well as their service needs. We are also asking for this information, so we can see whether our services are beneficial for people of different genders and sexualities.*

Additional Resources

See the Additional Resources for more information about:

- how to ask questions about client gender and sexuality, and
- how to create a space in which LGBTIQ+ and trans communities feel safe

Table 2: Gender and sexual identity - Data items and definitions

Variable	Question text	Response categories / options
Gender identity	What is your gender? Gender refers to current gender. This may be different from the sex recorded at birth and/or what is indicated on legal documents.	(1) Male/ Man/ Boy (2) Female/ Woman/ Girl (3) Non-binary (4) I use another term (please specify) (X) Client does not know (R) Client would prefer not to say (99) Not asked

[3] R Bjarnadottir et al. (2017). 'Patient Perspectives on Answering Questions about Sexual Orientation and Gender Identity: An Integrative Review'. *Journal of Clinical Nursing* 26(13–14):p.1814.

Sex recorded at birth	What was your sex recorded at birth?	(1) Male (2) Female (3) Client uses another term (please specify) (X) Client does not know (R) Client would prefer not to say (99) Not asked
Sexual orientation	What is your sexual orientation?	(1) Straight (heterosexual) (2) Gay/Lesbian (3) Bisexual (4) I prefer another term (please specify) (X) Client does not know (R) Client would prefer not to say (99) Not asked

Client Characteristic: Health status – disability and mental health

Why collect this information?

- The Disability Royal Commission emphasised the importance of collecting information about people with disability – especially in justice settings where they may be at particular risk of violence, abuse, neglect and exploitation.[4]
- To improve service delivery and outcomes for people living with disability
- Not identifying that someone has a disability may result in the infringement of their human rights
- Mental health issues may underlie or contribute to some offending behaviour
- Criminal justice interventions may also lead to the development or exacerbation of mental ill health

Additional Resources

See additional resources for more information about:

- how to ask about the health status of clients.
- how to ask questions about mental health, and
- alternative questions for Aboriginal and/or Torres Strait Islander clients

Table 3: Health status - Data items and definitions

Variable	Question text	Response categories / options
Disability	Do you have difficulty with…	
	(a) seeing, even if wearing glasses?	(1) No difficulty (2) Some difficulty (3) A lot of difficulty (4) Cannot do at all
	(b) hearing, even if using a hearing aid?	
	(c) walking or climbing steps?	
	(d) remembering or concentrating?	
	(e) self-care, such as washing all over or dressing?	
	(f) communicating, for example understanding or being understood?	

[4] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (2023). *Volume 8 - Criminal Justice and People with Disability*. Australian Government.

Mental illness	Overall, how would you rate your mental health during the past 4 weeks?	(1) Excellent (2) Very good (3) Good (4) Fair (5) Poor (X) Don't know (R) Refused (99) Not asked
Psychological distress	These questions are about how you have been feeling in the past 4 weeks, that is, since about this time last month. In the past 4 weeks, about how often did you feel:	(1) All of the time (2) Most of the time (3) Some of the time (4) A little of the time (5) None of the time (X) Don't know (R) Refused (99) Not asked
	Nervous?	
	Hopeless?	
	Restless or fidgety?	
	So sad that nothing could cheer you up?	
	Worthless?	

NOTE: Psychological distress measure is from the Kessler 6, a screening tool that is commonly used with people in contact with the criminal legal system to assess their level of psychological distress.

Client Characteristic: Health status – substance use

Why collect this information?

- Substance use is a key risk factor relevant to offending
- Substance use among clients has implications for service delivery (e.g., engagement and drop-out)

Preamble to help with disclosure of sensitive information

Using the preamble may increase accuracy of information collected from clients by increasing transparency and feelings of safety. Suggested preamble:

> *I'd like to spend a few minutes completing a short interview (called the ATOP) with you. The questions look at substance use over the last four weeks. We ask all our clients to complete the ATOP, and some of the questions may not be relevant to you. We use the information to help plan your treatment, look at changes over time, and to evaluate the service. It's important that you answer as accurately as you can, but if you don't want to answer any question, please say so and I'll move on.*

Additional Resources

See additional resources for information about:

- other options for collecting information about client's substance use, and
- alternative questions for Aboriginal and/or Torres Strait Islander clients

Table 4: Substance use - data items and definitions

Variable	Question text	Response categories / options
Substance use	We are going to look at your substance use for each week, for the past for weeks. In the past week, on how many days did you have <substance *name*>: • Alcohol • Cannabis • Amphetamine type substances (ice MDMA) • Benzodiazepines (prescribed and illicit) • Heroin • Other opioids (not including methadone) • Other substance (describe) • Other substance (describe) • Tobacco **In the week before that,** on how many days did you have <substance *name*>: **In the week before that,** on how many days did you have <substance *name*>: **In the week before that,** on how many days did you have <substance *name*>:	Week 4 (most recent): 0 1 2 3 4 5 6 7 Week 3 (week after) 0 1 2 3 4 5 6 7 Week 2 (week after) 0 1 2 3 4 5 6 7 Week 1 (week after) 0 1 2 3 4 5 6 7 (X) Don't know (R) Refused (99) Not asked

Client Characteristic: Cultural and linguistic diversity (CALD) status

Why collect this information

- People from CALD backgrounds can experience significant barriers to accessing justice
- CALD status has implications for client-provider communication and program delivery

Additional Resources

See additional resources for more information about:

- the implications of CALD status for service delivery.

Table 5: CALD status - data items and definitions

Variable	Question text	Response categories/options
Country of birth	What country were you born in?	(1) Australia (2) England (3) New Zealand (4) India (5) Philippines (6) Vietnam (7) Italy (8) South Africa (9) Malaysia (10) Nepal (11) Other (please specify) (R) Refused (X) Client is not sure (99) Not asked
Language spoken at home most of the time	What language do you speak most of the time at home?	(1) English (2) Language other than English (please specify) (X) Client is not sure (R) Refused (99) Not asked
Residency status	What is your residency status?	(1) Australian citizen (2) Permanent resident (3) Permanent visa (4) Temporary visa (R) Refused (X) Client is not sure (99) Not asked

NOTE: The question about Residency Status was developed by the Australian Institute of Health and Welfare and is also used by the Australian Bureau of Statistics.

Client Characteristic: Indigenous status

Why collect this information

- According to the Australian Institute of Health and Welfare, this simple question (Are you of Aboriginal or Torres Strait Islander origin?) is crucial to 'closing the gap' in the outcomes between Indigenous and non-Indigenous Australians.[5]
- Indigenous peoples can experience significant barriers to accessing justice
- Indigenous status may have implications for program delivery – e.g., Indigenous clients may want to be connected to Aboriginal-controlled organisations

Additional resources

See additional resources for:

- reasons why Indigenous clients may choose not to disclose,
- how to ask questions about Indigenous status, and
- follow-up questions when a client discloses that they are Indigenous.

Table 6: Indigenous status - data items and definitions

Variable	Question text	Response categories/options
Indigenous status	Are you of Aboriginal or Torres Strait Islander origin?	(1) No (2) Yes – Aboriginal (3) Yes – Torres Strait Islander (4) Yes - Aboriginal and Torres Strait Islander Not stated/Inadequately described [to be used where the person does not want to say]

[5] Australian Institute of Health and Welfare (2024). *'Alcohol and Other Drug Treatment Services National Minimum Data Set*'. https://www.aihw.gov.au/about-our-data/our-data-collections/alcohol-other-drug-treatment-services.

Client characteristic: Housing status

Why collect this information?

- Clients' housing status is relevant to their program needs and participation, and intersects with other issues that will also impact on their program engagement, such as health and employment
- Housing status has implications for criminal justice system decision-making (e.g., bail decisions)

Additional Resources

See additional resources for information about:

- how to ask about housing status

Table 7: Housing status - data items and definitions

Variable	Question text	Response categories/options
Housing status (at time of referral into the service)	At time of referral, where was the client living?	(1) Own home (2) Private rental (3) Rent Housing ACT (4) Homeless/ Sleeping rough/ In a car/ Tent / The street (5) Temporary accommodation/Boarding house/Caravan park (6) Supported accommodation (including through NDIS or other service) (7) Living at a partner's/relative's/friend's house (8) Prison/youth detention/in-patient (9) Other (please specify) (X) Client does not know (R) Refused (99) Not asked
Satisfaction with housing arrangements	How satisfied are you with your current living arrangements?	(1) Completely satisfied (2) Somewhat satisfied (3) Neutral (4) Somewhat dissatisfied (5) Completely dissatisfied (X) Client does not know (R) Refused (99) Not asked

Client characteristic: Education level

Why collect this information

- Education allows people to build the knowledge and skills that empower them to make informed decisions about their lives, including their program engagement.
- Education is usually a prerequisite for employment and is therefore an important milestone which creates opportunities and shapes future pathways.
- Improper access to education, (eg not able to access education that is inclusive and culturally appropriate), can negatively influence a person's capacity and willingness to engage with services throughout their lives.

Additional resources

See additional resources for more information about how to ask about education level.

Table 8: Education level - data items and definitions

Variable	Question text	Response categories/options
Education level	What is the highest level of education you have completed?	(1) Postgraduate degree (2) Graduate Diploma/Certificate (3) Bachelor degree (4) Advanced Diploma/Associate Degree/Diploma (5) VET Certificate (I-IV) (6) Secondary School Certificate (Year 12) (7) Some secondary school (Year 7-10) (8) Primary school (9) No education
Enrolment status	Are you currently enrolled in a tertiary education or a training program?	(1) Yes – postgraduate tertiary program (2) Yes – undergraduate tertiary program (3) Yes – vocational education or training (VET) course (4) Yes – another type of apprentice or traineeship (5) No

Client characteristic: Employment status

Why collect this information

- Employment has been shown to influence longer-term outcomes, particularly when employment is viewed as meaningful and satisfactory.
- Employment can create barriers to service engagement (e.g., inability to attend appointments).
- Clients' employment is relevant to their program needs and participation, and intersects with other issues that will also impact on their program engagement, such as health and housing.
- Employment has implications for criminal justice system decision-making (e.g., bail decisions).

Additional resources

See additional resources for information about:

- how to ask about employment status.

Table 9: Employment status - data items and definitions

Variable	Question text	Response categories/options
Employment status	Are you currently in paid work?	(1) Yes (2) No
Hours working	How many hours a week do you usually work?	(1) Less than 10 hours (2) 10–19 hours (3) 20–29 hours (4) 30–39 hours (5) 40+ hours
Under-employment	Would you like to be working more hours?	(1) Yes, I want a lot more hours (2) Yes, I want a few more hours (3) No, I'm happy with my current hours
Job stability	How stable do you feel your current job is?	(1) Very stable – I expect to stay in this job long-term (2) Somewhat stable – I am not sure how long I can keep this job (3) Unstable – I could lose this job soon (4) I don't have a job right now

Job satisfaction	Thinking about your current job or work situation, how good do you think it is overall? (This includes things like how safe it feels, how steady it is, how you get along with people at work, and whether it suits your needs.)	(1) Very bad (2) Bad (3) OK (4) Good (5) Very good

Client Characteristic: Carer responsibilities

Why collect this information?

- Provides visibility of potential barriers to clients engaging in your service (e.g., client may not be able to attend meetings due to carer responsibilities)
- Carer responsibilities, particularly for children, can be a strong motivator for justice-involved people to desist from crime and improve their lives.
- ACT Inspector of Correctional Services recommended that criminal justice agencies collect information about 'carer responsibilities a detainee has to a person with disability or an elderly person'.[6]

Table 10: Carer responsibilities - data items and definitions

Variable	Question text	Response categories/options
Number of children	How many children do you have?	Free text (X) Client does not know (R) Refused (99) Not asked
Carer arrangements	Do any of these children live with you as their parent/ guardian (full- or part- time)? *Is the client living with their children on a part or full-time basis?*	(1) Yes (full-time) (2) Yes (part-time) (3) No (X) Client does not know (R) Refused (99) Not asked
Child protection orders	Are there any care orders in place for these children?	(1) Yes (2) No (X) Client does not know (R) Refused (99) Not asked
Reunification	Are you currently working towards reunification?	(1) Yes (2) No (X) Client does not know (R) Refused (99) Not asked

[6] ACT Inspector of Correctional Services (2022). *Healthy Prison Review of the Alexander Maconochie Centre 2022*. ACT ICS.

Other carer responsibilities	Do you have full- or part-time carer responsibilities for someone who is elderly or disabled? This includes any children in your care	(1) Yes (2) No (X) Client does not know (R) Refused (99) Not asked

Client Characteristic: Veteran status

Why collect this information?

- Incarcerated veterans may have unmet physical or mental health needs (e.g. PTSD, moral injury, chronic pain) and are considered at higher risk of suicidality than other people in prison.[7]
- For the purposes of understanding potential veteran over-representation in the criminal justice system, and understanding their experiences and outcomes
- Veterans may be eligible for a range of dedicated supports (e.g. Department of Veterans' Affairs entitlements; veteran specific housing; employment; mental health; and/or justice services etc) – i.e. ensures they are linked to the right supports as early as possible
- Research suggests that military service may attract people with characteristics associated with criminal justice system involvement, or with a history of adverse experiences similarly associated with CJS involvement. This is because military service can be seen as a pathway out of challenging circumstances.[8]

Additional Resources

See additional resources for information about:

- the potential reasons why veterans may be more likely to come into contact with the criminal legal system,
- how to ask about veteran status.

Table 11: Veteran status - data items and definitions

Variable	Question text	Response categories/options
Veteran status	Have you ever served in the military/Australian Defence Force?	(1) Yes (2) No (X) Client does not know (R) Refused (5) (99) Not asked

[7] B Wadham et al. (2023). *Research into Experiences of Ex-Serving Australian Defence Force (ADF) Personnel in Corrective Services Systems in Australia*. Flinders University, University of Adelaide and University of Southern Queensland.

[8] U Orak (2023). *From Service to Sentencing: Unraveling Risk Factors for Criminal Justice Involvement among US Veterans*. Council on Criminal Justice.

Client Characteristic: Readiness to change

Why collect this information:

- Understanding the level of treatment readiness that a client has at the start of their engagement in the service could help staff to identify whether additional work or activities may be required to support their engagement in programs
- Treatment readiness can have important implications for client engagement with your service, as well as their completion; clients with low levels of treatment readiness are more likely to drop out of services. As such, having this information can be crucial for explaining any findings you may have about treatment completion within your client population (see Guideline 4)
- Improvement in program readiness may be a key outcome that you are working towards with clients – in particular, motivation to change and the perceived ability to change. By collecting information readiness to change at entry into the program, you are setting yourself up to be able to demonstrate the impact of your service against some of these outcomes as part of future evaluations

Additional resources

See additional resources for information about:

- a definition of readiness to change, and
- other options for measuring readiness to change

Table 12: Readiness to change - data items and definitions

Variable	Question text	Response categories/options
Readiness to change	Which statement do you think is closest to you right now?	(1) I have stopped offending (2) I have made a definite decision to try and stop offending (3) I would like to stop offending but I'm not sure if I can (4) I am unlikely to stop offending (X) Client does not know (R) Refused (6) (99) Not asked

Motivation to change (record a score for each statement)	I think it's important that I change my life I want to change my life I owe it to myself to change I am really working hard to change my life Anyone can talk about change themselves; I'm actually going to do something about it The people who care about me want me to change my life There's nothing that I really need to change about myself	(1) Strongly agree (2) Agree (3) Neither agree or disagree (4) Disagree (5) Strongly disagree (X) Client does not know (R) Refused (99) Not asked

Additional resources

Age

Recording information about age

Ideally, age is usually measured by calculating the time that has passed (usually in complete years) between a person's date of birth (DOB) and a specific point in time (e.g., date of entry into a program).[9] However, if your service has concerns about recording this level of detail about a client, you can record data in the same format as the ABS, i.e., age of clients in 10-year increments (e.g., 25-34, 35-44). Where an agency works with young people, it will be preferable to use smaller increments (e.g., 12-13, 14-15).

How to ask questions about age

The preferred approach is to ask the person's DOB. This is because it provides the most accurate means of identifying how old a client is at key points of their involvement in the service. It is also necessary information for the purpose of data linkage (e.g., linking clients to administrative datasets maintained by third-party agencies, like ACT Policing).

However, it is important to understand that some people involved in the justice system may not know this and/or it may raise traumatic issues for them. This may especially be the case if they grew up in state care or experienced childhood family violence. Some other ways to ask about a person's age include:

- 'What was your age last birthday?' or
- 'What is your age in complete [full] years?'.[10]

In addition, many justice-involved people do not have a birth certificate. Previous research has examined the links between the lack of a birth certificate and involvement in the criminal justice system.[11] Many justice-involved people also experience 'accelerated ageing', to the extent that the self-reported health of people in prison may be equivalent to someone in the community who is up to 40 years older.[12] All these issues are likely to disproportionately affect Aboriginal and Torres Strait Islander people.[13] Sensitivity is therefore required, when asking/discussing a client's age. It is also important to recognise that this may not accord with their apparent age (e.g., the person may look older than their actual age, as a result of their life experiences). In addition, where there are disability issues (e.g., cognitive impairment), their chronological age may not align with their capacity.

[9] Australian Bureau of Statistics (2014). '*Age Standard*'. <https://www.abs.gov.au/statistics/standards/age-standard/latest-release>.
[10] Ibid.
[11] Victorian Law Reform Commission (2013). *Birth Registration and Birth Certificates: Report.* VLRC.
[12] Australian Institute of Health and Welfare (2023). *The Health of People in Australia's Prisons 2022.* AIHW.
[13] Ibid; Pathfinders (2024) '*National Aboriginal Birth Certificate Program'.* <https://pathfinders.ngo/projects/aboriginals/aboriginal-birth-certificate-project/>.

Gender and sexual identity

How to ask questions about sexual and gender identity

Asking and answering questions about gender and sexual identity can be tricky. This is personal and private information and LGBTIQ+ clients may have experienced negative reactions previously when they have disclosed in different contexts. This is why LGBTIQ+ community members may choose to disclose in some contexts (e.g., to a doctor) but not in others (e.g., the workplace).[14]

It is crucial then, that questions about gender and sexual identity are asked in a sensitive and appropriate way, to maximise disclosure. It is also necessary to create spaces in which LGBTIQ+ people feel safe to disclose this information.

The question text and response categories recommended below have been taken from the Australian Bureau of Statistics Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables, 2020.[15] These items were developed to reflect the intent of the Australian Government Guidelines on the Recognition of Sex and Gender,[16] which encouraged government departments to ensure that appropriate options are provided to individuals who may identify as LGBTIQ+.

Critically, these items have been refined and tested by the ABS, in consultation with an LGBTIQ+ Expert Advisory Committee in preparation for the inclusion of these questions in the 2026 Census. The Expert Advisory Group comprises representatives from peak bodies for LGBTIQ+ people, academic, research and medical institutions, and government agencies. Feedback from the testing process indicated that the items were understandable by the general public and there were high levels of comfort answering these questions.

The ABS standard is also supported by research which has involved directly engaging with LGBTIQ+ community members about how they would like their gender and sexual identities reflected in tools like the MDS.[17] In particular, although there is not universal agreement that a two-step approach to collecting information about sex and gender identity is the best approach, it has been suggested by LGBTIQ+ community members as being an appropriate way of collecting this information.[18]

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[14] J Puckett et al. (2020). 'Perspectives from Transgender and Gender Diverse People on How to Ask About Gender' *LGBT Health 7*(6): p.305; L Suen et al. (2022). 'Do Ask, Tell, and Show: Contextual Factors Affecting Sexual Orientation and Gender Identity Disclosure for Sexual and Gender Minority People', *LGBT Health, 9*(2): p.73.

[15] Australian Bureau of Statistics (2021). *'Standard for Sex, Gender, Variations of Sex Characteristics and Sexual Orientation Variables, 2020*'. <https://www.abs.gov.au/statistics/standards/standard-sex-gender-variations-sex-characteristics-and-sexual-orientation-variables/latest-release>.

[16] Australian Government (2015). *Australian Government Guidelines on the Recognition of Sex and Gender*. Australian Government.

[17] J Puckett et al. (2020). 'Perspectives from Transgender and Gender Diverse People on How to Ask About Gender' *LGBT Health 7*(6): p.305.

[18] Ibid.

Creating a safe space for disclosure of sexual and gender identity

A client's willingness to disclose their gender and sexual identity is likely to be influenced by a number of factors:

- **Context** - clients want to know *why* this information is being collected. As such, before asking these questions, it is important to explain why this information is being collected. We have provided some suggested introductory statements in the above table.
- **Administration method** – LGBTIQ+ clients may be more comfortable self-completing questions about their gender/sexual identity (rather than being asked directly by a service provider). However, if the service provider has a pre-existing relationship with the client, or has done a good job of making the client feel safe, then this may not be necessary.
- **Feelings of safety** – When being asked about their gender/sexual identity, LGBTIQ+ clients are often looking for signs that the service is a 'safe' space.[19] Generally, this means that the client does not believe that they will be discriminated against, treated badly, or experience any other negative consequences (e.g., poor service), based on the information they disclose, and that their information will be treated securely. Ways in which you can communicate that your service is a safe space include having friendly, welcoming and non-judgemental staff; embedding the use of pronouns as common practice among staff; celebrating key days (e.g., IDAHOBIT, Wear it Purple Day); LGBTIQ+ people feeling comfortable sharing their own identity in the workplace (while respecting their right to privacy) etc. However, this is not intended to be a tokenistic exercise. This is an opportunity for you to think deeply about whether or not your service is a safe space for LGBTIQ+ clients.

Health status

Collecting information about health status

There are numerous different ways of asking clients about their disability and chronic health condition status, including asking them:

- directly if they have a diagnosed disability,
- if they receive the disability pension, and
- if they have a plan with the National Disability Insurance Scheme (NDIS).

However, these questions may be difficult for clients to answer accurately. For example, a person may be aware of having impairments but not identify with the label of disability. They may also not know they have a disability – research suggests that many people in contact with the criminal justice system likely have a disability (particularly intellectual or psychosocial disability) but have never received a diagnosis. Using the above listed questions will exclude information about people who may have a disability but have never been assessed or diagnosed.

[19] L Suen et al. (2022). 'Do Ask, Tell, and Show: Contextual Factors Affecting Sexual Orientation and Gender Identity Disclosure for Sexual and Gender Minority People', *LGBT Health, 9*(2): p.73.

While more comprehensive approaches to data collection are being developed, questions like those suggested below are appropriate as a way to capture the presence of disability, regardless of diagnostic status. The questions we have recommended using (see Table 3) are drawn from the Washington Group Short Set on Functioning, developed by the Washington Group on Disability Statistics. For more background information, see the Washington Group's publications[20] on the development and use of these questions.

These questions have been designed to be used for people aged five and over from all cultures. They also recognise that disability is dynamic and should not be considered in purely binary (yes/no) terms. The Washington Group questions are already in use in the ACT criminal justice system.[21]

A client's disability 'score' is calculated by summing responses to the six questions; each response to the six questions is typically assigned a numerical value with "no difficulty" being scored as 1, "some difficulty" as 2, "a lot of difficulty" as 3, and "cannot do at all" as 4. The minimum total score possible is 6, and the maximum total score possible is 24 (i.e., total score range: 6-24). Higher scores indicate higher levels of disability.

We note the need to ensure that disability issues are identified among Aboriginal and Torres Strait Islander peoples in a culturally appropriate way. The Disability Royal Commission[22] recognised that many Aboriginal and Torres Strait Islander people do not identify with the concepts of 'disability', as this is not a recognised concept in some communities. The Washington Group questions do not use specific labels like 'disability' but are instead focused on functional issues; ideally, this will reduce stigma and help service providers to develop appropriate adjustments and supports. However, the use of these questions should be validated with key Aboriginal and Torres Strait Islander stakeholders, including people with both disability and lived experience of the criminal justice system, to confirm that they are seen as legitimate and appropriate.

Collecting information about mental illness

We have recommended asking a general one-item measure about quality of mental health in the past four weeks. However, this measure lacks sensitivity to various types of mental ill health, so we propose using the Kessler 6 (K6) as well.[23] This is a well-established screener for severe mental illness and a key mental health indicator, which is also used in the ACT Wellbeing Framework.[24] It assesses how often people have been feeling a range of emotions (e.g., fidgety) in the last four weeks. In line with previous ABS use,[25] probable serious mental illness is based on a score of 19-30.

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[20] Washington Group on Disability Statistics (2020). *An Introduction to the Washington Group on Disability Statistics Question Sets.* WG.; Washington Group on Disability Statistics (2022). '*The Washington Group Short Set on Functioning (WG-SS)*' <https://www.washingtongroup-disability.com/question-sets/wg-short-set-on-functioning-wg-ss/>.

[21] ACT Government (2023). *Disability Justice Strategy – Fourth Annual Progress Report.* ACT Government.

[22] Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (2023). *Volume 8 - Criminal Justice and People with Disability*. Australian Government.

[23] Harvard Medical School (2005). '*K10 and K6 Scales*'. https://www.hcp.med.harvard.edu/ncs/k6_scales.php.

[24] ACT Government (n.d.) '*Mental Health'*. <https://www.act.gov.au/wellbeing/explore-overall-wellbeing/health/mental-health>.

[25] Australian Bureau of Statistics (2012). *4817.0.55.001 - Information Paper: Use of the Kessler Psychological Distress Scale in ABS Health Surveys, Australia, 2007-08.* ABS.

Some caution may be warranted when interpreting findings from the K6 among people involved in the criminal justice system, as some of the characteristics it measures (e.g., anxiety, depression, hopelessness) may be produced by situational factors, such as the prison environment or justice system contact, rather than being robustly indicative of underlying mental illness. It may also be distressing for some people to talk about their mental health, so remind people that they can skip these questions, if they prefer.

To calculate a client's level of psychiatric distress using the K6, sum the total of all six questions. The minimum total score possible is 0, and the maximum total score possible is 24 (i.e., total score range: 0-24). A score of 13 or more is likely to indicate high risk for serious mental illness.

Collecting information about mental illness from Aboriginal and Torres Strait Islander clients

There have been criticisms of the use of these tools with Aboriginal and Torres Strait Islander populations. Some tools have been adapted or designed to be more culturally appropriate. For example, the Adapted Patient Health Questionnaire (aPHQ-9) asks questions like 'Have you been feeling unhappy, depressed, really no good, that your spirit was sad?' and 'Have you felt tired or weak, that you have no energy?' to assess for depression.[26]

The Indigenous Risk Impact Screen (IRIS) uses six questions to ask Aboriginal and Torres Strait Islander people about their AOD use[27] (for background, see Schlesinger et al.,[28]). Notably, this tool also asks 'Do past events in your family still affect your well-being today (such as being taken away from family)?'

A client's 'score' is calculated by summing responses to the six questions (see Table 1). The minimum total score possible is 6, and the maximum total score possible is 18 (i.e., total score range: 6-18). A score of 11 or more is likely to indicate high risk for mental health and emotional wellbeing.

Where possible, it is preferable for sensitive information of this nature to be collected by another Aboriginal and/ or Torres Strait Islander person.

Table 13: IRIS Mental health and wellbeing scale

Question	Response categories
How often do you feel down in the dumps, sad or slack?	(1) Never/Hardly ever (2) Sometimes (3) Most days/every day
How often have you felt that life is hopeless?	

[26] George Institute for Global Health Australia (2019). '*New Screening Tool to Help Aboriginal and Torres Strait Islander People Combat Depression*.' <https://www.georgeinstitute.org.au/media-releases/new-screening-tool-to-help-aboriginal-and-torres-strait-islander-people-combat>; The Getting it Right Collaborative Group, (2019). 'Getting It Right: Validating a Culturally Specific Screening Tool for Depression (aPHQ-9) in Aboriginal and Torres Strait Islander Australians', *Medical Journal of Australia*, 211(1).
[27] NovoPsych (2024). '*Indigenous Risk Impact Screen (IRIS)*' <https://novopsych.com.au/assessments/outcome-monitoring/indigenous_risk_impact_screen/>.
[28] Carla M Schlesinger et al. (2007)., 'The Development and Validation of the Indigenous Risk Impact Screen (IRIS): A 13-item Screening Instrument for Alcohol and Drug and Mental Health Risk'. *Drug and Alcohol Review*, 26(2): p.109.

How often do you feel nervous or scared?
Do you worry much?
How often do you feel restless and that you can't sit still?
Do past events in your family still affect your well-being today (such as being taken away from family)?

Collecting information about alcohol and drug use

The questions about substance use come from the Australian Treatment Outcomes Profile (ATOP) which appears to be commonly used in Australia, and the ACT.[29] ATOP assesses clients' responses about substance use, focusing on the past four weeks. It enables monitoring of outcomes and feedback about changes over time. It can also help with treatment care planning, communication between service providers, quality improvement and evaluation activities.[30]

Although we have only included the substance use questions here, the ATOP also includes questions about the client's health and wellbeing, carer responsibilities and housing status in the past four weeks. This means, that the full ATOP, which includes 22 questions, could be used to collect more information about clients than just substance use. The full tool, and manual for scoring responses, is available here.

Some other tools are used by ACT agencies which may be more appropriate, depending on the clients' specific needs. These include:

- Drug and Alcohol Star (UK) https://www.outcomesstar.org.uk/using-the-star/see-the-stars/drug-and-alcohol-star/
- Alcohol and Other Drug Outcome Measure (NZ) Alcohol and Drug Outcome Measure | Data and outcomes | Te Pou
- Substance Use Recovery Evaluator SURE: Substance Use Recovery Evaluator | King's College London (kcl.ac.uk)
- Treatment Outcomes Profile (UK) Development of the Treatment Outcomes Profile - PubMed (nih.gov)

In addition, the Alcohol, Tobacco and Other Drug Association ACT (ATODA) conducts the Service Users' Satisfaction and Outcomes Survey.[31] This focuses on use of AOD services and includes data on a range of service users' demographics (e.g., age, gender, sexual orientation, cultural status, disability, parenting status, employment and education, housing and transport).

[29] N Lintzeris et al. (2025). *Australian Treatment Outcomes Profile (ATOP) Manual 1: Using the ATOP with Individual Clients.* Client Outcomes and Quality Indicator Project.; NSW Government (2025). *'Australian Treatment Outcomes Profile'* <https://www.seslhd.health.nsw.gov.au/australian-treatment-outcomes-profile>.

[30] Lintzeris et al (ibid); M Rossner et al. (2022). *ACT Drug and Alcohol Sentencing List: Process and Outcome Evaluation Final Report*. ANU.

[31] Alcohol Tobacco & Other Drug Association ACT (2025). *Service Users Survey of Outcomes, Satisfaction and Experience 2023: A Survey of People Accessing Alcohol, Tobacco and Other Drug Services in the ACT*. ATODA.

All alcohol and other drug services that receive government funding are also required to report on demographic and output measures to the Alcohol and Other Drug Treatment Services National Minimum Dataset.[32] This includes, for example, information on cannabis use, completion of AOD treatment and the number of treatment episodes, by the client's principal drug of concern.

Collecting information about alcohol and drug use from Aboriginal and Torres Strait Islander clients

The IRIS uses seven questions to ask Aboriginal and Torres Strait Islander people about their AOD use, as well as mental health issues[33]. A client's 'score' is calculated by summing responses to the questions. The minimum total score possible is 7, and the maximum total score possible is 28 (i.e., total score range: 7-28). A score of 10 or more is likely to indicate risky AOD drug use (Table 14).

Table 14: IRIS Alcohol and other drug scale

Question	Response categories
In the last six months have you needed to drink or use drugs more to get the effects you want?	(1) No (2) Yes, a bit more (3) Yes, a lot more
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?	(1) Never (2) Sometimes when I stop (3) Yes, every time
How often do you feel that you end up drinking or using drugs much more than you expected?	(1) Never/Hardly ever (2) Once a month (3) Once a fortnight (4) Once a week (5) More than once a week (6) Most days/Every day
Do you ever feel out of control with your drinking or drug use?	(1) Never/Hardly ever (2) Sometimes (3) Often (4) Most days/every day
How difficult would it be to stop or cut down on your drinking or drug use?	(1) Not difficult at all (2) Fairly easy (3) Difficult

[32] Australian Institute of Health and Welfare (2024). *'Alcohol and Other Drug Treatment Services National Minimum Data Set*'. https://www.aihw.gov.au/about-our-data/our-data-collections/alcohol-other-drug-treatment-services.

[33] NovoPsych (2024). '*Indigenous Risk Impact Screen (IRIS)*' <https://novopsych.com.au/assessments/outcome-monitoring/indigenous_risk_impact_screen/>; Carla M Schlesinger et al. (2007)., 'The Development and Validation of the Indigenous Risk Impact Screen (IRIS): A 13-item Screening Instrument for Alcohol and Drug and Mental Health Risk'. *Drug and Alcohol Review*, 26(2):p.109.

	(4) I couldn't stop or cut down
What time of the day do you usually start drinking or using drugs?	(1) At night (2) In the afternoon (3) Sometimes in the morning (4) As soon as I wake up
How often do you find that your whole day has involved drinking or using drugs?	(1) Never/ Hardly ever (2) Sometimes (3) Often (4) Most days/ Every day

Cultural and linguistic diversity

The recommended questions about CALD status have been taken from the Australian Bureau of Statistics' (ABS) Census survey.

Implications of CALD status for service delivery

Shepherd and Masuka[34] suggested the following considerations can apply when working with CALD young people, which might affect client-provider communication and program delivery. Most would equally apply to older CALD clients:

- Culturally specific manifestations of illness and cultural idioms of distress, differing explanatory models of health and traditional remedies that may require accommodation in conventional health care settings.
- Precarious migration experiences and how they underpin contemporary social circumstances.
- A cultural group's family structures, social hierarchies and religious/spiritual conventions and how these may shape community/familial expectations and responsibilities.
- Resistance or hostility in therapeutic or justice settings, because of mistrust, fear and perceived discrimination, as a result of historical injustices committed in similar settings.
- Experiences of racism, which may affect self-esteem, distress levels, cooperation with authority, adherence to clinical recommendations, threat perception, feelings of safety, access to services and vulnerability to anti-social peer group membership.
- A need for interpreters or bilingual staff: even if someone speaks English well enough to function on an everyday level, they may not possess the language skills to communicate about complex problems.
- The cultural context of behaviour: is placing someone in a foreign environment by itself leading to symptoms? This involves taking into account diverse cultural backgrounds and practices, while recognising the person's experiences of living in Australia.

[34] S Shepherd and G Masuka (2021). 'Working With At-Risk Culturally and Linguistically Diverse Young People in Australia: Risk Factors, Programming, and Service Delivery' *Criminal Justice Policy Review,* 32(5): p.469.

Aboriginal and Torres Strait Islander status

The recommended question about Aboriginal and Torres Strait Islander status was developed by the Australian Institute of Health and Welfare.

Reasons why clients may choose not to disclose

It is important to recognise the different purposes of the criminal justice system and health-based services where this question could be asked – the criminal justice system is coercive rather than treatment-oriented. There may be additional reasons why someone may choose not to disclose their Aboriginal and Torres Strait Islander status and/or may identify in one setting, but not another. This includes fear of unequal treatment and loss of contact with children, as well as their pre-existing relationship with the service provider. In recognition of this, and to promote self-determination, it is important to respect that some Aboriginal and Torres Strait Islander people may choose not to disclose this to authorities. In some circumstances, they may become more comfortable speaking about their identity over time, as a more trusting relationship develops.

Asking questions about Aboriginal and Torres Strait Islander status

The Australian Institute of Health and Welfare has developed best practice guidelines around asking about Aboriginal and Torres Strait Islander status in health settings[35]. This includes guidance on when a client:

- wants to know why they are being asked the question,
- objects to the question or declines to answer,
- chooses not to answer the question 'correctly', and
- wishes to change their previously recorded Aboriginal and Torres Strait Islander status.

Other information in this guideline includes what to do when staff are reluctant to ask the question and recommendations for staff training and data quality and assurance. Much of this information is also of relevance to criminal justice contexts.

Follow-up questions

Where a person identifies as Aboriginal and/or Torres Strait Islander, it will generally be appropriate and highly desirable to ask additional questions. These may include whether the client would like to be connected with Aboriginal community-controlled organisations (e.g., Winnunga Nimmityjah, Gugan-Gulwan, Aboriginal Legal Service) and the nature or quality of their current relationships with their family or community ('mob'). We have not set out questions about this here, because this will depend on the nature of the service (e.g., whether it is delivered by an Aboriginal community-controlled organisation). More specific questions designed to promote the cultural needs of Aboriginal and Torres Strait Islander clients and support the specific program's goals should therefore be developed, in consultation with relevant stakeholders (e.g., JACS First

[35] Australian Institute of Health and Welfare (2010). *National best practice guidelines for collecting Indigenous status in health data sets.* Australian Government.

Nations Justice Branch, Aboriginal and Torres Strait Islander Elected Body, Ngunnawal Elders Council).

Housing status

The questions about housing are informed by the questions asked of clients in the Justice Housing Program evaluation,[36] as well as the ABS[37] and ACT Wellbeing Framework, which includes measures on homelessness; rental stress; housing affordability and availability; and housing suitability.[38] The items have also been informed by the Footprints Survey used by ACT Corrective Services. Asking an open-ended question about the client's satisfaction will provide the opportunity for service providers to explore issues such as housing suitability and financial stress, as well as interpersonal stresses at home.

Asking about housing status

Homelessness takes many forms and can include:

- staying in temporary or supported accommodation, such as boarding houses, hostels and shelters,
- sleeping rough,
- staying temporarily with family and friends (including 'couch surfing'), and
- living in severely crowded dwellings.

Many people experiencing homelessness experience shame or embarrassment.[39] It is therefore particularly important to build trust and avoid judgement, when asking questions about a person's housing situation. People experiencing homelessness may also go to significant lengths to hide their housing experiences (e.g., using public facilities or gyms to wash and change) and use a variety of ways to describe their situation (e.g., 'just staying with friends', 'between places at the moment'). The type of housing the client is living in may be relevant to their program goals (e.g., moving to a more permanent place or saving a bond to move out of a friend's house).

Education level

Asking about education level

Some people may have had negative experiences with educational institutions and systems, which may not necessarily be captured with quantitative data about educational attainment/participation. For example, 'mainstream' education is typically inaccessible for people living with disability, and there are criticisms about the use of segregated schools and classrooms. For First Nations peoples, Australia's education system also carries a history of oppression and

[36] H Taylor et al. (2023). *Process Evaluation of the Justice Housing Program*. Australian National Univeristy.
[37] Australian Bureau of Statistics (2023). '*Estimating Homelessness: Census*.' <https://www.abs.gov.au/statistics/people/housing/estimating-homelessness-census/latest-release>.
[38] ACT Government (2020). *ACT Wellbeing Framework*. ACT Government.
[39] W Squires (2019). 'One of the Worst Things About Homelessness Is the Shame', *The Age* (online, 2019) <https://www.theage.com.au/national/victoria/one-of-the-worst-things-about-homelessness-is-the-shame-20190528-p51rvr.html>.

cultural erasure, and access to culturally appropriate forms of education is still limited (e.g. on-country learning, traditional systems of knowledge embedded within curriculums).

As such, it is important to use broad definitions of education when asking clients about it, and avoid terminology like “mainstream” schooling.

Employment status

Asking about employment status

Asking about employment can be sensitive, particularly for clients experiencing financial insecurity, unstable or informal work, or long-term unemployment. For many people, their job—or lack of one—is closely tied to their sense of identity, self-worth or social standing. Others may have negative experiences with job service providers or feel shame discussing their work status.

Clients may also be engaged in non-standard forms of work—such as caring for family members, participating in the gig economy, cash-in-hand labour, or culturally specific roles—which may not fit neatly into mainstream definitions of “employment.”

To maximise comfort and accuracy:

- **Use a warm, non-judgemental tone**, and explain why the question is being asked. For example:

"We ask all clients about their current work situation—not to judge, but to better understand how we can support you, and to help evaluate how effective our programs are over time."

- **Avoid technical language** like “employment status” and instead ask plainly:

"Are you currently in paid work, even if it’s just a few hours a week or off-the-books?"

- **Clarify that all kinds of work count**, including casual, part-time, gig work, and informal arrangements.
- **Let clients know they can skip the question** or come back to it later if they prefer. This is especially important when the topic brings up distress or discomfort.
- **Use follow-up prompts carefully**. If someone says they’re not working, you might ask:

"Would you like to be working, or working more hours, if something came up?"

These approaches help ensure that the data collected is respectful, inclusive and reflective of the client’s actual circumstances—without making them feel judged or categorised in rigid ways.

Veteran status

Why Veteran status is important in criminal justice evaluations

Approximately 2.8% of the Australian population over 15 years of age has served in the regular or reserve service,[40] but little is known about the experiences of incarcerated veterans in Australia.

[40] Australian Bureau of Statistics (2022). *‘Service with the Australian Defence Force: Census*’. https://www.abs.gov.au/statistics/people/people-and-communities/service-australian-defence-force-census/latest-release

While there is very little Australian research on the topic, international evidence suggests that there may be a link between military service and offending behaviour.[41] Research is inconclusive about overall representation in prison populations - some studies suggest that veterans are disproportionately represented in prisons and other studies suggest they are not. However, it seems likely that military service is related to offence type: there is consistent evidence from the UK, US and Canada that veterans are more likely than non-veterans to be serving sentences for violent offences, and are particularly over-represented in homicide offences, including multiple shootings.[42]

Research suggests that military service may attract people with characteristics associated with criminal justice system involvement, or with a history of adverse experiences similarly associated with CJS involvement. This is because service can be seen as a pathway out of challenging circumstances.[43] For this reason, some people might benefit from service, while for others the potentially negative experiences associated with service might exacerbate pre-existing risk factors. According to Orak[44] and Wadham et al.[45], service-related risk factors include:

- combat exposure and deployment trauma,
- Post-Traumatic Stress Disorder (PTSD) and traumatic brain injury,
- substance use disorder;
- moral injury (injury to someone's moral conscience and values resulting from an act of perceived moral transgression; can manifest as shame and aggression), and
- mistreatment during service such as military institutional abuse and military sexual trauma.

After serving, risk factors include readjustment challenges and lack of support with these; barriers to healthcare utilisation; and homelessness/housing instability.

How to ask about veteran status

"Have you ever served in the military/Australian Defence Force?" is the preferred screening question vs. "Are you a Veteran?" as it enables those who don't feel comfortable with the term Veteran or don't identify as a Veteran to be recognised.

[41] B Wadham et al. (2023). *Research into Experiences of Ex-Serving Australian Defence Force (ADF) Personnel in Corrective Services Systems in Australia*. Flinders University, University of Adelaide and University of Southern Queensland.
[42] Ibid.
[43] U Orak (2023). *From Service to Sentencing: Unraveling Risk Factors for Criminal Justice Involvement among US Veterans*. Council on Criminal Justice.
[44] Ibid.
[45] B Wadham et al. (2023). *Research into Experiences of Ex-Serving Australian Defence Force (ADF) Personnel in Corrective Services Systems in Australia*. Flinders University, University of Adelaide and University of Southern Queensland.

Readiness to change

What is readiness to change?

Readiness to change (sometimes described as treatment readiness) is a global term that encompasses the range of different factors impacting client engagement with your service. This includes internal factors (e.g., motivation, perceived self-efficacy) as well as external factors (e.g., the timing of the intervention, the therapeutic setting).[46] Treatment readiness is an important responsivity factor in the Risk-Needs-Responsivity model, which underpins many programs that involving working with justice-involved individuals.

Measuring readiness to change

Readiness to change as a concept has been measured a number of different ways, using various different tools. One of the most common is through surveys completed by clients, which are often underpinned by the Trans-Theoretical Model of Change framework (TTM). TTM suggests that individuals progress through a series of stages, in order for change to occur, with each stage representing varying (but increasing) levels of motivation and willingness on the part of the individual to alter their behaviour and take agentic action to bring about the desired change. The model has traditionally been used to understand changes in addiction-related behaviours.[47] It has also commonly been used to measure changes in offending behaviours.[48]

There are several other options for collecting information about the client's readiness to change, other than what we have recommended in the MD. Considering the complexity of treatment readiness as a concept, Mossière and Serin[49] suggest collecting information about client readiness to change from multiple sources. For example, in the table below we have suggested that a staff assessment of the client's readiness to change could be collected instead of, or in addition to, the items included in the MD. Alternatively, a comprehensive assessment could be undertaken. One of the most commonly used measures of readiness to change is the University of Rhode Island Change Assessment-24 (URICA-24) which includes 24 questions.

Table 15: Treatment readiness – alternative questions

Variable	Item text	Response categories/options
Treatment readiness (motivation - staff assessment)	To what extent do you believe the client is motivated to change their behaviours?	(1) Very motivated (2) Somewhat motivated (3) Not motivated (4) Very unmotivated

[46] N Burrowes & A Needs (2009). 'Time to Contemplate Change? A Framework for Assessing Readiness to Change with Offenders' *Aggression and Violent Behavior,* 14(1):p.39.
[47] K Disbury et al. (2015). 'Pre- to Posttreatment Differences in Measures of Risk of Relapse and Reoffending for Participants of RAPt's 6-Week Programs' *Journal of Offender Rehabilitation,* 54(8):p.556.
[48] A Yong et al. (2015). 'How Do Offenders Move through the Stages of Change?' *Psychology, Crime & Law* 21(4): p. 375.
[49] A Mossière & R Serin (2014). 'A Critique of Models and Measures of Treatment Readiness in Offenders' *Aggression and Violent Behavior,* 19(4): p.383.

Treatment readiness (confidence - staff assessment)	To what extent do you believe the client is confident that they can change their behaviours?	(1) Very confident (2) Somewhat confident (3) Not confident (4) Very unconfident
Treatment readiness (client assessment – URICA-24)	As per assessment instrument	