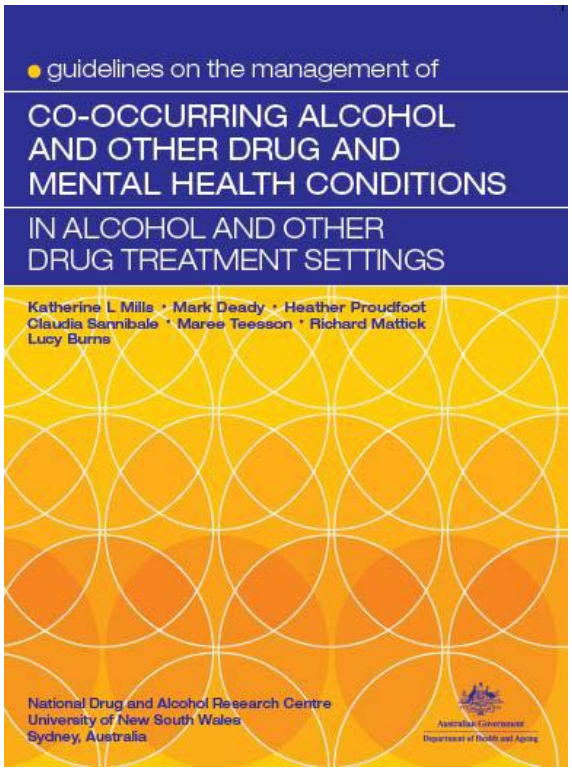
Australian Government
Department of Health and Ageing

Overview of the Training Package on the

Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings



About the Training Guide

Aims of the Training Guide

This training guide has been developed to support training on the *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings* (hereafter referred to as the Guidelines).

The aim of the Training Package is to provide clinical educators, team leaders and other suitably qualified personnel to deliver training on the Guidelines within the workplace. It is hoped that by delivering targeted, workplace based training on the information within the Guidelines, AOD and related professionals will significantly improve their knowledge, skills and confidence when working with clients with co-occurring AOD and mental health concerns.

The Guidelines and the training do not aim to create "mental health experts". They are designed to raise the level of awareness of commonly presenting mental health issues within the AOD context and to increase the confidence of AOD workers to identify, work with and appropriately refer to mental health services as necessary.

Objectives for the Training

At the completion of all sections of the training, participants will be able to:

- Describe the rationale and purpose of the Guidelines;
- Define comorbidity in the AOD context;
- Explain the relationship between AOD use and mental health concerns;
- Understand the prevalence of comorbidity within the Australian context;

- Discuss some of the consequences of co-existing AOD and mental health issues;
- Describe the guiding principles for working with clients with comorbidity;
- Understand the classification of mental health disorders;
- Explain a range of mental health conditions including mood, anxiety, psychotic and personality disorders;
- Identify methods for assessing comorbidity, including a range of standardised tools for assessing mental health;
- Describe methods for working effectively with specific mental health concerns;
- Describe a range of broad and specific strategies for treating mental health issues;
- Understand commonly prescribed medications for use in the treatment of mental health conditions;
- Explain the process involved in effective referrals and interagency management of clients with co-occurring AOD and mental health issues;
- Identify the specific needs of some special interest groups.

Contents of Training Package

The Training Package has been divided into 6 sessions:

1. Overview of the Guidelines and Comorbidity
2. Classification of Mental Health Disorders
3. Assessment of Comorbidity
4. Management and Treatment of Comorbidity
5. Working Collaboratively
6. Specific Population Groups.

(NB: not all sessions are of equal length due to the varying content within each session).

The following documents have been developed for each of the six sessions:

- Training program with suggested activities and times
- PowerPoint slides;
- Handouts;

As well, for the overall training package there is:

- Pre and post training questionnaires
- Evaluation forms.

Delivery of the Training

It is, of course, essential that anyone involved in the delivery of training be fully cognisant of the content of the *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings.* Further training on the content of some of the sessions (such as the mental state exam, pharmacotherapies or motivational interviewing) may be necessary for the person delivering the training prior to delivering the relevant session.

Trainer characteristics

People involved with the delivery of training on the Comorbidity Guidelines should possess the following characteristics and skills:

- Strong background in mental health
- Sound understanding of the symptoms of mental illness
- Practical experience in the assessment and management of clients with mental health concerns
- Demonstrated skills in delivering education and training consistent with adult learning principles.

The Training Package is designed to be run as individual, short sessions or as whole days of training. The times allocated to each of the sessions are a guide only and will vary according to factors such as the size of the group, the background of the participants involved in the training and the context in which the training is being delivered.

This training is designed as a broad overview of the content of the Guidelines. More extensive training may be required/recommended within some AOD and related workplaces on the following topics:

- Undertaking and writing a mental state assessment
- Suicide risk assessment, prevention and management
- Assessing and working with trauma survivors
- Understanding and working with clients with personality disorders
- PsyCheck
- Managing aggression and challenging behaviours
- Motivational interviewing
- Cognitive-behavioural therapy
- Pharmacotherapies for mental health disorders

Evaluation of the Training

Accompanying this Training Package are pre and post workshop questionnaires and an evaluation form for each session. These forms are designed to provide feedback to the trainer on the effectiveness of the session delivered and on further training required by those who attend the training.

Management of co-occurring drug and alcohol and mental health conditions in alcohol and other drug settings

Pre-Training Questionnaire

Thank you for completing this questionnaire prior to participating in the training on the Comorbidity Guidelines. The purpose of this questionnaire is to assess the training, not the participants. Please answer the questions below according to your current level of knowledge and confidence. You will be asked to complete a similar questionnaire at the end of the training.

How confident do you feel in general when working with clients with co-occurring mental health and AOD issues?

1 2 3 4 5 6 7 8 9 10
Not at all extremely

How knowledgeable are you about the different classifications of mental illness?

1 2 3 4 5 6 7 8 9 10
Not at all extremely

How confident do you feel in regards to assessing a client's mental health in general?

1 2 3 4 5 6 7 8 9 10
Not at all extremely

How confident do you feel in regards to undertaking a mental state assessment?

1 2 3 4 5 6 7 8 9 10
Not at all extremely

How confident do you feel in regards to using formal tools for assessing mental illness?

1 2 3 4 5 6 7 8 9 10
Not at all extremely

How <u>confident</u> do you feel in regards to managing a client who is suicidal?

1 2 3 4 5 6 7 8 9 10
Not at all extremely

How <u>confident</u> do you feel in regards to managing a client with symptoms of depression?

1 2 3 4 5 6 7 8 9 10
Not at all extremely

How <u>confident</u> do you feel in regards to managing a client who is experiencing anxiety?

1 2 3 4 5 6 7 8 9 10
Not at all extremely

How <u>confident</u> do you feel in regards to managing a client with a history of trauma?

1 2 3 4 5 6 7 8 9 10
Not at all extremely

How <u>confident</u> do you feel in regards to managing a client who is aggressive or violent?

1 2 3 4 5 6 7 8 9 10
Not at all extremely

How <u>confident</u> do you feel in regards to managing a client with symptoms of personality disorder?

1 2 3 4 5 6 7 8 9 10
Not at all extremely

How <u>confident</u> do you feel in regards to managing a client with cognitive impairment?

1 2 3 4 5 6 7 8 9 10
Not at all extremely

How knowledgeable are you about the different treatment approaches for co-occurring AOD and MH conditions?

1 2 3 4 5 6 7 8 9 10
Not at all extremely

How knowledgeable are you about a range of medications used to treat mental illness?

1 2 3 4 5 6 7 8 9 10
Not at all extremely

How confident do you feel in regards to working collaboratively with mental health services?

1 2 3 4 5 6 7 8 9 10
Not at all Extremely

Any other comments?

Thank you for completing this questionnaire

Comorbidity Guidelines Training Program

Session One – Overview of the Guidelines and Comorbidity

Aim of Session One:
The aim of this session is to introduce the *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*, provide a rationale for the Guidelines and to explain the prevalence of comorbidity.

Session One Objectives:
- Describe the rationale and purpose of the Guidelines;
- Define comorbidity in the AOD context;
- Explain the relationship between AOD use and mental health concerns;
- Understand the prevalence of comorbidity within the Australian context;
- Discuss some of the consequences of co-existing AOD and mental health issues;
- Describe the guiding principles for working with clients with comorbidity.

For this session you will need:
√ Copy of the Guidelines

√ Session One PowerPoint slides

√ Copies of PPT slides as handouts

√ Pre-training questionnaire

√ Session One evaluation (if stand alone session)

Total recommended time: One and ½ hours

Topic / Time	Delivery	Resources
Introduction 10 minutes	• Display PPT slide 1 at beginning of session • Individual participants to complete pre-workshop questionnaire • Participants to state what they want to achieve from the training	• Pre-workshop QA • PPT slide 1
Overview of Guidelines 10 minutes	• Show PPT slides 2 and 3 referring participants to the reference for the Guidelines and the relevant sections in the Guidelines • Referring to PPT slides 4 to 6, presentation by trainer on the purpose of Guidelines.	• PPT slides 2 to 6
Challenges 15 minutes	• Divide the group into pairs to discuss the question: *"What are the challenges I face when working with clients with co-existing AOD and MH issues?"* • Take feedback in whole group • Referring to PPT slides 7 and 8 and discuss.	• PPT slides 7 and 8

Defining Comorbidity 10 minutes	• Ask the whole group to define “Comorbidity” in the AOD and MH context. • Show PPT slide 9 • Explain that “comorbidity” simply means “two diagnosable conditions” and is used in other medical contexts. However in the AOD context comorbidity refers to presence of co-occurring mental health condition. Discuss with the group other possible terms, such as “dual disorders”, “dual diagnosis”. • Make sure all participants are aware of the DSM-IV-TR and its purpose.	• PPT slide 9
Why does comorbidity occur? 10 minutes	• Ask the group to provide you with some examples of commonly co-occurring combinations of mental health and AOD concerns, such as depression and alcohol dependence, anxiety and cannabis use, methamphetamines and psychosis. Write these on the whiteboard. • Discuss with the group their thoughts on “which came first?” ie: causality.	• PPT slides 10 to 13

	• Show PPT slides 10 and 11. • Ask the group the question: "Does causality matter?" and discuss. Show PPT slides 12 and 13.	
Prevalence of comorbidity 10 minutes	• Ask the group "from your clinical experience, how common is it for AOD clients to present with mental health issues?" • Present the information on slides 14 to 18 and discuss.	• PPT slides 14 to 18
Harms associated with comorbidity 10 minutes	• Ask the whole group to provide a list of possible harms and consequences associated with comorbidity. • Show PPT slides 19 and 20 and discuss, reinforcing the rationale for addressing mental health issues within AOD treatment settings.	• PPT slides 19 and 20
Guiding Principles 10 minutes	• Referring to the principles on PPT slides 21 to 23, provide an outline of the Guiding Principles for the management of co-occurring AOD and mental health conditions. • Discuss the "No Wrong Door" concept as per PPT slide 24, eliciting what it means for clinical practice.	• PPT slides 21 to 24
Ending the session	• Show PPT slide 25 to sum up. Allow time for any final	• PPT slide 24

10 minutes	questions. • Refer the participants back to the Guidelines, in particular Chapters 1 to 4. • If running session one as a “stand alone” session, handout out the Session 1 Evaluation Form for participants to complete and return.	• Session One Evaluation Form

Management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings

Session One – Overview of Comorbidity

Evaluation Form

Thank you for taking the time to complete this evaluation form. Your responses will remain confidential. No attempts will be made to identify individual's answers. Your feedback on the session will be appreciated.

"This session will be useful in my work with clients with co-occuring mental health and AOD conditions"

1	2	3	4	5	6	7	8	9	10
Not at all									*Extremely*

"This session met my expectations"

1	2	3	4	5	6	7	8	9	10
Not at all									*Totally*

Which aspect(s) of this session did you find most useful and why?

Which aspect(s) of this session did you find least useful and why?

Any further comments

Comorbidity Guidelines Training Program

Session Two – Classification of Mental Health Disorders

Aim of Session Two:

This session aims to provide an overview of the most commonly occurring mental health conditions within AOD treatment settings.

Session Two Objectives:

- Understand the classification of mental disorders;
- Explain a range of mental health conditions including mood, anxiety, psychotic and personality disorders;
- Understand the differentiation between substance-induced and independent symptoms of mental illness.

For this session you will need:

√ Copy of the Comorbidity Guidelines

√ Session Two PowerPoint slides

√ Copies of PPT slides as handouts

√ Session Two Handouts – Scenarios

√ Session Two evaluation (if stand alone session)

Total recommended time: Two hours

Topic / Time	Delivery	Resources
Overview of Classification of Mental Health Disorders 30 minutes	• Start the session showing PPT slide 1. • Begin this session by explaining that there are standardised systems for classifying and diagnosing mental disorders. Refer the participants to the relevant sessions in the Guidelines as per PPT slide 2. • If available, show the group a copy of the DSM–IV-TR as the main source of reference for classifying mental illness. • Referring to PPT slides 3 and 4, stress that not all AOD workers are qualified to diagnose mental illnesses however it is important for AOD workers to be aware of the range of mental health conditions and related symptoms. • Referring to PPT slide 5, discuss the fact that clients may present to AOD services with symptoms related to mental illness but may not necessarily meet the criteria for a diagnosis of mental illness. These symptoms can be equally debilitating and distressing for the client at the time and need to be addressed within the context of the AOD setting. • Ask the group to provide examples from their work where clients presented with symptoms of mental illness. (Eg: cannabis withdrawal and anxiety, methamphetamine withdrawal and depression, drug-induced psychosis). Record these on the whiteboard.	• Copies of PPT slides as handouts • Scenarios • PPT slides 1 to 7 • Copy of DSM-IV-TR

	• Discuss these examples in terms of whether the participants felt the mental health symptoms were related to the client's AOD use/withdrawal or whether there was a more substantial, underlying mental illness. Reinforce the point that regardless of their thoughts about AOD use or withdrawal being the "cause" of the symptoms of mental illness, the situation can be equally distressing for the client and requires thorough and on-going assessment and management. • Show PPT slide 6 to introduce the 5 main categories of mental health disorders. • Explain to the group that the rest of this session will be a broad overview of the symptoms of these 5 main categories by referring to a number of case scenarios. • NOTE: The case scenarios listed in the handouts for Session 2 are examples only and can be altered to be more specific to your service.	
Understanding common mental health disorders 45 minutes	• For this section, six scenarios will be referred to. Handout the Session 2 Handouts. • Divide the group into 6 pairs/groups and allocate them one scenario (this will depend on group size; make sure all scenarios are covered). • For their allocated scenario, ask the 6 groups to consider the questions listed at the beginning of Session 2 Handout. • Recall the group, taking feedback from each of the groups. As you are taking the feedback refer to the relevant disorders as per the slides below. Stress that there is not enough	• Scenarios 1 and 2 • PPT Slides 7 to 29

	information about the scenarios to ascertain the extent to which the mental health symptoms are substance-induced or not. Ask the group to consider what else they need to know in order to establish the contribution of substance use to the current mental health symptoms. • Also mention that there is not enough information in the scenario to make a diagnosis but that the symptoms may be indicative of the disorder, requiring further assessment. • When discussing scenario 1 “Adam”, refer to PPT slides 7 to 9. Reinforce the point that the most immediate concern is the risk of suicide. The assessment of suicide will be discussed in the next session. • When discussing scenario 2 “Stephanie”, refer to PPT slides 10 and 11. Reinforce the point that the reduction of harm from injecting is the most immediate concern in the case of Stephanie. • When discussing scenario 3 “Sonia”, refer to PPT slides 12 to 14. Reinforce the point that the most immediate concern is for Sonia is the possibility of a panic attack. Managing the symptoms of anxiety and reducing the likelihood of a panic attack will be more fully addressed in Session 4. • When discussing scenario 4 “Shane”, refer to PPT slides 16 to 19. Discuss some of the immediate concerns including self-harm, aggression and impulsivity (which will be further addressed in Session 4). • When discussing scenario 5 “Melanie”, refer to PPT slides 20 and 21. Reinforce the point that diagnosing personality disorder is a complex process requiring careful assessment by qualified professionals. The personality disorder label needs to	

	be used with great caution! • When discussing scenario 6 “Cathy”, refer to PPT slides 22 to 29. Reinforce the point that the process of diagnosing a disorder such as schizophrenia is a very complex and extensive process and needs to be done by a psychiatrist. The most immediate concerns for Cathy are her safety, particularly when in a delusional state. The management of the symptoms of psychosis will be addressed in Session 4.	
Substance-Induced Disorders 30 minutes	• Ask the group for examples from their work where clients have shown symptoms of mental disorder where it was possibly due to either the intoxication or withdrawal from AOD. • Show PPT slides 30 to 35 discussing substance-induced disorders. • Stress the following points: - it can be difficult to distinguish substance-induced from non substance-induced for a range of mental health disorders - Regardless of the “cause” of the symptoms, the client experiencing the mental illness will be equally distressed and requiring careful assessment and attention, possibly involving mental health specialist services.	• PPT slides 30 to 35
Discussion and Summary	• Explain to the group that this session was a broad overview of the most commonly presenting mental disorders. A range of other mental disorders exist that have not been covered (such	• PPT slide 36 • Session 2 Evaluation

15 minutes	as obsessive compulsive disorder and eating disorders). Refer the participants to the DSM–IV-TR for greater explanation of these and other disorders. • Show PPT slide 36 to reinforce a few key points. • If this is a stand alone session, ask the participants to complete the Session Two evaluation form.	Form

Comorbidity Guidelines Training Program

Session Two Handouts

Scenarios

For each of the scenarios below answer the following questions:

- What are your immediate concerns for this person?
- Could these symptoms be substance-induced? How would you know?
- What further information would you need about this person's situation to make an assessment of their AOD use, mental health and other possible risk factors?
- Who else may need to be involved in the assessment and management of this person?

1. "Adam"

Adam is a 21 year old male who was brought into your service by his mother, Susan. Adam has a 10 year history of regular cannabis use and occasional alcohol and amphetamine use. Adam's mother has become increasingly worried about her son's behaviour and believes that if he stopped smoking cannabis that he would feel better. Susan is particularly worried about Adam because her father committed suicide when she was only 10. Susan reports that Adam has become increasingly withdrawn, rarely comes out of his room and eats very little – Susan thinks he has lost a lot of weight over the past few months. Adam has dropped out of his TAFE course and has little contact with friends. Susan has also heard Adam crying in his room. Adam broke up with his girlfriend of two years about six months ago. Upon meeting Adam he makes no eye-contact with you and does not reply to your greeting. He sits slumped in a chair.

2. “Stephanie”

Stephanie is a 32 year old woman who has recently been diagnosed with bipolar disorder. She was referred by mental health services for assessment of her AOD use. Stephanie initially came to the mental health services’ notice when she was referred by a GP who had prescribed antidepressants in the past. Stephanie presented to the GP in a very excited state, seeking a pregnancy test claiming “I am pregnant with the new messiah!” It was noted by the GP that Stephanie has lost a significant amount of weight and that she had injection marks on her arms. The pregnancy test was negative. Stephanie has been using methamphetamines increasingly over the past year. Stephanie has been prescribed mood stabilising medication but is reluctant to take it as “it makes me feel terrible. I hate feeling depressed all the time. It’s such a downer!”

3. “Sonia”

Sonia is a 42 year old woman with a history of alcohol and nicotine dependence. When you meet Sonia she appears to be tremulous and perspiring. Sonia has had a number of attempts to withdraw from alcohol and cigarettes with limited success due to the panic she experiences in withdrawal. She tells you on admission that she is really worried about failing again this time. Sonia describes the feelings she has experienced during past withdrawal attempts as “*I feel like the world is caving in on me and that I am going to die. I just can’t handle it! I used to feel like this when I was a kid. I should be over it*”.

4. “Shane”

Shane is a 39 year old who regularly drinks at harmful levels and occasionally uses amphetamines. Shane has been diagnosed as having an antisocial personality disorder and has also been treated for depression following a suicide attempt. In the past, Shane has been convicted for dealing and fraud. He is currently on bail for assault charges. Shane attempted suicide again by overdosing on drugs and alcohol following his recent arrest.

5. “Melanie”

Melanie is a 34 year old woman with a long history of opiate dependence. Melanie was referred by the emergency department after she was recently taken by ambulance following an overdose – her neighbour happened to find her. Melanie has been prescribed methadone in the past however she has continued to use heroin, oxycontin and methamphetamine. Melanie has three children to three different fathers – the children are currently in DoCS care. She is currently pregnant. Melanie has spent time in gaol for fraud. You notice that Melanie has significant scarring on her arms and legs. Melanie wants to stop using drugs but is worried as she has had many attempts in the past with little success.

6. “Cathy”

Cathy is a 19 year old university student who has been using a variety of substances, including ecstasy, crystal meth and alcohol. Cathy was very successful at school and went straight from school to university to study Law. Cathy started to experience symptoms of psychosis during her second year exams. She was heard by her friends at the University college to be shouting at 3am. Her friends reported that Cathy claimed to be hearing someone telling her “you’re no good… you’re a failure”. Cathy had also smashed the TV in her room as she believed that the TV was broadcasting her thoughts. Cathy spent some time in an acute mental health unit and was stabilised on antipsychotics. Cathy continues to regularly use alcohol and other drugs. She was referred by the mental health services to AOD services following a further psychotic episode. The mental health worker suspects Cathy had been using “ice”.

7. “John”

John is a 54 year old man who was medically retired 2 years ago from his job in the bank. John experienced an armed hold up at his workplace about 5 years ago. He received some initial counselling following the event however he continued to experience flashbacks and nightmares. He avoids going near banks and is very easily startled by loud noises. He sleeps very little despite the use of sleeping tablets. His use of alcohol dramatically increased following the hold up and has become even more frequent since he has stopped working. John was referred by his GP for an assessment of his alcohol dependence and for withdrawal from benzodiazepines.

Management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings

Session Two – Classification of Mental Disorders

Evaluation Form

Thank you for taking the time to complete this evaluation form. Your responses will remain confidential. No attempts will be made to identify individual's answers. Your feedback on this session will be appreciated.

"This session will be useful in my work with clients with co-occuring mental health and AOD conditions"

1	2	3	4	5	6	7	8	9	10
Not at all									*Extremely*

"This session met my expectations"

1	2	3	4	5	6	7	8	9	10
Not at all									*Totally*

Which aspect(s) of this session did you find most useful and why?

Which aspect(s) of this session did you find least useful and why?

Any further comments

Comorbidity Guidelines Training Program

Session Three – Assessment of Comorbidity

Aim of Session Three:

This session aims to provide learners with knowledge, tools and skills to undertake an assessment of client mental health within AOD treatment settings.

Session Three Objectives:

- Understand the importance of identifying comorbidity;
- Explain the process of case formulation;
- Understand informal and formal assessment processes;
- Demonstrate the use of the mental state examination;
- Describe the process of assessing trauma;
- Demonstrate the assessment of risk, in particular suicide;
- Explain the importance of assessing readiness for change for both AOD and mental health concerns;
- Describe a range of standardised tools for assessing mental health;
- Demonstrate the provision of feedback following a mental health assessment.

For this session you will need:

√ Copy of the Guidelines – particularly Chapter 6

√ Session Three PowerPoint slides

√ Copies of PPT slides as handouts

√ Session Three Handouts

√ Session Three evaluation (if stand alone session)

Total recommended time: Three hours

Topic	Delivery	Resources
Overview of assessment of mental health 20 minutes	• Start the session with PPT slide 1. • Explain to the group that the purpose of this session is to provide the participants with an overview of the assessment of mental health within the AOD treatment setting. This session will provide some tools and strategies for assisting with assessing a range of mental health concerns. • Show PPT slide 2 referring participants to the relevant sections in the Guidelines. • Ask the group the following question – *"what are some of the challenges you have faced when attempting to assess a client's mental health?"* Note the challenges on the whiteboard, acknowledging that assessment of mental health can be challenging and requires a level of skill and knowledge. The tools and guides being introduced today will hopefully assist with the challenges. • Show PPT slide 3 which raises the importance of routinely screening and assessing all AOD clients for their mental health. Reinforce the point that assessment is a process, not a single event! This is particularly important when trying to make sense of a client's ongoing mental health status throughout the AOD treatment process. • State that a thorough and accurate assessment, particularly	• Copy of PPT slides as handouts • Session Three Handouts • Scenarios from Session 2 Handouts • PPT slides 1 to 3

	using one of the standardised tools, is an essential part of communicating with other services, including specialist mental health services.	
Case Formulation 10 minutes	• Show PPT slides 4 and 5 and discuss the role of both formal and informal assessment in the process of case formulation. • Emphasise that assessment is a process not a single event, particularly in the case of comorbidity. Repeated assessments are essential for determining the extent of mental health concerns and the effectiveness of interventions. Ask the group *"How many times do you currently assess a client for their mental health?"* • Ask the group to give examples of where they have noticed changes in clients' symptoms during treatment (both increases and decreases in symptoms of mental illness) • Referring to PPT slide 6, provide an overview of the range of areas for assessment in a comprehensive assessment. Ask the group *"Which of the listed elements of the assessment do you currently routinely complete?"* Then *"which of the elements listed do you need to add to your assessment of clients?"*	• PPT Slides 4 to 6
Mental State Examination 45 minutes	• Ask the group to indicate their current level of confidence to routinely carry out a mental state examination (MSE). • Show PPT slide 7 to reinforce that the MSE is an essential tool for assessing as client's current mental health status, for having a baseline for later referral and for communicating with other services in a standardised manner. Explain that the MSE is NOT a mental health history but a report on a client's current mental state.	• PPT slides 7 and 8 • Session 3 Handouts pages 1 to 6 • Scenario 1 from Session 2 Handouts

	• Showing PPT slide 8 and referring to the Session 3 handouts pages 1 to 6, provide an overview of the components involved in undertaking and reporting a MSE. • Using scenario 1 ("Adam") from the Session 2 Handouts, ask a participant to play the role of Adam. Demonstrate a MSE interview with Adam. Refer the participant playing Adam to the completed MSE report on pages 5 and 6 of the Session 3 Handouts to provide more details of the scenario. • Instruct the participants watching the MSE demonstration to use the blank MSE (pages 3 and 4 of Handouts) to take notes for later writing of the MSE report. • Following the completion of the MSE demonstration, ask the group to provide you with what they thought should be included in a report on the MSE. • Refer the participants to the completed MSE report on pages 5 and 6 of the handout. • Discuss with the group the usefulness of the MSE. Reinforce that the MSE and subsequent report takes practice. Consider setting up opportunities following the training for the participants to seek feedback on MSE reports on actual clients.	
Mental Health History and Risk Assessment 45 minutes	• Referring to PPT slide 9, discuss with the group the broad questions that can be useful for assessing a client's history of mental illness. • Explain to the group the importance of assessing a client for any experiences of trauma they may have experienced in the past. A history of trauma is common among people with AOD concerns. Ask the group if they have any concerns about raising the issue of trauma with clients and discuss these	• PPT slides 9 to 15 • Session 3 Handouts pages 7 to 10

Risk Assessment	concerns. • Referring to PPT slide 10, reinforce with the group that discussing trauma can be delicate issue that requires a high degree of sensitivity on the worker's part. Strongly suggest that workers need to be trained in working with trauma and have clinical supervision prior to assessing and managing clients who have experienced trauma (as per slide 9). • Show PPT slides 11 and 12 discussing the some of the factors to be aware of when assessing trauma. • Refer the participants to the Trauma Screening Questionnaire on page 7 of the Session 3 Handouts and discuss the use of the TSQ. • Ask the group what some of the risks may be in regards to mental health concerns within the AOD context • Referring to PPT slide 13, raise the examples of possible risks to be aware of in the mental health and AOD context. • Ask the group whether they have had any experience of assessing for risk of suicide. If so, what was that like for them. Ask "*why might workers be reluctant to ask clients about their thoughts of, or plans for, suicide?"* Acknowledge with the group that raising the issue of suicide can be a delicate issue. However, raising it does NOT mean a client is more likely to attempt suicide. Indeed it has been found the opposite is true – encouraging a client to discuss any thoughts of suicide may in fact be preventative of suicide attempts. • Referring to PPT slides 14 and 15, discuss the key questions to ask a client in regards to the risk of suicide. • Refer the participants to the Session 3 Handouts, pages 8 to 10 for an example of a standardised suicide risk assessment. Refer to the table on page 10 and discuss with the group the	

	risk levels and suggested responses. • Reinforce that, given the high rates of comorbidity within AOD treatment settings, it is important to routinely assess clients for any history of trauma, suicide attempts and any current suicidal thoughts.	
Assessing Readiness and Using Standardised Screening Tools 45 minutes	• Refer to PPT slide 16 raising the importance of assessing readiness for change for both AOD and mental health issues. • Briefly ask the group to recap the stages of change. • Refer to the IMAT on page 21 of the handouts as a way to assess both AOD and MH. Stress that the IMAT can be a useful guide to assist workers with a starting point only. The IMAT grid is not meant as a tool to include or exclude clients from services. • Show PPT slides 17 and 18 providing an overview of the use of standardised tools for assessing mental health. Refer to PPT slide 19 for a list of some of the tools that can be used to assess MH. Also refer the group to Appendix G, page 154 of Guidelines for additional screening instruments. • Refer the participants to the standardised tools on pages 11 to 19 of the Session 3 Handouts. Briefly discuss the purpose and scope of each of the tools. • Divide the group into pairs. Ask them to choose one of the scenarios from the Session 2 Handouts. Choose one of the screening tools for the participants to practice using in a role-play. Allow time for the participants to swap roles. Reform the group and take feedback from the perspective of the "worker" and the "client". Debrief the participants from the "client" roles. • Show PPT slides 20 and 21, discussing the role of feedback	• PPT slides 16 to 21 • Session 3 Handouts pages 11 to 21 • Session 2 Handouts - scenarios

	following the use of a standardised tool. • Stress that further training and practice may be required to feel confident to use tools such as PsyCheck and to give clients feedback following the use of such tools. • Ask the group to consider what would be the process of obtaining further assessment and possibly a diagnosis if they thought the client had a mental health condition. (NB: Session 5 focuses on working collaboratively in greater detail)	
Wrapping up session 15 minutes	• Provide the participants with an opportunity to clarify any of the issues raised in this session. • Show PPT slide 22 to reinforce some general points about assessment. • If this is a stand alone session, ask the participants to complete the Session Three evaluation form.	• PPT slide 22 • Session 3 Evaluation Form

Comorbidity Guidelines Training Program

Session Three Handouts

Assessment of Mental State

Appearance *(How does the client look?)*
- Posture – slumped, tense, bizarre.
- Grooming – dishevelled, poor personal hygiene (nails, hair etc.).
- Clothing – bizarre, inappropriate, dirty.
- Nutritional status – weight loss, not eating properly.
- Evidence of AOD use – intoxicated, flushed, dilated/pinpoint pupils, track marks.

Behaviour *(How is the client behaving?)*
- Motor activity – immobile, pacing, restless, hyperventilating.
- Abnormal movements – tremor, jerky or slow movements, abnormal walk.
- Bizarre/odd/unpredictable actions.

Attitude *(How is the client reacting to the current situation and worker?)*
- Angry/hostile towards interviewer/others.
- Unco-operative.
- Withdrawn.
- Over familiar/inappropriate/seductive.
- Fearful, guarded, hypervigilant.

Speech *(How is the client talking?)*
- Rate – rapid, uninterruptible, slow, mute.
- Tone/volume – loud, angry, quiet, whispering.
- Quality – clear, slurred.
- Anything unusual about the client's speech?

Language *(How does the client express himself/herself?)*
- Incoherent/illogical thinking (word salad: communication is disorganised and senseless and the main ideas cannot be understood).
- Derailment (unrelated, unconnected or loosely connected ideas, shifting from one subject to another).
- Tangentiality/loosening of associations (replies to questions are irrelevant or may refer to the appropriate topic but fail to give a complete answer).
- Absence/retardation of, or excessive thought and rate of production.
- Thought blocking (abrupt interruption to flow of thinking so that thoughts are completely absent for a few seconds or irretrievable).

Mood *(How does the client describe his/her emotional state?)*
- Down/depressed; angry/irritable; anxious/fearful; high/elevated.

Affect *(What do you observe about the client's emotional state?)*
- Depressed – flat, restricted, tearful, downcast.
- Anxious – agitated, distressed, fearful.
- Irritable, hostile.

– Labile – rapidly changing.
– Inappropriate – inconsistent with content
– High/elevated – excessively happy or animated.

Thought Content *(What is the client thinking about?)*
– Delusional thoughts (e.g., bizarre, grandiose, persecutory, self-referential).
– Preoccupations: paranoid/depressive/anxious/obsessional thoughts; overvalued ideas.
– Thoughts of harm to the self or others.
– Does the client believe that his/her thoughts are being broadcast to others or that someone/thing is disrupting or inserting his/her own thoughts?

Perception *(Is the client experiencing any misinterpretations of sensory stimuli?)*
– Does the client report auditory, visual, olfactory or somatic hallucinations? Illusions?
– Are they likely to act on these hallucinations?
– Do you observe the client responding to unheard sounds/voices/unseen people/ objects?
– Any other perceptual disturbances (e.g., derealisation, depersonalisation, heightened/ dulled perception)?

Cognition:
Level of consciousness
– Is the client alert and oriented?
– Is the client attentive during the interview (drowsy, stupor, distracted)?
– Does the client's attention fluctuate during the interview?
– Does the client present as confused?
– Is the client's concentration impaired? (can he/she count from 100 or say the months of the year backwards?)

Orientation
– Does the client know:
- Who he/she is?
- Who you are?
- Where he/she is?
- Why he/she is with you now?
- The day of the week, the date, the month and the year?

Memory
– Can the client remember:
- Why he/she is with you? (Immediate)
- What he/she had for breakfast? (Recent)
- What he/she was doing around this time last year? (Remote)
– Are they able to recall recent events (memory and simple tasks e.g., calculation)?

Insight and Judgment
– How aware is the client of what others consider to be his/her current difficulty?
– Is the client aware of any symptoms that appear weird/bizarre or strange?
– Is the client able to make judgments about his/her situation?

MENTAL STATE EXAMINATION REPORT

Name_____ D.O.B._____
Date_____

Appearance

Physical appearance? (posture, grooming, clothing, signs of AOD use, nutritional status)

Behaviour

General behaviour? Behaviour to situation and to examiner? (angry/hostile, unco-operative, withdrawn, inappropriate, fearful, hypervigilant)

Speech

Rate, volume, tone, quality and quantity of speech?

Language (form of thought)

Incoherence/illogical/irrelevant thinking? Amount? Rate?

Mood and affect

How does the client describe his/her emotional state (mood)? What do you observe about the person's emotional state (affect)? Are these two consistent and appropriate?

Thought content

Delusions, suicidality, paranoia, homicidality, depressed/anxious thoughts?

Perception

Hallucinations? Depersonalisation? Derealisation?

Cognition

Level of consciousness? Attention? Memory? Orientation? Abstract thoughts? Concentration?

Insight and judgement

Awareness? Decision making?

SAMPLE MENTAL STATE EXAMINATION REPORT

Name: ADAM JONES (fictional person) D.O.B. 1/1/89 Date: 22/1/10

Appearance

21 year old Adam Jones presented to the service in the company of his mother. Adam sat slumped in a chair. He appeared unshaven with unkempt hair. His clothes were clean and ironed. Adam appeared to be underweight for his height. (Adam's mother reported that he has recently lost weight).

Behaviour

Adam made very little eye-contact during the assessment interview. He appeared quite withdrawn and gave minimal or no responses to the questions asked. He remained slumped in the chair throughout the interview.

Speech

Adam said very little during the interview. When he did speak it was barely audible. The rate of his speech was slow.

Language (form of thought)

Although Adam said very little during the interview, he did at times respond appropriately to some questions. For example, when asked about what he liked about smoking cannabis, Adam responded with "It makes me feel relaxed, it helps me to sleep". Later in the interview Adam appeared to be crying and stated "I feel like I've made a mess of things".

Mood and affect

When asked how he was feeling, Adam shrugged his shoulders and stated "I dunno. Sort of nothing". His affect was flat and congruent with his mood.

Thought content

Adam did not appear to be paranoid or delusional. When assessed for suicidal thoughts, Adam stated "I just want to go to sleep and not wake up". He denies having a plan to commit suicide or to self-harm. Adam also has no thoughts of harming others. He stated towards the end of the interview "I know mum's worried about me. I don't want to hurt her.".

Perception

Adam denied hearing voices or any other perceptual disturbance.

Cognition

Adam remained conscious throughout the interview. Adam had difficulty answering questions at times. Twice he asked the interviewer to repeat the question. He appeared to be oriented to time, place and person.

Insight and judgement

Adam showed some insight into his situation when he stated “I just want to feel better”. His concern about worrying his mother was also noted. Adam did agree to return in the near future to talk further about his use of cannabis and the possibility of making a change. He wants to return to his TAFE course at some time.

TRAUMA SCREENING QUESTIONNAIRE (TSQ)

Please consider the following reactions which sometimes occur after a traumatic event. This questionnaire is concerned with your personal reactions to the traumatic event which happened to you. Please indicate (Yes/No) whether or not you have experienced any of the following at least twice in the past week.

1. Upsetting thoughts or memories about the event that have come into your mind against your will	□ No	□ Yes
2. Upsetting dreams about the event	□ No	□ Yes
3. Acting or feeling as though the event were happening again	□ No	□ Yes
4. Feeling upset by reminders of the event	□ No	□ Yes
5. Bodily reactions (such as fast heartbeat, stomach churning, sweatiness, dizziness) when reminded of the event	□ No	□ Yes
6. Difficulty falling or staying asleep	□ No	□ Yes
7. Irritability or outbursts of anger	□ No	□ Yes
8. Difficulty concentrating	□ No	□ Yes
9. Heightened awareness of potential dangers to yourself and others	□ No	□ Yes
10. Being jumpy or being startled at something unexpected	□ No	□ Yes

Source: Brewin, C. R., Rose, S., Andrews, B., Green, J., Tata, P., McEvedy, C., Turner, S. & Foa, E. B. (2002) Brief screening instrument for post-traumatic stress disorder. *British Journal of Psychiatry, 181*, 158-162.

SUICIDE RISK ASSESSMENT CHECKLIST

Name_____ D.O.B._____ Date_____

Questions used to complete this assessment might include:

- Have things been so bad lately that you have thought you would rather not be here?
- Because of the high rates of suicide, I ask all my clients about whether they have ever had any suicidal thoughts. I am wondering if you have ever been feeling so awful that you have begun thinking about suicide?
- Have you had any thoughts of harming yourself?
- Are you thinking of suicide?
- How often do you have these thoughts of killing yourself?
- Have you made any current plans?
- What has happened that makes life not worth living?
- Have you ever tried to harm yourself?
- Do you have access to firearms or any other lethal means?
- Is there anyone you rely upon for support?
- Is there anything that is preventing you from acting on your thoughts?
- Do you think that the treatment offered is going to help you get better?

---

1. ***Previous history of suicidal behaviour***
   (Self-harm, previous attempts)

---

2. ***Risk factors***
   (Social isolation, recent loss/death, family/relationship problems, incarceration, unemployment/lack of skills, lack of problem-solving skills, impulse control problems, hopelessness, physical/mental illness, does motivation exist for treatment?)

3. ***Current suicidal thoughts***

   (Presence of thoughts, frequency, duration, intensity, intent)

4. ***Plans***

   (How? When? Where? Access to chosen method)

5. ***Protective factors***

   (Actively in treatment, good physical health, good problem-solving abilities, social/spiritual support, employment/financial/educational stability, reasons for living, plans for future)

Assessment of Suicide Risk Level

Level of risk	Suggested response
Non-existent: No identifiable suicidal thoughts, plans or intent	• Monitor risk periodically or when indicated
Mild/Low: Suicidal thoughts of limited frequency, intensity and duration. No plans or intent, mild dysphoria, no prior attempts, good self-control (i.e., subjective or objective), few risk factors, identifiable protective factors	• Review frequently • Identify potential supports/contacts and provide contact details • Contract with client to seek immediate assistance if fleeting thoughts become more serious or depression deepens
Moderate: Frequent suicidal thoughts with limited intensity and duration, some plans but no intent (or some intent but no plans), limited dysphoria, some risk factors present, but also some protective factors	• Request permission to organise a specialist MHS assessment as soon as possible • Continue contract as above • Review daily
Severe/High: Frequent, intense and enduring suicidal thoughts. Specific plans, some intent, method is available/accessible, some limited preparatory behaviour, evidence of impaired self-control, severe dysphoria, multiple risk factors present, few if any protective factors, previous attempts	• If risk is high and the client has an immediate intention to act, contact the mental health crisis team immediately and ensure that the client is not left alone • Call an ambulance/police if the client will not accept a specialist assessment, or the crisis team is not available • Consult with a colleague or supervisor for guidance and support
Extreme/Very high: Frequent, intense, enduring suicidal thoughts and clear intent, specific/well thought out plans, access/available method, denies social support and sees no hope for future, impaired self-control, severe dysphoria, previous attempts, many risk factors, and no protective factors	

Adapted from: Lee N, Jenner L, Kay-Lambkin F, Hall K, Dann F, Roeg S, et al. PsyCheck: Responding to mental health issues within alcohol and drug treatment. Canberra: Commonwealth of Australia; 2007;
Rudd MD, Joiner T, Rajab MH. Treating Suicidal Behaviour: An effective, time-limited approach. New York: Guilford Press; 2001.
Schwartz RC, Rogers JR. Suicide assessment and evaluation strategies: A primer for counselling psychologists. Counselling Psychology Quarterly. 2004; 17(1):89-97.

Standardised Screening Tools

Kessler – 10 (K-10)

Name.....Date.....

For all questions, please circle the answer *most* commonly related to you. Questions 3 and 6 automatically receive a score of one if the proceeding question was "none of the time".

In the past four weeks:	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1. About how often did you feel tired out for no good reason?	1	2	3	4	5
2. About how often did you feel nervous?	1	2	3	4	5
3. About how often did you feel so nervous that nothing could calm you down?	1	2	3	4	5
4. About how often did you feel hopeless?	1	2	3	4	5
5. About how often did you feel restless or fidgety?	1	2	3	4	5
6. About how often did you feel so restless you could not sit still?	1	2	3	4	5
7. About how often did you feel depressed?	1	2	3	4	5
8. About how often did you feel that everything is an effort?	1	2	3	4	5
9. About how often did you feel so sad that nothing could cheer you up?	1	2	3	4	5
10. About how often did you feel worthless?	1	2	3	4	5
Total:					

Test: Kessler, R.C. (1996). *Kessler's 10 Psychological Distress Scale*. Harvard Medical School: Boston, MA.
Normative data: National Survey of Mental Health and Well-being, Australian Bureau of Statistics 1997.

PsyCheck Screening Tool

Client's Name:		DOB:		
Service:		UR:		
Mental health services assessment required?		□ No □ Yes		
Suicide/self-harm risk (please circle):		High	Moderate	Low
Date:	Screen completed by:			
Clinician use only				
Complete this section when all components of the *PsyCheck* have been administered.				
Summary				
Section 1	Past history of mental health problems	□ No	□ Yes	
Section 2	Suicide risk completed and action taken	□ No	□ Yes	
Section 3	SRQ score	□ 0	□ 1-4	□ 5+
Interpretation/score – Self-Reporting Questionnaire (SRQ)				
Score of 0* on the SRQ	No symptoms of depression, anxiety and/or somatic complaints indicated at this time. **Action:** Re-screen using the *PsyCheck* Screening Tool after four weeks if indicated by past mental health questions or other information. Otherwise monitor as required.			
Score of 1-4* on the SRQ	Some symptoms of depression, anxiety and/or somatic complaints indicated at this time. **Action:** Give the first session of the *PsyCheck* Intervention and screen again in four weeks.			
Score of 5+* on the SRQ	Considerable symptoms of depression, anxiety and/or somatic complaints indicated at this time. **Action:** Offer sessions 1–4 of the *PsyCheck* Intervention.			
Re-screen using the *PsyCheck* Screening Tool at the conclusion of four sessions.				
If no improvement in scores evident after re-screening, consider referral.				

PsyCheck General Screen

Clinician to administer this section

The following questions are about your emotional wellbeing. Your answers will help me get a clearer idea of what has been happening in your life and suggest possible ways that we might work together to relieve any distress you may be experiencing. We ask these questions of everybody, and they include questions about mental, physical and emotional health.

1	Have you ever seen a doctor or psychiatrist for emotional problems or problems with your "nerves"/anxieties/worries?	□ No	□ Yes
	Details		
2	Have you ever been given medication for emotional problems or problems with your "nerves"/anxieties/worries?		
	□ No, never		
	□ Yes, in the past but not currently	Medication(s):	
	□ Yes, currently	Medication(s):	
3	Have you ever been hospitalised for emotional problems or problems with your "nerves"/anxieties/worries?	□ No	□ Yes
	Details		
4	Do you have a current mental health worker, psychiatrist, psychologist, general practitioner or other health provider? **If "No", go to Question 5.**		
	□ **Psychiatrist** Name: Contact details: Role:	□ **Psychologist** Name: Contact details: Role:	
	□ **Mental health worker** Name: Contact details: Role:	□ **General practitioner** Name: Contact details: Role:	
	□ **Other – specify:** Name: Contact details: Role:	□ **Other – specify:** Name: Contact details: Role:	
5	Has the thought of ending your life ever been on your mind?	□ No	□ Yes — If "No", go to Section 3
	Has that happened recently?	□ No	□ Yes — If "Yes", go to Section 2

PsyCheck Risk Assessment

Clinician to administer this section

If the person says "Yes" to recently thinking about ending his/her life (Question 5), complete the suicide/self-harm risk assessment below. Specific questions and prompts and further guidance can be found in the *PsyCheck* User's Guide.

Risk factor		Low risk	Moderate risk	High risk
1	Previous attempts: Consider lethality and recency of attempts. Very recent attempt(s) with moderate lethality and previous attempts at high lethality both represent high risk. Recent and lethal attempts of family or friends represent higher risk.			
	History of harm to self	□ Previous low lethality	□ Moderate lethality	□ High lethality, frequent
	History of harm in family members or close friends	□ Previous low lethality	□ Moderate lethality	□ High lethality, frequent
2	Suicidal ideation: Consider how the suicidal ideation has been communicated; non-disclosure may not indicate low risk. Communication of plans and intentions are indicative of high risk. Consider non-direct and non-verbal expressions of suicidal ideation here such as drawing up of wills, depressive body language, "goodbyes", unexpected termination of therapy and relationships etc. Also consider homicidal ideation or murder/suicide ideation.			
	Intent	□ No intent	□ No immediate intent	□ Immediate intent
	Plan	□ Vague plan	□ Viable plan	□ Detailed plan
	Means	□ No means	□ Means available	□ Means already obtained
	Lethality	□ Minor self-harm behaviours, intervention likely	□ Planned overdose, serious cutting, intervention possible	□ Firearms, hanging, jumping, intervention unlikely
3	Mental health factors: Assess for history and current mental health symptoms, including depression and psychosis.			
	History of current depression	□ Lowered or unchanged mood	□ Enduring lowered mood	□ Depression diagnosis
	Mental health disorder	□ Few or no symptoms or well-managed significant illness	□ Pronounced clinical signs	□ Multiple symptoms with no management
4	Protective factors: These include social support, ability or decision to use support, family involvement, stable lifestyle, adaptability and flexibility in personality style etc.			
	Coping skills and resources	□ Many	□ Some	□ Few
	Family/friendships/networks	□ Many	□ Some	□ Few
	Stable lifestyle	□ Many	□ Some	□ Few
	Ability to use supports	□ Many	□ Some	□ Few

Psycheck Self-reporting questionnaire

Client or clinician to complete this section			
First: Please tick the **"Yes"** box if you have had this symptom in the **last 30 days**. **Second:** Look back over the questions you have ticked. For every one you answered **"Yes"**, please put a tick in the circle if you had that problem at a time when you were NOT using alcohol or other drugs.			
1. Do you often have headaches?	□ No	□Yes	→ ○
2. Is your appetite poor?	□ No	□Yes	→ ○
3. Do you sleep badly?	□ No	□Yes	→ ○
4. Are you easily frightened?	□ No	□Yes	→ ○
5. Do your hands shake?	□ No	□Yes	→ ○
6. Do you feel nervous?	□ No	□Yes	→ ○
7. Is your digestion poor?	□ No	□Yes	→ ○
8. Do you have trouble thinking clearly?	□ No	□Yes	→ ○
9. Do you feel unhappy?	□ No	□Yes	→ ○
10. Do you cry more than usual?	□ No	□Yes	→ ○
11. Do you find it difficult to enjoy your daily activities?	□ No	□Yes	→ ○
12. Do you find it difficult to make decisions?	□ No	□Yes	→ ○
13. Is your daily work suffering?	□ No	□Yes	→ ○
14. Are you unable to play a useful part in life?	□ No	□Yes	→ ○
15. Have you lost interest in things?	□ No	□Yes	→ ○
16. Do you feel that you are a worthless person?	□ No	□Yes	→ ○
17. Has the thought of ending your life been on your mind?	□ No	□Yes	→ ○
18. Do you feel tired all the time?	□ No	□Yes	→ ○
19. Do you have uncomfortable feelings in the stomach?	□ No	□Yes	→ ○
20. Are you easily tired?	□ No	□Yes	→ ○
	Total score (add circles):		

DEPRESSION ANXIETY STRESS SCALE – DASS 21

Name: *Date:*

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to overreact to situations	0	1	2	3
7	I experienced trembling (e.g., in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

Source: Lovibond, S.H. & Lovibond, P.F. (1995) *Manual for the Depression Anxiety Stress Scales.* 2nd edition. Sydney: Psychology Foundation.

THE PRIMARY CARE PTSD SCREEN (PC-PTSD)

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:		
1. Have had nightmares about it or thought about it when you did not want to?	□ No	□ Yes
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	□ No	□ Yes
3. Were constantly on guard, watchful, or easily startled?	□ No	□ Yes
4. Felt numb or detached from others, activities, or your surroundings?	□ No	□ Yes

Source: Prins, A., Ouimette, P., Kimerling, R., Cameron, R. P., Hugelshofer, D. S., Shaw-Hegwer, J., Thrailkill, A., Gusman, F.D., Sheikh, J. I. (2004). The primary care PTSD screen (PC-PTSD): Development and operating characteristics. *Primary Care Psychiatry, 9*, 9-14.

PSYCHOSIS SCREENER

1. In the past 12 months, have you felt that your thoughts were being directly interfered with or controlled by another person?	□ No	□ Yes
1a. Did it come about in a way that many people would find hard to believe, for instance, through telepathy?	□ No	□ Yes
2. In the past 12 months, have you had a feeling that people were too interested in you?	□ No	□ Yes
2a. In the past 12 months, have you had a feeling that things were arranged so as to have a special meaning for you, or even that harm might come to you?	□ No	□ Yes
3. Do you have any special powers that most people lack?	□ No	□ Yes
3a. Do you belong to a group of people who also have these special powers?	□ No	□ Yes
4. Has a doctor ever told you that you may have schizophrenia?	□ No	□ Yes

Source: Degenhardt, L., Hall, W., Korten, A., & Jablensky, A. (2005). *Use of brief screening instrument for psychosis: Results of a ROC analysis. Technical Report No. 210.* Sydney: National Drug and Alcohol Research Centre

INDIGENOUS RISK IMPACT SCREEN (IRIS)

1. In the last 6 months have you needed to drink or use more to get the effects you want?			
1. No	2. Yes, a bit more	3. Yes, a lot more	
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/runny gonna, feeling really down or worried, problems sleeping, aches and pains?			
1. Never	2. Sometimes when I stop	3. Yes, every time	
3. 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	
4. 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
5. How difficult would it be to stop cut down on your drinking or drug use?			
1. Not difficult at all	2. Fairly easy	3. Difficult	4. I couldn't stop or cut down
6. 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
7. 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
8. How often do you feel down in the dumps, sad or slack?			
1. Never/Hardly ever	2. Sometimes	3. Most days/Every day	
9. How often have you felt that life is hopeless?			
1. Never/Hardly ever	2. Sometimes	3. Most days/Every day	
10. How often do you feel nervous or scared?			
1. Never/Hardly ever	2. Sometimes	3. Most days/Every day	
11. Do you worry much?			
1. Never/Hardly ever	2. Sometimes	3. Most days/Every day	
12. How often do you feel restless and that you can't sit still?			
1. Never/Hardly ever	2. Sometimes	3. Most days/Every day	
13. Do past events in your family still affect your wellbeing today (such as being taken away from family)?			
1. Never/Hardly ever	2. Sometimes	3. Most days/Every day	

Integrated Motivational Assessment Tool

	Motivation regarding AOD treatment					
Motivation regarding psychiatric treatment		Pre-contemplation	Contemplation	Preparation / Determination	Action	Maintenance
	Pre-contemplation					
	Contemplation					
	Preparation / Determination					
	Action					
	Maintenance					

Management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings

Session Three – Assessment of Comorbidity

Evaluation Form

Thank you for taking the time to complete this evaluation form. Your responses will remain confidential. No attempts will be made to identify individual's answers. Your feedback on this session will be appreciated.

"This session will be useful in my work with clients with co-occuring mental health and AOD conditions"

1	2	3	4	5	6	7	8	9	10
Not at all									*Extremely*

"This session met my expectations"

1	2	3	4	5	6	7	8	9	10
Not at all									*Totally*

Which aspect(s) of this session did you find most useful and why?

Which aspect(s) of this session did you find least useful and why?

Any further comments

Comorbidity Guidelines Training Program

Session Four – Management and Treatment of Comorbidity

Aim of Session Four:

This session aims to provide an overview of a range of management and treatment approaches for effectively working clients with mental health conditions within AOD treatment settings.

Session Four Objectives:

- Understand the principles for managing the symptoms of commonly occurring mental health issues;
- Explain the suggested "dos and don'ts" for a range of mental health conditions including suicidality, depression, anxiety and panic, trauma, grief and loss, aggression and psychosis;
- Describe some methods for managing clients with cognitive impairment;
- Understand the principles of treating comorbidity;
- Describe models of care for co-existing AOD and MH concerns;
- List a range of techniques for treating co-existing disorders including motivational interviewing, cognitive behavioural techniques, psychosocial and self-help groups, mindfulness and contingency management;
- List the commonly prescribed medications for treating mental illness and describe strategies for improving medication adherence.

For this session you will need:

√ Copy of the Comorbidity Guidelines

√ Session Four PowerPoint slides

√ Copies of PPT slides as handouts

√ Session Four Handouts

√ Session Two Handouts – scenarios

√ Session Four Evaluation Form (if stand-alone session)

Total recommended time: Two and ¼ hours

Topic	Delivery	Resources
Overview of Management of Comorbidity 15 minutes	• Display PPT slide 1 at beginning of session. • Explain that this session will firstly provide an overview of some suggested techniques for managing commonly occurring mental health concerns. Secondly this session will raise some of the commonly used treatment approaches for addressing mental health disorders. Note that the session will provide an overview of these and that further training in some of the recommended treatment approaches is suggested. • Refer participants to the relevant sections in the Guidelines, highlighting the worksheets in the appendices as per PPT slide 2. • Refer to PPT slide explaining the difference between management and treatment. • Referring to PPT slides 3 to 6, provide an overview of the key points for managing comorbidity. Allow for reflection and discussion of these within the group.	• Copies of PPT slides as handouts • Session 4 Handouts • Session 2 Handouts - Scenarios • PPT slides 1 to 6
Managing specific symptoms of	• Start this session by dividing the group into 4 smaller groups to review the scenarios Adam, Sonia, Shane and Cathy from Session 2 Handout. Allocate 1 scenario to each group (this will	• PPT Slides 7 to 22 • Session 2 Handouts –

mental health disorders 60 minutes **Managing Depression** **Managing Anxiety and Panic** **Trauma**	obviously depend on the size of your group. You may need to get the groups to look at more than one scenario). • Ask the groups to consider the following questions in light of the scenario they have been allocated: - *What are some of the immediate issues that need to be addressed with this client?* - *List some ideas for managing the identified issues.* • The rest of this part of Session 4 is based around the feedback the groups give for each of the scenarios • Take feedback on Scenario 1 (Adam). Refer to PPT slides 7 to 9 and Session 4 Handouts, pages 1 and 2 to reinforce the points made by the group. • Refer to the information in Appendix Q of the Guidelines and the diagram on slide 10 for the information on cognitive restructuring. Ask the group to think about some of the negative thoughts that Adam may have. Use the Cognitive Restructuring worksheet in Appendix Y, page 187 of the Guidelines and discuss how this could be used with a person with symptoms of depression. • Take feedback on Scenario 3 (Sonia). Refer to PPT slides 11 and 12 and Session 4 Handouts, page 3 to reinforce the points made by the group. • Refer to the information in Appendix R on Anxiety Management Techniques. If time, you could practice one of the strategies, such as Progressive Muscle Relaxation with the group. Discuss how this and other techniques can be used successfully in the treatment of anxiety and panic. Refer the group to Worksheets in Appendices CC, Dd, and Ee in the Guidelines. • Provide the information on managing symptoms of trauma	scenarios 1, 3, 4 and 6 • Session 4 Handouts pages 1 to 9

Aggression **Psychosis** **Personality Disorders** **Cognitive Impairment**	and grief and loss by referring the participants to Session 4 Handouts pages 4 and 5 and slides 13 and 14. Allow time to discuss the points. • Provide the information on managing aggression referring to PPT slides 15 to 17 and Session 4 Handouts, page 6. Allow time to discuss the challenges of managing aggression. • Take feedback on Scenario 6 (Cathy). Refer to PPT slide 18 and Session 4 Handouts, page 7 to reinforce the points made by the group. Acknowledge the challenges of communicating with a client experiencing psychosis. • Take feedback on Scenario 4 (Shane). Refer to PPT slide 19 and Session 4 Handouts, page 8 to reinforce the points made by the group. Again, discuss any challenges the group may have experienced when working with clients displaying symptoms of personality disorders. • Provide the information on managing cognitive impairment referring to PPT slides 20 to 22 and Session 4 Handouts, page 9. Allow time to discuss the challenges of communicating with clients with cognitive impairment. • End this session by acknowledging that this was a broad overview and that further training on specific approaches (such as managing aggression, working with suicide or understanding trauma) may be necessary for workers to feel more confident in managing clients with complex needs.	
Treatment Approaches 45 minutes	• This session provides a broad overview of a range of evidence-based and other treatment approaches for working with clients with co-existing AOD and MH disorders. As mentioned above, services may need to assess the degree to which their workers require further training on the recommended treatment approaches.	• PPT slides 23 to 32 • Session 4 Handouts pages 10 to 12 • Session 2 Handouts – scenario 2

	• Also mention that little research has been undertaken in the relation to the treatment of comorbidity to guide how best to treat but the evidence is growing. • Show PPT slides 23 and 24 providing an overview of the principles for the treatment of comorbidity. Discuss these with the group. • Show PPT slide 25 and refer to Session 4 Handout page 10 and discuss the different treatment approaches. Divide the whiteboard in half and write "pros" on one side and "cons" on the other. Work through the 4 approaches and ask the group to provide some of the pros and cons for each of the models of care. Reinforce that there is no perfect model – all have their advantages and disadvantages. The major concern is the extent to which the client's AOD and MH concerns are effectively addressed. There is also a need to consider what is possible within existing services in the local area and how to best work together. • Refer to slide 26 providing a broad overview of the use of motivational interviewing (MI). If many of the participants have received training on MI, ask them to reflect on the pros and cons of using MI with clients with co-existing AOD and MH concerns. (If there is a need, further training on MI is highly recommended for AOD workers). Refer to the Appendices in the Comorbidity Guidelines for useful MI worksheets. • Refer to slide 27 providing a broad overview of the use of CBT. If many of the participants have received training on CBT, ask them to reflect on the pros and cons of using CBT with clients with co-existing AOD and MH concerns. (If there is a need, further training on CBT is highly recommended for AOD workers). Refer to the Appendices in the Comorbidity Guidelines for useful CBT worksheets. • Refer to slide 28 which lists other useful treatment approaches	

Medications	and discuss with the group. If some of the participants have received training on any of these approaches, ask them to reflect on the pros and cons of using them with clients with co-existing AOD and MH concerns. (If there is a need, further training on mindfulness and group process is highly recommended for AOD workers). • Show PPT slide 29 to raise the discussion on the use of mental health medications within AOD services. Ask the group to discuss some of the challenges of working with clients on prescribed medication in AOD settings. Reinforce with the group that for some clients, being stabilised on their prescribed medication may lead to a far better outcome from AOD treatment and prevent relapse from occurring. • Also raise the point that the use of AOD may interfere with the effectiveness of medications in a range of ways. Hence the importance of assisting clients to more effectively manage their use of prescribed medications. • Emphasise that in general psychosocial therapies are recommended as the first line approach but medications have an important role in the treatment of both AOD and MH concerns. • Write on one side of the whiteboard "medications" and on the other "psychotherapy" (eg: MI, CBT) Ask the group to provide you with the pros and cons of each and debate the merits of both. Follow up with a comment about the importance of combining both for some clients with comorbid mental health and AOD concerns. • Refer the group back to the Comorbidity Guidelines, Chapter 8 for a more detailed overview of the treatment approaches. • Show PPT slide 30 listing some of the commonly prescribed medications. Refer to Session 4 Handouts pages 11 to 13.	

	Allow time for the participants to discuss the medications and to clarify any concerns. • Refer the group to Scenario 2 (Stephanie) from the Session 2 Handouts. Discuss as a whole group the challenges of clients continuing to take their prescribed medication. Ask the group how they would address "Stephanie's" reluctance to take the mood stabilising medications. • Show PPT slides 31 and 32 to reinforce some of the points made in regards to working with clients around medication adherence.	
Discussion and Summary 15 minutes	• Explain to the group that this session was a broad overview of some methods for managing common symptoms of some mental disorders as well as a range of treatment approaches. Assess with the group what further training they feel they need on the specific strategies and interventions raised in this session. • Show PPT slide 33 to reinforce a few key points. • If this is a stand alone session, ask the participants to complete the Session Four evaluation form.	• PPT slide 33 • Session 4 Evaluation Form

Management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings

Session Four – Management and Treatment of Comorbidity

Evaluation Form

Thank you for taking the time to complete this evaluation form. Your responses will remain confidential. No attempts will be made to identify individual's answers. Your feedback on this session will be appreciated.

"This session will be useful in my work with clients with co-occuring mental health and AOD conditions"

1	2	3	4	5	6	7	8	9	10
Not at all									*Extremely*

"This session met my expectations"

1	2	3	4	5	6	7	8	9	10
Not at all									*Totally*

Which aspect(s) of this session did you find most useful and why?

Which aspect(s) of this session did you find least useful and why?

Any further comments

Comorbidity Guidelines Training Program

Session Five – Working Collaboratively: Referral and Discharge Planning

Aim of Session Five:

This session aims to provide an opportunity for participants to reflect on the importance of working collaboratively with other services and to effectively assist clients with referral and discharge procedures.

Session Five Objectives:

- Understand the importance of working collaboratively with other agencies when working with clients with co-existing AOD and MH issues;
- Explain some effective ways to communicate with other services;
- Describe the process of discharge planning.

For this session you will need:

√ Copy of the Comorbidity Guidelines

√ Session Five PowerPoint slides

√ Copies of PPT slides as handouts

√ Session Five Handouts

√ Session Two Handouts – Scenarios

√ Session Five Evaluation Form (if stand alone session)

NOTE: Prior to this session you will need to make up the cards for the Referral Game found at the end of this Program. See page 5 for instructions on making up the cards.

Total recommended time: Two hours

Topic	Delivery	Resources
Referral Game 45 minutes	• Prior to the start of the session, set up the Referral Game around the room, separating the places so that participants have to physically move from place to place. • Show PPT slide 1 at the beginning of the session, informing the participants of the content of this session. • Refer participants to the relevant sections in the Guidelines as per PPT slide 2. • Instruct the participants to stand up and to play the Referral Game (as per the instructions on page 5 of this Program). • When all of the participants have completed the game (or have given up in frustration!), show PPT slide 2 and direct them to complete the questions on page 1 of the Session 5 Handouts. • Take feedback from the participants in regards to their experiences during the Referral Game. Spend time in particular on their response to the final question about referral between services. • Show PPT slides 3 and 4 and discuss the importance of AOD services being actively involved with other services and in the	• Copies of PPT slides as handouts • Session 5 Handouts • Session 2 Handouts - Scenarios • PPT slides 1 to 5 • The Referral Game cards

	referral process.	
Communicating with Other Services 30 minutes	• Refer the participants to Scenario 5 (Melanie) in the Session 2 Handouts. Divide the group into pairs and instruct them to consider the following questions: - "Who else may be involved in the care of Melanie?" - "What are some of the potential conflicts of interest?" - "How would you effectively communicate with other services in relation to Melanie?" • Recall the pairs and take feedback on their responses. • Show PPT slide 6 and discuss the range of services that may be involved in the collaborative care of clients with AOD and MH issues. • Discuss the different methods of referral as per PPT slide 7 and Session 5 Handouts, page 2. Reinforce the point that an Active Referral is recommended for clients with co-existing AOD and MH issues. • Refer to PPT slides 8 to 11 and discuss the process of referral with other services, including a discussion on involving the client in the referral process. • Refer to the Session 5 Handouts, pages 3 and 4 for a proforma for referring clients to other services. Discuss with the group how they could use this form or adapt this form for use within their current work practices.	• PPT Slides 6 to 11 • Session 2 Handouts – Scenario 5, Melanie • Session 5 Handouts, pages 3 and 4

Discharge Planning 15 Minutes	• Refer the participants to Scenario 3 (David) in the Session 2 Handouts. As a whole group, reflect on the importance of discharge planning for David. Ask the group the following questions: - "What are your concerns for David following discharge?" - "What other services could you involve in the support of David following his discharge from AOD treatment?" - "How would you involve David in the discharge planning process?" • Show PPT slides 12 and 13 and discuss the processes involved in planning for a client's discharge from AOD treatment.	• PPT slides 12 and 13 • Session 2 Handouts – Scenario 3 - David
Discussion and Summary 30 minutes	• Facilitate a discussion with the group about their involvement with local services, encouraging the sharing of any positive experiences and also how, as a service, they might improve the relationship between this and other services in the local area. • Show PPT slide 14. Allow time for the participants to clarify any of the issues raised in this session. • Refer the group to Chapter 9 in the Guidelines for further information • If this is a stand alone session, ask the participants to complete the Session Five Evaluation Form.	• PPT slide 14 • Session 5 Evaluation Form

The Referral Game

Adapted from the original Referral Game developed by the Centre for Education and Information on Drugs and Alcohol (CEIDA) for the Dual Diagnosis workshop by Christine Minkov, October 1995

Referral Game Cards:

For this game you will need large pieces of cardboard 20cm x 30cm and small cards 8cm x 10cm. It works best if you can make up the set of cards in ten different colours, one for each of the different places in the game lines. This will help to set up the game and orient the "players". Write or paste the printed words onto the centre of the cards as per the lists on the pages that follow.

Playing the Referral Game:

Spread the Big cards around the room making sure the participants can see where each 'place' is. Place the appropriate Small cards in a pile under their respective headings. Place the DRUNK/STONED pile in the most prominent position, as this is the starting point.

Instruct the participants to start at the DRUNK/STONED pile of cards, to read the instructions, place the card on the bottom of the pile and to follow the instructions around the room. Ask them to keep going until they get a GAME OVER card. (A more challenging exercise involves removing the GAME OVER cards until about ten minutes into the exercise. This means that all learners will be wandering around and around until you place the GAME OVER cards in their respective piles).

After about 5 minutes ask the learners to stop where they are and to tell you how they are feeling. They may make comments such as 'frustrated', 'sick of it',' bored' etc. Remind the learners that they have only been going for about 5 minutes. Then ask them to keep going. Keep playing the game until all of the learners have received a GAME OVER message.

- Once everyone has returned to their seats, ask for feedback and discussion on their experiences of the exercise.

DRUNK & STONED

PSYCHIATRIC ADMISSION WARD

HOME

CRISIS TEAM

DETOX

GENERAL HOSPITAL

FAMILY

AOD COUNSELLOR

MENTAL HEALTH WORKER

LEGAL

DRUNK & STONED PILE

During a recent psychotic episode and binge you were verbally abusive in the street.
Go to LEGAL.

In a drunken stupor you propositioned a man walking his dog.
Go to LEGAL.

You have been on a binge for 2 weeks and have become ill.
Go to GENERAL HOSPITAL.

Go home and sleep it off.
Go to HOME.

In an intoxicated state you fall down some stairs and break numerous bones.
GAME OVER.

You scored some really strong cannabis head and are feeling very paranoid. Go to PSYCHIATRIC ADMISSION WARD.

You are remorseful about all the trouble you've caused your family.
Go to FAMILY.

Your hallucinations are getting worse the more you drink and smoke pot.
Go to MENTAL HEALTH WORKER.

In a moment of clarity you realise you need to do something about your substance use.

Go to A&OD COUNSELLOR

FAMILY PILE

Your family are worried about your mental state and call the crisis team.
Go to CRISIS TEAM.

Your family suggest you get help for your substance use.
Go to A&OD COUNSELLOR.

Your family book you into a Detox
Go to DETOX.

Your family are no longer willing to support you while you are drinking and using.
Go to DRUNK & STONED.

Your family have had enough of your chaotic behaviour and call the police.
Go to LEGAL.

Your family have moved out and you don't know where they are!
Go to HOME.

LEGAL PILE

The police take pity on you and drive you home. Go to HOME.

You are detained overnight. Sit down for 2 minutes then go to DRUNK & STONED.

Police take you to DETOX.

Police suggest you need help.
Go to A&OD COUNSELLOR.

Police take you to the GENERAL HOSPITAL.

Police suggest you need help.
Go to MENTAL HEALTH WORKER.

You are put in jail for a very long time.. GAME OVER.

Police arrest you for assaulting an officer whilst intoxicated. Wait 2 minutes in jail then go to HOME.

Police arrest you for DUI on your way here. Wait 2 minutes then go to compulsory A&OD COUNSELLING.

AOD COUNSELLOR PILE

The A&OD counsellor cannot see you as you have a mental illness.
Go to MENTAL HEALTH WORKER.

You don't like your counsellor -
Go to HOME.

You show up intoxicated
Go to DETOX.

Your A&OD counsellor is on holidays and funding has not allowed a replacement.
Go to DRUNK & STONED.

You are in a withdrawal state.
Go to GENERAL HOSPITAL

Your A&OD Counsellor is abstinence based and suggests you go off your medication.
Go to PSYCHIATRIC ADMISSION WARD.

The A&OD Counsellor believes you are not motivated enough.
Go to MENTAL HEALTH WORKER.

You are out of area.
Go to HOME.

Your A&OD counsellor recognises you have a dual diagnosis and liaises closely with the mental health team. Congratulations.
GAME OVER

COMMUNITY MENTAL HEALTH WORKER PILE

The counsellor can't see you while you are still drinking. Go to DETOX.

You look awful - your counsellor sends you to hospital. Go to GENERAL HOSPITAL

The Mental Health Worker recognises you have a dual diagnosis and liaises closely with the A&OD team. Congratulations.
GAME OVER

Your diagnosis has changed and you need to start new medication. Go to PSYCHIATRIC ADMISSION WARD.

The counsellor only likes to do family therapy. You need to convince your entire family to come in. Go to FAMILY.

The counsellor will not see you until you stop drinking and smoking pot. Go to A&OD COUNSELLING.

You are unsatisfied with your treatment.
Go to HOME.

You arrive intoxicated.
Go to DETOX

DETOX PILE

You experience hallucinations during detox. Your doctor feels it is because of your mental illness rather than alcoholic hallucinosis. Go to PSYCHIATRIC ADMISSION WARD.

You leave detox and continue drinking.
Go to DRUNK & STONED.

You aren't allowed to smoke cigarettes in detox. You discharge yourself.
Go to HOME.

You get involved in a fight in detox.
Go to LEGAL.

You sober up and are discharged.
Go to HOME.

You sober up and stop smoking dope. Your psychiatric symptoms improve. You take up writing. Later you win a major literary prize, marry your agent and live on an organic farm up the North Coast. GAME OVER

You opt for home detox.
Go to A&OD COUNSELLOR.

You have a withdrawal fit and are transferred to a hospital.
Go to GENERAL HOSPITAL

PSYCHIATRIC ADMISSION WARD

Admission ward is full.
Go to GENERAL HOSPITAL

You can't pay your medical expenses.
Go to FAMILY.

Your problem is alcohol & other drugs, not psychiatric. Go to A&OD COUNSELLOR

You are not deemed suitable for admission. Go to HOME.

You don't think it is necessary for you to be here. You sign yourself out.
Go to DRUNK AND STONED.

You are started on a new medication but the side effects make you physically ill.
Go to GENERAL HOSPITAL.

Your new medication is working well but you need follow up.
Go to MENTAL HEALTH WORKER.

GENERAL HOSPITAL

Accident and Emergency leave you waiting for 3 hours. You get angry and leave.
Go to DRUNK & STONED.

Your doctor doesn't ask you about alcohol. She suggests relaxation training.
Go to HOME for a quiet lie down.

No one knows what to do with you.
Go to CRISIS TEAM.

You are transferred.
Go to PSYCHIATRIC ADMISSION WARD.

You are given an enema and told to go home.
Go to DRUNK & STONED

We don't have the resources to manage you here! Go to PSYCHIATRIC ADMISSION WARD.

CRISIS TEAM

Crisis Team can't see you - it's after midnight and the service can't afford to pay overtime.
Go to PSYCHIATRIC ADMISSION WARD.

Crisis Team is understaffed. You are told to make an appointment with your case manager in the morning.
Go to DRUNK & STONED.

Inappropriate referral to Crisis Team.
Go to A&OD COUNSELLOR.

It's before 5pm.
Go to MENTAL HEALTH WORKER.

You need hospital admission.
Go to GENERAL HOSPITAL.

Crisis Team can't get you into hospital.
Go to FAMILY

You are banned from using the crisis team because of your inappropriate calls late at night.
Go to PSYCHIATRIC ADMISSION WARD.

HOME PILE

Too much pressure at home.
Go to DRUNK & STONED.

You become depressed from all the running around you are doing.
Go to MENTAL HEALTH WORKER.

You become very ill from drinking.
Go to GENERAL HOSPITAL.

Your neighbours hear you yelling at your voices and they call the Crisis Team.
Go to CRISIS TEAM.

You become depressed and fearful.
Go to CRISIS TEAM.

You are making too much noise - neighbours call the police.
Go to LEGAL.

You have a terrible argument with your wife and she kicks you out.
Go to FAMILY.

You are bored so decide to get drunk and stoned. Go to DRUNK & STONED.

The boarding house you are living in has refused to have you back.
Go to FAMILY.

Comorbidity Guidelines Training

Session Five Handouts

The Referral Game

You have just participated in the "Referral Game". Reflect on your involvement in the game and answer the following questions.

1. What were your experiences during the game as a "player"?

2. Reflect on your experience of the game from a professional perspective.

3. What are some of the implications for clients and their families/carers who may be caught up in the "referral game"?

4. What are some possible solutions to the "referral game" in the delivery of services to clients?

Referral Processes

Passive referral

Passive referral occurs when the client is given the details of the referral agency in order to make his/her own appointment. This method is almost never suitable for clients with comorbidity.

Facilitated referral

Facilitated referral occurs when the client is helped to access the other service, for example, with the client's permission, the worker makes an appointment with the other service on his/her behalf.

Active referral

Active referral occurs when the worker telephones the other agency in the presence of the client and an appointment is made. The worker, with the client's consent, provides information that has been collected about the client with his/her professional assessment of the client's needs. Such referral is necessary when clients are unmotivated, unlikely, or unable to do so themselves. This method of referral is recommended for clients with comorbidity.

Adapted from Clemens S, Cvetkovski S, Tyssen E. DirectLine Telephone Counselling and Referral Service. Melbourne: Turning Point Alcohol and Drug Centre Inc; 2006.

Referral Proforma

Client identified with possible Mental Health Disorder

Date:

Referral from:

CLIENT DETAILS

Name: _____ Year of Birth:_____

Address: _____ Postcode:_____

Aboriginal/TSI: Yes ☐ No ☐

Client lives: Alone ☐ With Carer / Family ☐

Client Contact Details:

Phone _____

Client may be contacted at this number	Yes ☐ No ☐
Client can be contacted at home during B/H	Yes ☐ No ☐
Leave message with household member	Yes ☐ No ☐

REASON FOR REFERRAL

Multiple responses permitted

☐ Diagnostic assessment
☐ Psycho-education
☐ Cognitive behavioural therapy (CBT)
☐ Interpersonal therapy
☐ Other: ……

PRESENTING PROBLEM

Multiple responses permitted

☐ Alcohol and drug disorder
☐ Psychotic disorder
☐ Depression
☐ Anxiety disorder
☐ Unexplained somatic disorder
☐ Unknown
☐ Other: ……

PROVIDE RELEVANT CLINICAL INFORMATION

CURRENT MEDICATIONS

RISK ASSESSMENT

Within 2 weeks ☐ within 1 month ☐

Management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings

Session Five – Working Collaboratively: Referral and Discharge Planning

Evaluation Form

Thank you for taking the time to complete this evaluation form. Your responses will remain confidential. No attempts will be made to identify individual's answers. Your feedback on this session will be appreciated.

"This session will be useful in my work with clients with co-occuring mental health and AOD conditions"

1	2	3	4	5	6	7	8	9	10
Not at all									*Extremely*

"This session met my expectations"

1	2	3	4	5	6	7	8	9	10
Not at all									*Totally*

Which aspect(s) of this session did you find most useful and why?

Which aspect(s) of this session did you find least useful and why?

Any further comments

Comorbidity Guidelines Training Program

Session Six – Specific Population Groups

Aim of Session Six:

This session aims to provide an outline of the specific mental health issues potentially faced by certain population groups within AOD treatment settings.

Session Six Objectives:

- Describe the importance of being sensitive to the needs of specific population groups;
- Explain a range of mental health conditions including mood, anxiety, psychotic and personality disorders.
- Describe the symptoms of substance-induced disorders.

For this session you will need:

√ Copy of the Comorbidity Guidelines

√ Session Six PowerPoint slides

√ Copies of PPT slides as handouts

√ Session Two Handouts – Scenarios

√ Session Six Evaluation Form(if stand alone session)

√ Overall Training Evaluation

√ Post-training Questionnaire

Total recommended time: One and ½ hours

Topic	Delivery	Resources
Introduction 10 minutes	• Start the session by displaying PPT 1. • Refer participants to Chapter 10 of the Guidelines as per PPT slide 2. • Show PPT slide 3 listing the specific groups that will be the focus of this session • Ask the group to list some of the reasons why specific factors need to be taken into consideration when working with some clients with mental health disorders in AOD settings. • Show PPT slide 4 and discuss the fact that much of the research into the AOD field and into the treatment of comorbidity has been conducted on a limited population group and may not always generalise to specific groups.	• Copies of PPT slides as handouts • Scenarios • PPT slides 1 to 4
Scenarios Revisited 20 minutes	• Refer the participants to Session 6 Handouts, pages 1 to 3. Tell the participants that these are the same scenarios that have been referred to over the past 5 sessions however, each of the scenarios has had a small amount of information added. • Divide the group into pairs and allocate one scenario to each of the pairs (will depend on the group size). Ask the pairs to identify the new information in their allocated scenario and consider how this additional information may alter the way in which they work with this client. • (NB: The following information has been added to each of the	• Session 6 Handouts pages 1 to 3 • PPT slide 5

	scenarios: 1. Adam believes he is gay which was the reason for breaking up with his girlfriend 2. Stephanie is from an Arabic speaking Moslem background 3. Sonia lives on a wheat and sheep farm. Her only child lives in the city 4. Shane has been coerced into compulsory treatment for his alcohol and other drug use by the courts 5. Melanie is an Indigenous Australian 6. Cathy has a history of bulimia and is estranged from her father. • Show PPT slide 5 listing the range of issues that need to be taken into consideration when assessing and addressing the needs of clients with co-existing AOD and MH issues.	
General Issues related to specific population groups 30 minutes	• **Indigenous Australians**: refer to PPT slide 6 and Session 6 Handout, pages 4 and 5 and discuss the general issues to be aware of when working with Indigenous Australians. You may want to make copies of the IRIS found in Appendix P, page 171 of Guidelines for discussion. • **CALD**: refer to PPT slide 7 and Session 6 Handout, pages 6 to 8 and discuss the general issues to be aware of when working with CALD groups. The use of the TSQ in Appendix N, page 169 may be appropriate to discuss. • **GLBT**: refer to PPT slide 8 and Session 6 Handout, page 8 and	• PPT slides 6 to 13 • Session 6 Handouts pages 4 to 9

	discuss some of the assessment issues to be aware of when working with GLBT communities. • **Rural/Remote**: refer to PPT slide 9 and discuss the general issues to be aware of when working with clients with AOD and MH concerns in rural and remote places. • **Homeless persons**: refer to PPT slide 10 and discuss some of the challenges and possibilities when working with homeless persons living with MH and AOD disorders. • **Gender**: refer to PPT slide 11 and discuss some of the issues that may be unique to working with men vs women in the context of co-existing AOD and MH concerns. • **Coerced clients**: refer to PPT slide 12 and Session 6 Handout, page 9 and discuss the challenges and realistic options when working with clients who have been pressured into addressing their AOD and MH disorders. • **Youth**: refer to PPT slide 13 and Session 6 Handout, page 9 and discuss some of the challenges and strategies for working with young people affected by AOD and MH disorders. • Facilitate a discussion with the group of their experiences of having successfully adapted their work for specific population groups. Ask the group to also consider how their service could be more accommodating of specific population groups.	
Wrapping it Up 20 minutes	• End Session 6 referring to PPT slide 14, allowing for any further questions or comments • As this is the final session, handout the Post-training Questionnaire. Let the participants know that this is almost	• PPT slide 14 • Session 6 Evaluation Form **OR** Overall Training Evaluation

	exactly the same as the Pre-training Questionnaire. • If this is a stand-alone session, ask the participants to complete the Session 6 Evaluation Form. If it is the end of a longer training workshop, ask the participants to complete the Overall Training Evaluation Form. • Provide participants with an opportunity to discuss their on-going training and support needs in relation to working more effectively with clients with co-existing AOD and MH issues. Make a note of any specific training requests. • Hold up a copy of the Comorbidity Guidelines and suggest that participants regularly refer back to the Guidelines for further information and to help guide their work with clients with mental health concerns in the AOD treatment setting.	Form • Post-training Questionnaire

Comorbidity Guidelines Training

Session Six Handouts

Scenarios Revisited

Below are the seven scenarios that have been referred to in the previous 5 sessions. A small amount of information has been added to each of the scenarios.

Consider how this new information may alter the approach you take with each of the scenarios.

1. "Adam"

Adam is a 21 year old male who was brought into your service by his mother, Susan. Adam has a 10 year history of regular cannabis use and occasional alcohol and amphetamine use. Adam's mother has become increasingly worried about her son's behaviour and believes that if he stopped smoking cannabis that he would feel better. Susan is particularly worried about Adam because her father committed suicide when she was only 10. Susan reports that Adam has become increasingly withdrawn, rarely comes out of his room and eats very little – Susan thinks he has lost a lot of weight over the past few months. Adam has dropped out of his TAFE course and has little contact with friends. Susan has also heard Adam crying in his room. Adam broke up with his girlfriend of two years about six months ago because he believes he might be gay. Upon meeting Adam he makes no eye-contact with you and does not reply to your greeting. He sits slumped in a chair.

2. “Stephanie”

Stephanie is a 32 year old woman who has recently been diagnosed with bipolar disorder. Stephanie comes from an Arabic speaking Moslem background and changed her name when she came to Australia 7 years ago to study science. She was referred by mental health services for assessment of her AOD use. Stephanie initially came to the mental health services’ notice when she was referred by a GP who had prescribed antidepressants in the past. Stephanie presented to the GP in a very excited state, seeking a pregnancy test claiming “I am pregnant with the new messiah!” It was noted by the GP that Stephanie has lost a significant amount of weight and that she had injection marks on her arms. The pregnancy test was negative. Stephanie has been using methamphetamines increasingly over the past year. Stephanie has been prescribed mood stabilising medication but is reluctant to take it as “it makes me feel terrible. I hate feeling depressed all the time. It’s such a downer!”

3. “Sonia”

Sonia is a 42 year old woman with a history of alcohol and nicotine dependence. When you meet Sonia she appears to be tremulous and perspiring. Sonia lives on a wheat and sheep property in a small rural community. Her husband is away from home all day. They have one child who boards at school in the city. Sonia has had a number of attempts to withdraw from alcohol and cigarettes with limited success due to the panic she experiences in withdrawal. She tells you on admission that she is really worried about failing again this time. Sonia describes the feelings she has experienced during past withdrawal attempts as “*I feel like the world is caving in on me and that I am*

going to die. I just can't handle it! I used to feel like this when I was a kid. I should be over it".

4. "Shane"

Shane is a 39 year old who regularly drinks at harmful levels and occasionally uses amphetamines. He was referred for compulsory treatment of his AOD use by the courts. Shane has been diagnosed as having an antisocial personality disorder and has also been treated for depression following a suicide attempt. In the past, Shane has been convicted for dealing and fraud. He is currently on bail for assault charges. Shane attempted suicide again by overdosing on drugs and alcohol following his recent arrest.

5. "Melanie"

Melanie is a 34 year old Aboriginal woman with a long history of opiate dependence. Melanie was referred by the emergency department after she was recently taken by ambulance following an overdose – her neighbour happened to find her. Melanie has been prescribed methadone in the past however she has continued to use heroin, oxycontin and methamphetamine. Melanie has three children to three different fathers – the children are currently in DoCS care. She is currently pregnant. Melanie has spent time in gaol for fraud. You notice that Melanie has significant scarring on her arms and legs. Melanie wants to stop using drugs but is worried as she has had many attempts in the past with little success.

6. “Cathy”

Cathy is a 19 year old university student who has been using a variety of substances, including ecstasy, crystal meth and alcohol. Despite a long history of bulimia, Cathy was very successful at school and went straight from school to university to study Law. Cathy started to experience symptoms of psychosis during her second year exams. She was heard by her friends at the University college to be shouting at 3am. Her friends reported that Cathy claimed to be hearing someone telling her “you’re no good… you’re a failure”. Cathy had also smashed the TV in her room as she believed that the TV was broadcasting her thoughts. Cathy spent some time in an acute mental health unit and was stabilised on antipsychotics. Cathy continues to regularly use alcohol and other drugs. She was referred by the mental health services to AOD services following a further psychotic episode. The mental health worker suspects Cathy had been using “ice”. Cathy is close to her mother but refuses to have anything to do with her father

7. “John”

John is a 54 year old man who was medically retired 2 years ago from his job in the bank. John is gay and lives with his partner of 10 years. John experienced an armed hold up at his workplace about 5 years ago. He received some initial counselling following the event however he continued to experience flashbacks and nightmares. He avoids going near banks and is very easily startled by loud noises. He sleeps very little despite the use of sleeping tablets. His use of alcohol dramatically increased following the hold up and has become even

more frequent since he has stopped working. John was referred by his GP for an assessment of his alcohol dependence and for withdrawal from benzodiazepines. John's alcohol use and on-going distress are causing problems within his relationship.

Issues to be aware of when working with Indigenous Australian clients

- The concept of family (including extended family and relatives) and community in Indigenous culture is important and includes immediate and extended relations. With the permission of the client, family members should be included in therapy as much as possible. Community and Indigenous support groups may also be useful services.

- Many Indigenous Australians have a holistic concept of health which includes physical, psychological, social, cultural and spiritual health and therefore consideration of all these factors is important during treatment.

- There are high rates of trauma, grief and loss in Indigenous communities as Indigenous people are faced with death and serious illness within their extended family more often than non-Indigenous people, and at a younger age. There are also issues of grief, loss and trauma regarding the European invasion and Indigenous treatment since then (e.g., stolen generations).

- Current issues of stigma and victimisation exist today which are likely to impact on mental health and AOD use. Issues of domestic violence, poverty and family AOD use are also likely to play a key role.

- When working with Indigenous clients with apparent psychotic symptoms, it is important to clarify the cultural appropriateness of such symptoms. For example, it is not uncommon for some Indigenous people to hear recently departed relatives and see spirits representing ancestors. This kind of spiritual experience is culturally valid and therefore is not a symptom of psychosis.

- Counsellors should be aware of the impact of intensely distressing levels of shame that many Indigenous clients experience. This shame can be exacerbated when dealing with a non-Aboriginal counsellor/worker

- Use appropriate language (e.g., avoid jargon, use culturally appropriate terms to describe AOD) and include appropriate written materials.

- Consider that you may be viewed as a member of a culture that has caused damage to Indigenous culture. Anticipate and prepare a plan to deal with issues of anger, resentment and/or suspicion. Engagement is likely to require increased attention.

- Enclosed space may increase anxiety in Indigenous clients.
- Direct questioning can be perceived as being threatening and intrusive and therefore should be kept to a minimum. A method of three-way talking may often be helpful, in which a client uses a third person (such as a family member) as a mediator to exchange information with the service provider.
- Watch the client's body language and mirror it if possible. For instance, direct eye contact is often viewed as impolite in Indigenous communities and is often avoided. Speaking softly with brief answers may be a sign of shyness or good manners.
- Be respectful of cultural prohibitions such as:
    - Referring to a dead person by name.
    - Referring to certain close relatives by name (for example, a Torres Strait Islander male may not refer to his brother-in-law by name).
    - Do not appear to criticise elders or family members.
    - Confiding personal information to a member of the opposite sex – men's and women's business are usually kept separate (this may require a same sex AOD worker).
- Consultation may take longer so set aside extra time.
- Be aware that levels of literacy may be low.
- It is important to be clear about your role and the types of things you would like to cover in the consultation.
- Assessment of Indigenous clients should occur within their own cultural context.
- Act as an advocate for the client where necessary in guiding them through the health care system.

Issues to be aware of when working with CALD clients

Potential barriers to treatment:

- Strong feelings of shame and guilt.
- Fear of stigmatisation/judgement surrounding treatment.
- Cultural differences between client and therapist.
- Confusion and lack of education or exposure to public health campaigns.
- Different expectations of treatment and difficulty clarifying these due to language barriers.
- Lack of familiarity with what AOD treatment services are available.
- Language difficulties which make participation in AOD treatment programs difficult.

Important aspects for assessment:

- **Context of migration:** if the client migrated to Australia, why they left their country of origin, how they got to Australia, their legal status, whether they have residency, any trauma experiences in the context of their country of origin or migrating to Australia (e.g., refugees of war). Helping clients to place their AOD problems in the context of such experiences can help to reduce shame and increase self-compassion.
- **Subgroup membership:** ethnicity, gender, sexual orientation, area in which they live, refugees or immigrants, religious affiliation.
- **Degree of acculturation:** *traditional* (client adheres completely to beliefs, values and behaviours of his/her country of origin); *bicultural* (client has a mix of new and old beliefs, values and behaviours); *acculturated* (client has modified his/her old beliefs, values and behaviours in an attempt to adjust); *assimilated* (client has completely given up his/her old beliefs, values and behaviours and adopted those of the new country).

Improving assessment and treatment with CALD clients:

- Where possible, and with the client's permission, involve the family in treatment. Allow the client to pick who from his/her family or community participates.

- Try to find out before the session if the client requires an interpreter. Keep in mind that even clients with basic English proficiency might benefit by having an interpreter because describing symptoms, especially feelings, can be very difficult when English is a second language. Be sure the dialect is correct and be aware that some clients may have a preferred gender for the interpreter. Even when families are involved in the client's treatment, it is inappropriate to use family members as interpreters. The client may not wish to divulge certain information to his/her family, or family members may not want certain information disclosed to people outside the family, and may edit what is being said. When using interpreters, be aware that some meaning can be lost in translation and address issues of confidentiality.

- Be sure to address the client appropriately and pronounce his/her name correctly.

- Discuss the client's expectations of treatment.

- Keep what you know about mental illness in mind but ensure that you try to understand the client's cultural understanding of his/her problems. People from different cultures often have different views on what constitutes mental illness. The DSM-IV-TR makes it clear that diagnoses can only be made if the person's behaviour is abnormal within his/her culture. While there are similarities in the forms of illnesses across different cultures, the specific symptoms and signs vary for different societies. For example, a man in Australia with psychosis may talk of aliens controlling his thoughts, while a man in Fiji might blame black magic. It is also not uncommon for people from some cultures (particularly South-East Asian countries) to express psychological distress through somatic (physical) symptoms.

- Be aware that some CALD clients may come from collectivist cultures (in which greater emphasis is placed on group identity, goals and concerns than is placed on individual ones) and may require a greater involvement of family and community for successful treatment.

- Maintain a focus on healing, coping or rehabilitation rather than on cure.
- Set aside at least twice the usual time, especially if you need to use an interpreter.
- Be mindful of embarrassment and cultural taboos.
- Be clear, concrete and specific.

(Source: NSW Dept Health 2007)

Issues to be aware of when working with GLBT clients

Sexuality and related issues require sensitive exploration and may require the AOD worker to assist the client with safety, support, accommodation, harm reduction and education needs that may arise. It is important to consider and use professional judgement in raising and discussing issues of sexual orientation, for instance:

- How comfortable is the person with his/her sexuality and with talking about it with others?
- Has he/she told family/friends? How have these people (or how will these people) react?
- Is it his/her decision to tell someone or is he/she being forced?
- How much support does he/she have?
- Is he/she financially, physically or emotionally independent?

(Source: Howard et al. 2002)

Steps for Working with Coerced Clients

- Clear the air with the client (including a positive attitude and efforts with engagement).
- Identify legitimate client interests.
- Identify non-negotiable aspects of intervention.
- Identify negotiable aspects of intervention.
- Negotiate the case plan.
- Agree on criteria for progress.

(Source: Barber 1991)

Strategies for Working with Young People

- Limit the use of scare tactics.
- Ensure confidentiality is maintained.
- Allow the young client some freedom to choose his/her own goals.
- Young people learn best from experience.
- Adopt a harm-reduction approach.
- Use concrete, behavioural strategies.
- Take longer to establish rapport and trust within therapy.
- Provide structure, and set and reinforce clear limits.
- Remember that the young client operates within the context of a family, so he/she should also be involved where possible.

(Source: Marsh and Dale 2006)

Management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings

Session Six – Specific Population Groups

Evaluation Form

Thank you for taking the time to complete this evaluation form. Your responses will remain confidential. No attempts will be made to identify individual's answers. Your feedback on this session will be appreciated.

"This session will be useful in my work with clients with co-occuring mental health and AOD conditions"

1	2	3	4	5	6	7	8	9	10
Not at all									*Extremely*

"This session met my expectations"

1	2	3	4	5	6	7	8	9	10
Not at all									*Totally*

Which aspect(s) of this session did you find most useful and why?

Which aspect(s) of this session did you find least useful and why?

Any further comments

Management of co-occurring drug and alcohol and mental health conditions in alcohol and other drug settings

Comorbidity Guidelines Training Evaluation Form

Thank you for taking the time to complete this evaluation form. Your responses will remain confidential. No attempts will be made to identify individual's answers. Your feedback on the training and your suggestions for the future will be appreciated.

"This training will be useful in my work with clients with co-occuring mental health and AOD conditions"

1	2	3	4	5	6	7	8	9	10
Not at all									*Extremely*

"This training met my expectations"

1	2	3	4	5	6	7	8	9	10
Not at all									*Totally*

Which aspect(s) of the training did you find most useful and why?

Which aspect(s) of the training did you find least useful and why?

What do you feel you would like in terms of further training or support in relation to working with clients with co-occurring AOD and mental health conditions?

Any further comments

Management of co-occurring drug and alcohol and mental health conditions in alcohol and other drug settings

Post-Training Questionnaire

Thank you for completing this questionnaire at the completion of the training on the Comorbidity Guidelines. You will notice that this questionnaire is very similar to the one you completed at the beginning of the training. The purpose of this questionnaire is to assess the training, not the participants. Please answer the questions below according to your current level of knowledge and confidence.

How confident do you feel in general when working with clients with co-occurring mental health and AOD issues?

1 2 3 4 5 6 7 8 9 10
Not at all extremely

How knowledgeable are you about the different classifications of mental illness?

1 2 3 4 5 6 7 8 9 10
Not at all extremely

How confident do you feel in regards to assessing a client's mental health in general?

1 2 3 4 5 6 7 8 9 10
Not at all extremely

How confident do you feel in regards to undertaking a mental state assessment?

1 2 3 4 5 6 7 8 9 10
Not at all extremely

How <u>confident</u> do you feel in regards to using formal tools for assessing mental illness?

1 2 3 4 5 6 7 8 9 10
Not at all extremely

How <u>confident</u> do you feel in regards to managing a client who is suicidal?

1 2 3 4 5 6 7 8 9 10
Not at all extremely

How <u>confident</u> do you feel in regards to managing a client with symptoms of depression?

1 2 3 4 5 6 7 8 9 10
Not at all extremely

How <u>confident</u> do you feel in regards to managing a client who is experiencing anxiety?

1 2 3 4 5 6 7 8 9 10
Not at all extremely

How <u>confident</u> do you feel in regards to managing a client with a history of trauma?

1 2 3 4 5 6 7 8 9 10
Not at all extremely

How <u>confident</u> do you feel in regards to managing a client who is aggressive or violent?

1 2 3 4 5 6 7 8 9 10
Not at all extremely

How <u>confident</u> do you feel in regards to managing a client with symptoms of personality disorder?

1 2 3 4 5 6 7 8 9 10
Not at all extremely

How <u>confident</u> do you feel in regards to managing a client with cognitive impairment?

1 2 3 4 5 6 7 8 9 10
Not at all extremely

How <u>knowledgeable</u> are you about the different treatment approaches for co-occurring AOD and MH conditions?

1 2 3 4 5 6 7 8 9 10
Not at all extremely

How <u>knowledgeable</u> are you about a range of medications used to treat mental illness?

1 2 3 4 5 6 7 8 9 10
Not at all extremely

How <u>confident</u> do you feel in regards to working collaboratively with mental health services?

1 2 3 4 5 6 7 8 9 10
Not at all Extremely

Any other comments?

Thank you for completing this questionnaire