guidelines on the management of

CO-OCCURRING ALCOHOL AND OTHER DRUG AND MENTAL HEALTH CONDITIONS

IN ALCOHOL AND OTHER DRUG TREATMENT SETTINGS

Katherine L Mills • Mark Deady • Heather Proudfoot
Claudia Sannibale • Maree Teesson • Richard Mattick
Lucy Burns

National Drug and Alcohol Research Centre
University of New South Wales
Sydney, Australia

Australian Government
Department of Health and Ageing

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

Katherine L Mills, Mark Deady, Heather Proudfoot, Claudia Sannibale, Maree Teesson, Richard Mattick, Lucy Burns

National Drug and Alcohol Research Centre

University of New South Wales

Sydney, Australia

Funded by the Australian Government Department of Health and Ageing

ISBN: 978-0-7334-2827-2

Legal disclaimer

This document is a general guide to appropriate practice, to be followed only subject to the practitioner's judgement in each individual case.

The Guidelines are designed to assist decision making and are based on the best information available at the date of publication.

In recognition of the pace of advances in the field, it is recommended that these guidelines be reviewed and updated within five years time.

ACKNOWLEDGMENTS

We would like to express our sincere gratitude to the members of the Expert Panel, key stakeholders and all other individuals who have made contributions to this important document.

In particular, we would like to thank Dr John Howard, Dr Rod MacQueen, A/Prof Michael Baigent, Dr Glenys Dore, Dr Sandra Sunjic, Dr Laura Vogl, Dr Tim Slade, Ms Rachel Grove, and Mr John Redmond.

Our sincere thanks also go to the Australian Government Department of Health and Ageing for funding the development of these Guidelines through the National Comorbidity Initiative.

Finally, we would like to acknowledge previous work that has influenced the development of these Guidelines; in particular, these Guidelines drew upon the following important documents:

Australian Department of Health and Ageing. (2007). Alcohol treatment guidelines for Indigenous Australians. Canberra: Australian Government Department of Health and Ageing.

Baker, A., Kay-Lambkin, F., Lee, N. K., Claire, M. & Jenner, L. (2003). A brief cognitive behavioural intervention for regular amphetamine users. Canberra: Australian Government Department of Health and Ageing.

Baker, A. & Velleman, R. (2007). Clinical handbook of co-existing mental health and drug and alcohol problems. London and New York: Routledge.

Croton, G. (2007). Screening for and assessment of co-occurring substance use and mental health disorders by alcohol and other drug and mental health services. Victoria: Victorian Dual Diagnosis Initiative Advisory Group.

Jenner, L. & Lee, N. (2008). Treatment approaches to users of methamphetamine: A practical guide for front line workers. Canberra: Australian Government Department of Health and Ageing.

Marsh, A., Dale, A. & Willis, L. (2007). A counsellor's guide to working with alcohol and drug users (2nd edition). Perth: Drug and Alcohol Office.

Lee, N., Jenner, L. Kay-Lambkin, F., Hall, K., Dann, F., Roeg, S., et al. (2007). *PsyCheck*: Responding to mental health issues within alcohol and drug treatment. Canberra: Commonwealth of Australia.

NSW Department of Health. (2007). Mental health reference resource for drug and alcohol workers. Sydney: NSW Department of Health.

NSW Department of Health. (2008). NSW Health drug and alcohol psychosocial interventions: Professional practice guidelines. Sydney: NSW Department of Health.

Teesson, M. & Proudfoot, H. (2003). Comorbid mental disorders and substance use disorders: Epidemiology, prevention and treatment. Canberra: Australian Government Department of Health and Ageing.

EXPERT PANEL

A/Prof Michael Baigent	Department of Psychiatry, Flinders Medical Centre and Flinders University
A/Prof Amanda Baker	Centre for Brain and Mental Health Research, University of Newcastle
Mr Kelvin Chambers	Drug and Alcohol Multicultural Education Centre
Prof Helen Christensen	Centre for Mental Health Research, Australian National University
Dr Glenys Dore	Drug and Alcohol Services, Northern Sydney Central Coast Area Health Service
Dr John Howard	National Cannabis Prevention and Information Centre, National Drug and Alcohol Research Centre, University of NSW
Prof David Kavanagh	Institute of Health and Biomedical Innovation and School of Psychology and Counselling, Queensland University of Technology
Dr Frances Kay-Lambkin	National Drug and Alcohol Research Centre, University of NSW; Centre for Brain and Mental Health Research, University of Newcastle
Dr Nicole Lee	Turning Point Alcohol and Drug Centre
Dr Rod McQueen	Lyndon Withdrawal Unit
Mr Wade Norrie	Drug and Alcohol Nurses Australasia
Ms Coralie Ober	Queensland Alcohol and Drug Research and Education Centre
Mr James Pitts	Odyssey House, Sydney
Prof Ann Roche	National Centre for Education and Training on Addiction
Mr Glenn Rutter	Substance Use and Mental Illness Treatment Team, North Western Mental Health
Mr Tony Trimingham	Family Drug Support
Mr Andrew Trist	NSW Users and AIDS Association
Emeritus Prof Ian Webster	University of NSW
Dr Adam Winstock	Drug Health Services, South Western Sydney Area Health Service; National Drug and Alcohol Research Centre, University of NSW

KEY STAKEHOLDERS

Mr Andris Banders & Mr Andrew Biven	South Australian Network of Drug and Alcohol Services
Mr Steve Byrne	Youth Coalition of the ACT
Prof Jan Copeland	National Centre for Prevention and Information on Cannabis
Ms Angela Corry & Ms Melinda Spencer	Western Australian Network of Alcohol and Other Drug Agencies
Ms Jo Khoo	Network of Alcohol and Drug Agencies
Ms Janice Jones	Australasian Therapeutic Communities Association
Mr Kim McAnally	Alcohol, Tobacco and other Drugs Council of Tasmania
Ms Robin Murray & Ms Deborah Lindsay	Drug and Alcohol Services, Northern Sydney Central Coast Area Health Service
Ms Loris Semple	Northern Territory Council of Social Service
Ms Jo Starky	Queensland Network of Alcohol and other Drugs Agencies
Ms Gail Ward	Victorian Alcohol and Drug Association

TABLE OF CONTENTS

LIST OF APPENDICES

LIST OF ABBREVIATIONS

AA	Alcoholics Anonymous	IRIS	Indigenous Risk Impact Screen
AOD	Alcohol and Other Drugs	K10	Kessler Psychological Distress Scale
ASPD	Antisocial Personality Disorder	LSD	Lysergic acid diethylamide
BAI	Beck Anxiety Inventory	MAOI	Monoamine Oxidase Inhibitors
BDI	Beck Depression Inventory	MI	Motivational Interviewing
BHS	Beck Hopelessness Scale	NA	Narcotics Anonymous
BPD	Borderline Personality Disorder	NDARC	National Drug and Alcohol Research Centre
BPRS	Brief Psychiatric Rating Scale	NSMHWB	Australian National Survey of Mental Health and Wellbeing
BSI	Brief Symptom Inventory	OCD	Obsessive Compulsive Disorder
BSSI	Beck Scale for Suicidal Ideation	PBS	Pharmaceutical Benefits Scheme
CALD	Culturally and Linguistically Diverse	PC-PTSD	Primary Care PTSD Screen
CAT	Crisis Assessment and Treatment	PCP	Phenylcyclohexylpiperidine
CBT	Cognitive Behavioural Therapy	PDSQ	Psychiatric Diagnostic Screening Questionnaire
CM	Contingency Management	PS	Psychosis Screener
DASS	Depression Anxiety Stress Scale	PSS-SR	PTSD Symptom Scale Self-Report
DBT	Dialectical Behavioural Therapy	PTSD	Post Traumatic Stress Disorder
DRA	Dual Recovery Anonymous	SA-45	Symptom Assessment
DSM	Diagnostic and Statistical Manual of Mental Disorders	SCL-90-R	The Symptom Checklist-90-Revised
GAD	Generalised Anxiety Disorder	SSRI	Selective Serotonin Reuptake Inhibitors
GHQ	General Health Questionnaire	STAI	Spielberger State Trait Anxiety Inventory
GLBT	Gay, Lesbian, Bisexual, Transgender	SUD	Substance Use Disorder
GP	General Practitioner	TCA	Tricyclic Antidepressants
ICD	International Classification of Diseases	TSQ	Trauma Screening Questionnaire

GLOSSARY OF TERMS

The following terms are used throughout this document and are defined here for ease of reference.

Alcohol and/or other drug (AOD) use disorders	The presence of abuse or dependence on AOD as defined by the DSM-IV-TR [1]. This term is used interchangeably with "substance use disorders".
AOD workers	All those who work in AOD treatment settings in a clinical capacity. This includes, but is not limited to, nurses, medical practitioners, psychiatrists, psychologists, counsellors, social workers, and other AOD workers.
AOD treatment settings	Specialised services that are specifically designed for the treatment of AOD problems and include, but are not limited to, facilities providing inpatient or outpatient detoxification, residential rehabilitation, substitution therapies (e.g., methadone or buprenorphine for opiate dependence), and outpatient counselling services. These services may be in the government or non-government sector.
Comorbidity	Use of the term "comorbidity" in these Guidelines refers to the co-occurrence of an AOD use disorder with one or more mental health conditions. The terms "comorbid" and "co-occurring" are used interchangeably throughout this document.
Mental health disorders	Refers to the presence of a mental health disorder (other than AOD use) as defined by the DSM-IV-TR [1].
Mental health conditions	Refers to those with a diagnosable mental health disorder as well as those who display *symptoms* of disorders while not meeting criteria for a *diagnosis* of a disorder.

IN A NUTSHELL…

These Guidelines aim to provide alcohol and other drug (AOD) workers with evidence-based information to assist with the management of co-occurring, or comorbid, AOD and mental health conditions. Population estimates indicate that more than one-third of individuals with an AOD use disorder have at least one comorbid mental health disorder; however, the rate is even higher among those in AOD treatment programs. Additionally, there are a large number of people who present to AOD treatment who display *symptoms* of disorders while not meeting criteria for a *diagnosis* of a disorder.

The primary goal of AOD treatment services is to address clients' AOD use. However, in order to do so effectively, AOD workers must take into account the broad range of issues clients present with, including their mental health. The high prevalence of comorbidity means that AOD workers are frequently faced with the need to manage complex psychiatric symptoms or problems, which may interfere with their ability to treat clients' AOD use. As such, it is important that all AOD workers are aware of the mental health symptoms that clients commonly present with, and are aware of how to manage these symptoms.

The first step is being able to identify mental health symptoms (see Chapter 6). Despite high rates of comorbidity among clients of AOD services, it is not unusual for comorbid mental health conditions to go unnoticed by AOD workers. This is mostly because they are not routinely looking for them. It is a recommendation of these Guidelines that all clients of AOD treatment services should be screened and assessed for comorbidity as part of routine clinical care.

Once identified, these symptoms may be effectively managed while the person is undergoing AOD treatment (see Chapter 7). The goal of management is to allow AOD treatment to continue without mental health symptoms disrupting the treatment process, and to retain clients in treatment who might otherwise discontinue such treatment. Comorbidity is not an insurmountable barrier to treating people with AOD use disorders. Indeed, research has shown that clients with comorbid mental health conditions can benefit just as much as those without comorbid conditions from usual AOD treatment.

Some clients with comorbidity may require additional treatment for their mental health problems (see Chapter 8). Some interventions have been designed for the treatment of specific comorbidities; however, these interventions generally have not been well researched. In the absence of specific research on comorbid disorders, it is recommended that best practice is to use the most effective treatments for each disorder. Both psychosocial and pharmacological interventions have been found to have some benefit in the treatment of many comorbidities.

In addition to mental health services, AOD workers may need to engage with a range of other services to meet clients' needs (see Chapter 9). Clients with comorbid mental health conditions often have a variety of other medical, family and social problems (e.g., housing, employment, welfare, legal problems). A broad, multifaceted and multidisciplinary approach is needed in order to address all of these issues effectively and it is important that AOD services and workers develop links with a range of local services. When referring clients to other services, active referral with assertive follow-up is recommended.

Chapter 1: About these guidelines

CHAPTER 1: ABOUT THESE GUIDELINES

KEY POINTS

- The purpose of these Guidelines is to provide AOD workers with up-to-date, evidence-based information on the management of comorbid mental health conditions in AOD treatment settings.
- All AOD workers should be "comorbidity informed" – that is, knowledgeable about the symptoms of the common mental health conditions that clients present with and how to manage these symptoms.
- The Guidelines are not a policy directive and are not intended to replace or take precedence over local policies and procedures.
- The Guidelines should be used in conjunction with existing guidelines and discipline-specific practice standards.
- The Guidelines do not provide formal recommendations, but rather guidance for AOD workers when working with clients who have comorbid mental health conditions.
- The Guidelines are based on the best available evidence and draw upon the experience and knowledge of clinicians, researchers, consumers and carers.

As part of the National Comorbidity Initiative, the Australian Government Department of Health and Ageing funded the National Drug and Alcohol Research Centre (NDARC) to develop guidelines on the management of comorbid mental health conditions in AOD treatment settings (hereafter referred to as the "Guidelines").

Rationale

A review in Victoria in 1993 reported that AOD workers felt overwhelmed and fearful when treating people with comorbid mental health disorders as their knowledge and the resources available to them were inadequate [2]. Consequently, they reported little confidence in their ability to manage clients with comorbid AOD and mental health disorders. Although this report was written more than a decade ago, the sentiments remain true today. Numerous reviews and policy documents have identified the need for educational resources for AOD workers as a priority [3-8]. This need has also been identified by AOD workers themselves [9]. In terms of AOD workforce development, the management of co-occurring mental health conditions has been described as "the single most important issue… a matter akin to blood-borne viruses in the 1980s" [10] (p.234). Despite this acknowledged need, there have been few resources available to the AOD sector to improve knowledge, skills and confidence in managing comorbidity. These Guidelines seek to redress this gap. By increasing the capacity of AOD workers to respond to comorbidity, it is anticipated that the outcomes for people with comorbid mental health conditions will be improved.

Purpose

The purpose of these Guidelines is to provide AOD workers with up-to-date, evidence-based information on the management of comorbid mental health conditions in AOD treatment settings. They are based on the best available evidence and draw upon the experience and knowledge of clinicians, researchers, consumers and carers.

The Guidelines aim to:

- Increase AOD workers' knowledge and awareness of mental health conditions.
- Improve the confidence and skills of AOD workers working with clients with comorbid mental health conditions.
- Provide guiding principles for working with clients with comorbid mental health conditions.
- Improve AOD workers' ability to identify mental health conditions.
- Provide practical information on the management of comorbid mental health conditions.
- Provide information regarding the treatment of comorbid mental health conditions.
- Provide information regarding referral processes.
- Provide resources that may be used to facilitate all of the above.

These Guidelines are not a policy directive and are not intended to replace or take precedence over local policies and procedures. The Guidelines are not formal recommendations, but instead provide guidance for AOD workers when working with clients who have comorbid mental health conditions. The Guidelines are not a substitute for training; rather, they should be used in conjunction with appropriate comorbidity training and supervision.

Intended audience

These Guidelines have been developed primarily for AOD workers. When referring to AOD workers, we are referring to all those who work in AOD treatment settings in a clinical capacity. This includes nurses, medical practitioners, psychiatrists, psychologists, counsellors, social workers, and other AOD workers. AOD treatment settings are those specialised services that are specifically designed for the treatment of AOD problems and include, but are not limited to, facilities providing inpatient or outpatient detoxification, residential rehabilitation, substitution therapies (e.g., methadone or buprenorphine for opiate dependence), and outpatient counselling services. These services may be in the government or non-government sector.

Although these Guidelines focus on AOD workers, a range of other health professionals may find them useful. However, it should be noted that different patterns of comorbidity are seen across different health services. For example, AOD treatment services are most likely to see comorbid mood, anxiety and personality disorders; mental health services, on the other hand, are more likely to see individuals with schizophrenia and bipolar disorder comorbid with AOD use disorders [11].

The amount of time that AOD workers spend with clients varies widely depending on the type of service provided, and the presentation of the client. For example, AOD workers may have very brief contact with clients who present in medical or psychiatric crisis (who may then be referred to other services); they may work with them for one week if they are entering detoxification, or they may work with them for several months or years if they present for substitution therapy, residential rehabilitation, or outpatient counselling. AOD workers also differ in their job descriptions, education, training and experience. This may range from those who are highly educated with little experience to those with little education but much experience [8].

Given these differences in AOD workers' roles, education, training and experience, it is not expected that all AOD workers will be able to address comorbid conditions to the same extent. Each AOD worker should use these Guidelines within the context of his/her role and scope of practice. At a minimum, however, it is suggested that all AOD workers should be "comorbidity informed". That is, all AOD workers should be knowledgeable about the symptoms of the common mental health conditions that clients present with (Chapters 3 and 5) and how to manage these symptoms (Chapter 7). The provision of opportunities for continuing professional development for AOD staff in the area of comorbidity should be a high priority for AOD services.

Relationship with existing guidelines

These Guidelines should be used in conjunction with existing guidelines and discipline-specific practice standards. There are a growing number of guidelines being developed on the management and treatment of people with comorbid mental health and AOD use disorders across jurisdictions and disciplines. Other existing guidelines are listed in Appendix A. These Guidelines have drawn on these key resources and reference is made to them throughout this document.

All AOD workers should refer to the standards and competencies relevant to their own professions; for example, those specified by the Australian Psychological Society, the Royal Australian and New Zealand College of Psychiatrists, the Australian Medical Association, the Nursing Board, the Australian Association of Social Workers, the Australian Counselling Association, and Volunteering Australia. In addition, the National Practice Standards for the Mental Health Services (currently under revision) and the National Practice Standards for the Mental Health Workforce [12] provide practice standards for services and professionals who work with people who have mental health conditions (see Appendix B).

Development

These Guidelines are based on a comprehensive review of the best available evidence and the experience of an expert panel of academic researchers, clinicians, consumers and carers (see p.ii). In developing these Guidelines, we have relied where possible on evidence from well-designed research studies. Where this evidence was not available, recommendations are based upon appropriate clinical experience. Prior to publication, the Guidelines were reviewed by a number of key stakeholders with expertise in the field (see p.iii) and pilot tested in non-government AOD treatment services across Australia.

Chapter 2:
What is comorbidity?

CHAPTER 2: WHAT IS COMORBIDITY AND WHY DOES IT OCCUR?

KEY POINTS

- Although other types of "comorbidity" exist, the use of the term in this document refers to the co-occurrence of an AOD use disorder with any other mental health condition.
- In this document we use the term comorbid "mental health disorder" when referring to those who have a diagnosable mental health disorder, as defined by the DSM-IV.
- When using the term "mental health condition", we are referring to both those who have a diagnosable disorder as well as those who display *symptoms* of disorders while not meeting criteria for a *diagnosis* of a disorder.
- There are a number of possible explanations as to why two or more disorders may co-occur. It is most likely, however, that the relationship between comorbid conditions is one of mutual influence.

What is comorbidity?

Use of the term "comorbidity" in these Guidelines refers to the co-occurrence of an AOD use disorder with one or more mental health conditions. This phenomenon is often referred to as "dual diagnosis"; however, this is a misnomer as many clients present with a range of co-occurring conditions of varying severity [13]. It should be noted, however, that there are other types of comorbidity. For example, a person may have co-occurring AOD use disorders (i.e., more than one AOD use disorder). Indeed, the most common and often overlooked comorbidity in AOD clients is tobacco use [14, 15]. Other conditions that are often found to co-occur with AOD use disorders are physical health conditions (e.g., cirrhosis, hepatitis, heart disease, diabetes), intellectual and learning disabilities, cognitive impairment, and chronic pain [16-23]. While there are a number of different types of comorbidity, these Guidelines focus only on the co-occurrence of AOD use disorders and mental health conditions.

To be classified as having a mental health disorder, a person must meet a number of diagnostic criteria (see Chapter 5 for a discussion of the classification of mental health disorders). There are, however, a large number of people who present to AOD treatment who display *symptoms* of disorders while not meeting criteria for a *diagnosis* of a disorder. For example, a person may exhibit depressed mood or anxiety without having a diagnosable mood or anxiety disorder. Although these individuals may not meet full diagnostic criteria according to the classification systems, their symptoms may nonetheless impact significantly on their functioning and treatment outcomes [10]. For example, people who report symptoms of depression but do not meet diagnostic criteria have reduced productivity, increased help-seeking and an increased risk of attempted suicide [24]. Therefore, rather than viewing mental health as merely the presence or absence of disorder, mental health conditions can be viewed as a continuum ranging from mild symptoms (e.g., mild depression) to severe disorders (e.g., schizophrenia or psychotic/suicidal depression).

In this document we use the term comorbid "mental health disorder" when referring to those who have a diagnosable mental health disorder, as defined by the DSM-IV-TR [1]. When using the term "mental health condition", we are referring to both those who have a diagnosable disorder as well as those who display *symptoms* of disorders while not meeting criteria for a *diagnosis* of a disorder.

Why does comorbidity occur?

There are a number of possible explanations as to why comorbidity may occur (see Figure 1):

- The presence of a mental health condition may lead to an AOD use disorder, or vice versa (known as the direct causal hypothesis).
- There may be an indirect causal relationship.
- There may be factors that are common to both the AOD and mental health condition, increasing the likelihood that they will co-occur.

Direct causal hypothesis

The AOD use disorder may be a consequence of the mental health condition

In some cases where there is comorbidity, the AOD use disorder occurs as a consequence of repeated AOD use to relieve mental health symptoms. This is often described as the "self-medication hypothesis", in that substances are used in an attempt to medicate mental health symptoms [25, 26]. In these circumstances, mental health conditions may become more apparent after the AOD use has ceased. Certain mental health conditions may also impair a person's ability to make sound judgements regarding his/her AOD use. For example, individuals with some personality characteristics or cognitive impairment may have difficulty identifying social cues about appropriate use. This may lead the person to use in greater quantities or with greater frequency, increasing the likelihood of developing an AOD use disorder.

The mental health condition may be a consequence of AOD use

Alternatively, AOD intoxication and withdrawal can induce a variety of mental health symptoms and disorders, such as depression, anxiety, and psychosis (see Chapter 5 for a discussion of substance-induced disorders). For example, alcohol use and withdrawal can induce symptoms of depression or anxiety [27]; manic symptoms can be induced by intoxication with stimulants, steroids or hallucinogens; and psychotic symptoms can be induced by withdrawal from alcohol, or intoxication with amphetamines, cocaine, cannabis, LSD or PCP [28]. Other disorders that may result from AOD use include substance-induced delirium, amnestic disorder, dementia, sexual dysfunction and sleep disorder [1]. In the majority of cases, these effects subside and eventually disappear with abstinence [29, 30]. For some, however, symptoms may continue even after they have stopped drinking or using drugs.

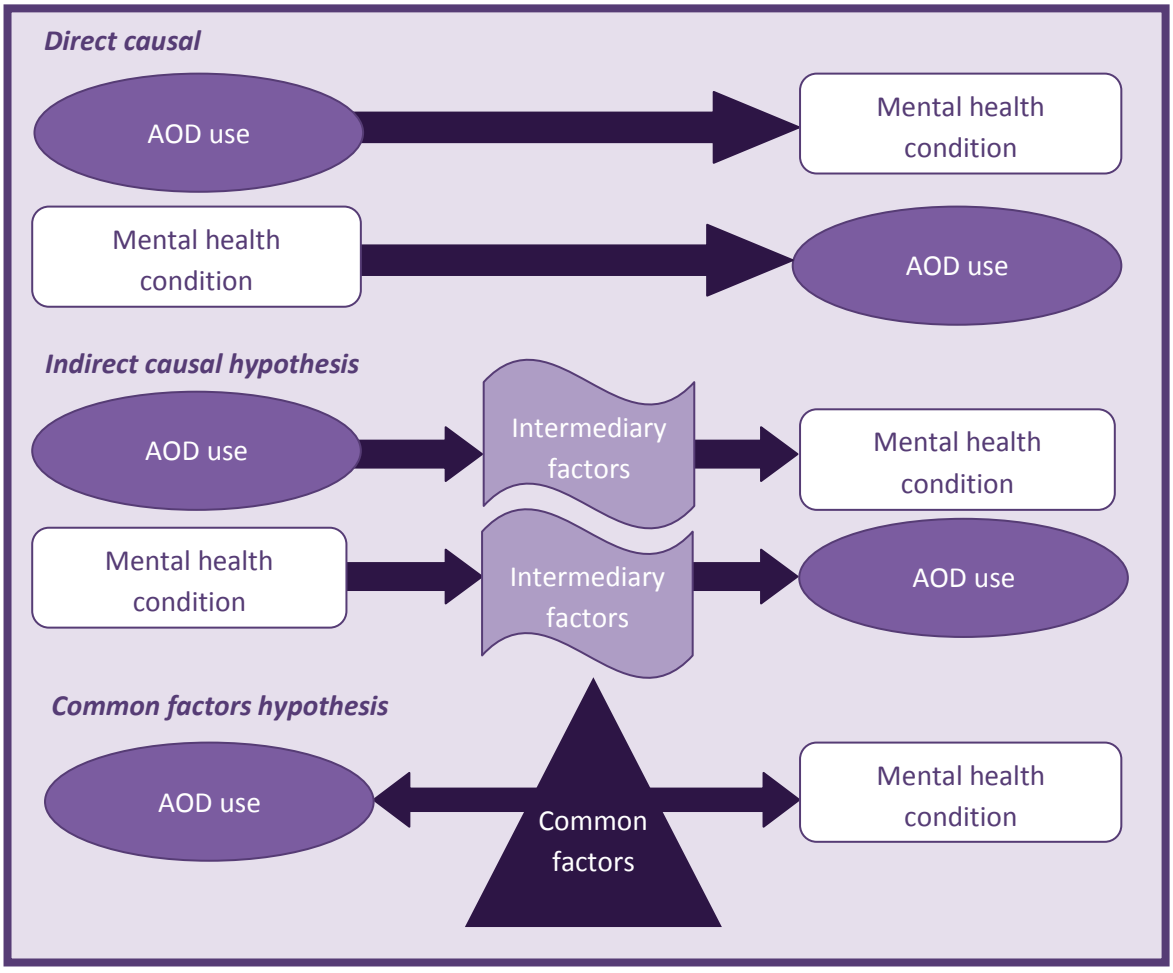
Indirect causal relationship

An indirect causal relationship is said to exist if one condition has an effect upon an intermediary factor that, in turn, increases the likelihood of developing the second condition [31]. For example, research has shown that the presence of early onset AOD use reduces the likelihood of completing high school, entering tertiary education, and completing tertiary education [32]. This poor level of education may lead to later life difficulties (e.g., unemployment) that may lead to other problems, such as depression [31]. Similarly, the reverse is possible, whereby a mood disorder may lead to difficulties in completing study and work commitments, which may in turn lead to difficulties finding employment, increasing the risk of AOD misuse [33, 34].

Common factors

The co-occurrence of two conditions may also come about due to the presence of shared biological, psychological, social or environmental risk factors. That is, the factors that increase the risk of one condition may also increase the risk for another [31]. For example, both AOD and mental health conditions have been associated with lower socio-economic status, cognitive impairment, the presence of conduct disorder in childhood and antisocial personality disorder (ASPD). It is also possible that a genetic vulnerability to one disorder may increase the risk of developing another disorder [35].

Figure 1. Explaining comorbidity

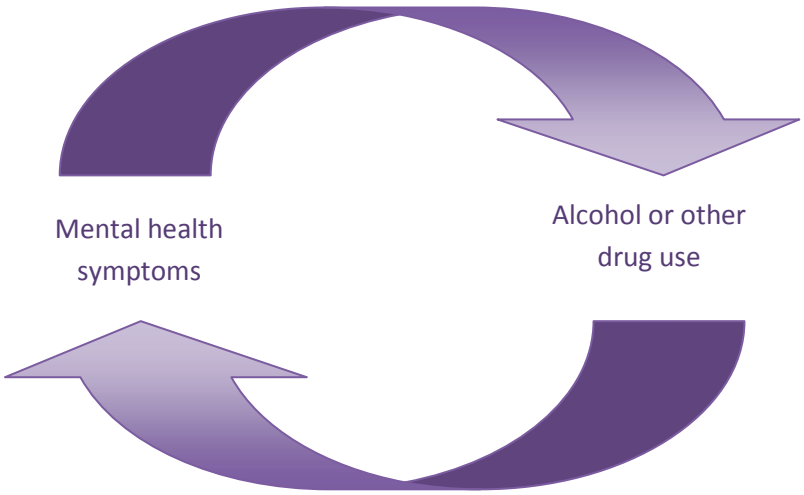


Does causality matter?

In the past, there has been a focus on establishing the order of onset of conditions to identify which is the primary disorder. Conditions may occur in any order, or they may develop at the same time. The evidence regarding the typical order of onset of disorders is not consistent. It appears, however, that social phobia, specific phobia, agoraphobia and post traumatic stress disorder (PTSD) tend to predate the AOD use disorder in most cases; generalised anxiety disorder (GAD), on the other hand, tends to have its onset after the onset of an AOD use disorder [36].

Establishing the order of onset of conditions can be useful in understanding the relationship between conditions. It is important to note, however, that once comorbid conditions have been established it is most likely that the relationship between them is one of mutual influence rather than there being a clear causal pathway [28] (see Figure 2). Regardless of how the comorbidity came about, both conditions may serve to maintain or exacerbate the other. For example, a person may engage in AOD use to reduce symptoms of anxiety; however, research suggests repeated use may lead to increased anxiety [37]. It is also possible that the relationship between disorders may change over time [38]. For example, depression may trigger alcohol use on some occasions, while it may be the result of alcohol use on others [39]. Irrespective of what order comorbid conditions have developed, the strategies used to manage these conditions are the same.

Figure 2. Relationship of mutual influence between AOD and mental health conditions



Chapter 3: How common is comorbidity?

CHAPTER 3: HOW COMMON IS COMORBIDITY AND WHY IS IT OF CONCERN?

KEY POINTS

- Mental health disorders are common among clients of AOD services.
- The most common comorbid mental health disorders are mood, anxiety and personality disorders.
- In addition to those with mental health disorders, there are a large number of people who present to AOD treatment who display *symptoms* of disorders while not meeting criteria for a *diagnosis* of a disorder.
- Although people with comorbid mental health conditions may have more complex profiles, they have been found to benefit as much from traditional AOD treatment methods as those without comorbid mental health conditions.

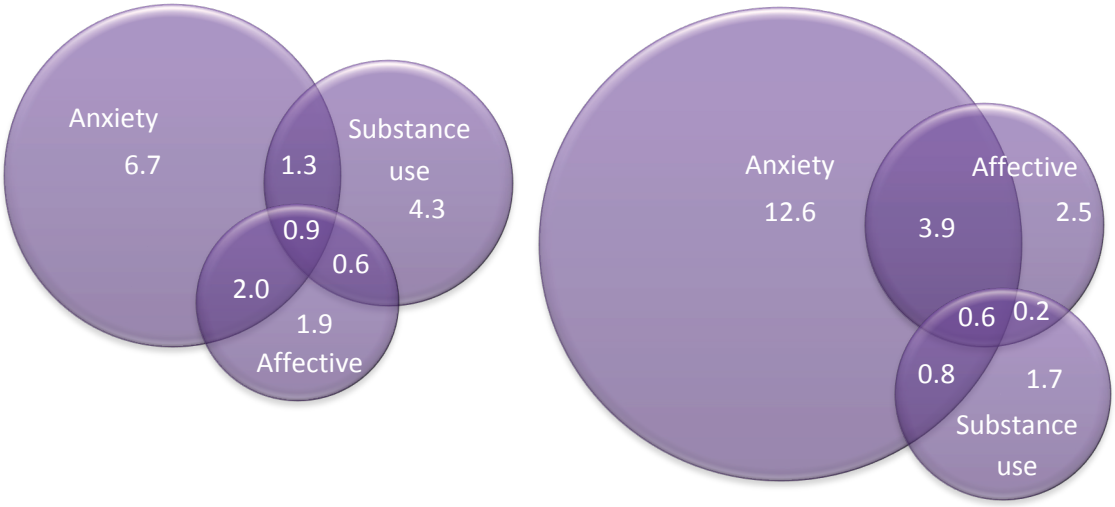
How common are mental health disorders?

Estimates from the United States suggest that close to one in two (46%) people will develop a mental disorder at some point in their life [40]. In Australia, mental disorders are the third leading cause of burden of disease following cancer and cardiovascular disease [41]. The 2007 Australian National Survey of Mental Health and Wellbeing (NSMHWB) found that one in five Australian adults (17.6% of men and 22.3% of women) had an anxiety, mood or substance use disorder in the past year, representing approximately 3,197,800 Australian adults [34]. Approximately 25% of people with mental disorders were found to have two or more classes of mental disorder [34]. The prevalence of single and comorbid affective (i.e., mood), anxiety and substance use disorders amongst Australian men and women from the NSMHWB is depicted in Figure 3. The overlapping portions of the circles indicate the proportion of the population who have co-occurring disorders. For example, 1.3% of men and 0.8% of women have a substance use and anxiety disorder.

How common is comorbidity among clients of AOD services?

Comorbidity among clients of AOD treatment services has always occurred and AOD workers have been responding effectively to it for many years with very little guidance from the research field. There has, however, been an increase in awareness of this phenomenon due to the development of structured diagnostic interviews, and their use in large-scale population surveys [42]. The high prevalence of comorbid mental health disorders among individuals with AOD use disorders in the Australian general population was highlighted by the 2007 NSMHWB (see Table 1). These estimates indicate that 35% of individuals with a substance use disorder (31% of men and 44% of women) have at least one co-occurring affective or anxiety disorder, representing nearly 300,000 Australians.

Figure 3. Prevalence (%) of single and comorbid DSM-IV affective, anxiety and substance use disorders amongst Australian males (left) and females (right) in the past year



Source: Slade, et al.[34] .

Table 1. Prevalence (%) of mental health disorders in the past year among adults with substance use disorders in the 2007 National Survey of Mental Health and Wellbeing

Disorder	% Men	% Women	% Total
Affective disorders			
Major depressive disorder	16.1	20.3	17.4
Dysthymia	7.5	7.9	7.6
Bipolar affective disorder	3.9	5.1	4.3
Any affective disorder	19.1	22.0	20.0
Anxiety disorders			
Generalised anxiety disorder	11.5	10.7	11.3
Social phobia	10.9	14.7	12.1
Post traumatic stress disorder	9.3	19.8	12.6
Panic disorder (with or without agoraphobia)	6.6	4.1	5.8
Obsessive compulsive disorder	9.1	10.2	9.5
Agoraphobia (without panic disorder)	2.3	4.7	3.1
Any anxiety disorder	28.1	38.5	31.4
Any disorder (affective/anxiety)	31.1	44.0	35.2

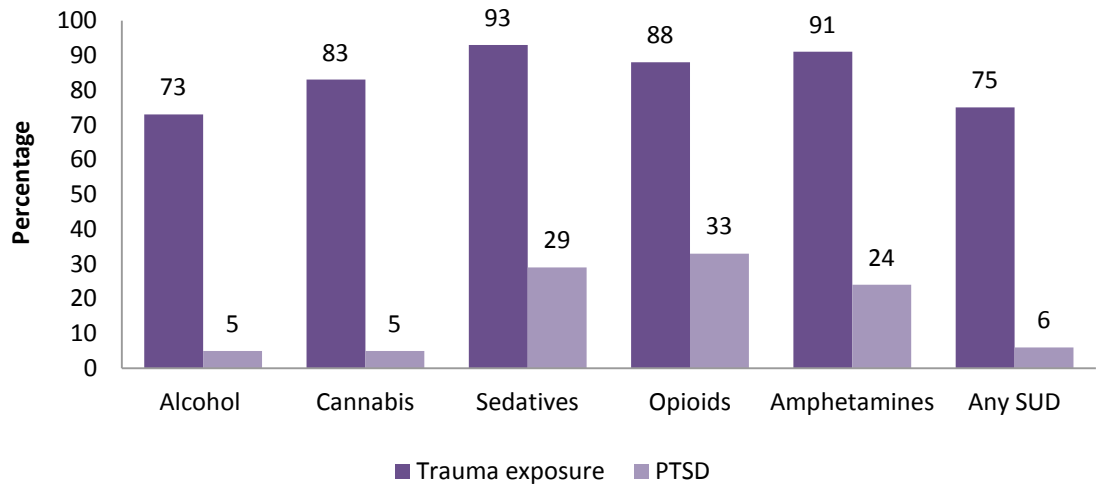
The prevalence of comorbidity is even higher among individuals entering AOD treatment programs, because the presence of co-occurring disorders increases the likelihood of treatment seeking [43, 44]. In their summary of the clinical literature, Brems and Johnson [45] note that rates of mental illness among individuals in AOD treatment programs range from 51-84%. The most common mental disorders seen among individuals with AOD use disorders are mood, anxiety and personality disorders [11, 44].

An Australian study found that more than two thirds (69%) of people undergoing outpatient treatment for alcohol dependence had at least one co-occurring depressive or anxiety disorder. The most common disorder was major depressive disorder, followed by generalised anxiety disorder and social phobia [46]. Rates of trauma exposure and PTSD are also extremely high among people with AOD use disorders (see Figure 4). Among treatment seeking heroin users, trauma exposure is almost universal at 92% [47]. Personality disorders are also overrepresented among this group, in particular, antisocial and borderline personality disorders, 62% and 47% respectively [48].

Although mood, anxiety and personality disorders are the most frequently encountered mental health conditions in AOD treatment settings, AOD workers are seeing an increase in psychotic symptoms among their clients (characterised by delusions, hallucinations, paranoia, and aggressive or violent behaviour) with the increasing use of methamphetamine [49, 50]. A study of Australian amphetamine users found that 13% had been diagnosed with psychosis [51].

It should be borne in mind that the prevalence of mental health disorders may vary between substances. Little research has been conducted comparing the rates of mental health disorders across different types of AOD use disorders; however, there is some evidence to suggest that co-occurring disorders are higher among those who use stimulants and opioids [44]. For example, as shown in Figure 4, the prevalence of PTSD is much higher among individuals with opioid, sedative or amphetamine use disorders compared to those with alcohol or cannabis use disorders [52].

Figure 4. The prevalence (%) of trauma exposure and post traumatic stress disorder among Australians with AOD use disorders



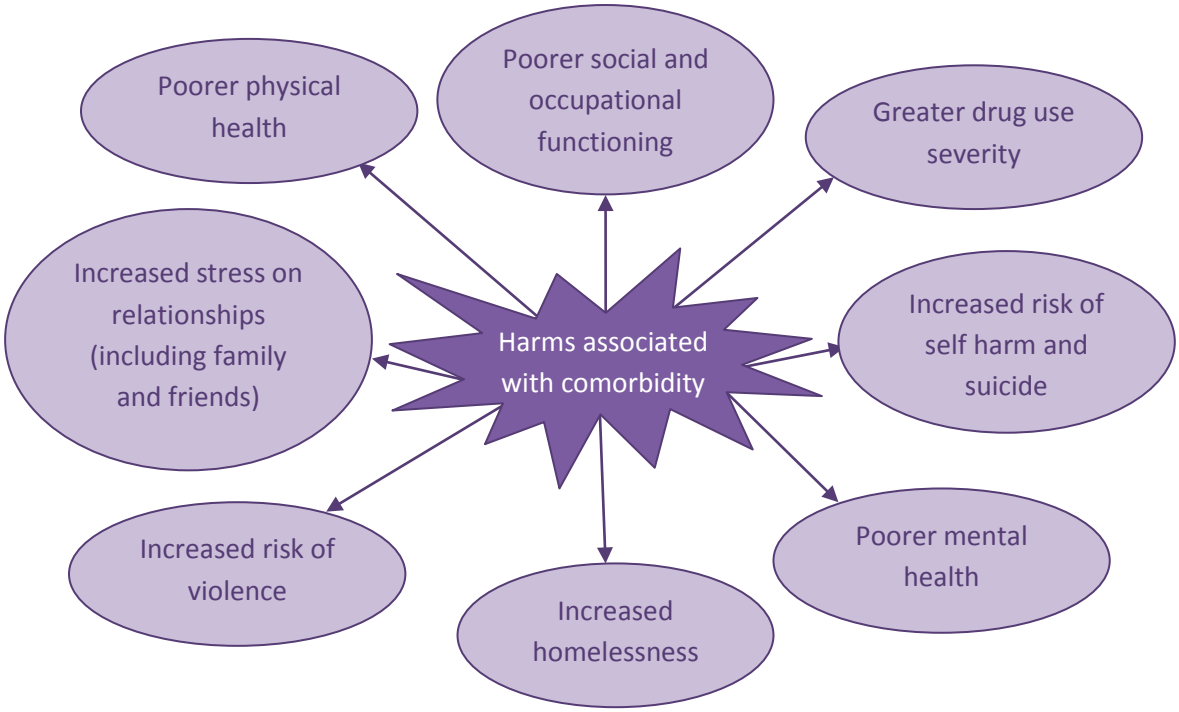
Based on data provided in Mills et al. [52].

While the aforementioned disorders are those most commonly encountered by AOD workers, the number of potential combinations of disorders and symptoms is infinite. Furthermore, as mentioned in Chapter 2, there is a large number of people who present to AOD treatment who display *symptoms* of disorders while not meeting criteria for a *diagnosis* of a disorder [53]. Individuals who display a number of symptoms of a disorder but do not meet criteria for a diagnosis are sometimes referred to as having a "subsyndromal" or "partial" disorder. Although these individuals may not meet full diagnostic criteria according to the classification systems (described in Chapter 5), their symptoms may nonetheless impact significantly on their functioning and treatment outcomes [10, 54].

What are the harms associated with comorbidity?

The high prevalence of comorbidity means that AOD workers are frequently faced with the need to manage complex psychiatric symptoms or problems, which may interfere with their ability to treat the clients' AOD use [55]. Clients with comorbidity present to treatment with a more complex and severe clinical profile, including poorer general physical and mental health, greater drug use severity, and poorer functioning [46, 56-60] (see Figure 5). It is not only AOD workers who must cope with the increased burden associated with comorbidity. The presence of comorbid mental health conditions can place an enormous strain on clients' families and others close to them, both emotionally and financially. The case studies reported in Appendix C highlight some of the harms that are experienced by AOD clients with comorbid mental health conditions.

Figure 5. Harms associated with comorbidity



What is the impact of comorbidity on treatment outcomes?

Some studies have shown that clients with comorbid mental health disorders have poorer treatment outcomes [59, 61, 62]. There are, however, a growing number of more recent studies that have clearly demonstrated that clients with comorbidity benefit as much as those without comorbid conditions in terms of their AOD use, general physical and mental health, and functioning – even those with severe mental health disorders [46, 63-65]. However, while both those with and without comorbid conditions follow a similar course in terms of their treatment outcomes (i.e., both groups improve), those with comorbid conditions continue to drink or use more, be in poorer physical and mental health, and display poorer functioning following treatment. These findings indicate that AOD services and AOD workers do exceptionally well at treating AOD use (despite the poorer clinical profile described in the previous section) and its associated disability, but that the disability associated with the comorbid condition remains.

Chapter 4:
Guiding principles

CHAPTER 4: WHAT ARE THE GUIDING PRINCIPLES FOR WORKING WITH CLIENTS WITH COMORBIDITY?

KEY POINTS

- In working with clients with comorbid mental health conditions, it is recommended that AOD services and AOD workers take the following principles into consideration:
  - First, do no harm
  - Work within your capacity
  - Engage in ongoing professional development
  - Recognise that the management of comorbidity is part of AOD workers' core business
  - Provide equity of access to care
  - Adopt a "no wrong door policy"
  - Recognise that comorbidity is common and that all clients should be routinely screened for comorbid conditions
  - Conduct ongoing monitoring of symptoms and assessment of client outcomes
  - Adopt a holistic approach
  - Adopt a client-centred approach
  - Emphasise the collaborative nature of the treatment
  - Have realistic expectations
  - Express confidence in the effectiveness of the treatment program
  - Adopt a non-judgemental attitude
  - Adopt a non-confrontational approach to treatment
  - Involve families and carers in treatment
  - Consult and collaborate with other health care providers
  - Ensure continuity of care.

In working with clients with comorbid mental health conditions, it is recommended that AOD services and AOD workers take the following principles into consideration. AOD services need to provide the infrastructure, policy and systems support for AOD workers to put these principles into practice. The implementation of these principles may help to engage the client in treatment, enhance the therapeutic alliance, and increase the likelihood of improved client outcomes.

- **First, do no harm**

The principle "first, do no harm" is not unique to comorbidity; it underscores the provision of all health care. AOD workers must consider the risks and benefits of potential actions and avoid those that may result in harm to the client.

- **Work within your capacity**

In line with the principle above, each AOD worker should work within his/her capacity to address comorbid conditions. As mentioned in Chapter 1, AOD workers differ with regard to their roles, education, training and experience. It is not expected that all AOD workers will be able to address comorbid conditions to the same extent. It is essential that appropriate supervision be provided to those working with comorbid clients, particularly for those who are less experienced in mental health.

- **Engage in ongoing professional development**

All AOD workers should be knowledgeable about the symptoms of the common mental health conditions that clients present with and how to manage these symptoms. Where AOD workers do not have these skills, professional development should be provided to bring them to a level of confident and competent performance. The provision of opportunities for continuing professional development for AOD staff should be a high priority for AOD services. AOD workers should seek out and actively engage in comorbidity specific training. It is important that professional development in this area be ongoing, as it is an evolving area for research with many studies currently underway. AOD workers are encouraged to update their knowledge by accessing new research and training opportunities, and new clinical guidelines as they emerge (Appendix E provides a list of research organisations).

- **Recognise that the management of comorbidity is part of AOD workers' core business**

AOD treatment services and AOD workers need to recognise that working with comorbidity is part of their core business. Indeed, managing comorbidity is the core business of all health care providers.

- **Provide equity of access to care**

Cases have been documented where clients of AOD services have received prejudicial treatment or were refused entry to treatment due to the presence of comorbid disorders [9]. All clients, regardless of their mental health status, are morally and legally entitled to equal access to the highest quality of care [66].

- **Adopt a "no wrong door policy"**

In line with the above principles, AOD services (and all other health services) should adopt a "no wrong door policy". No client should be turned away from treatment; rather, it is necessary to establish where the client will receive the most appropriate care. When a person presents at a facility that is not equipped to provide a particular type of service, he/she should be guided to appropriate facilities (using active referral methods discussed in Chapter 9), with follow-up by staff to ensure that he/she receive appropriate care [63]. In this way, every door in the health care system should provide access to the services needed. Guidance about which sector of the health care system should have primary responsibility for comorbid presentations is provided in Figure 6. It should be noted, however, that it can be difficult to discern which areas should take

primary responsibility for individual cases as the severity of conditions may be interpreted differently by various service providers.

Figure 6. Clinical governance

AOD services Primarily responsible for people severely disabled by current substance use and adversely affected by mental health problems.	**Mental health services** Primarily responsible for people severely disabled by current mental health problems and adversely affected by substance use.
AOD and mental health services Shared responsibility for people severely disabled by both substance use and mental health disorders. The client should be treated by the service that best meets his/her needs.	**General Practitioners** Primarily responsible for people with mild to moderate AOD and/or mental health conditions but with access to specialist AOD and mental health services as required.

Source: NSW Health [67].

- **Recognise that comorbidity is common and that all clients should be routinely screened for comorbid conditions**

Despite the fact that comorbid mental health conditions are common among people with AOD use disorders, they are often overlooked in AOD treatment settings [68]. This is mostly because AOD workers are not routinely looking for it. As part of routine clinical care, all clients should be screened for comorbidity. Chapter 6 discusses how to screen and assess for comorbidity.

- **Conduct ongoing monitoring of symptoms and assessment of client outcomes**

Assessing mental health is a process, not a one-off event. It is important to monitor a person's mental health symptoms throughout treatment as they may change over time. For example, a person may present with symptoms of anxiety and depression upon treatment entry; however, these symptoms may subside with abstinence. Alternatively, a person may enter treatment with no mental health symptoms, but such symptoms may develop after a period of reduced use or abstinence.

Clients should also be provided with feedback regarding changes in their mental health. It is often difficult for clients to detect subtle changes over time. Evidence of a reduction in psychiatric symptoms may help to maintain their motivation. On the other hand, evidence that there has been no change or that their psychiatric symptoms have worsened may help them understand why they have been using substances and alert them to the need to address these issues.

- **Focus on engaging the client in treatment**

The development of a trusting therapeutic alliance with the client is essential to engaging the client in the treatment process [69, 70]. Engaging clients in treatment can be difficult, particularly clients with personality or psychotic disorders. This may be due to a history of poor relationships with AOD and other health professionals, a bias towards suspiciousness or paranoid interpretation of relationships, or a chaotic lifestyle, making appointment scheduling and engaging in structured work more difficult [71]. The following strategies may assist in engaging the client in treatment [67]:

- Express empathetic, non-judgemental and compassionate attitudes.
- Provide individualised care that includes identified strengths as well as problems.
- Adopt a holistic approach.
- Be flexible with appointments.
- Protect confidentiality and privacy.
- Promote self-efficacy.
- Work with the client's current stage of readiness to change (as discussed in Chapter 6).

- **Adopt a holistic approach**

The primary goal of AOD treatment services is to address clients' AOD use. However, in order to do so effectively, AOD workers must take into account the broad range of issues that clients present with, including their mental health. When considering comorbidity, one cannot look at the person's AOD use and mental health alone. Clients with comorbid conditions often have a variety of other medical, family and social problems (e.g., housing, employment, welfare and legal problems). These problems may be contributing to the client's AOD and mental health conditions, or they may be the product of his/her AOD and mental health conditions. Clients also need to be viewed in light of their age, gender, sexual orientation, culture, ethnicity, spirituality, socio-economic status, and cognitive abilities.

- **Adopt a client-centred approach**

AOD workers are specialists in their field. It important to acknowledge, however, that it is the client who is the expert on him/herself. It is important that AOD workers listen to what clients want to achieve from treatment. This will assist in developing the treatment plan and identifying other services that may need to be engaged.

In terms of clients' AOD use, the goal of abstinence is usually favoured, particularly for those whose mental health conditions are exacerbated by AOD use. Abstinence is also preferred for those with more severe mental disorders (or cognitive impairment) because even low level substance use may be problematic for these individuals [38]. Those taking medications for mental health conditions (e.g., antipsychotics, antidepressants) may also find that they become intoxicated even with low levels of AOD use due the interaction between the drugs. Although abstinence is favoured, it is recognised that many people with comorbid conditions prefer a goal of moderation. In order to successfully engage with the client, AOD workers should accommodate a range of treatment goals and adopt a harm reduction approach [72].

- **Emphasise the collaborative nature of the treatment**

Clients with comorbid conditions often feel that they have very little control over their lives. It is important that they understand that you will be working together in this treatment, to help them re-establish a sense of control.

- **Have realistic expectations**

It is important that AOD workers have realistic expectations regarding the course of treatment and outcomes to be expected of clients with comorbidity. It is commonly believed that clients with comorbid mental health conditions are more difficult to treat, require more intensive treatments, and have poorer treatment outcomes. However, comorbidity is not an insurmountable barrier to treating people with AOD use disorders. As discussed in Chapter 3, research has shown that clients with comorbid mental health conditions can benefit just as much as those without comorbid conditions from usual AOD treatment [46, 63-65].

- **Express confidence in the effectiveness of the treatment program**

As mentioned above, positive outcomes can be achieved in clients with comorbid conditions. AOD workers' confidence in the treatment will increase clients' confidence that the treatment they are entering can help them.

- **Adopt a non-judgemental attitude**

Clients with comorbid problems have often been subjected to stigmatisation and discrimination in relation to their AOD use (particularly those who use illicit drugs) and their mental health condition. People with mental health disorders have traditionally been viewed by society as violent, brain damaged, intellectually disabled, unimportant, untrustworthy or worthless. As a result, clients with comorbidity will often feel too ashamed or embarrassed to tell people about it, even health professionals [66]. It is important that clients with comorbid conditions do not feel that AOD workers have the same negative attitudes towards them. AOD and other health professionals should view and treat people with comorbidity with the same respectful care that would be extended to someone with any other health condition. Just as people with an AOD use disorder should not be thought of or referred to as an "addict", a person with schizophrenia should not be referred to or thought of as "schizophrenic". The mental health condition does not define the person; rather, it is one aspect of the person.

- **Adopt a non-confrontational approach to treatment**

Sustained emotional distress can worsen a number of mental health conditions and a highly demanding or confrontational treatment approach may be harmful to those with mental health conditions [38]. Emotional distress may be triggered by criticism, rejection or an inability to deal with task demands [73]. It is recommended instead that a non-confrontational approach, such as a motivational enhancement approach, be taken with clients with comorbidity. Motivational interviewing techniques are described in Appendix D.

- **Involve families and carers in treatment**

With the client's consent, AOD workers should involve the client's family and carers where possible and appropriate. Families and carers should be involved as much as possible in decisions regarding treatment and discharge planning, as they will often need to facilitate the client's access to other services. With the client's consent, family members/carers should be provided with regular feedback so that they know their views and feelings are valued. It is important to clarify with clients specifically what information they consent to being shared with their families or carers. Families and carers should also be informed of services available to them in the form of advocacy and support groups. A useful resource, the *Consumer and Carer Involvement in Comorbidity Treatment Planning* package [74], developed by Health Outcomes International for the Australian Government Department of Health and Ageing is available at www.health.gov.au.

- **Consult and collaborate with other health care providers**

AOD clients present with diverse issues that cannot possibly be addressed by one health professional or service alone. A broad multifaceted and multidisciplinary approach is needed in order to address all of these issues effectively [66, 75]. It is important that AOD services and AOD workers develop links with local services and engage them in clients' treatment. Such services include mental and community health practitioners, as well as housing, employment and welfare services. General practitioners (GPs) in particular play an important role in delivering care to people with comorbidity, as they are often their first and most consistent point of contact [76, 77]. Ideally, case management and treatment should be shared by health care providers/services, and there should be good communication and sharing of information between these professionals.

- **Ensure continuity of care**

People with comorbid conditions often have difficulty navigating their way through the services required to address all of their needs. It is crucial that systems be established that ease clients' transitions between services to prevent them from "falling into the gaps" between services. Chapter 9 discusses methods that may be used to refer clients to other services.

CHAPTER 5: HOW ARE MENTAL HEALTH DISORDERS CLASSIFIED?

KEY POINTS

- Disorders represent particular combinations of signs and symptoms that are grouped together to form criteria. A certain number of criteria need to be met within a certain time frame for a person to be diagnosed as having a disorder.
- Not all AOD workers are able to formally diagnose the presence or absence of mental health disorders. Diagnoses of mental health disorders should only be made by suitably qualified and trained health professionals.
- It is nonetheless useful for all AOD workers to be aware of the characteristics of disorders so that they are able to describe and elicit mental health symptoms when undertaking screening and assessment, and to inform treatment planning.
- It is important that clients suspected of having a comorbid mental health condition undergo a medical assessment as many symptoms of mental health disorders mimic those of physical disorders.

This chapter provides a brief overview of the mental disorders most commonly seen among clients of AOD treatment settings. Not all AOD workers are able to formally diagnose the presence or absence of mental health disorders. Diagnoses of mental health disorders should only be made by suitably qualified and trained health professionals (e.g., registered or clinical psychologists, and psychiatrists). Indeed it would be unethical for non-trained workers to use diagnostic labels in clinical notes, or to inform the client that they have a diagnosis, unless they have received written confirmation from a suitably qualified professional.

It is nonetheless useful for all AOD workers to be aware of the characteristics of disorders so that they are able to describe and elicit mental health symptoms when undertaking screening and assessment (discussed in Chapter 6), and to inform treatment planning. Indeed, many more people will present with some symptoms than will meet criteria for a diagnosis of a disorder; however, these symptoms are distressing and need to be managed nonetheless. It is hoped that the descriptions provided here will increase AOD workers' knowledge and awareness of different signs (i.e., what is objectively visible about the client, such as sweating) and symptoms (i.e., what the client describes, such as sadness) of disorders. The case studies provided in Appendix C also provide examples of some of the common symptoms that clients present with.

Disorders represent particular combinations of signs and symptoms that are grouped together to form criteria. A certain number of criteria need to be met within a certain time frame for a person to be diagnosed as having a disorder. There are two main classification systems used to diagnose mental health disorders:

- The Diagnostic and Statistical Manual of Mental Disorders, currently in its fourth edition (DSM-IV-TR) [1].
- The International Classification of Diseases, currently in its 10th revision (ICD-10) [78].

These systems are similar; however, there are a number of important differences. The disorder descriptions outlined in this chapter are based on those provided by the DSM-IV-TR [1]. AOD workers are encouraged to familiarise themselves with the DSM-IV-TR [1], in particular its uses, limitations and recommendations regarding differential diagnosis (i.e., determining which symptoms are attributable to which disorder).

We have divided disorders into five main categories:

- Mood disorders.
- Anxiety disorders.
- Personality disorders.
- Psychotic disorders.
- Substance-induced disorders.

There are, however, a number of other disorder types that individuals with AOD use disorders may experience. These include eating disorders, somatoform disorders, sleep disorders, and adjustment disorders. For further information on these disorders readers are referred to the DSM-IV-TR [1].

It is also important to note that many symptoms of mental health disorders mimic those of physical disorders. For example, heart palpitations may be related to anxiety, or they may be a symptom of a heart condition. Similarly, depressed mood may be a symptom of major depressive disorder, or it may be a symptom of hypothyroidism. For this reason, it is important that clients suspected of having a comorbid mental health condition undergo a medical assessment to rule out the possibility of an underlying physical condition. This is particularly pertinent for those individuals with advanced AOD use disorders, who may suffer from malnutrition or organ damage.

What are mood disorders?

The predominant feature of mood disorders is a disturbance of mood where emotions are experienced to the extreme. They involve having "episodes" of dysfunction. There are four types of episodes (see Figure 7 and Table 2):

- Major depressive episodes.
- Manic episodes.
- Mixed episodes.
- Hypomanic episodes.

Figure 7. The spectrum of mood episodes

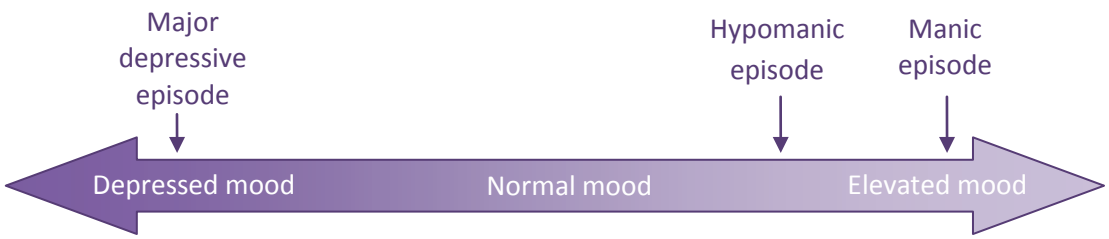


Table 2. Mood episodes

Major Depressive Episode
In a major depressive episode, some of the following symptoms are experienced nearly every day for at least two weeks: • Depressed mood or loss of interest or enjoyment in activities. • Reduced interest or pleasure in almost all activities. • Change in weight or appetite. • Difficulty concentrating or sleeping (i.e., sleeping too much or too little). • Restlessness and agitation. • Slowing down of activity. • Fatigue or reduced energy levels. • Feelings of worthlessness or excessive/inappropriate guilt. • Recurrent thoughts of death, suicidal thoughts, attempts or plans.
Manic Episode
During a manic episode, the person experiences an abnormally or persistently elevated, expansive, or irritable mood for at least one week. The episode is characterised by the person experiencing some of the following symptoms: • Inflated self-esteem. • Decreased need for sleep. • Increased talkativeness or racing thoughts. • Distractibility. • Agitation or increase in goal directed activity (e.g., at work or socially). • Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., buying sprees, sexual indiscretions, dangerous driving).
Hypomanic Episode
A hypomanic episode is the same as a manic episode but is less severe. A hypomanic episode need only last four days and does not require the episode to be severe enough to cause impairment in social or occupational functioning.
Mixed Episode
In a mixed episode, the person experiences both a manic episode and major depressive episode for at least one week.

What are the different types of mood disorders?

There are two types of mood disorders which represent different combinations of the episodes mentioned above:

- Depressive disorders.
- Bipolar disorders.

What are depressive disorders?

Depressive disorders involve only the experiencing of major depressive episodes (described in Table 2; Case Studies 1, 2 and 5 in Appendix C). Depressive disorders are distinct from feeling unhappy or sad (which is commonly referred to as "depression") in that they involve more severe and persistent symptoms. Depressive disorders are often long-lasting, recurring illnesses. Individuals with depressive disorders feel depressed, sad, hopeless, discouraged, or "down in the dumps" almost all the time. They also experience other symptoms including sleep disturbances (including difficulty getting to sleep, frequent waking during the night, being unable to wake in the morning, or sleeping too much); loss of interest in daily activities; a lack of energy, tiredness and fatigue; restlessness, irritability, or anger; difficulty concentrating, remembering, and making decisions; feelings of guilt or worthlessness; appetite changes (either decreased or increased appetite); loss of sex drive; and thoughts of death or suicide.

There are two main types of depressive disorders (see Table 3):

- Major depressive disorder.
- Dysthymic disorder.

Table 3. Depressive disorders

Major Depressive Disorder
Major depressive disorder is characterised by one or more major depressive episodes in which some of the following symptoms are experienced nearly every day for at least two weeks: a depressed mood; loss of interest or enjoyment in activities; change in weight and appetite; sleeping problems; fatigue; feelings of worthlessness or inappropriate guilt; difficulty concentrating; and/or recurrent suicidal thoughts, attempts or plans. A person may have a single episode or they may have recurrent episodes over his/her lifetime. The duration of depressive episodes may range from weeks to years.
Dysthymic Disorder
Dysthymic disorder is characterised by chronic symptoms of depression that do not meet the diagnostic criteria for a major depressive episode. The person experiences at least two years of depressed mood more days than not, as well as other depressive symptoms such as appetite changes, sleeping problems, fatigue, feelings of worthlessness and hopelessness.

What are bipolar disorders?

Bipolar disorders (also known as bipolar affective disorders or manic depression) are characterised by recurrent episodes of mania (or hypomania) and major depression. In between episodes, the person is usually completely well. Most people with a bipolar disorder experience

their first serious mood episode in their 20s. However, the onset of bipolar disorders may occur earlier or later in life and they can be diagnosed in children as well as adults. The first episode of illness is most commonly a depressive illness and bipolar disorder may not be diagnosed until treatment with antidepressant medication triggers a manic illness. Recognition of bipolar disorders can often be difficult and many people are not diagnosed until they have experienced a number of years of severe mood swings. People tend to seek treatment for the depressive phases of the disorder but not for the periods of elation, so they are often mistakenly diagnosed as having a depressive disorder.

There are three main types of bipolar disorders (see Table 4):

- Bipolar I disorder.
- Bipolar II disorder.
- Cyclothymic disorder.

Table 4. Bipolar disorders

Bipolar I Disorder
Bipolar I disorder is characterised by one or more manic or mixed episodes. Often the individual has also had one or more major depressive episodes.
Bipolar II Disorder
Bipolar II disorder is characterised by one or more major depressive episodes with at least one hypomanic episode.
Cyclothymic Disorder
Cyclothymic disorder is a chronic (at least two years) fluctuating mood disturbance involving numerous periods of hypomanic and depressive symptoms. The symptoms do not meet the criteria for either a major depressive episode or a manic episode.

What are anxiety disorders?

Feeling anxious is not necessarily problematic. Many people feel anxious because they have reason to – for example, they may be facing economic hardship, or difficulties with housing or relationships. Many people undergoing AOD treatment will experience anxiety which can be a consequence of intoxication, withdrawal, or learning to live without using substances. This anxiety usually reduces over time with a period of abstinence. A person's anxiety is problematic, however, when it is persistent, or so frequent and intense that it prevents the person from living his/her life in the way that he/she would like.

People with anxiety disorders often experience feelings of fear and panic. Panic attacks are not a specific disorder, but rather a symptom that is common amongst many of the anxiety disorders. The symptoms of a panic attack are outlined in Table 5, although not all panic attacks include all

symptoms. Panic attacks are described as a terrifying experience. As many of the symptoms of a panic attack mirror those of a heart attack, many people who experience them (particularly for the first time) have a genuine fear that they are going to die. Given the overlap in symptoms (e.g., shortness of breath, chest pain and tightness, numbness and tingling sensations), it is important that a person displaying these symptoms be referred to a medical practitioner.

Table 5. Symptoms of a panic attack

Panic symptoms	
• Sweating. • Shaking. • Shortness of breath. • Feeling of choking. • Light headedness. • Heart palpitations, chest pain or tightness.	• Numbness or tingling sensations. • Chills or hot flushes. • Nausea and/or vomiting. • Fear of losing control, going crazy or dying. • Feelings of unreality or being detached from oneself.

What are the different types of anxiety disorders?

There are a number of different types of anxiety disorders (see Table 6):

- Generalised anxiety disorder (GAD).
- Obsessive compulsive disorder (OCD).
- Panic disorder (with or without agoraphobia).
- Agoraphobia.
- Social phobia.
- Specific phobia.
- Post traumatic stress disorder (PTSD).
- Acute stress disorder.

Some examples of these are provided in Case Studies 1, 3, 4, 7 and 9 in Appendix C.

Table 6. Anxiety disorders

Generalised Anxiety Disorder (GAD)
GAD is marked by excessive anxiety or worry that is difficult to control and focuses on a number of events or activities (e.g., finances, health, work, personal relationships), which the person feels more often than not for at least six months. Symptoms include feeling restless, fatigue, difficulty concentrating, irritability, muscle tension and sleeping problems.
Panic Disorder (with or without agoraphobia)
Panic disorder involves the experiencing of unexpected panic attacks followed by persistent concern or worry about having another attack, and the implications of having another attack. As a result the person changes his/her behaviour in relation to the attacks. Panic disorder is sometimes accompanied by agoraphobia.

Table 6. Anxiety disorders (continued)

Agoraphobia
Agoraphobia involves having anxiety about being in places or situations from which escape might be difficult or embarrassing, or in which help may not be available in the event of symptoms of a panic attack (e.g., crowded areas, aeroplanes, public toilets). The person avoids these places or situations, or if such situations are endured there is considerable distress or anxiety, or the need for a companion.
Obsessive Compulsive Disorder (OCD)
OCD is made up of either (and sometimes both) obsessions or compulsions. Obsessions are recurrent, persistent, intrusive and inappropriate thoughts, impulses or images. Compulsions are repetitive behaviours acted out in response to an obsession. Examples of obsessions include persistent fears of contamination, thinking that they are to blame for something, or an overwhelming need to do things perfectly. Examples of compulsive behaviours include the need to repeatedly wash one's hands due to the fear of contamination, check that things have been done (e.g., whether doors or windows have been locked, appliances switched off), or avoid certain objects and situations (holes in the road, cracks or lines in pavement). The person recognises that his/her obsessions and/or compulsions are excessive and this causes him/her significant distress or anxiety. As the performance of these rituals is time consuming, they can significantly interfere with the person's social and occupational functioning.
Social Phobia
Social phobia involves a marked and persistent fear of social or performance situations in which the person is exposed to unfamiliar people or the possibility of scrutiny. Examples of situations the person may fear include being introduced to other people, being teased or criticised, being the centre of attention, being watched while doing something, meeting people in authority, social encounters, speaking in a group, or public speaking. The person fears that they will act in a way that will be humiliating or embarrassing. Exposure to the feared situation causes anxiety and/or panic attacks and hence the person usually avoids the situations. If such situations are endured there is considerable distress or anxiety.
Specific Phobia
Specific phobia involves excessive or unreasonable fear of a specific object or situation causing immediate anxiety and/or panic attacks. Phobic cues may include animals; blood, injury or injections; situations involving the natural environment (such as heights or storms); or other specific situations such as airplanes, lifts or enclosed spaces. The person avoids the feared places or situations, or if such situations are endured there is considerable distress or anxiety. Having a fear is not so unusual, but when it interferes with getting on with the responsibilities in a person's life, it can become a problem. For example, having a fear of flying is not a problem until one finds oneself planning a holiday overseas or that he/she needs to travel for work.

Table 6. Anxiety disorders (continued)

Post Traumatic Stress Disorder (PTSD)
PTSD is a disorder that may develop after a person has experienced a traumatic event during which the individual perceived his/her own (or someone else's) life or physical integrity to be at risk, causing a feeling of intense fear, helplessness or horror. The trauma may be a one-off event or it may have occurred over a period of time. Examples of traumatic events include combat exposure, being in a place of war, experiencing a natural disaster (e.g., fire, flood), physical or sexual assault, being in a life-threatening accident, being threatened with a weapon, or witnessing any of these events. Following the event, for at least one month, the person experiences some of the following symptoms: • Intrusions: re-experiencing the event in the form of unwanted memories, nightmares, or "flashbacks". • Avoidance: avoiding thoughts, feelings, people, places or activities that remind him/her of the event, feeling detached from others, or having a restricted range of emotions (e.g., unable to have loving feelings). • Hyperarousal: increased startle response, hypervigilance, irritability or anger, or difficulty sleeping and concentrating. These symptoms may begin immediately after the traumatic event, or they may appear days, weeks, months or years after the trauma occurred.
Acute Stress Disorder
This disorder is similar to PTSD but lasts for less than one month.

What are personality disorders?

Individuals with personality disorders have enduring destructive patterns of thinking, feeling, behaving, and relating to other people across a wide range of social and personal situations. These maladaptive traits are stable and long lasting. Personality disorders tend to develop in adolescence or early adulthood and are generally lifelong.

AOD use disorders may cause fluctuating symptoms that mimic the symptoms of personality disorders (e.g., impulsivity, dysphoria, aggressiveness and self-destructiveness, relationship problems, work dysfunction, engaging in illegal activity, and dysregulated emotions and behaviour) making it difficult to determine whether a person has a personality disorder (see Case Study 7 in Appendix C).

What are the different types of personality disorders?

Based on their similarities, personality disorders are grouped into three clusters (see Table 7):

- **Cluster A:** Individuals with these personality disorders often appear to be odd or eccentric. They have significant impairment but infrequently seek out help. Cluster A includes paranoid, schizoid and schizotypal personality disorders.
- **Cluster B:** Individuals with these personality disorders tend to be dramatic, emotional and erratic. Generally they experience significant impairment and they are of considerable concern to health care providers. Of all the personality disorders, people with Cluster B disorders are the ones that most commonly present to services. Cluster B includes antisocial, borderline, histrionic, and narcissistic personality disorders.
- **Cluster C:** Individuals with these personality disorders tend to be anxious and fearful and are generally less impaired than those with Cluster B personality disorders. Cluster C includes avoidant, dependent, and obsessive-compulsive personality disorders.

Among those with AOD use disorders, two Cluster B personality disorders, antisocial personality disorder (ASPD) and borderline personality disorder (BPD), are most prevalent and tend to impact most upon treatment [79-82]. These are discussed in turn.

Antisocial personality disorder

The main feature of ASPD (previously known as "psychopathy" or "sociopathy") is a pattern of complete disregard for the rights of others. Deceit and manipulation are central features of this disorder. ASPD begins in childhood or early adulthood and continues into adulthood. For a diagnosis of ASPD to be made, the individual must be at least 18 years old, and have had a history of some symptoms of "conduct disorder" before age 15. The behaviours characteristic of conduct disorder fall into the following characteristics: aggression to people and animals, destruction of property, deceitfulness or theft, and serious violation of rules. This pattern of antisocial behaviour then continues into adulthood.

The main characteristics of ASPD are:

- Failure to conform to social norms with respect to lawful behaviour. Individuals with ASPD may repeatedly be involved in actions that are grounds for arrest (e.g., destroying property, harassing others, stealing, or pursuing illegal occupations). They tend to have disregard for the wishes, rights and feelings of others.
- Being deceptive and manipulative in order to gain personal profit or pleasure (e.g., to obtain money, sex or power). Individuals with ASPD may repeatedly lie or con others.
- Reckless disregard for their own or other's safety (e.g., recurrent speeding, driving while intoxicated, multiple accidents, or high-risk sex).
- A tendency for impulsive behaviour due to a failure to plan ahead. Decisions may be made on the spur of the moment, without forethought, and without consideration of the consequences for themselves or others. This may lead to sudden changes of jobs, residences or relationships.
- Irritability and aggression; repeated involvement in physical fights or assaults.

- Consistent and extreme irresponsibility. Behaviour that is indicative of this may include irresponsible work behaviour, for example, long periods of unemployment despite several job opportunities, abandonment of jobs without a plan for getting another, or repeated unexplained absences from work. Financial irresponsibility may include acts such as defaulting on debts and failing to provide child support.
- The absence of remorse for the consequences of their actions. Individuals with ASPD tend to provide superficial excuses for having hurt, mistreated or stolen from someone. They may blame the victims of their actions for being foolish, helpless or deserving their fate. They generally fail to correct their wrongdoings, or to apologise or show remorse for their behaviour.

Borderline personality disorder

BPD is marked by persistent patterns of instability in relationships, mood, and self-image. BPD is also characterised by marked impulsivity, particularly in relation to behaviours that are self-damaging. The main characteristics of BPD include:

- Extreme efforts to avoid rejection or abandonment (these threats of rejection may be real or imagined).
- A pattern of unstable and intense relationships, whereby the person alternates between idealising a person and completely devaluing him/her.
- Unstable self-image or sense of self (e.g., the individual may suddenly change his/her goals or values in life, jobs or career aspirations, sexual identity, friends).
- Impulsivity, particularly in relation to behaviours that are self-damaging (e.g., spending money irresponsibly, binge eating, substance abuse, unsafe sex and reckless driving).
- Recurrent suicidal behaviour, gestures, threats, or self-mutilating behaviour (e.g., cutting or burning) are also common.
- Unstable mood (e.g., intense dysphoria, irritability or anger usually lasting only a few hours).
- Chronic feelings of emptiness.
- Inappropriate intense anger or difficulty controlling anger.
- Transient, stress-related paranoid thoughts or severe dissociative symptoms (i.e., where the person temporarily loses touch with where he/she is in time and/or space).

Table 7. Personality disorders

CLUSTER A
Paranoid personality disorder is characterised by a pattern of distrust and suspiciousness such that others' motives are interpreted as malevolent.
Schizoid personality disorder is characterised by a pattern of detachment from social relationships and a restricted range of emotional expression.
Schizotypal personality disorder is characterised by a pattern of acute discomfort in close relationships, cognitive or perceptual distortions and eccentricities of behaviour.

Table 7. Personality disorders (continued)

CLUSTER B
Antisocial personality disorder is characterised by a pattern of disregard for and violation of the rights of others. Individuals with this personality disorder are typically aggressive, unlawful and impulsive.
Borderline personality disorder is characterised by a pattern of instability in interpersonal relationships, self-image and feeling states with marked impulsivity and chaoticness.
Histrionic personality disorder is characterised by a pattern of excessive emotionality including being dramatic, attention-seeking, and seductive.
Narcissistic personality disorder is characterised by a pattern of grandiosity and self-centredness and thus lacking empathy for others.
CLUSTER C
Avoidant personality disorder is characterised by a pattern of social inhibition with feelings of inadequacy and hypersensitivity to negative evaluation. Individuals tend to be needy but scared of relationships. There is some debate that this is a form of long-term social phobia.
Dependent personality disorder is characterised by a pattern of submissive and clinging behaviour related to an excessive need to be taken care of. These individuals tend to be indecisive and fear abandonment.
Obsessive-compulsive personality disorder is characterised by a pattern of preoccupation with orderliness, perfectionism and control; thus, these individuals are rigid and inefficient.

What are psychotic disorders?

People experiencing a psychotic episode lose touch with reality. Their ability to make sense of both the world around them and their internal world of feelings, thoughts and perceptions is severely altered. The most prominent psychotic symptoms are delusions and hallucinations.

Delusions are false beliefs that usually involve a misinterpretation of perceptions or experiences. For example, sufferers may feel that someone is out to get them, that they have special powers, or that passages from the newspaper have special meaning for them. Delusions may be either bizarre or non-bizarre. Bizarre delusions are those that are clearly implausible, not understandable, and not derived from ordinary life experiences (e.g., the belief that one's internal organs have been removed and replaced with someone else's by a stranger without leaving any wounds or scars). Non-bizarre delusions are those which involve situations that could conceivably occur in real life (e.g., being followed, poisoned, or deceived by one's partner). Hallucinations are false perceptions such as seeing, hearing, smelling, sensing or tasting things that others cannot. It is important to note that the classification of an experience as either a

delusion or a hallucination is dependent upon culture. That is, the experience must be one that most members of that culture would deem a misrepresentation of reality.

Other symptoms of psychotic disorders may include:

- Disorganised speech (e.g., difficulty keeping on track, incoherence).
- Grossly disorganised behaviour (e.g., difficulty maintaining hygiene, inappropriate behaviour, silliness).
- Catatonic behaviour (e.g., decreased reactivity to the environment sometimes to the extreme of complete unawareness, maintaining a rigid or inappropriate posture, resisting efforts to be moved).
- Affective flattening (i.e., a reduced range and intensity of emotional expressiveness).
- Alogia (i.e., restricted fluency and productivity of thought and speech).
- Avolition (i.e., lack of interest in initiating or continuing with activities).

The particular combination of symptoms a person displays, and their duration, determines what diagnostic category they may fall into.

What are the different types of psychotic disorders?

Individuals with AOD use disorders may display symptoms of psychosis that are due to either intoxication or withdrawal from substances. However, if the person experiences psychotic episodes even when they are not intoxicated or withdrawing, it is possible that they may have one of the disorders described in Table 8 (see Case Studies 6 and 8 in Appendix C). These are severely disabling mental health disorders. Psychotic symptoms may also present in people with major depressive disorder or bipolar I disorder, and they may also arise from a medical condition.

Table 8. Psychotic disorders

Schizophrenia
Schizophrenia is one of the most common, and one of the most disabling, of the psychotic disorders. It affects a person's ability to think, feel and act. To be diagnosed with schizophrenia, symptoms must have been continuing for a period of at least six months. The symptoms of schizophrenia are grouped within two types: • Positive symptoms. • Negative symptoms. Positive symptoms reflect an excess or distortion of normal functioning and include hallucinations, delusions, disorganised speech, grossly disorganised behaviour, and catatonia. Negative symptoms reflect a loss of normal functioning and include affective flattening, avolition, and alogia. These symptoms cause significant impairment in a person's functioning. People are considered to have particular "types" of schizophrenia depending upon the predominance of symptoms displayed (paranoid, disorganised, catatonic, undifferentiated, or residual type).

Table 8. Psychotic disorders (continued)

Schizophreniform Disorder
Schizophreniform disorder is characterised by a symptomatic presentation that is equivalent to schizophrenia except its duration is limited to less than six months and it is not necessary to have a decline in social or occupational functioning.
Schizoaffective Disorder
Schizoaffective disorder is characterised by the symptoms of schizophrenia alongside a major depressive, manic, or mixed episode (described earlier in this chapter). This disorder may thus be divided into two types: i) bipolar type (if the mood episode is manic or mixed); and ii) depressive type (if the mood episode is major depressive).
Delusional Disorder
Delusional disorder is characterised by at least one month of non-bizarre delusions. Hallucinations and other positive symptoms of schizophrenia are relatively absent.
Brief Psychotic Disorder
Brief psychotic disorder is a disturbance when positive psychotic symptoms are present for at least one day but less than one month.
Shared Psychotic Disorder
Shared psychotic disorder (commonly referred to as *folie a deux*) develops in an individual who is influenced by someone else who already has a psychotic disorder with prominent delusions of a similar content.

What are substance-induced disorders?

Substance-induced disorders are disorders that occur as a direct physiological consequence of AOD intoxication or withdrawal. For a diagnosis of a substance-induced disorder to be made, symptoms of the disorder must only be present following intoxication or withdrawal. If the person displays symptoms of the disorder in the absence of intoxication or withdrawal, it is possible that they have an independent mental health disorder. Symptoms of substance-induced disorders tend to reduce over time with a period of abstinence [83].

Symptoms of mood, anxiety and psychotic disorders may all be induced as a result of AOD use or withdrawal. For example, alcohol use and withdrawal can induce symptoms of depression or anxiety [27]; manic symptoms can be induced by intoxication with stimulants, steroids, or hallucinogens; and psychotic symptoms can be induced by withdrawal from alcohol, or intoxication with amphetamines, cocaine, cannabis, LSD or PCP [28]. Other disorders that may

result from AOD use include substance-induced delirium, amnestic disorder, dementia, sexual dysfunction, and sleep disorder.

It is often extremely difficult to distinguish substance-induced psychosis from other psychotic disorders. With substance-induced psychosis, symptoms tend to appear quickly and last a relatively short time, from hours to days, until the effects of the drug wear off. For some, however, psychosis can persist for days, weeks, months or longer [29]. It is possible that these individuals were already at risk for developing a psychotic disorder which has been triggered by substance use [84].

Visual hallucinations are generally more common in substance withdrawal and intoxication than in primary psychotic disorders [85]. Stimulant intoxication in particular, is more commonly associated with tactile hallucinations, where the patient experiences a physical sensation that they interpret has having bugs under the skin. These are often referred to as "ice bugs" or "cocaine bugs" [85]. Tactile hallucinations can also occur in alcohol withdrawal; however, auditory and visual hallucinations are more common [85].

Those with stimulant psychosis will sometimes be more agitated, energetic and physically strong, more challenging to contain in a safe environment, and more difficult to calm with sedating or psychiatric medication than people with psychosis not related to the use of stimulants [86]. Other features that differentiate substance-induced psychosis from schizophrenia include a lack of negative and cognitive symptoms with a return to normal inter-episode functioning during periods of abstinence.

It is important to differentiate between symptoms of psychosis and delirium. Delirium presents as a disturbance of consciousness and cognition that represents a significant change from the person's previous level of functioning. The person has a reduced awareness of his/her surroundings, his/her attention wanders, questions often have to be repeated, he/she has difficulty concentrating, and it may be difficult to engage him/her in conversation. Changes in cognition may include short-term memory impairment, disorientation (in regards to time or place) and language disturbance (e.g., difficulty finding words, naming objects, writing). Perceptual disturbances (e.g., hallucinations) may also occur. Delirium develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day. For example, a person may be coherent and co-operative in the morning but in the afternoon may be disruptive and wanting to go home to a partner who died years ago. The identification of substance-induced delirium is particularly important for clients undergoing alcohol withdrawal as delirium may progress to delirium tremens, a serious complication that may result in death [87].

CHAPTER 6: HOW DO YOU IDENTIFY COMORBIDITY?

KEY POINTS

- Given the high rates of co-occurring mental health conditions among clients of AOD treatment services, it is essential that routine screening and assessment be undertaken for these conditions as part of case formulation.
- Screening and assessment set the scene for the future client-worker relationship and need to be conducted in a friendly and empathic manner.
- It is important to consider a range of aspects in the process of case formulation, not only AOD and mental health issues (e.g., socio-cultural factors, motivation, living situation and medical and personal history).
- Full assessment should ideally occur subsequent to a period of abstinence, or at least when not withdrawing or intoxicated. Multiple assessments should be conducted throughout a person's treatment as symptoms may change over time.
- It is important to provide assessment feedback to the client in a positive, easily understood manner.

Despite high rates of mental health conditions among clients of AOD services, it is not unusual for these comorbid conditions to go unnoticed by AOD workers [68]. This is mostly because they are not routinely looking for these conditions. As mentioned in Chapter 4, all clients should be screened and assessed for comorbidity as part of routine clinical care. This chapter describes methods of screening and assessing for mental health conditions, which should form part of the case formulation process for all clients.

Identifying the needs of clients is the first step. It is important whatever needs the client might have are recognised because they will undoubtedly impact upon AOD treatment. Early diagnosis and treatment of mental health disorders can improve treatment outcomes [88]. Identification does not necessarily mean that the AOD worker has to personally treat the difficulty the client is experiencing; however, they do need to consider the impact of these needs, manage them accordingly, and engage other services where necessary. It is often difficult to determine which symptoms are attributable to which disorders. Once symptoms are identified more specialised assessment may be required by mental health providers, psychologists, or psychiatrists to determine whether the person has a diagnosable disorder (client referral is discussed further in Chapter 9). It is equally important that other issues identified (e.g., problems involving employment, housing, medical care) are dealt with appropriately, which may also require consultation with other services.

Case formulation

Case formulation involves the gathering of information regarding factors that may be relevant to treatment planning, and formulating a hypothesis as to how these factors fit together to form the current presentation of the client's symptoms [89]. The primary goal of AOD treatment services

is to address clients' AOD use. However, in order to do so effectively, AOD workers must take into account the broad range of issues that clients present with. As discussed in Chapter 3, clients of AOD treatment services, those with comorbid conditions in particular, often have a variety of other medical, family and social problems (e.g., housing, employment, welfare or legal problems). These problems may be the product of the client's AOD and mental health conditions, or they may be contributing to the client's AOD and mental health conditions, or both. According to the stress-vulnerability model [90], the likelihood of developing a mental health condition is influenced by the interaction of these biological, psychological and social factors. These factors also affect a person's ability to recover from these symptoms and the potential for relapse.

After developing a case formulation, the AOD worker should be aware of:

- What problems exist? How they developed? How they are maintained?
- All aspects of the client's presentation, current situation, and the interaction between these different factors and problems.

This information is the first step to devising (and later revising) the client's treatment plan. There is no standardised approach to case formulation [91], but it is crucial that a range of different dimensions be considered, including history of present illness, AOD use history (amount and frequency, abuse or dependency syndrome), physical/medical conditions, mental state, psychiatric history, trauma history, suicidal or violent thoughts, readiness to change, family history, criminal history, and social and cultural issues. Consideration also needs to be given to the client's age, sex, sexual orientation, ethnicity, spirituality, socio-economic status, and cognitive abilities.

Given the high rates of co-occurring mental health conditions among clients of AOD treatment services, it is essential that routine screening and assessment be undertaken for these conditions as part of case formulation. Screening is the initial step in the process of identifying possible cases of co-occurring mental health conditions [92]. This process is not diagnostic (i.e., it cannot establish whether a disorder actually exists); rather, it identifies the presence of symptoms which may indicate the presence of a disorder. Thus, screening helps to identify individuals whose mental health requires further investigation by a professional trained and qualified in diagnosing mental health disorders (e.g., registered or clinical psychologists, or psychiatrists).

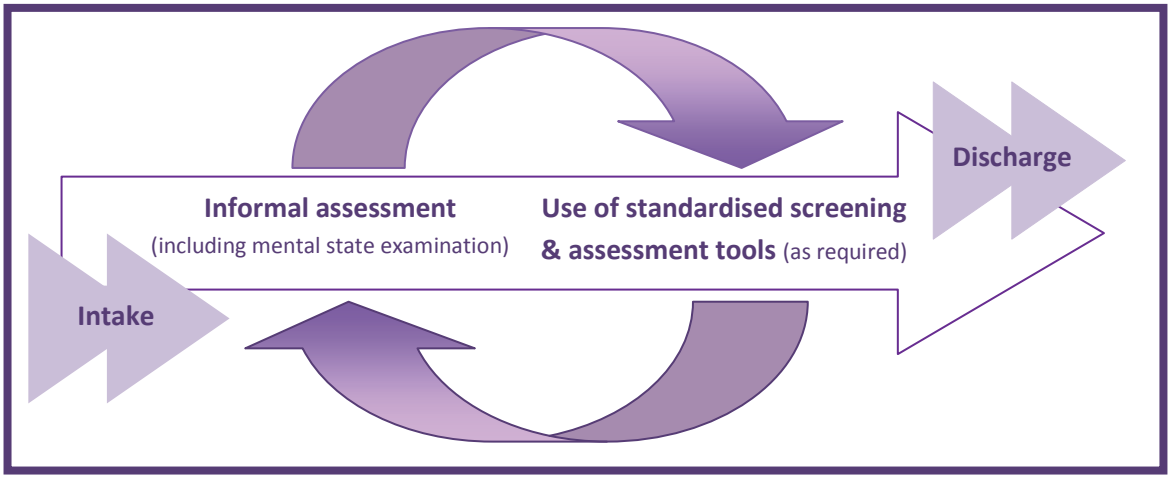
The potential clinical issues that these conditions can present suggest that screening for co-occurring mental health conditions should always be completed in the initial phases of AOD treatment. Early identification allows for early intervention, which may lead to better prognosis, more comprehensive treatment, and the prevention of secondary disorders [93]. Diagnostic assessment should ideally occur subsequent to a period of abstinence [94, 95], or at least when the person is not intoxicated or withdrawing. While the length of this period is not well established, a stabilisation period of between two to four weeks is recommended [96]. If symptoms persist after this period, they can be viewed as independent rather than substance-induced. Realistically, such a period of abstinence is a luxury rarely afforded in AOD treatment settings and, therefore, to avoid possible misdiagnosis, it has been recommended that multiple assessments be conducted over time [53, 97]. This process allows the AOD worker to formulate a

hypothesis concerning the client's individual case and to constantly modify this formulation, allowing for greater accuracy and flexibility in assessment.

Screening forms the first part of the assessment process. Unlike screening, assessment is a process rather than a one-off event, which involves the ongoing monitoring of clients' mental health symptoms. Ongoing assessment is important because clients' mental health symptoms may change throughout treatment. For example, a person may present with symptoms of anxiety and/or depression upon treatment entry; however, these symptoms may subside with abstinence. Alternatively, a person may enter treatment with no mental health symptoms, but symptoms may develop after a period of reduced use or abstinence, particularly if the person has been using substances to self-medicate these symptoms.

Groth-Marnat [98] suggests that a combination of both informal and standardised assessment techniques is the best way to develop a case formulation. Figure 8 depicts how these techniques work together. In addition to these assessments, with the client's consent, it may be useful to talk with family members or carers; they can provide invaluable information regarding the client's condition which the client may not recognise or may not want to divulge [74].

Figure 8. The ongoing case formulation process



Note: Figure 8 illustrates the need for assessment to be repeated throughout treatment, from intake through to discharge, to inform the ongoing revision of a person's treatment plan.

Informal assessment

The informal assessment takes the form of a semi-structured interview and should cover the following:

- Mental state.
- Source of referral and current health care providers.
- Presenting issues.
- AOD use history.
- Current situation.
- Personal, medical and family history.
- Trauma history.
- Psychiatric history.
- Risk assessment.
- Criminal history.
- Strengths and weaknesses.
- Readiness for change.

For an effective assessment, it is important to provide a non-judegmental, empathetic, private and confidential environment. Any limits to confidentiality should also be explained.

Mental state

A crucial component of the assessment process is the evaluation of the client's mental state and presentation. An assessment of mental state should include:

- Appearance.
- Behaviour.
- Speech and language.
- Mood and affect.
- Thought content.
- Perception.
- Cognition.
- Insight and judgement.

The type of information sought in each of the above domains is outlined in Table 9. It should be noted that all of the aforementioned factors may be affected by intoxication or withdrawal from substances. The mental state examination should not consist of a series of direct questions, but rather should be based on an overall evaluation of the client during the assessment (or preferably a number of assessments). A record of the mental state examination should be completed after (rather than during) conversations with the client. Appendix F presents a form which may be useful in guiding note-taking for the mental state examination.

Table 9. Assessment of mental state

Appearance
How does the client look? • Posture – slumped, tense, bizarre. • Grooming – dishevelled, make-up inappropriately applied, poor personal hygiene. • 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.
How is the client reacting to the current situation and assessor? • Angry/hostile towards assessor/others. • Unco-operative or withdrawn. • Over familiar/inappropriate/seductive. • Fearful, guarded, hypervigilant.

Table 9. Assessment of mental state (continued)

Speech and language
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?
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 and affect
How does the client describe his/her emotional state (i.e., mood)? • Down/depressed; angry/irritable; anxious/fearful; high/elevated.
What do you observe about the client's emotional state (i.e., affect)? • Depressed – flat, restricted, tearful, downcast. • Anxious – agitated, distressed, fearful. • Irritable, hostile. • Labile – rapidly changing. • Inappropriate – inconsistent with content (e.g., laughs when talking about mother's death). • 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 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?

Table 9. Assessment of mental state (continued)

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 or unseen people/ objects? • Any other perceptual disturbances, such as derealisation (feeling one is separated from the outside world), depersonalisation (feeling separated from one's own personal physicality), heightened/ dulled perception?
Cognition
Level of consciousness • Is the client alert and oriented to time, place, person? • Is the client attentive during the interview (drowsy, stuporous, 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 judgement
• 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 judgements about his/her situation?

Adapted from NSW Department of Health [99].

Source of referral and current health care providers

Clients may have various sources of referral to treatment. For instance, they may be referred by their GP, family or friends, or corrective services. The most common form of referral is self-referral [100].

In addition to identifying the source of referral, it is important to identify all health care providers currently involved in the person's care (e.g., counsellors, psychiatrists, prescribers, GP, probation/community offender service officers, case workers, social workers). With the client's permission, the AOD worker should liaise with these providers regarding the person's treatment to ensure continuity of care.

Presenting issues

Ascertain what the client perceives to be his/her biggest issues and the reasons why he/she is in treatment. This is usually broader than the AOD issue (e.g., psychological, social, health, legal, accommodation, financial).

AOD use history

It is important to gain an understanding of the range of substances used, the quantity and frequency of use, duration of use, previous AOD-related problems, circumstances of use, risk behaviours related to use, and previous treatment/attempts to change (and why these were successful or unsuccessful). It can be useful to ask the client to describe a normal day, to attain some of this information and try to help the client evaluate the ways in which his/her AOD use affects his/her health, relationships, legality and livelihood (e.g., finances, work). This typical day situation is explained in greater detail in Appendix D on motivational interviewing.

Current situation

Enquire about the client's current accommodation, living arrangements, social support, significant relationships, physical health, study, work, legal and financial issues.

Personal, medical and family history

Enquire about the client's family context, past experiences, occupational history, leisure interests, legal issues, risk-taking behaviour, medical history, current and past medications (including psychiatric medication) and family history of AOD and/or mental health problems.

Trauma history

It is important to identify whether the client has experienced any traumatic events in his/her life [101, 102]. As described in Chapter 5, traumatic events do not refer to any event that the person has found upsetting. Rather, they are events where the individual perceived his/her own (or someone else's) life or physical integrity to be at risk, causing them to feel intense fear, helplessness or horror. The trauma may be a one-off event or it may have occurred over a period of time [1].

A history of trauma exposure may be integrally linked with the person's current substance use; a number of people with substance use disorders who have experienced trauma describe their use as an attempt to self-medicate the thoughts and feelings they have had since the trauma. The presence of a trauma history also indicates that further investigation is required to determine whether the person may have symptoms of PTSD (described in Chapter 5).

While identification of past trauma is important, questioning needs to be sensitive and should not be pursued if the client does not wish to discuss it. Before conducting trauma assessments, workers should seek training and supervision in dealing with trauma responses. Some AOD workers may be reluctant to discuss trauma with their clients due to events that have happened in their own lives. These workers should seek assistance from their colleagues and should not be forced to conduct trauma assessments if they are not comfortable doing so.

Before questioning the client, the AOD worker should:

- Seek the client's permission to ask him/her about exposure to traumatic events.
- Advise the client that he/she does not have to talk about these experiences or provide any detail if he/she does not want to.
- Clearly communicate the reasons for asking about past trauma. It may not be readily apparent to the client that his/her current situation may be related to his/her past [101].
- Advise the client that talking about traumatic events can be distressing; even clients who want to talk about his/her trauma history may underestimate the level of emotion that results [102]. It should be noted that studies have found that while some people may become upset when talking about these events, talking about the trauma does not overwhelm or re-traumatise the majority of people. On the contrary, most people describe the process as a positive experience [103-105].
- Advise the client of any restrictions on confidentiality; for example, in relation to the mandatory reporting of children at risk or serious indictable offenses.

When broaching the subject of trauma, ask the client if he/she has ever experienced any traumatic events such as witnessing or experiencing: car accidents or other types of accidents, natural disasters, war, adult/childhood physical or sexual assault, having been threatened. Reliable reporting of events is best obtained by asking about specific event types. Under-reporting of exposure tends to occur when people are asked only broad questions such as "have you ever experienced a traumatic event?" [106]. Standardised screening tools such as the Traumatic Life Events Questionnaire (TLEQ) and Trauma History Questionnaire (THQ) described in Appendix G may be used to assess for a history of trauma exposure. Some clients find it easier to complete a self-report screener than to say aloud to the assessor that they have, for example, been raped [102]. However, such screeners should always be completed with an AOD worker present and should never be given to the client to complete at home.

It is important to understand that clients may be uncomfortable answering questions relating to past trauma because of the personal nature of such questions. Client discomfort may also be associated with distrust of others in general (or of service providers in particular), a history of having their boundaries violated, or fear that the information could be used against them [101].

During the trauma assessment it is essential that the AOD worker questioning the client does not "dig" for information that is not forthcoming as this may result in destabilisation [102]. For those who have experienced interpersonal trauma in particular, such pressure from an authority figure may imitate the interpersonal dynamics that were evident in an abusive relationship and exacerbate trauma symptoms. There is an inherent power imbalance in the helper-helped relationship and AOD workers must do their best to reduce this inequity [101]. Trauma and substance use are both characterised by the loss of control and it is important that a sense of control be re-established. The following are some additional guidelines on discussing traumatic experiences with clients [107]. Further information regarding the management of trauma symptoms is provided in Chapter 7.

- **Adopt a non-judgemental attitude.** Individuals who have experienced trauma often feel a great deal of shame and guilt either in relation to the trauma itself or how they reacted to the trauma. It is important not to judge how the person reacted during or after the trauma. It is easy to judge people harshly with the benefit of hindsight, but even if they did make a mistake in judgement, they did not deserve to suffer.
- **Display a comfortable attitude if the client describes their trauma experience.** Some clients will have had experiences which people do not want to hear about, especially the gruesome or horrific details. They need to know that they can tell you anything.
- **Praise the client for having the courage to talk about what happened.** The client needs to know that you appreciate how difficult it is for him/her to talk about his/her trauma.
- **Normalise the client's response to the trauma and validate their experiences.** Many people who have experienced trauma (especially those with PTSD) feel that they are "going crazy" because of the feelings they may have had since the trauma (e.g., re-experiencing the event, avoidance, hypervigilance). Just hearing from a professional that the reactions they are experiencing are common helps normalise their experience. Normalisation and validation are discussed in further detail in Chapter 7.

Psychiatric history

Enquire as to whether the client has any current mental health symptoms (such as depression, anxiety, psychosis), whether he/she has experienced these in the past, and whether he/she has ever been diagnosed with a mental health disorder. Some of the common symptoms that clients describe are illustrated in the case studies provided in Appendix C. If the client has experienced mental health symptoms or has been diagnosed with a mental health disorder, ask about the timing of these symptoms:

- When did the symptoms start (did they start prior to AOD use)?
- Do they only occur when the person is intoxicated or withdrawing?
- Have the symptoms continued even after a period of abstinence (approximately one month)?
- Do the symptoms change when the client stops using substances (i.e., do they get better or worse, or stay the same)?
- Is there a family history of the particular mental health condition?

If symptoms arise only in the context of intoxication or withdrawal, it is likely that they are substance induced, and will resolve with a period of abstinence without the need for any direct intervention [30, 83, 108]. It is nonetheless important for these symptoms to be managed to prevent the client from relapsing in the early stages (see Chapter 7). The duration of abstinence may vary depending on substances used; however, most should start to see considerable improvement over a period of one month [109].

If the mental health symptoms started prior to the onset of substance use, symptoms persist even during periods of abstinence, or there is a family history of the particular mental health condition, the client may have a mental health condition that is independent of his/her substance use.

Risk assessment

It is important to assess the risk a client poses to him/herself or others in the informal assessment interview. This includes suicidal thoughts/attempts, self-harm, domestic violence (perpetration or victimisation), homicidal thoughts/attempts, and child welfare. In any situation where you perceive the risk as alarming, other services may need to be enlisted (e.g., police, ambulance, crisis teams). This assessment also includes the evaluation of safety regarding sexual practices, injecting practices and other high-risk behaviours as appropriate.

Clients of AOD treatment services are at high-risk of suicide [110]. The presence of comorbid mental health disorders further increases this risk [111, 112]. Therefore, it is important to conduct suicide risk assessments in the initial consultation phases and to monitor this risk throughout treatment. The assessment is a simple process through which an AOD worker can ascertain risk by directly enquiring about suicidal thoughts (frequency, intensity, plans, intent), history of suicidal behaviour and self-harm, current stressors, hopelessness, and protective factors (e.g., family, friends, other services). Discussing suicide with clients is vital and does not increase the risk of suicidal behaviour [113]. Rather, sensitive questioning by a worker can be a relief for clients who have been harbouring thoughts of self-harm, and an opportunity to receive the help and support that is needed [86]. Appendix H provides a suicide risk assessment template. Questions used to complete this assessment might include [99]:

- 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?

If the client appears to be at high risk based on this initial screen, immediate intervention should be sought from a crisis mental health team. A guide as to what might entail various levels of risk and responses to these risk levels are given in Figure 9. Even moderate risk requires serious attention. If the risk is lower (e.g., no specific plan, or previous attempts) then the goal should be keeping the client in a safe and supportive environment and engaging with mental health or counselling services as appropriate.

Criminal history

Enquire about past and present criminal behaviour, arrest history, any impending court cases or outstanding warrants.

Strengths and weaknesses

A client's strengths and weaknesses can usually be deduced from other information collected during the assessment process. Some examples of strengths may include good social support, high self-esteem and insight. Some weaknesses may be unemployment, risk-taking behaviour or negative self-image.

Figure 9. Guide to rating severity of suicidal risk

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 (subjective or objective), few risk factors, identifiable protective factors (e.g., social support, specific cultural/religious beliefs, problem solving skills).	• 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 mental health 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 unavailable. • 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 the future, impaired self-control, severe dysphoria, previous attempts, many risk factors, and no protective factors.	

Adapted from Lee et al. [114], Rudd et al. [115], and Schwartz et al. [116].

Readiness for change

It may be helpful to ascertain how motivated the client is to change his/her current AOD habits. This involves an exploration of the client's perception of the positive and negative aspects of continued drug use. Prochaska and DiClemente [117] suggest that clients fall into one of six stages of change. Table 10 summarises these stages and outlines some useful interventions to use at each stage of change.

The stages of change model is also relevant in assessing motivation to receive treatment for comorbid mental health conditions. Just because a person has presented for treatment for his/her AOD use, does not necessarily mean that he/she has the same readiness to receive mental health treatment. For example, just because the client is willing to consider reducing AOD use, this does not automatically mean that he/she is also ready to deal with the trauma-related symptoms they experience due to abuse suffered as a child.

Appendix I provides a useful matrix for assessing motivation for both AOD and mental health treatment.

Table 10. Readiness for change

Stage	Description	Interventions
Pre-contemplation	Client shows no interest in behaviour change.	• Aim to raise doubt about perceptions. • Link behaviour with consequences. • Reduce harm. • Highlight negative consequences. • Build confidence and hope.
Contemplation	Change is being considered, with negative concerns rising in awareness but ambivalence remains.	• Motivational interviewing can assist in resolving ambivalence. • Elicit reasons for change and risks of not changing.
Preparation or Determination	Client is committing to and preparing for change.	• Goal setting, match to needs. • Identify risks for relapse. • Build self-efficacy. • Discuss treatment options.
Action	Active behavioural change occurs.	• Support self-efficacy. • Assist with coping and education. • Reinforce positive behaviour. • Avoid exposure to AOD use environment.
Maintenance	Changes are consolidated and maintained.	• Reinforce positives and assist with lapses. • Self-help groups. • Provide relapse prevention techniques. • Emphasise client alertness. • Work towards longer-term goals.
Relapse	Not so much a stage in itself, but rather any slip or lapse into any of the previous stages.	• Avoid demoralisation. • Remain positive. • Normalise the process of lapsing. • Help the client to learn from mistakes.

Adapted from Clancy and Terry [118].

Standardised screening and assessment

The informal assessment process can be aided by a range of standardised screening and assessment tools. Standardised tools can be a useful means of gathering data by providing a reliable and valid view of the client's difficulties and current life situation [119, 120]. Furthermore, when conducted appropriately, the process of standardised assessment can be a source of rapport building [121].

Groth-Marnat [98] suggests that when conducting standardised assessment, it is important to:

- Provide the client with the reasons for assessment and the purpose of each instrument.
- Explain that it is a standard procedure.
- Explain how standardised assessment can be useful in helping clients achieve their goals (e.g., by providing an objective measure).
- Provide appropriate and timely feedback of the results of the assessment.

Standardised assessment should be completed upon entry into and exit from treatment, as well as at follow-up [119, 122]. Test results can provide useful clinical information (for both the client and AOD worker) on the client's case and an evaluation of how effective treatment has been. A variety of different tools are used, some of which are empirically established instruments, whilst others are purpose-built, internally designed tools with increased practicality and utility but unknown validity and reliability [91]. Some helpful screening tools have been included in Appendices J-P.

Standardised tools cover a range of areas which may be relevant to AOD services. Here we provide an overview of some useful standardised tools that can be used to screen and assess for co-occurring mental health conditions. Focus has been given to tools that require minimal training to use and are freely available. A range of additional screening tools are described in Appendix G. It should be noted that some of these tools require specialist training, or else mislabelling, misinterpretation, or inappropriate use may occur [98]. Some tools are copyright protected and need to be purchased, and/or require the user to have specific qualifications. The requirements of each tool described here (and in Appendix G) are explained accordingly. It is important that workers are aware of what they are and are not trained to use, and seek training where required. Readers are also referred to Dawe and colleagues [123] for a comprehensive review of screening tools. This document is available online at www.alcohol.gov.au.

The following is an overview of some of the tools that AOD workers can use to screen for symptoms of mental health conditions in their clients. As mentioned earlier in this chapter, screening is designed only to highlight the existence of symptoms, not to diagnose clients. Most of the measures described are self-reporting (i.e., they may be self-completed by the client). Others, however, need to be administered by the AOD worker. It should be noted that, unfortunately, there are no brief measures with established reliability and validity for the identification of possible personality disorders. The possible presence of these disorders needs to be assessed by a health professional who is qualified and trained to do so (e.g., a registered or clinical psychologist, or psychiatrist).

Kessler Psychological Distress Scale (K10)

The **Kessler psychological distress scale (K10)** [124] is a widely used, simple self-report measure of psychological distress which can be used to identify those in need of further assessment for anxiety and depression (Appendix J). This measure was designed for use in the general population; however, it may also serve as a useful clinical tool. The K10 comprises 10 questions that are answered using a five-point scale (where 5 = all of the time, and 1 = none of the time). For all questions, the client circles the answer truest for them in the past four weeks. Scores are then summed with the maximum score of 50 indicating severe distress, and the minimum score of 10 indicating no distress. A guide to interpreting K10 scores is provided in Table 11.

Table 11. Severity of psychological distress according to K10 score

K10 score	Level of psychological distress
10-15	Low
16-21	Moderate
22-29	High
30-50	Very High

Adapted from Andrews and Slade [125].

PsyCheck

The Australian **PsyCheck** screening tool (Appendix K) was recently developed and has been shown to be a valid and useful resource for clinicians [114]. The screening tool has three sections:

- A General Mental Health Screen, including history of treatment.
- Suicide/Self-Harm Risk Assessment.
- The Self Reporting Questionnaire (SRQ) [126], that assesses for current symptoms of depression and anxiety.

The PsyCheck manual [114] includes training on how to administer, score and interpret the results of each section, and the subsequent steps to take according to the screening results. If the results of the screening tool indicate a high presence of symptomology, further assessment may be warranted. More information on the PsyCheck screening tool is available at www.psycheck.org.au.

The Depression Anxiety Stress Scales (DASS)

The **Depression Anxiety Stress Scale (DASS)** [127] has also been shown to be a valid and reliable measure of the dimensions of depression, anxiety and stress separately but also taps into a more general dimension of psychological distress [128]. The DASS is available in two forms: the DASS-21 and the DASS-42. The use of either test is sufficient in the screening process (i.e., the use of both is unnecessary). The two forms have 21 and 42 items respectively and are each rated on a four-point scale of how much each particular statement applies to the individual. The DASS is a self-

report instrument, and no special skills are required to administer or score it. However, decisions based on particular score profiles should be made only by experienced clinicians who have carried out an appropriate clinical examination [127]. Nevertheless, it is a useful tool for screening and assessment and the DASS-21 is included in Appendix L. A guide to interpreting DASS scores is provided in Table 12.

Table 12. Interpreting DASS scores

DASS scale score	Level of psychological distress
0-77	Normal
78-87	Mild
87-95	Moderate
95-98	Severe
98-100	Extremely severe

Adapted from Lovibond and Lovibond [127].

The Primary Care PTSD Screen

The **Primary Care PTSD Screen (PC-PTSD)** [129] is a very brief four-item screen that was designed for use in primary care and other medical settings to screen for PTSD [129]. The screen includes an introductory sentence to cue respondents to traumatic events; however, it does not include a list of potentially traumatic events. Among patients with AOD use disorders, a score of three or above has been shown to indicate the presence of PTSD [130]. This scale is included in Appendix M.

Trauma Screening Questionnaire (TSQ)

The **Trauma Screening Questionnaire (TSQ)** [131] is a recently developed 10-item screening tool for PTSD which has shown promising results in preliminary investigations. Respondents endorsing at least six items should be assessed for the presence of PTSD [131]. The TSQ has been shown to be superior to a range of other PTSD screening measures [123]. The scale is included in Appendix N.

The Psychosis Screener

The **Psychosis Screener (PS)** [132] is an interview-style questionnaire rather than self-report and is therefore administered by the AOD worker (Appendix O). It uses elements of the Composite International Diagnostic Interview (CIDI) to assess the presence of characteristic psychotic symptoms. The PS has been shown to have a moderate ability to discriminate between those who meet diagnostic criteria for psychotic disorders and those who do not in community and prison samples [132, 133]. The PS consists of seven items; the first six items cover the following features of psychotic disorders: delusions of control, thought interference and passivity, delusions of reference or persecution and grandiose delusions. The final item records whether a respondent has ever received a diagnosis of schizophrenia.

The Indigenous Risk Impact Screen (IRIS)

The **Indigenous Risk Impact Screen (IRIS)** [134] was developed by an expert group of Indigenous and non-Indigenous researchers in Queensland to assist with the early identification of AOD problems and mental health risks. This screen has been shown to be reliable, simple and effective [135]. The IRIS consists of 13 items which are asked by the AOD worker. The IRIS is made up of two sets of questions, with items 1 through 7 forming the "AOD risk" component and items 8 through 13 forming the "mental health and emotional well-being risk" component. The items assessing mental health and emotional well-being focus on symptoms of anxiety and depression. The client chooses the answer from a list of response options which best describes his/her current situation. After tallying up the corresponding numbers, a score of 10 or greater on the AOD component indicates problematic use of AOD is likely, while a score of 11 or greater indicates the need for further assessment or brief intervention regarding mental health and emotional well-being [135]. The IRIS is included in Appendix P.

Feedback

Following completion of assessment procedures, it is important to interpret the results for the client in a manner that the client can understand (i.e., not just giving them numerical test scores). When feeding back assessment results, consider the following [121]:

- Focus first on the client's strengths.
- Gently and tactfully outline the client's difficulties.
- Focus on the pattern of results rather than just an overall score.
- Pull the assessment results together and offer hope for the future by discussing a treatment plan.

Again it is important to stress that these screening measures are not diagnostic; therefore, it is important not to label a client as having a diagnosis of a disorder unless it has been made by a suitably qualified mental health professional (e.g., a registered or clinical psychologist, or psychiatrist). Rather, it is best to focus on the symptoms displayed by the client.

If mental health symptoms are identified, it is important to discuss with the client what they may expect to experience in relation to these symptoms should he/she reduce or stop using substances. As discussed in Chapter 4, if these symptoms are substance-induced, they are likely to dissipate if the person reduces or stops his/her use. On the other hand, the client's mental health symptoms may increase when he/she reduces or stops using, particularly if he/she has been using to self-medicate these symptoms. The latter scenario is especially common among people who have a history of post-traumatic stress symptoms. It is important that the client knows that you will be monitoring these symptoms to determine whether further treatment may be required.

Chapter 7:
Managing comorbidity

CHAPTER 7: HOW DO YOU MANAGE CLIENTS WITH COMORBIDITY?

KEY POINTS

- Comorbid mental health symptoms can be managed and controlled whilst the client undergoes AOD treatment.
- It is essential to consider the whole person (from psychological, physical and sociodemographic perspectives) when managing symptoms of comorbid mental conditions.
- Suicide risk should be monitored throughout treatment.
- Motivational enhancement, simple CBT-based strategies, relaxation and grounding techniques can be useful in managing AOD use as well as mental health conditions.
- Symptoms of trauma, grief, and loss can be managed through anxiety management strategies and open discussion with the client. It is important to normalise the experience of these symptoms for the client.
- When dealing with more challenging clients, it is necessary to ensure a safe environment, set clear boundaries and place strong emphasis on engagement and rapport building.

There are various ways to effectively manage the symptoms of comorbid mental health conditions while treating AOD use. This chapter aims to provide AOD workers with a range of techniques with which to manage mental health symptoms. These symptoms may be identified through screening and assessment processes (described in Chapter 6), or they may arise spontaneously during the client's treatment. There is a distinction between the management of comorbid mental health conditions and their treatment. The goal of management is to allow AOD treatment to continue without mental health symptoms disrupting the treatment process, and to retain clients in treatment who might otherwise discontinue such treatment. Without further treatment, these techniques on their own may not provide long-term relief from symptoms; however, they may allow the client's AOD use to be treated in the interim.

It is essential to consider the whole person and accept that one approach is not necessarily going to work for all clients. Different clients present with unique psychological and sociodemographic backgrounds and it is important to take these factors into consideration in managing symptoms of comorbid mental health conditions. One advantage of these management techniques is that no diagnosis is required prior to their use (i.e., symptoms are managed rather than disorders being treated). Readers are nonetheless encouraged to read Chapter 5 of these Guidelines to familiarise themselves with the signs and symptoms of mental health disorders.

Suicidality

The term "suicide" is used in reference to any self-inflicted injury resulting in death, where death was the deliberate intention [136]. Suicidality therefore relates to any behaviours, thoughts, or

intentions which precede this act or suggest that death may be desired (e.g., self-harming, risk-taking behaviour, suicidal thoughts, previous attempts, current plans).

A thorough assessment of suicide risk should take place in the initial consultation phases and should also be monitored throughout treatment. How to assess for suicide risk and appropriate responses to varying levels of risk is explained in depth in Chapter 6 of these Guidelines. Table 13 outlines the dos and don'ts in regard to the management of suicidality.

Table 13. Dos and don'ts of managing a client who is suicidal

Do:

- ✓ Ensure the client has no immediate means of self-harm; remove weapons and potentially dangerous objects.
- ✓ Talk to the client alone – without any family or friends present.
- ✓ Allow sufficient time to discuss the issue.
- ✓ Discuss limits of confidentiality.
- ✓ Introduce suicide in an open, yet general way.
- ✓ Be non-judgmental and empathetic.
- ✓ Emphasise that there is help available.
- ✓ Validate the client's feelings and emphasise the fact that speaking with you is a positive thing.
- ✓ Consider what is the predominate concern for the client and how you might be able to help remedy this concern (e.g., removal of stresses, decreasing social isolation).
- ✓ Contact the local mental health crisis team if the client appears to be at high-risk.

Don't:

- × Invalidate the person's feelings (e.g., "all you have to do is pull yourself together", "things will work out").
- × Panic if someone starts talking about their suicidal feelings. These feelings are common and talking about them is an important, encouraging first step.
- × Be afraid of asking about suicidal thoughts. Most clients are quite happy to answer such questions.
- × Worry that questions about suicide may instil the idea in the client's mind.
- × Leave a high-risk client unattended.

Adapted from NSW Department of Health [99].

Symptoms of depression

Depressive symptoms include low mood; markedly diminished interest or pleasure in all, or most activities; sleep disturbances; appetite disturbances; irritability; fatigue; psychomotor agitation or retardation; poor concentration; feelings of guilt, hopelessness, helplessness and worthlessness; and suicidal thoughts (see Case Studies 1, 2, and 5 in Appendix C).

On occasion these symptoms can alternate with mania (a persistently elevated, euphoric, irritable or expansive mood state). Manic symptoms include grandiosity, flights of ideas, hyperactivity, decreased sleep, psychomotor agitation, talkativeness and distractibility.

In order to avoid the risk of poor outcomes during AOD treatment, symptoms of depression need to be managed. Furthermore, negative mood is often a trigger for relapse, and therefore addressing depressive symptoms is also an important part of relapse prevention [137]. The techniques outlined in Table 14 can help AOD workers to manage clients with depressive symptoms.

Table 14. Dos and don'ts of managing a client with symptoms of depression

Do:

- ✓ Encourage and emphasise successes and positive steps (even just coming in for treatment).
- ✓ Take everything they say seriously.
- ✓ Maintain eye contact and sit in a relaxed position – positive body language will help you and the client feel more comfortable.
- ✓ Use open-ended questions such as "So tell me about...?" which require more than a "yes" or "no" answer. This is often a good way to start a conversation.
- ✓ Constantly monitor suicidal thoughts and talk about these thoughts openly and calmly.
- ✓ Encourage the client to express his/her feelings.
- ✓ Be available, supportive and empathetic.
- ✓ Offer realistic hope (i.e., that treatment is available and effective).
- ✓ Provide contact details of counselling services and offer to make referrals if required (many depressed people struggle to do this alone).
- ✓ Encourage participation in healthy, pleasurable and achievement-based activities (e.g., exercise, hobbies, work).

Don't:

- × Make unrealistic statements or give unrealistic hope, like "everything will be fine".
- × Invalidate the client's feelings.
- × Be harsh, angry, or judgmental. Remain calm and patient.
- × Act shocked by what the client may reveal.

Adapted from Scott et al. [138] and Clancy and Terry [118].

A number of simple strategies based on cognitive behavioural therapy (CBT) are also useful in managing clients with these symptoms, including [114, 139]:

- Cognitive restructuring.
- Pleasure and mastery events scheduling.
- Goal setting.
- Problem solving.

These techniques are discussed in greater detail in Appendix Q.

It is important to note that many depressive symptoms (and many anxiety symptoms) will subside after a period of abstinence and stabilisation [30, 108, 121]. It is useful to explain to clients that it is quite normal to feel depressed (or anxious) when entering treatment but that these feelings usually improve over a period of weeks. During and after this time, constant monitoring of symptoms will allow the worker to determine if the client requires further treatment for these symptoms. If the client has a history of depressive episodes in circumstances when he/she is not intoxicated or withdrawing, he/she may have an independent depressive disorder. For these clients, it is unlikely that their depressive symptoms will resolve completely with abstinence – indeed their symptoms may even increase. In such cases, clients should be assessed for a depressive disorder and the treatment options described in Chapter 8 should be considered.

Symptoms of anxiety, panic or agitation

Anxiety involves excessive fear or worry, difficulty controlling this worry, and/or repetitive intrusive thoughts or actions. Symptoms include poor concentration, inability to relax, sleep disturbances, depersonalisation, and physical symptoms such as dizziness, faintness, headaches, nausea, indigestion, loss of sexual pleasure, breathing difficulties, sweating, tension and muscle pain, and heart palpitations (see Case Studies 1 and 3 in Appendix C). Techniques for managing clients with symptoms of anxiety are outlined in Table 15. Relaxation techniques are also a common means to manage the distressing and distracting symptoms of anxiety [140].

Some useful relaxation methods include:

- Progressive muscle relaxation.
- Controlled or abdominal breathing.
- Calming response.
- Visualisation and imagery.
- Grounding.

Each method works best if practiced daily by clients for 10-20 minutes; however, not every technique may be appropriate for every client. These techniques are described in detail in Appendix R. Some of the cognitive behavioural techniques described in Appendix Q (i.e., cognitive restructuring, structured problem solving, and goal setting) may also be useful in managing symptoms of anxiety [46, 141, 142], but again, no one strategy is effective for all clients. If the client experiences unpleasant effects from any strategy, he/she should discontinue its use.

Like depressive symptoms, many anxiety symptoms will subside after a period of abstinence and stabilisation [30, 108, 121]. It is useful to explain to clients that it is quite normal to feel anxious when entering treatment but that these feelings usually improve over a period of weeks. During and after this time, constant monitoring of symptoms will allow the worker to determine if the client requires further treatment for these symptoms. If the client has a history of anxiety in circumstances when he/she is not intoxicated or withdrawing, he/she may have an independent anxiety disorder. For these clients, it is unlikely that their anxiety symptoms will resolve completely with abstinence – indeed their symptoms may even increase. In such cases, clients

should be assessed for an anxiety disorder and the treatment options described in Chapter 8 should be considered.

Table 15. Dos and don'ts of managing a client with symptoms of anxiety

Do:

- ✓ Approach the client in a calm, confident and receptive way.
- ✓ Move and speak at an unhurried speed.
- ✓ Be patient in order to allow the client to feel comfortable to disclose information.
- ✓ Minimise the number of staff present and attending to the client.
- ✓ Minimise surrounding noise to reduce stimulation.
- ✓ Reassure the client frequently e.g., "this won't take much longer".
- ✓ Explain the purpose of interventions.
- ✓ Remain with the client to calm him/her down.

Don't:

- × Crowd or pressure the client.
- × Get frustrated or impatient.
- × Panic. The more relaxed you are the more relaxed the client is likely to feel.

Adapted from NSW Department of Health [99] and Clancy and Terry [118].

Symptoms of trauma

Following exposure to a traumatic event (e.g., witnessing or experiencing car accidents or other types of accidents, natural disasters, war, adult/childhood physical or sexual assault; being threatened) during which one feels fear, helplessness or horror, an individual may experience symptoms of PTSD (described in Chapter 5) such as:

- Recurrent "re-experiencing" of the traumatic event, through nightmares, "flashbacks" and intrusive memories.
- Persistent avoidance of thoughts, reminders or situations which are associated with the trauma, and a general numbing of emotional responsiveness.
- Persistent symptoms of increased physiological arousal, including hypervigilance towards distressing cues, sleep difficulties, exaggerated startle response, increased anger and concentration difficulties.

Examples of clients presenting with these symptoms are described in Case Studies 3 and 9 in Appendix C. Like depressive symptoms, it is common for the frequency of these symptoms to increase when a person stops drinking or using drugs [143-145]. This is because clients often use these substances to suppress these feelings and control traumatic thoughts. However, it is important to note that avoidance symptoms, rather than re-experiencing symptoms, have been associated with the perpetuation of trauma-related symptoms [146, 147]. It is therefore crucial that if a person does become upset due to these traumatic thoughts, that they are not encouraged to avoid or suppress these thoughts or feelings. Telling a person not to think or talk about what

happened may also intensify feelings of guilt and shame. For those who have experienced abuse it may closely re-enact his/her experience of being told to keep quiet about it [101]. This does not mean that clients should be pushed to revisit events or disclose information if they are not ready to do so. Rather, it means that it is understandable that the person may be upset by these thoughts and feelings that may arise, and he/she should be allowed to engage with these feelings in order to help process the trauma emotionally.

As mentioned in Chapter 6, it is crucial that clients are not forced to discuss any details about past events if they do not wish to. It is preferable that clients develop good self-care and have skills to regulate their emotions before they delve deeply into their traumatic experiences or are exposed to the stories of others; however, choice and control should be left to the client [101]. In-depth discussion of a person's trauma experiences should only be conducted by someone who is trained in dealing with trauma responses.

Notwithstanding, even without knowing the details of a client's trauma, AOD workers can use the techniques outlined in Table 16 to help clients manage their symptoms (Chapter 6 also provides guidance on how to discuss trauma with clients). Praising clients for their resilience in the face of adversity is important even if past adaptations and ways of coping are now causing problems (e.g., substance use). Understanding substance use as an adaptive response reduces the client's guilt and shame and provides a framework for developing new skills to better cope with symptoms [101].

It is important to normalise clients' feelings and convey that such symptoms are a typical and natural reaction to an adverse, traumatic event; they are not "going crazy". Letting them know that their reactions are quite normal may also help to alleviate some of the shame and guilt they have been feeling about not recovering from the trauma sooner. It is also important that trauma sufferers hear that what happened was not their fault, especially for those who have experienced sexual assault. An information sheet for clients on common reactions to trauma is provided in Appendix S. Clients may also find the relaxation techniques described in Appendix R useful for managing trauma symptoms.

Elliot and colleagues [101] also identify a number of measures that can be taken at a service level to help prevent the amplification of trauma symptoms. Staff approaches, programs, procedures, and the physical setting can be modified to create a place perceived as safe and welcoming. Such an environment is one in which there is sufficient space for comfort and privacy, the absence of exposure to violent or sexual material (e.g., staff should screen the magazines in the waiting area) and sufficient staffing to monitor the behaviour of others that may be perceived as intrusive or harassing. Many common procedures and practices may retrigger trauma reactions. For example, aggressive or confrontational group techniques can trigger memories of past abuse. Such techniques are counterproductive; those who have been exposed to abuse in particular may revert to techniques used to cope during the trauma such as dissociating or shutting down emotionally. This may then lead to the client being labelled as "treatment resistant" and, consequently, feelings of self-blame.

Table 16. Dos and don'ts of managing a client with symptoms of trauma

Do:

- ✓ Display a comfortable attitude if the client chooses to describe his/her trauma experience.
- ✓ Give the client your undivided attention, empathy and unconditional positive regard.
- ✓ Normalise the client's response to the trauma and validate his/her feelings.
- ✓ Praise the client for his/her resilience in the face of adversity.
- ✓ Praise the client for having the courage to talk about what happened.
- ✓ Use relaxation and grounding techniques where necessary.
- ✓ Educate the client on what to expect if they undergo detoxification (i.e., a possible increase in trauma-related symptoms).
- ✓ Maximise opportunities for client choice and control over treatment processes.
- ✓ Monitor depressive and suicidal symptoms.

Don't:

- × Rush or force the client to reveal information about the trauma.
- × Engage in an in-depth discussion of the client's trauma unless you are trained in trauma responses.
- × Judge the client in relation to the trauma or how he/she reacted to the trauma.
- × Abruptly end the session.
- × Encourage the client to suppress his/her thoughts or feelings.
- × Engage in aggressive or confrontational therapeutic techniques.
- × Be afraid to seek assistance.

Adapted from Ouimette and Brown [148] and Elliot and colleagues [101].

Symptoms of grief or loss

There is a multitude of different sources of grief and loss, and clients in AOD settings are often highly likely to experience these emotions for a variety of reasons (see Case Study 2). Feelings of grief or loss are often associated with traumatic experiences. It is also common for AOD clients to have lost partners, family members or friends as a result of drug use. Finally, receiving treatment for AOD issues is likely to cause feelings of loss due to the heavy role AOD use plays in the client's life [149]. Symptoms of grief and loss fall into a number of categories including [149]:

- **Emotional** – feelings of shock, numbness, disbelief, loss of control, fear, panic, confusion, anger, sadness, guilt, desire to blame, or hostility. The person is likely to fluctuate between different emotional states.
- **Psychological** – in addition to these emotions, clients may also have a preoccupation with the deceased, or a sense of the presence of the deceased. Temporary cognitive impairments are also common (e.g., concentration and memory complaints).

- **Physical/behavioural/social** – inappropriate behaviour (e.g., laughter), gastro-intestinal complaints, decreased sex drive, tension, headaches, sleep disturbances, fatigue, lethargy, avoidant or absentminded behaviour, withdrawal, social interaction changes, appetite changes, restlessness, crying, or obsessive behaviour.

Table 17 presents strategies for managing these symptoms. The main issue in grief management is to normalise the process for the client. That is, encourage and support the grieving process, and remind the client that this process is natural [149]. Everyone deals with grief and loss differently and therefore not all approaches work for all individuals. An information sheet for clients on grief and loss reactions is provided in Appendix T.

Table 17. Dos and don'ts of managing a client with symptoms of grief or loss

Do:

- ✓ Encourage the acceptance of the reality of the situation (e.g., discuss the loss, encourage client to attend gravesite), as well as the identification and experience of feelings (positive and negative) associated with loss.
- ✓ Help the client find a suitable way to remember, but also reinvest in life.
- ✓ Continually monitor levels of depression and suicidal thoughts and act accordingly; risk is increased during periods of grief (e.g., the first 12 months after a death, anniversaries, holidays).
- ✓ Be aware and understanding of feelings associated with grief, including anger.
- ✓ Give both practical and emotional support.
- ✓ Give the client your undivided attention and unconditional positive regard.
- ✓ Be aware that concentration may be affected, therefore repeat instructions, write down instructions and so on.
- ✓ Encourage healthy avenues for the expression of grief (e.g., physical activity, relaxation, artistic expression, talking, writing) rather than AOD use.
- ✓ Encourage the client to seek social support. This may include bereavement services.

Don't:

- × Avoid the reality of the situation or the feelings associated with it (e.g., use the name of deceased).
- × Judge or be surprised at how the client reacts – every person is different.
- × Time-limit the client when discussing grief, it can be a slow process.
- × Be afraid to seek assistance.

Adapted from Marsh et al. [149].

Aggressive, angry or violent behaviour

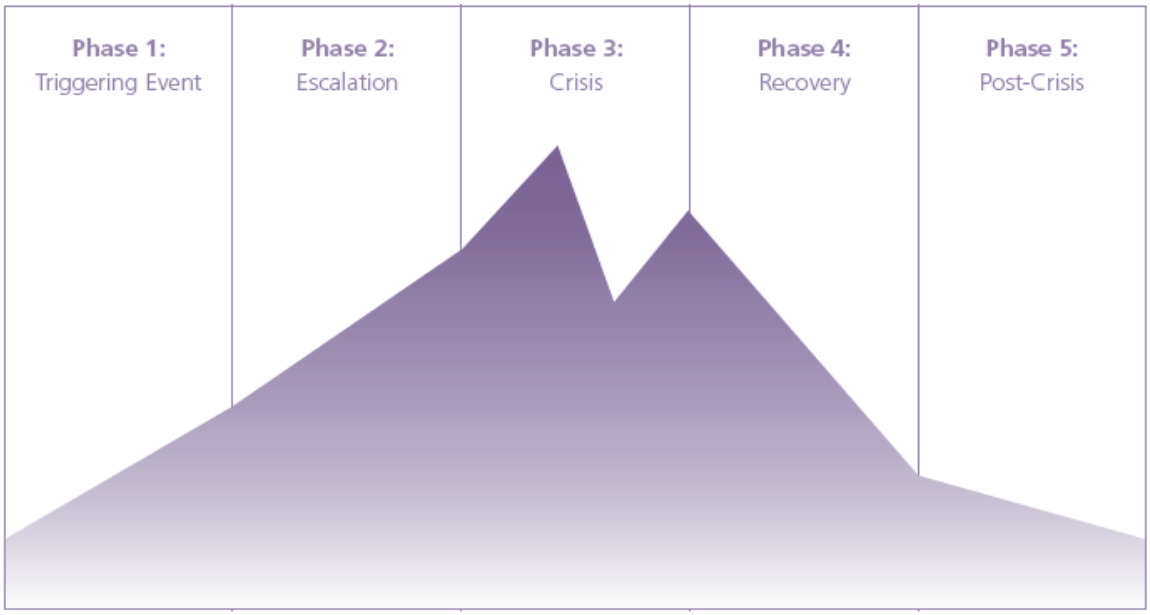
Problems relating to anger and aggression are not uncommon in AOD services and should be managed appropriately. Anger and aggression may occur regardless of whether a person has a comorbid mental health condition. Most services have their own policies and procedures in

relation to the management of aggressive or violent behaviour which workers should refer to. Table 18 outlines some general strategies for managing aggressive clients.

Phases of aggression

This section has been adapted from information provided by Sunshine Coast Mental Health Service (SCMHS) [150] and NSW Department of Health [99]. Aggressive episodes may be broken down into more detailed phases. Gaining an understanding of these phases and some of the symptom-control strategies is useful in controlling anger and aggression. Figure 10 outlines these phases of aggression.

Figure 10: Phases of aggression



Source: NSW Department of Health [99].

Phase 1: Triggering event

Phase 1 is the initial triggering event which elicits the aggression. This can be any number of things that are perceived by the client as threatening or frustrating. Some useful ways to avoid this primary phase include:

- Allowing the client personal space of up to six metres if possible.
- Avoiding standing over the client (i.e., if they are sitting, sit as well).
- Maintaining minimal eye contact (direct eye contact is confronting).
- Informing the client of anticipated delays.
- Keeping the environment relaxed, non-stimulating and non-stressful.
- Keeping your own posture and body language non-threatening (e.g., open stance and palms).
- Allowing the client to talk and be empathetic to his/her concerns.

Phase 2: Escalation

Phase 2 is the escalation phase. It is important to recognise and address signs of distress and conflict to avoid aggressive acts. Common signs include pacing, voice quivering, quick breathing, flushed face, twitching, dilated pupils, tense appearance, abusive, intimidating and derogatory remarks, and clenched fists. The LASSIE model is a useful tool for communication and de-escalation of the situation at this phase:

L Listen actively: allow the client to run out of steam before you talk.

A Acknowledge the problem/situation: validate the client's feelings, empathise.

S Separate from others: to ensure the safety of others if escalation occurs.

S Sit down: symbolises readiness to negotiate.

I Indicate possible options: give alternatives to alleviate the situation.

E Encourage the client to try these options: assist the client to follow through.

The following may also be useful in managing escalating aggression:

- Provide a safe environment for the client, yourself and others.
- The presence of a familiar person may help to calm and reassure the client.
- Do not assume aggressive behaviour is necessarily associated with mental illness.
- Know your own limits and refer/seek help if necessary.
- Be warm, friendly and non-judgemental; re-assure the client.
- Stay focused on the current situation but anticipate problems.
- Carefully monitor the physical and psychological condition of the client.
- If the client's behaviour escalates, withdraw and seek assistance immediately.
- Try to maintain a quiet, non-stimulating environment for the client (excessive noise or people may contribute to aggression).

Phase 3: Crisis

Phase 3 is the crisis phase, in which the client reacts with aggressive behaviour. The aggression can often be released indiscriminately and it is best for workers to remove themselves and any clients during this stage unless the service has other policies on dealing with violence, aggression, self-defence and/or restraint.

Phase 4: Recovery

Phase 4 is the recovery phase in which tension tends to reduce; however, the person is still in a state of high arousal and if this phase is not handled properly, aggressive behaviour may reignite. It is important to be supportive and empathic to the client at this stage, but do not crowd or threaten him/her. It is important that workers be given the opportunity to debrief. Any violence should be documented in the client's file.

Phase 5: Post-crisis depression

Phase 5 is the post-crisis depression stage. Generally the client feels fatigued and exhausted and may show feelings of guilt and dejection at having had an outburst. Support may be required from workers during this stage.

Table 18. Dos and don'ts of managing a client who is angry or aggressive

Do:

- ✓ Stay calm and keep your emotions in check.
- ✓ Adopt a passive and non-threatening body posture (e.g., hands by your side with empty palms facing forward, body at a 45 degree angle to the aggressor).
- ✓ Let the client air his/her feelings and acknowledge them.
- ✓ Ask open-ended questions to keep a dialogue going.
- ✓ Be flexible within reason.
- ✓ Use space for self-protection (position yourself close to the exit, don't crowd the client).
- ✓ Structure the work environment to ensure safety (i.e., have safety mechanisms in place such as alarms and remove items that can be used as potential weapons).
- ✓ Use the client's name when speaking to him/her.
- ✓ Make sure other clients are out of harm's way.

Don't:

- × Challenge or threaten the client by tone of voice, eyes or body language.
- × Say things that will escalate the aggression.
- × Turn your back on the person.
- × Rush the client.
- × Argue with the client.
- × Stay around if the person doesn't calm down.
- × Ignore verbal threats or warnings of violence.
- × Tolerate violence or aggression.
- × Try to disarm a person with a weapon or battle it alone.

Adapted from NSW Department of Health [99] and Malcolm [151].

Symptoms of psychosis

Acute psychosis represents one of the most severe and complex presentations, and one of the most intrusive when attempting to treat AOD use [152]. During an acute episode of psychosis a person's behaviour is likely to be disruptive and/or peculiar (see Case Studies 6 and 8 in Appendix C). Psychotic symptoms include [153]:

- Hallucinations – false perceptions such as seeing, hearing, smelling, sensing or tasting things that others cannot.
- Delusions – false beliefs that usually involve a misinterpretation of perceptions or experiences (e.g., thinking that someone is out to get you, that you have special powers, or that passages from the newspaper have special meaning for you).
- Rapid or extreme mood swings or behaviour that is unpredictable or erratic (often in response to delusions or hallucinations; e.g., shouting in response to voices, whispering).
- Disorganised thought – difficulties in goal direction such that daily life is impaired.
- Disorganised speech – illogical, disconnected, or incoherent speech.
- Catatonic behaviour – decrease in reactivity to environment (e.g., immobility, peculiar posturing, motiveless resistance to all instructions, absence of speech, flattened affect).

It is important to note that mood swings, agitation and irritability without the presence of hallucinations or delusions does not mean that the person is psychotic. Workers should respond to these clients in the usual way for such behaviour (described in this chapter), such as providing a calming environment so their needs can be met [86].

Individuals in AOD settings commonly present with sub-acute psychosis, particularly as a result of methamphetamine use. These clients may display a range of low-grade psychotic symptoms such as [86]:

- Increased agitation, severe sleep disturbance.
- Mood swings.
- A distorted sense of self, others or the world.
- Suspiciousness, guardedness, fear or paranoia.
- Odd or overvalued ideas.
- Illusions/fleeting, low-level hallucinations.
- Erratic behaviour.

Table 19 presents some strategies for managing acute psychotic symptoms. Some clients may be aware that they are unwell and will voluntarily seek help; others may lack insight into their symptoms and refuse help. Active phase psychosis can put both the client and others at risk of harm and therefore mental health services should be contacted, whether the client wants such a referral to be made or not.

Some clients with psychotic disorders may present to treatment when stable on antipsychotic medication and thus may not be displaying any active symptoms. These clients should be encouraged to take any medication as prescribed, and ensure they receive an adequate diet, relaxation and sleep because stress can trigger some psychotic symptoms [154].

Despite the risk of further psychotic episodes, some people decide to keep using substances that may induce psychosis. In such cases the following strategies may be helpful [86]:

- Educate the client about "reverse tolerance" (i.e., increased sensitivity to a drug after a period of abstinence) and the increased chance of future psychotic episodes.
- Encourage the client to avoid high doses of drugs and riskier administration methods (e.g., injecting in the case of methamphetamine).
- Encourage the client to take regular breaks from using and to avoid using multiple drugs.
- Teach the client to recognise early warning signs that psychotic symptoms might be returning (e.g., feeling more anxious, stressed or fearful than usual, hearing things, seeing things, feeling "strange"), and encourage them to immediately stop drug use and seek help to reduce the risk of a full-blown episode.
- Inform the client that the use of AOD can make prescribed medications for psychosis ineffective.

Social stressors can be an added pressure for clients with psychotic conditions and the client may require assistance with a range of other services including accommodation, finances, legal problems, child care or social support. With the client's consent, it can be helpful to consult with the person's family or carers, and provide them with details of other services that can assist in these areas. Family members and carers may also require reassurance, education and support.

Table 19. Dos and don'ts of managing a client with symptoms of psychosis

Do:

- ✓ Ensure the environment is well lit to prevent perceptual ambiguities.
- ✓ Try to reduce noise, human traffic or other stimulation within the person's immediate environment (e.g., reduce clutter).
- ✓ Ensure the safety of the client, yourself and others.
- ✓ Ensure both you and the client can access exits – if there is only one exit, ensure that you are closest to the exit.
- ✓ Arrange transfer to an emergency department for assessment and treatment by calling an ambulance on 000 if psychosis is severe.
- ✓ Have emergency alarms/mobile phones, and have crisis teams/police on speed dial.
- ✓ Allow the person as much personal space as possible.
- ✓ Be aware of your body language – keep your arms by your sides, visible to the client.
- ✓ Ignore strange or embarrassing behaviour if you can, especially if it is not serious.
- ✓ Listen attentively and respectfully.
- ✓ Appear confident, even if you are anxious inside, this will increase the client's confidence in your ability to manage the situation.
- ✓ Speak clearly and calmly, asking only one question or giving only one direction at a time.
- ✓ Use a consistently even tone of voice, even if the person becomes aggressive.
- ✓ Limit eye contact as this can imply a personal challenge and might prompt a hostile, protective response.
- ✓ Point out the consequences of the client's behaviour. Be specific.

Don't:

- × Get visibly upset or angry with the client.
- × Confuse and increase the client's level of stress by having too many workers attempting to communicate with him/her.
- × Argue with the client's unusual beliefs or agree with or support unusual beliefs – it is better to simply say "I can see you are afraid, how can I help you?"
- × Use "no" language, as it may provoke hostility and aggression. Statements like "I'm sorry, we're not allowed to do ____ but I CAN offer you other help, assessment, referral…" may help to calm the client whilst retaining communication.
- × Crowd the client or make any sudden movements.
- × Leave dangerous items around that could be used as a weapon or thrown.
- × Laugh (or let others laugh) at the person.
- × Act horrified, worried or panic.

Adapted from NSW Department of Health [99] and Jenner et al. [86].

Symptoms of personality disorders

Clients with personality disorders have frequent and enduring problems in coping and interpersonal interaction. Symptoms can include:

- Manipulative behaviour.
- Impulsivity.
- Social impairments.
- Emotional detachment.
- Suspiciousness.
- Difficulty accepting responsibility or accommodating others.
- Emotional instability and hypersensitivity.
- Pervasive and persistent anger/aggression.
- Being overly self-involved.
- Excessive dependence on others.
- Inflexible, maladaptive responses to situations.

These symptoms are often present to varying degrees in many clients and do not necessarily indicate a personality disorder; however, they can make the therapeutic process more difficult. Strategies for managing the symptoms of personality disorders are outlined in Table 20. Some of these personality characteristics, impulsivity in particular, place clients at extremely high-risk for suicide. It is therefore particularly important to monitor the risk of suicide and self-harm. Assisting clients to develop skills (e.g., breathing retraining, meditation, cognitive restructuring) to manage negative emotions is also fundamental [63].

Clients with personality disorders tend to have difficulty forming a genuinely positive therapeutic alliance. They tend to frame reality in terms of their own needs and perceptions and not to understand those of others. They are also limited in their ability to receive, accept or benefit from corrective feedback; therefore, progress is likely to be slow and uneven [63].

Engagement and rapport building form an intensely important part of therapy and, as a result, these areas may require more time and attention than they do in other clients. Clients with personality disorders may have trouble engaging in treatment due to a history of poor relationships with AOD and other health professionals, a bias towards suspiciousness or paranoid interpretation of relationships, or a chaotic lifestyle, making appointment scheduling and engaging in structured work more difficult [71]. Structure and firm boundaries are very important components of the therapeutic process when managing clients with symptoms of personality disorders.

Table 20. Dos and don'ts of managing a client with symptoms of personality disorders

Do:

- ✓ Place strong emphasis on engagement to develop a good client-worker relationship and build strong rapport.
- ✓ Set clear boundaries and expectations regarding the client's role and behaviour. Some clients may seek to test these boundaries.
- ✓ Establish and maintain a consistent approach to clients and reinforce boundaries.
- ✓ Anticipate compliance problems and remain patient and persistent.
- ✓ Plan clear and mutual goals and stick to them; give clear and specific instructions.
- ✓ Help with the current problems the client presents with rather than trying to establish causes or exploring past problems.
- ✓ Assist the client to develop skills to manage negative emotions (e.g., breathing retraining, progressive muscle relaxation, cognitive restructuring).
- ✓ Take careful notes and monitor the risk of suicide and self-harm.
- ✓ Avoid judgment and seek assistance for personal reactions (including frustration, anger, dislike) and poor attitudes towards the client.
- ✓ Listen to and evaluate the client's concerns.
- ✓ Accept but do not confirm the client's beliefs.

Don't:

- × Reward inappropriate behaviour (such as demanding, aggressive, suicidal, chaotic or seductive behaviour).
- × Get frustrated and angry with the client. Remain firm, calm and in control.
- × Assume a difficult client has a personality disorder; many do not, and many clients with these disorders are not difficult.

Adapted from NSW Department of Health [99] and Davison [155].

Symptoms of cognitive impairment

In the process of treatment, it may become clear that the client has impaired or poor functioning in one or many areas of cognition, such as verbal or non-verbal memory, information processing, problem-solving, reasoning, attention and concentration, decision-making, planning, sequencing, response inhibition and emotional regulation. Sometimes these cognitive impairments can result in behaviour which is mistakenly interpreted as the result of poor motivation or lack of effort. These cognitive difficulties often bear no relation to mental illness and are frequently the result of heavy AOD use or intoxication. Table 21 presents some simple techniques which can be useful in overcoming cognitive impairment and the problems it can present for AOD treatment [149].

Table 21. Techniques for managing cognitive impairment

Techniques for problem-solving, planning, sequencing or decision-making difficulties
• Be clear and explicit in direction. • Encourage rehearsal of sequences within (and outside of) therapy. • Encourage routines. • Teach step-by-step decision-making and problem-solving. • Use timetables and other aids to help the client plan.
Techniques for slow information processing (mental speed)
• Constantly summarise and repeat important points and have the client relay these back to you. • Encourage questions. • Go slowly.
Techniques for poor attention/concentration
• Stress important points, repeat if necessary. • Minimise distractions.
Techniques for poor memory
• Use memory aids, routines and written instructions. • Make sessions at routine times. • Limit the amount of information covered, repeat key points, and go slowly. • Remind the client of appointments and key points where possible.

Adapted from Marsh et al. [149].

Confusion or disorientation

On occasion a client may present with no specific symptoms but is generally confused or disorientated. This may be the result of intoxication, or a physical or mental health condition. In such cases the AOD worker should:

- Provide frequent reality orientation.
- Attempt to keep the surroundings familiar.
- Ensure frequent supervision.
- Accompany the client to and from different places (e.g., the bathroom).

Medication adherence

Many clients who have been identified as having a comorbid mental health disorder will have been prescribed medication for that disorder (such as antidepressants, mood stabilisers, anti-anxiety agents, and antipsychotics; described in Chapter 8). Medications can be extremely helpful in managing mental health symptoms; however, some people experience unpleasant and distressing side effects from these medications which may lead to reduced compliance. Indeed,

some people with a mental health disorder choose to live with some symptoms of the disorder rather than take medication.

It is important for clients to be aware that in most instances there is a choice of medication but it may take time to establish which medication is best suited to his/her needs. Finding the best fit is particularly important for individuals with severe mental disorders such as schizophrenia, bipolar and severe depression as psychosocial interventions alone can prove ineffective.

When medications have been prescribed to a client it is important to assist the client to adhere to medication scheduling. In other illnesses such as diabetes and hypertension, medication compliance is recognised as an important issue in regaining good health and it is addressed proactively by the use of simple techniques to remind the client when he/she needs to take medication. Such techniques include [156]:

- Making regimes as simple as possible.
- Giving clear instructions.
- Associating medication with predictable daily events such as meal times.
- Using pill dispensing containers with daily organisers.
- Using alarms.

Motivational interviewing, contingency management and cognitive behavioural techniques (described in Appendix D, Chapter 8 and Appendix Q, respectively) have been shown to be particularly useful in improving medication compliance [157].

Burnout and clinical supervision

Working within AOD treatment settings can be a rewarding experience and both personally and professionally fulfilling. However, high levels of stress can also ensue, particularly when having to manage the complex issues surrounding comorbidity, and this can sometimes lead to burnout among workers [99]. “Burnout” is a term that describes the development of negative and cynical attitudes toward work as a result of emotional, physical and psychological exhaustion due to occupational stress [118].

Burnout is a slow process that occurs over a period of months or years and, therefore, it is important to be aware of the early warning signs and act accordingly to resolve the problems. Some early signs of dangerous job stress include [118]:

- **Physiological signs:** fatigue, irritability, headaches, back pain, weight or sleep pattern change.
- **Behavioural signs:** loss of enthusiasm, low performance, high staff turnover and absenteeism, frustration, withdrawal from colleagues, personal AOD reliance, rigidity.
- **Spiritual signs:** loss of faith, meaning, purpose, or job satisfaction; feelings of alienation and despair; changes in values and beliefs.
- **Clinical signs:** cynicism/hostility towards clients, boredom, daydreaming, quickness to medicate or diagnose, blaming clients.

It is important to make regular self-assessments regarding fatigue and stress and act on the results of such assessments. Ways to reduce burnout include [99]:

- Reflect on lifestyle and make changes where necessary.
- Be realistic about client goals and timeframes and avoid taking client relapses or setbacks personally.
- Eat a balanced, regular diet and exercise regularly.
- Schedule break times at work and regular holidays, conferences and education.
- Avoid isolation from peers.
- Balance family/personal and work commitments.
- Be aware of AOD use.
- Learn and use relaxation and problem-solving strategies (see Appendices R and S).

The agency/service provider through which the worker is employed also has a vital role to play in supporting the worker and relieving unreasonable workload pressures which are a contributing factor to burnout. It is crucial the agencies assist workers to avoid such negative outcomes. Clinical supervision is a useful method in which stress and burnout can be reduced. This supervision is a method by which workers are supported by fellow workers whose role it is to assure quality, maintain growth and improvement and monitor each other for signs of burnout and stress [99]. This can help foster an environment of collaboration and unification among workers, strengthen cohesiveness and concern in the workplace, and facilitate the acquisition of skills. Effective clinical supervision has been associated with higher levels of morale and staff retention. For workers, it provides a mechanism for support and debriefing in the workplace which helps to lessen stress and deal with issues arising from individual client interactions.

A thorough resource kit for clinical supervision in AOD treatment settings can be found at www.nceta.flinders.edu.au/csrk.

A handbook on burnout prevention is available at www.nceta.flinders.edu.au/pdf/stress-n-burnout/stress-n-burnout.pdf.

Chapter 8:
Treating comorbidity

CHAPTER 8: HOW DO YOU TREAT COMORBIDITY?

KEY POINTS

- Good treatment requires a good therapeutic alliance.
- Some interventions have been designed for the treatment of specific comorbidities; however, these interventions generally have not been well researched.
- In the absence of specific research on comorbid disorders, it is generally recommended that best practice is to use the most effective treatments for each disorder. In some cases this can be carried out at the same time for both disorders, but in others it must be carefully calibrated.
- Both psychosocial and pharmacological interventions have been found to have some benefit in the treatment of many comorbidities.
- When pharmacotherapy is used, this should be accompanied by supportive psychosocial interventions.

This chapter provides a discussion of current best practice in the treatment of the more common comorbid mental health disorders. AOD workers have widely varying roles, knowledge and experience; therefore, it is not expected that all AOD workers should be able to implement these treatments. However, this information may be used by all AOD workers to improve their understanding of best practice, and it may encourage workers to consider further training to improve their skills in these approaches.

It should be remembered that the provision of treatment for AOD use alone has positive effects for those with comorbid mental health disorders [46, 63-65]. As discussed previously, it is important to note that, for many people, symptoms of depression and anxiety will subside after a period of abstinence and stabilisation, without the need for any direct intervention [30, 108, 121]. However, if the mental health symptoms started prior to the onset of substance use, symptoms persist even during periods of abstinence, or there is a family history of the particular disorder, the client may have a condition that is independent of his/her substance use, which may require treatment [88].

In terms of clients' AOD use, the goal of abstinence is usually favoured, particularly for those whose mental health conditions are exacerbated by AOD use. Abstinence is also preferred for those with more severe mental disorders (or cognitive impairment) as even low-level substance use may be problematic for these individuals [38]. Those taking medications for mental health conditions (e.g., antipsychotics, antidepressants) may also find that they become intoxicated even with low levels of AOD use due to the interaction between the drugs. Although abstinence is favoured, many people with comorbid conditions prefer a goal of moderation. In order to successfully engage with the client, AOD workers should accommodate a range of treatment goals and adopt a harm reduction approach [72].

It is fundamentally important to discern the client's preferences regarding treatment for his/her mental health. Just because the client has sought treatment for his/her AOD use does not

necessarily mean that he/she is ready to address his/her mental health condition. It is important that the client is not forced to undergo treatment for his/her mental health if he/she is not ready to, as this may jeopardise the therapeutic relationship. Ultimately, it is up to the client to decide whether he/she wants to address the issue and how he/she would like to go about doing so.

This chapter provides a discussion of psychological/psychosocial and pharmacological options for the treatment of comorbid mental health disorders. It does not provide detailed information relating to the implementation of these treatment options, but, rather, an overview of the options available. Where appropriate, we refer readers to existing literature and resources for more detail about the use of particular interventions.

Many of the recommendations in this section are based on expert opinion rather than evidence from research. People with AOD use disorders are commonly excluded from trials of psychotherapies and pharmacotherapies for mental health disorders. Some interventions have been designed for the treatment of specific comorbidities; however, these interventions generally have not been well researched. In the absence of specific research on comorbid disorders, it is generally recommended that best practice is to use the most effective treatments for each disorder. It should be noted that the research evidence is based on trials of treatments for mental health disorders (see Chapter 5 for disorder descriptions); however, these treatments may also be useful for those who do not meet diagnostic criteria but have symptoms that cause significant distress or impairment.

Both psychosocial and pharmacological interventions have been found to have some benefit in the treatment of many comorbid mental health disorders. It is recommended, however, that when pharmacotherapy is used, this should be accompanied by supportive psychosocial interventions [158, 159]. Symptoms are less likely to return on completion of psychological treatment compared to pharmacotherapy, where relapse upon cessation is common. Pharmacotherapies are beneficial, however, in helping people to manage symptoms and obtain maximum benefit from psychotherapeutic interventions. The case studies presented in Appendix C provide examples of the use of both psychological and pharmacological treatments, and their combination.

With regard to pharmacotherapies, their introduction must be carried out in consultation with a medical practitioner, preferably a psychiatrist. Initial intake should establish past medication history as well as any current medications (see Chapter 6). When prescribing medications, the following should be taken into account:

- Possible interaction effects with other prescribed and non-prescribed substances.
- The possible presence of medical problems such as liver dysfunction related to long-term AOD use or hepatitis.
- The abuse potential of the medication being prescribed.

If clients are placed on medication, it is important that they understand the reason for the medication being prescribed, and the likely benefits and risks as well as its interactions with AOD. Potential side effects should be discussed as well as the possibility of trying other medications if the one prescribed does not suit the client.

Models of care

Prior to discussing specific treatment options, mention needs to be made of the various models that have been proposed to treat comorbid conditions. Four approaches have been suggested (see Table 22):

- Sequential treatment.
- Parallel treatment.
- Integrated treatment.
- Stepped care.

There has been much discussion of models of care for clients with comorbid conditions, but very little research is available to determine which models may suit which comorbidities. AOD workers need to make pragmatic decisions as to which model is most appropriate for individual clients.

The idea of integrated treatment for two disorders has considerable intuitive appeal, and presents a number of advantages over other treatment approaches. Integrated treatment by a single service helps to ensure that there is a single point of contact (the client does not "fall into the gaps"), there are common objectives, treatment is internally consistent, the relationship between AOD use and mental health conditions may be explored, and communication problems between agencies do not interfere with treatment [28]. While applying an integrated treatment approach to comorbidity is appealing, there has been very little research undertaken comparing the different models. Most supportive evidence to date has been gathered from research on the psychotic disorders [38]. Integrated models have been developed for depression, PTSD and personality disorders and, although showing promise, further research is needed to determine whether they are superior to other treatment models. There is also growing support for the use of a stepped care approach to treating comorbidity [139, 142]. A number of studies examining the efficacy of this approach are currently underway.

General psychological approaches

There are a number of psychological treatment approaches that are commonly used in the treatment of many mental health disorders [160]. These approaches include:

- Motivational interviewing.
- Cognitive behavioural therapy.
- Relapse prevention techniques.
- Psychosocial groups.
- Self-help groups.
- Mindfulness training.
- Contingency management.

Many AOD workers would be familiar with these approaches as they are also used in the treatment of AOD use disorders. In some cases, it may be necessary for a substantial reduction in substance use and withdrawal symptoms to occur before more intensive psychotherapies can be effective. Some clients may be more able to respond to cognitive interventions if they are taking pharmacotherapies for their substance use which free them from distracting cravings and physiological withdrawal symptoms (e.g., acamprosate or naltrexone for alcohol dependence).

Table 22. Approaches to treating comorbid AOD and mental health conditions

Sequential treatment
The client is treated for one condition first which is followed by treatment for the other condition. With this model, the AOD use is typically addressed first then the mental health problem, but in some cases, it may be whichever disorder is considered to be primary (i.e., which came first).
Parallel treatment
Both the client's AOD use and mental health condition are treated simultaneously but the treatments are provided independent of each other. Treatment for AOD use is provided by one treatment provider or service, while the mental health condition is treated by another provider or service.
Integrated treatment
Both the client's AOD use and mental health condition are treated simultaneously by the same treatment provider or service. This approach allows for the exploration of the relationship between the person's AOD use and his/her mental health condition.
Stepped care
Stepped care means the flexible matching of treatment intensity with case severity. The least intensive and expensive treatment is initially used and a more intensive or different form of treatment is offered only when the less intensive form has been insufficient.

Motivational interviewing

Motivational interviewing (MI) for AOD use disorders involves a non-judgemental discussion regarding specific medical, social, interpersonal, or psychiatric effects that AOD use has had on the client's life. Just as clients may be resistant to the idea of changing their AOD use, they may also be resistant to the notion of addressing their comorbid mental health disorder (see Chapter 6 for a discussion of readiness to change). MI may be used to increase the client's motivation in this regard [161].

MI is a directive, client-centred counselling strategy aimed at increasing a person's motivation to change. The strategy involves a non-confrontational conversation seeking out the ambivalence in the client's attitudes that can be used as encouragement for him/her to think about further change. For example, a client may say he/she is not really interested in dealing with his/her social anxiety, but agree that it is a problem. Probing around this "problem" may lead to the client contemplating further about ways to deal with it. The strategy is to use available openings to help the client advance towards a decision to have his/her mental health problem treated. Examples of MI strategies and techniques are provided in Appendix D and a number of useful resources for MI are given in Appendix B.

This strategy assumes equity in the client-counsellor relationship and emphasises a client's right to define his/her problems and choose his/her own solutions. It is, in this sense, a counselling style based on collaboration rather than confrontation, evocation rather than education and autonomy instead of authority, as opposed to a set of techniques [161].

Cognitive behavioural therapy

Cognitive behavioural therapies (CBT) emphasise the important role of thinking in how we feel and how we behave. CBT are among the most effective treatments for depressive, anxiety, and AOD use disorders [88]. Appendix Q describes a number of examples of CBT techniques that may be used in the management and treatment of AOD use and mental health conditions, including cognitive restructuring, pleasure and mastery events scheduling, goal setting, and problem solving. A more detailed discussion of CBT may also be found in Baker et al. [162] and Graham [163]. Many of the interventions designed for specific comorbid disorders (discussed later in this chapter) are based on these CBT techniques.

Relapse prevention

Clients with both mental health conditions and AOD issues can potentially experience a relapse of either condition, which is likely to affect the other. Relapse prevention strategies that are already used in AOD treatment can also be used to reduce risk of relapse to the mental health condition. Some simple strategies can be useful in helping a client reduce the risk of relapse [121, 164, 165]:

- Discuss and normalise the issue of relapse in therapy – this helps the client prepare and self-monitor.
- Enhance the client's commitment to change – regularly review costs of use and benefits of change in order to strengthen commitment.
- Explain that lapses are a temporary setback and that they do not need to lead to relapse. Feelings of shame, failure and guilt are likely to follow single lapses in AOD conditions, which is likely to be detrimental to mental health. This presents the risk of complete relapse. To avoid this, it can be useful to normalise lapses and explore the events that lead to a lapse, and how this could be avoided.
- Encourage the client to practise and use any of the strategies he/she has learnt about managing his/her mental health condition.
- Identify and plan for high-risk situations – this includes emotions, thoughts, places, events and people which are likely to make the client vulnerable to mental distress or substance use; plan ahead to anticipate these situations, monitor warning signs and develop coping strategies to deal with them.
- Consider social factors and support – relapse is more likely when social factors are difficult and support levels are low. It can be useful to discuss this with the client and plan for any foreseeable issues (e.g., housing, family, relationship). It can be useful to provide the client with information on services that can help in such situations.

Psychosocial groups

Psychosocial groups within the AOD treatment setting are also much appreciated by clients with comorbid conditions [166]. However, it is important that such groups are facilitated in such a way as to avoid confrontation. Sustained emotional distress can worsen a number of mental health conditions and a confrontational treatment approach may be harmful to clients with comorbidity [38]. It is important to assess whether the client experiences social anxiety or impairments in social judgement and social skills, as they may appear and feel awkward in group settings [167]. Readers are referred to Mueser and Pierce [167] for a more detailed discussion on the use of group interventions for comorbidity.

Self-help groups

Reviews in the research literature suggest that some clients of AOD services will benefit from joining a self-help group such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), SMART Recovery or alternative self-help groups [159, 168]. Dual Recovery Anonymous (DRA) groups, specifically for individuals with co-occurring disorders, are also becoming increasingly accessible in Australia. It is possible that one group may not suit the client but the next will – even in the same type of self-help group.

As mentioned with regard to psychosocial groups, it is important to assess whether the client experiences social anxiety or impairments in social judgement and social skills, as they may appear and feel awkward in group settings [167]. It should be noted that some groups, particularly those that adopt a 12-step philosophy, may be disapproving of the use of any medication; yet, clients with comorbid mental health disorders are often prescribed medication to help treat their mental health problems [168]. Some clients with comorbidity, particularly those who experience religious delusions, may also have difficulty with the strong spiritual focus of many self-help groups [167].

Mindfulness training

Clients with AOD use disorders often have thoughts about using or cravings to use. These thoughts are often automatic and tend to escalate when the client becomes aware of them. Similarly, clients who experience depression or anxiety may find that these negative or anxiety-provoking thoughts automatically occur and give rise to further negative or anxiety-provoking thoughts. For clients with comorbidity, this automatic thinking may result in a cycle of negative thoughts and cravings to use.

Mindfulness is a technique based on ancient meditative techniques which teaches the client to interrupt these automatic thought patterns. Mindfulness teaches people to pay attention to what is happening in the present moment, without judgement. In general, mindfulness involves deliberately focusing on the physical sensations associated with routine activities that are also carried out automatically (e.g., walking, eating, breathing). For a more detailed discussion of mindfulness, readers are referred to Segal et al. [169].

Contingency Management

Contingency Management (CM) for substance abusers involves rewarding or reinforcing desired behaviour in the client in a supportive manner [170]. Examples are vouchers for negative urine samples, for treatment attendance or for medication compliance. CM techniques are not commonly used in Australia despite evidence of their effectiveness [171-175]. In relation to comorbidity, studies have found CM to be effective in promoting cocaine and opiate abstinence amongst buprenorphine-maintained clients with comorbid major depression [176], and in promoting abstinence in a cocaine-abusing, comorbid homeless group [177].

Approaches to treating specific comorbidities

Depressive disorders

Expert reviewers have concluded that pharmacotherapy (i.e., antidepressants; see Table 23) for comorbid depression and alcohol use disorders has been found to be effective, provided an individualised approach is used [159, 168]. However, they point to the dearth of research on psychotherapies for this comorbid group. That which has been conducted demonstrates CBT techniques to be useful in the treatment of both AOD use disorders and depression [96, 139, 168, 178] and some tailored integrated programs have been developed [168, 179]. Recently, Lee et al. developed the PsyCheck program [114]. This resource includes a screening tool (discussed in Chapter 6) as well as a brief CBT program for the treatment of anxiety and depression. While the effectiveness of this intervention has yet to be established, the program appears promising.

Thase and colleagues [159] comment on the sometimes over-restrictive attitudes towards pharmacological treatments for depressive disorders among people with AOD use disorders, where clients can present in a state of physical and emotional despair that requires immediate intervention. Considering the safety of most of the newer antidepressants such as selective serotonin reuptake inhibitors (SSRIs), such caution as waiting for a minimum number of weeks of abstinence cannot be justified. This would particularly apply where a client has a history of depression during periods of abstinence, or where the person has had successful antidepressant intervention in the past. Clients being commenced on antidepressants should nonetheless be carefully monitored as there have been some well-publicised cases of increased suicidality on commencement of antidepressant treatment [180]. Such incidents are rare and their links with the introduction of antidepressant treatment have not been established.

There are limited numbers of randomised controlled trials investigating the efficacy of all currently available antidepressants on depression comorbid with AOD use disorders. In contrast, there is a broader literature available on the use of a range of antidepressant medications in major depressive disorder alone. Unless there are significant contraindications, it appears clinically appropriate to use medication which has proven efficacious in the treatment of major depression in those depressed patients with an AOD use disorder.

Reviews of the research literature have generally found that among clients with comorbid alcohol and depressive disorders, treatment with tricyclic antidepressants (TCAs) and SSRIs has a significant effect on symptoms of depression, but effects on alcohol use have been equivocal [159,

[168, 181]. Alcohol use responds well where the depressive symptoms have been reduced but sustained abstinence is not usually achieved [182-185]. There have been some studies which have shown a relatively negative effect on alcohol consumption in alcohol-dependent young men prescribed SSRIs [186-189]. Antidepressants that do not come under the umbrella of SSRIs or TCAs have been found to be effective in single studies [190, 191].

Table 23. Antidepressant medications

Drug type and name	Brand name
Tricyclic Antidepressant (TCA):	
Amitriptyline	Endep
Doxepin	Deptran, Sinequan
Dothiepin	Dothep, Prothiaden
Imipramine	Tofranil
Nortriptyline	Allegron
Clomipramine	Anafranil
Trimipramine	Surmontil
Monoamine Oxidase Inhibitor (MAOI):	
Tranylcypromine	Parnate
Phenelzine	Nardil
Reversible Inhibitor of Monamine Oxidase A (RIMA):	
Moclobemide	Aurorix, Clobemix
Selective Serotonin Reuptake Inhibitor (SSRI):	
Escitalopram	Lexapro
Citalopram	Cipramil
Fluoxetine	Lovan, Prozac
Fluvoxamine	Luvox
Sertraline	Zoloft
Paroxetine	Aropax
Serotonin and Noradrenaline Reuptake Inhibitor (SNRI):	
Venlafaxine XR	Efexor XR
Desvenlafaxine	Pristiq
Duloxetine	Cymbalta
Noradrenaline and Specific Serotonergic Agent (NaSSA):	
Mirtazapine	Avanza
Tetracyclic Antidepressant:	
Mianserin	Tolvon
Selective Noradrenaline Reuptake Inhibitor (NORI):	
Reboxetine	Edronax

Adapted from Stahl [192]

Compared to the newer antidepressants, TCAs are poorly tolerated, they are potentially lethal in overdose, and cause significant adverse effects when combined with other central nervous system depressants. In contrast, SSRIs are associated with fewer side effects, have better tolerability (resulting in improved compliance) and they are safer in overdose [85, 159]. Despite their

efficacy, some clients may be reluctant to take SSRIs due to the misconception that they are "addictive". SSRIs are not habit-forming; however, users may experience a discontinuation syndrome if the medication is stopped abruptly [85]. Symptoms are similar to some of those experienced during alcohol or opiate withdrawal (e.g., include flu-like symptoms, light-headedness, headache, nausea) [85]. When discontinuing SSRIs, the dose should be gradually tapered.

Although studies of comorbid alcohol dependence and major depression support the use of SSRIs, studies of cocaine and opiate dependent clients do not [88]. In a review of the research literature, it was concluded that different types of antidepressants seem to be suitable for different types of substance use disorders [175]. In particular, individuals with AOD use disorders tend to respond better to antidepressants that have a similar direct or side effect profile to their substance of abuse. Hence, the more sedating antidepressants such as doxepin or paroxetine are more effective in depressed abusers of alcohol, heroin and sedatives, and the more stimulating antidepressants such as desipramine and buproprion have greater efficacy in depressed abusers of stimulants and nicotine. As there are no guidelines as yet for the treatment of comorbidity with depression in users of psychostimulants such as amphetamines and ecstasy [50], the use of the more stimulating antidepressants for these clients provides the best guidance at this time.

For all AOD clients, extreme caution should be taken when prescribing monoamine oxidase inhibitors (MAOIs). These medications are potentially dangerous because of the dietary and medication restrictions involved [85]. Hypertensive crisis with intracranial bleeding and death can occur if combined with a tyramine-rich diet or contraindicated medications (including opioid and psychostimulant substances like over-the-counter cold and flu medications) [85, 88]. For this reason, MAOIs should only be used when other medication options have failed.

It is important to note that it can take one to two weeks before an antidepressant reaches therapeutic levels in the blood. If no improvement in mood occurs over the induction time specified by the drug manufacturer, then consideration should be given to increasing the dose. If still no improvement is observed, switching or augmenting with another antidepressant may be considered. It is recommended that there be at least one within-class switch before considering augmentation or other options [159].

Two medications that have been used for treating alcohol use disorders – naltrexone and acamprosate – have shown moderately positive outcomes in this single disorder [193-197]. Disulfiram can also be an effective treatment for some people with alcohol problems, particularly those who are highly motivated and who can be closely supervised. Research suggests that naltrexone, acamprosate and disulfiram are all tolerated well in clients with comorbid depression [198] but research has not been conducted to demonstrate any impacts of these pharmacotherapies on depression. Naltrexone has been found to be associated with better drinking outcomes in clients being treated with antidepressants for their depression and anxiety [199]. It should also be borne in mind that at least for naltrexone, treatment beyond 12 weeks may not improve drinking outcomes in those with alcohol use disorders alone [200]. While both acamprosate and naltrexone are available on the Pharmaceutical Benefits Scheme (PBS) for alcohol dependence, disulfiram is expensive and only available with a private prescription.

Although only a tentative finding requiring further research, another study found that buprenorphine had better outcomes with opiate abusers with comorbid depression than those who were not depressed [201]. This suggests that buprenorphine may prove to be an especially useful pharmacotherapy for this sub-group.

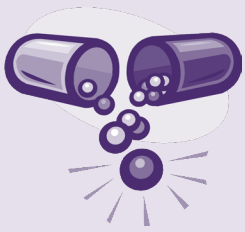
Bipolar disorders

Although research on psychological treatments for comorbid bipolar disorder is scarce, one group of researchers has developed an integrated psychosocial group treatment program for this comorbidity, showing some positive findings [202, 203]. Again, at present it can be recommended that if the client presents during a major depressive episode then treatment should follow the guidelines for the treatment of comorbid depression in general. If, however, the client is experiencing a manic episode or symptoms of psychosis, consultation with a medical practitioner is recommended for the prescription of appropriate pharmacological interventions.

Many clients with bipolar disorders are maintained on a mood stabiliser (see Table 24) and often an antipsychotic as well (see Table 26). A recent study reported in a review by Le Fauve et al. [181] found more positive drinking outcomes when sodium valproate was added to treatment as usual in a sample of bipolar clients with alcohol use disorders. They also found a trend toward improvements in manic symptoms as well. Other studies have suggested the potential of carbamazapine and lithium in controlling co-occurring substance misuse [204]. Some smaller studies have found positive findings for quetiapine and lamotrigine in clients with bipolar disorder and cocaine dependence. Clients with a comorbid bipolar disorder are less likely to comply with medication because they may enjoy their manic episodes. Measures to increase medication compliance may be particularly pertinent among this group (see Chapter 7).

Table 24. Mood stabiliser medications

Drug name	Brand name
Carbamazepine	Tegretol, Teril
Lithium carbonate	Lithicarb
Sodium valproate	Epilim, Valpro
Gabapentin	Neurontin
Lamotrigine	Lamictal
Topiramate	Topamax



Adapted from NSW Department of Health [99].

Anxiety disorders

As with depression, much of the anxiety exhibited by clients entering AOD treatment will subside following a period of abstinence and stabilisation without the need for any direct attention [108, 175]. However, if the anxiety is acute and disabling and interfering with a response to AOD treatment, then consideration should be given to pharmacotherapy, either for the substance use (in the case of alcohol – naltrexone, acamprosate or disulfiram), the anxiety, or both. Although the research is scarce on comorbid anxiety and substance use, it would be reasonable to draw similar conclusions for these comorbid groups as for depressed substance abusers – namely, use

of a medication such as a SSRI (which has anxiolytic properties), with a good side-effect profile, proven efficacy in the mental health disorder and minimal negative interactions with the substance of abuse [85]. Commonly prescribed anti-anxiety medications include some of the SSRIs (and other antidepressants, e.g., venlafaxine) listed in Table 23, and those listed in Table 25.

Despite their proven effectiveness in relieving anxiety, the use of benzodiazepines is not recommended due to their abuse liability [85, 88]. Benzodiazepines should only be prescribed among patients with a history of problematic substance use if there is a compelling reason to use them, there is no good alternative (i.e., other psychological and medication options have failed), close follow-up and supervision is provided, and monitoring for misuse is in place. If benzodiazepines are used, the client should only be prescribed the lowest possible dose for only a short period of time (no more than one month) [85].

Expert reviewers tend to agree that psychological interventions should accompany pharmacological treatments for anxiety disorders and suggest that a combination of psychotherapy and pharmacotherapy may be uniquely effective in the treatment of individuals with comorbid anxiety and alcohol use disorders [168]. In terms of psychotherapy, a recent Cochrane review concluded that CBT is effective in treating anxiety disorders [205] and, as discussed previously, there is good evidence that CBT and MI are effective psychotherapies for particular types of substance abuse. As mentioned with regards to depression, the *PsyCheck* program [114] includes a brief CBT program for the treatment of anxiety and depression. While the effectiveness of this intervention has yet to be established, the program appears promising.

Table 25. Anti-anxiety medications

Drug name	Brand name
Buspirone	Buspar
Chlordiazepoxide	Librium
Diazepam	Valium, Ducene, Propam, Antenex
Nitrazepam	Mogadon, Alodorm, Dormicum, Nitepam
Oxazepam	Serepax, Benzotran, Murelax, Alepam
Flunitrazepam	Rohypnol
Temazepam	Euhypnos, Normison

Adapted from NSW Department of Health [99].

Generalised anxiety disorder

A review of treatments for anxiety disorders concluded that a combination of psychosocial therapy and the newer antidepressants such as the SSRIs, venlafaxine, and paroxetine, promises best outcomes in the long-term for those with GAD [190, 191, 206, 207]. However, these findings have not been confirmed in those with comorbid AOD use disorders. The use of these medications is considered preferable to benzodiazepines for GAD because they are more effective in treating symptoms such as worry, tension, irritability and concentration problems; and they have a safer side-effect profile [208]. Some research has found that buspirone, a non-benzodiazapine anti-anxiety medication, is effective in treating anxiety in people with alcohol use disorders as well as increasing treatment retention in this group [88, 209, 210]. One study of buspirone found

improvements in drinking outcomes as well as in anxiety outcomes [209]. Unfortunately, buspirone is not subsidised in Australia for non-veterans and is only available at significant cost by private prescription. Buspirone has the added difficulty that it can take up to four weeks at a therapeutic dose to have anti-anxiety effects. This may prove unattractive to clients who want the instant relief from their anxiety that can be provided by alcohol or benzodiazepines.

Panic disorder

A recent Cochrane review concluded that in the treatment of panic disorder, it is equally efficacious to use CBT-based psychotherapy alone, pharmacotherapy alone (SSRIs in particular), or a combination of these, and that client preference should be taken into account when deciding on a course of treatment [211]. Although not confirmed with this group due to the absence of relevant research, it would be prudent to adopt similar strategies in clients with comorbid AOD use disorders. Behavioural techniques such as exposure and systematic desensitisation have been shown to be effective, and relaxation and supportive counselling may also be helpful [88]. It has been recommended that caution should be used when treating panic disorder with antidepressants such as TCAs and SSRIs because these agents may cause an initial worsening of panic symptoms. As mentioned with regard to the use of TCAs in the treatment of depression, they are poorly tolerated, are potentially lethal in overdose, and cause significant adverse effects when combined with other central nervous system depressants. In contrast, SSRIs are associated with fewer side effects, have better tolerability (resulting in improved compliance) and they are safer in overdose [159]. It is recommended that a low dose be prescribed to start with to avoid activation of panic symptoms [88].

Social phobia

Studies of psychological treatments for social phobia in clients with comorbid alcohol problems suggest that integrating treatments in this group may show no improvement over treating drinking alone [212], or it may even have a deleterious effect on drinking outcomes [213]. Exposure therapy is a commonly used effective component of CBT for anxiety disorders, involving gradual exposure to the feared object or situation. Where comorbid AOD use exists, exposure can be effective but it cannot operate well, or at all, if the client is affected by substances [68]. The individual would need to stop or significantly reduce AOD use before CBT could be effective. Because exposure therapy can be anxiety inducing, it is recommended that it should be carried out once the client has developed effective relapse prevention skills [214]. Other research has found that it is important to assess and use the social supports available to clients with social phobia in order to improve treatment outcomes [215]. In terms of pharmacological treatment, a recent Cochrane review found that treatment with SSRIs is effective in the treatment of social phobia [216].

Post traumatic stress disorder

Due to the inter-relatedness of PTSD and substance AOD use, experts recommend that these conditions should be treated in an integrated fashion [101, 217, 218]. A number of psychotherapies have been developed for the treatment of comorbid PTSD and AOD use; however, few have

undergone rigorous evaluation. Here we focus on two psychotherapies that have shown most promise: exposure therapy and *Seeking Safety*.

Exposure therapy is the gold standard for treating PTSD [219]. Like exposure for phobias, exposure therapy for PTSD involves gradual exposure to the feared object or situation; in this case, traumatic memories. Traditionally, exposure therapy for PTSD was considered inappropriate for people with AOD use disorders based on beliefs that the emotions experienced may be overwhelming and could lead to more substance use, or that the cognitive impairment associated with AOD use could impair the person's ability to carry out the exposure tasks. However, preliminary research has demonstrated exposure therapy to be safe and effective among AOD samples [220-222]. It is recommended, however, that exposure therapy not commence until the client has substantially reduced or stopped using substances. Currently, two randomised controlled trials are underway in Australia examining the efficacy of integrated treatments for PTSD and AOD use disorders using exposure therapy. A detailed guide to exposure therapy for PTSD and other CBT techniques may be found in Foa and Rothbaum [223].

Another integrated treatment which appears promising in the treatment of PTSD and AOD use is *Seeking Safety* [224]. *Seeking Safety* is a present-focused therapy aimed to help people attain safety from trauma/PTSD and substance abuse. The treatment has been conducted in group and individual format in a variety of settings (outpatient, inpatient, residential). *Seeking Safety* consists of 25 topics that can be conducted in any order. Therapists select, with their clients, the topics most suited to their needs. In a randomised controlled trial, individuals who received *Seeking Safety* had outcomes comparable to those who received relapse prevention in terms of their AOD use and PTSD symptoms [225]. Further information and training materials may be found at www.seekingsafety.org.

Australian guidelines on the treatment of PTSD [226] recommend psychotherapy as the first line treatment of adults with PTSD. They recommend that pharmacotherapies be used as an adjunctive treatment if the person has not gained benefit from psychological treatment; however, there is little evidence to suggest that combining psychological and pharmacological interventions leads to improved outcomes. Where pharmacotherapies are considered, SSRIs are the recommended first-line option. The use of mirtazapine and TCAs should be considered only as a second-line option, and phenelzine may be considered for people with treatment-resistant symptoms. However, as noted previously, extreme caution should used when be prescribing TCAs and MAOIs.

There have been only a few trials of pharmacotherapy for PTSD comorbid with substance abuse, all of which have examined the use of sertraline, a SSRI [227, 228]. These studies show support for the safety and effectiveness of this medication in this population; however, its efficacy in treating this comorbidity has yet to be established in a randomised controlled trial.

Personality disorders

As discussed in Chapter 5, the most common personality disorders seen in AOD services are borderline personality disorder (BPD – most frequently occurring in females) and antisocial personality disorder (ASPD – usually male). The Cochrane collaboration recently reviewed

psychological treatments for BPD [229] and concluded that some psychological interventions look promising. It reported that studies of dialectical behaviour therapy (DBT) have generally found few differences between DBT and treatment as usual in terms of BPD symptoms and hospitalisations. However, there have been some findings of decreased self-harm and suicidal behaviour due to DBT treatment and indications that it may impact positively on alcohol outcomes.

In general, research on psychological treatments for personality disorders is promising but such treatments may be too time consuming and technically demanding for staff and clients in AOD treatment settings. For clients with alcohol use disorders, it has been suggested that good outcomes are possible using alcohol-focused treatments alone. However, it is acknowledged that opiate and cocaine abusers with a personality disorder present a more severe client profile. Reviewers agree that AOD clients with personality disorders should be given more intensive psychological attention in order to promote the therapeutic alliance and maintain them in treatment [230]. However, although it is important to address the client's maladaptive personality traits, this will not be effective unless carried out in a long-term treatment program. Two programs have been designed for these comorbid clients – Dual Focus Schema Therapy [231, 232] and DBT-S [233-236], both of which have shown promise.

A Cochrane review of pharmacotherapies for BPD found little support for the use of pharmacotherapies for BPD but concluded that more trials are needed, especially to ascertain the usefulness of antidepressants [237, 238]. One study found that naltrexone and disulfiram are also safe for clients with comorbid personality disorders and alcohol dependence, and at least one study suggests that naltrexone may selectively benefit people with alcohol use disorders with antisocial traits and a family history of problem drinking [239].

Very little research has been conducted to date regarding the pharmacological treatment of ASPD among people with AOD use disorder. Studies that have been conducted have investigated the use of amantadine, desipramine [240, 241], bromocriptine, and nortriptyline [242, 243]. However, the conclusions that can be drawn from these studies are limited due to small sample sizes. Thus, there is currently no evidence of effective pharmacological treatments for people with ASPD and AOD use disorders. One study does, however, provide some evidence to suggest that bromocriptine and nortriptyline may be beneficial for people who have comorbid alcohol use disorders and ASPD who also have a current mood and/or anxiety disorder, but not for those without a current mood and/or anxiety disorder [243].

Psychotic spectrum disorders

Generally, if a person is well maintained on medication for his/her psychotic disorder, then management for substance misuse should proceed as usual. A recent Cochrane review [244] concluded that there is no good evidence so far regarding effective psychosocial treatments for psychotic spectrum disorders comorbid with substance abuse. However, studies incorporating integrated psychosocial treatments have been showing some promise [245-247]. In these programs, clients receive treatments addressing both disorders, including case management, vocational rehabilitation, family counselling and housing, as well as medications. Motivational interviewing strategies are used to prepare the client for abstinence from substance use. One study which

added MI, CBT and a family intervention to usual care for clients with schizophrenia comorbid with AOD use found significant improvements in outcomes for both disorders over care as usual [248]. An Australian study which used a 10-session intervention comprising of both MI and CBT for this comorbid group also found modest improvements in outcomes [249].

Barrowclough et al. [71] suggest that MI techniques may need to be adapted for clients with psychotic disorders because disorganised thoughts and speech may make it difficult for AOD workers to understand what the client is trying to say, and psychotic symptoms (combined with AOD use and heavy medication regimes) may impair clients' cognitive abilities. For this reason it is recommended that therapists:

- Make use of more frequent and shorter reflections to clarify meaning.
- Use frequent and concise summaries to draw together information.
- Avoid emotionally salient material which is likely to increase thought disorder.
- Provide sufficient time for the client to respond to reflections and summaries.
- Ask simple open questions and avoid multiple choices or complicated language.

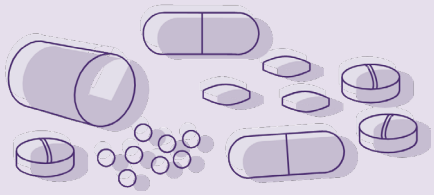
Further discussion of psychological approaches to the treatment of psychosis may be found in Barrowclough et al. [71].

Some of the newer antipsychotics have been studied for their impacts on AOD use as well as severe mental illness. In particular, it has been theorised that the increased substance abuse found amongst those with psychotic disorders relates to dopamine dysfunction which is better addressed by the newer (atypical) antipsychotic agents than the older (typical) agents. Table 26 lists the names of some of the more common antipsychotics. There has been considerable research on the effects of clozapine on substance misuse with generally positive outcomes [181]. Results for other newer antipsychotics in terms of impact on substance abuse have been equivocal. These findings highlight the potential of further research on the range of medications used to treat singular psychotic disorders and their effects on comorbid substance abuse.

There are several reasons why pharmacological interventions for the comorbid substance use disorder may prove more effective for this group than psychosocial treatments. Problems associated with negative symptoms such as amotivation and cognitive impairment may restrict involvement and outcomes in psychosocial interventions. On the other hand, greater tolerance of medication regimes may render clients with this comorbidity more amenable to pharmacotherapy for substance use. Caution should be taken when selecting pharmacotherapies for substance use and some are contraindicated in individuals with psychotic disorders as they may exacerbate symptoms (e.g., disulfiram).

Table 26. Antipsychotic medications

	Drug name	Brand name
Newer (atypical) antipsychotics	Clozapine	Clozaril
	Olanzapine	Zyprexa
	Quetiapine	Seroquel
	Risperidone	Risperdal
	Amisulpride	Solian
	Aripiprazole	Abilify
	Ziprasadone	Zeldox
Traditional (typical) antipsychotics	Chlorpromazine	Largactil
	Droperidol	Droleptan
	Fluphenazine	Anatensol, Modecate
	Flupenthixol	Fluanxol
	Haloperidol	Haldol, Serenace
	Pericyazine	Neulactil
	Pimozide	Orap
	Thioridazine	Aldazine, Melleril
	Thiothixene	Navane
	Trifluoperazine	Stelazine
	Zuclopenthixol	Clopixol



Adapted from NSW Department of Health [99].

Concluding remarks

Although much of this review of treatments leaves many questions to be answered, there are some guiding principles that tend to be repeated throughout. It is clear that much more research is needed before definitive practices can be prescribed that will improve outcomes for both mental health and substance use disorders. Despite this, it can be generally concluded that treatments that work for a single disorder will lead to some improvements in comorbid clients, if not in both disorders. Although appealing, the efficacy of integrated treatments has not yet been established [250].

For most comorbidities, both psychological/psychosocial and pharmacological interventions have been found to have some benefit. Both of these require some basic knowledge or qualifications on the part of the AOD worker. In particular, psychosocial interventions tend to be based on motivational and cognitive-behavioural approaches and AOD workers will benefit significantly if trained in these intervention styles. It is generally acknowledged that manual-based psychological interventions are easy to administer and most effective for CBT-style treatments. For pharmacological interventions, an important role of AOD workers is to inform themselves of the benefits, interactions and possible side effects of the medications prescribed for their clients. Workers can assist their clients with suggestions for medication scheduling as well as providing compliance therapy (see Chapter 7).

Chapter 9: Referral & discharge planning

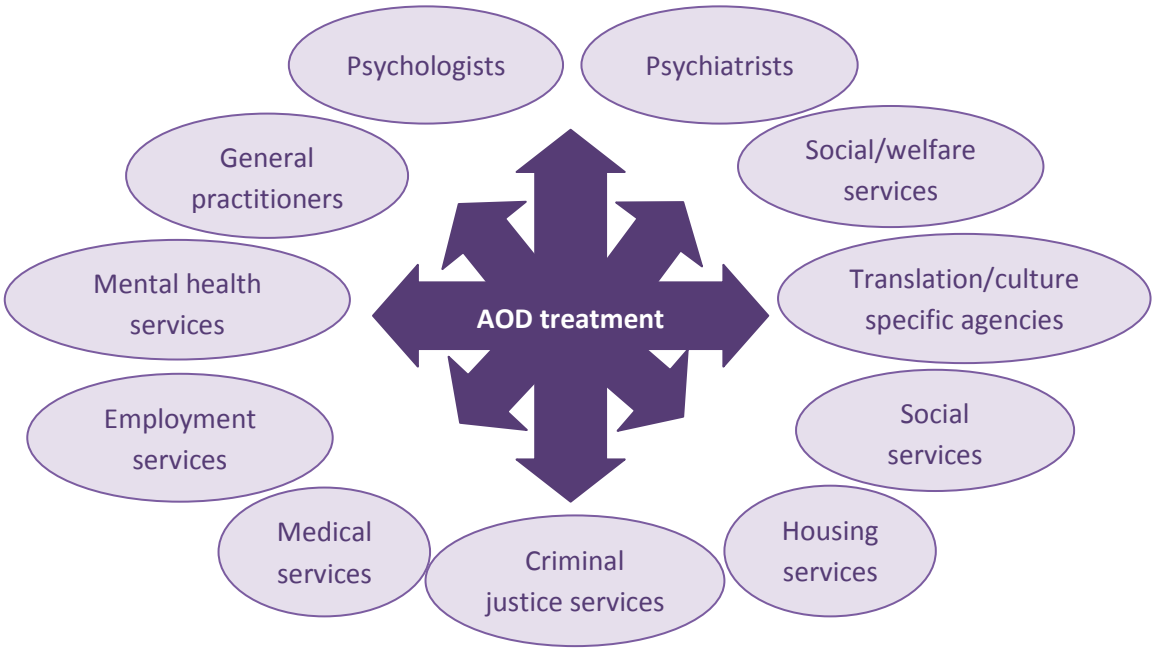
CHAPTER 9: REFERRAL AND DISCHARGE PLANNING

KEY POINTS

- AOD services and AOD workers should develop links with a range of local services and engage them in clients' treatment where appropriate.
- Where a client is referred to an outside agency, it is important to obtain client consent and to practise assertive follow-up.
- Active referral is the preferred process when referring clients with comorbidity.
- Discharge planning in close consultation with the client is integral to the treatment process.

As discussed in Chapter 3, there is great variability in the treatment needs of AOD clients that cannot possibly be addressed by one health professional or service alone. A broad, multifaceted and multidisciplinary approach is needed in order to address all of these issues effectively [66, 75]. The case studies described in Appendix C demonstrate the need to involve a number of health professionals in a client's care. It is important that AOD services and AOD workers develop links with local services and engage them in clients' treatment. Figure 11 illustrates some of the services that may be relevant.

Figure 11. Services that AOD workers may need to consult in client care



Engagement with other services is best thought of as a consultative process. Importantly, this consultation process is not limited to mental health services and can include a range of other services (e.g., housing, social services, medical services). GPs are of particular importance as, in many cases, they have a prior relationship with the client and they are often the client's only consistent form of contact with the health care system. Most importantly, consultation with other services should be based on the most essential and desired needs of the client. Although some clients may benefit from treatment by mental health professionals, they may not be ready for such treatment and it should not be forced at the risk of alienating them (unless they pose a risk to themselves or others). MI (discussed in Appendix D) can help clients gain willingness to receive treatment but others may not be ready even after such attempts are made. Each client is different and will manage his/her situation differently – the key is to support and guide clients and facilitate treatment as required.

While it is important to engage a number of services in clients' treatment, research has indicated that clients with co-occurring mental health conditions have better outcomes when the number of case workers is kept to a minimum [251]. This simplifies the process for the client and reduces the chances of the client falling out of treatment.

Referring clients to other services

Where possible, clients should be retained in his/her AOD treatment whilst accessing other services, rather than excluded from AOD services and referred to others. For example, a client entering residential rehabilitation who has been identified as having a bipolar disorder may be retained in AOD treatment, but it may be useful to obtain a short appointment with a psychiatrist who can undertake an assessment, provide a diagnosis, and prescribe medications; the client's condition can then be managed while he/she is in the residential service. Increasingly, a number of employment, welfare and medical services are providing consultation times within AOD services to facilitate client access to these services.

In some cases, however, it may be necessary to refer clients to outside services. For example, in cases of acute psychosis and suicidality, it may be necessary to contact the local mental health crisis assessment and treatment (CAT) service to come and assess the client for admission to appropriate mental health services. AOD workers should be aware that in instances where the client needs to leave the AOD treatment setting to have more immediate needs met prior to addressing their AOD use (e.g., acute mental health or medical issues), their relationship with the client should not cease. The client will still require AOD treatment after these issues have been addressed and it is important to follow up with the client and referral agency regarding the provision of this treatment.

One of the biggest risks in the referral of clients to external services is the potential for clients to "fall through the gaps" and disappear from treatment altogether. People with comorbid conditions in particular often have difficulty navigating their way through the available services. The act of trying to navigate the health care system has been likened to a roundabout with many points of entry and many options regarding the direction to be taken [53]. Therefore, it is crucial that the referral process focuses on linking the client with services as smoothly as possible. This

may be assisted by the development of formal links between services regarding consultation, referral pathways and collaboration, such as a memorandum of understanding.

Where referral is non-urgent (e.g., they do not require urgent medical or psychiatric attention), the referral process may be passive, facilitated, or active (Table 27). In the case of clients with comorbid conditions, active referral is recommended over passive or facilitated referral. When referring a client to an outside service, it is crucial that AOD workers consult with the referral agency to determine whether the client kept the appointment, whether assistance was provided and what progress was made. This process of assertive follow-up is particularly crucial in cases where the referral is related to a high-risk situation (e.g., suicidal intent).

With clients' permission, families and carers should be involved in the referral process wherever possible, as they will often need to facilitate clients' access to other services. Families and carers should also be informed of services available to them in the form of advocacy and support groups. As previously mentioned, the *Consumer and Carer Involvement in Comorbidity Treatment Planning Package* is a useful resource and is available at www.health.gov.au[74].

Table 27. 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 et al. [252].

Communicating with other services

Good communication and sharing of information between all health professionals involved in the care of people with comorbid conditions is essential to adequate care. Ensure that:

- You obtain the client's consent before sharing any information.
- The client is kept informed during this process.

- Confidentiality is maintained (e.g., obtain client's written permission for release of case notes and avoid faxing confidential information).

When consulting with or referring clients to other services, assessment reports are often requested by those services. When writing an assessment report for an external party the following should be considered [149]:

- Include only relevant and important information, including reasons for referral.
- Write in a clear, simple and objective writing style.
- Include mental state examination report if necessary.
- Be concise.
- Always cite the source of the information. For example "Andrew stated that…; his parents revealed that…"
- Consider all sources of information in your conclusions.
- Avoid jargon.
- Eliminate any ambiguous, biased, or judgemental wording.
- Mark all reports "STRICTLY CONFIDENTIAL".
- Avoid faxing confidential information.

A pro-forma which may be useful in the referral process is included in Appendix U.

Communicating with the client about referral

Referral to other services should involve openness with the client regarding the reasons for referral. To assist the client in attending a referral appointment, it can be useful to discuss issues such as:

- Name, phone number, and address of the referral service.
- Directions and transportation to and from the service appointment.
- What the client can expect upon arrival at the service, along with the nature, purpose and value of the referral.
- Written material about the service (if available).
- A method of contacting the AOD worker.

Discharge planning

It is important to prepare clients ahead of time for the cessation of treatment. This is known as the process of discharge planning, and centres around equipping the client with the skills and contacts to continue the positive progress of treatment and avoid relapse. It is important to involve clients in their discharge planning and make them fully aware of their options [253]. It is useful to plan follow-up consultations to monitor how well the client is maintaining the progress made during therapy; however, a client has the right to refuse further follow-up and if this occurs, note the refusal in the client's record and avoid judgemental reactions [253].

Attempt to link the client with further treatment or support and provide emergency assistance numbers. Communicate with relevant service providers where necessary as outlined above. As

with all other steps in the treatment process, the discharge plan should be documented in the client's record.

It is important to consider such aspects as stability of accommodation and social support when planning for discharge and, with the client's consent, to involve family and carers as they will play an important role in a maintaining treatment outcomes [254]. It is also useful to discuss relapse prevention and other strategies (e.g., problem solving, goal setting, relaxation) with the client during discharge planning and provide the client with skills to manage high-risk situations, lapses and symptoms of mental health conditions that may occur. Chapter 8 provides useful information regarding relapse prevention, support and self-help groups and other management techniques which clients may benefit from. Appendices R and S provide useful CBT and anxiety management strategies.

Chapter 10: Specific population groups

CHAPTER 10: SPECIFIC POPULATION GROUPS

KEY POINTS

- Cultural and contextual factors, such as the client's cultural background, age, sex, sexual orientation, stability of accommodation, whether he/she lives in remote locations, and whether treatment is coerced, need to be taken into account when treating clients.
- Overall, treatments and services for AOD and comorbidity have arisen from research on the dominant culture of city-dwelling westernised adults. This is not to say that these techniques will not work with clients from different backgrounds, but rather that approaches may need to be adapted depending on individual clients' characteristics.

A number of social groups require special consideration with regard to the management and treatment of comorbidity. It is important that AOD workers are aware of specific factors that may affect the management and treatment of people belonging to these groups so that they may tailor treatment appropriately. Much of what is discussed below applies to those with single AOD or mental health disorders as well as those with comorbid conditions.

Indigenous Australians

The standards of physical and mental health among Indigenous Australians are poor in comparison with the wider Australian community. Research shows that although there are proportionately more Indigenous people than non-Indigenous people who refrain from drinking [255], those who do drink are more likely to do so at high-risk levels [256, 257]. Between 2000 and 2004, Indigenous men died from alcohol-related causes at a rate seven times higher than their non-Indigenous counterparts, while this rate was 10 times higher for Indigenous women [256]. However, alcohol is not the only substance presenting a major concern for Indigenous peoples. According to Brady [258], over the last 10 years, alcohol use has been declining but there has been an increase in the use of other substances including opiates, cannabis, amphetamines, injecting drugs, and poly-drug use [258]. Sheldon [259] has also highlighted the devastating effects of petrol-sniffing among adolescent males in the remote areas of Central Australia.

Indigenous people are also over-represented in inpatient mental health care [260]. In the Northern Territory during 2002-2003, 84% of Indigenous mental health admissions were related to psychosis, depression and substance-related disorders [261]. It has been suggested that the factors which contribute to increasing rates of psychiatric morbidity in Indigenous communities include the destruction of social infrastructure, rapid urbanisation and poverty, cultural, spiritual and emotional alienation, loss of identity, family dislocation, and increased drug and alcohol consumption [262-264]. The trauma suffered by the stolen generations as a result of the assimilation policies of the Australian government has direct relevance to the psychological adjustment of Indigenous Australians by severely disrupting and damaging the quality of early parent-child attachment. A number of studies have found evidence of a direct link between the quality of early relationships and the development of depression in adulthood [265-267]. Indigenous people may be at increased risk of poor treatment outcomes due to poor physical health, social

disadvantage, comorbid substance misuse, and a burden of grief through suicide, homicide and incarceration [261].

Although only limited data exists regarding comorbidity specifically among Indigenous communities, Roxbee and Wallace [260] report that there are high rates of comorbidity, along with complexities in causality and treatment, which are unique to Australian Indigenous populations. Previous studies have shown an association between depression, anxiety, suicide and alcohol dependence in the Aboriginal community [268]. In addition, frequency of alcohol consumption in Indigenous communities has been found to be correlated with hallucinations, paranoia, self-mutilation and panic [262, 269]. A survey of Aboriginal admissions to Bloomfield hospital in 1995 also showed significant rates of comorbidity [270]. There is also more recent evidence that claims substance use and self-harm behaviour are rising in the Indigenous community [271, 272].

Existing mainstream models of practice in the AOD field have overwhelmingly been developed within western systems of knowledge. As a result, they are not necessarily generalisable to other cultures and may ignore important Indigenous perspectives and needs. Therefore, despite Indigenous Australia being a heterogeneous mix of diverse languages and customs, it is important that AOD workers be aware of general issues and try to familiarise themselves with more specific information regarding the Indigenous population in their community. Reports on this particularly vulnerable group emphasise the need for access to culturally appropriate and comprehensive services to address these problems, and the need for local links with Indigenous services and consultants [67, 268].

There are a number of general issues to be aware of when working with Indigenous clients [256, 273-276]:

- 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.

AOD workers may find the Indigenous Risk Impact Screen (IRIS, described in Chapter 6) useful in assisting to identify Indigenous clients with AOD problems and mental health risks [134].

Culturally and linguistically diverse groups

Little research has been carried out in Australia on culturally and linguistically diverse (CALD) groups in AOD services – let alone on those with comorbid mental health problems. It is not clear whether comorbidity is more common in CALD than other groups. Ethnic groups are under-represented in AOD services, but not because they have a lower prevalence of AOD problems [277, 278]. Rather, their under-representation is a product of many barriers to treatment including:

- 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.

Due to the multicultural nature of Australian society, it is imperative that counsellors develop an awareness of issues pertaining to working with people who belong to CALD groups. Each geographic area has its own unique cultural mix and AOD workers should learn as much as possible about the cultures represented in their treatment populations. In particular, AOD workers should be aware of conventions of interpersonal communication (e.g., communication style, interpersonal interactions), expectations of family, understanding of healing, views of mental illness, and perceptions of substance use. However, it is fundamental not to make assumptions based on the client's culture – just because he/she is from a certain cultural background that does not mean that he/she necessarily subscribes to the values and beliefs of that culture [63]. Reid et al. [278] recommend consultation with the separate ethnic communities to develop culturally relevant strategies for AOD treatment.

It has been suggested that information about three aspects of clients' lives is of crucial importance when treating CALD clients [149]:

- **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).

Even migrants from English-speaking countries are likely to struggle with cultural confusion and stresses associated with changes in environment, jobs, social supports and lifestyle. Migrants may experience a loss in social and occupational status if their qualifications are not recognised in Australia or face issues such as high unemployment levels, overcrowded living conditions, isolation, poverty, racial discrimination and family conflict.

The Australian Government Department of Health and Ageing [277] provides a general summary of the types of problems that are specific to CALD groups in the community and makes recommendations regarding the provision of treatment services. These recommendations (such as cultural and religious awareness and the appropriate use of interpreters) would also apply to

those with comorbid disorders. They emphasise that there are few screening tools that have been validated for these groups. As with Indigenous clients, screening tools should be validated for CALD groups and need to be administered and interpreted with care.

Below is a range of useful points which may improve assessment and treatment in CALD clients generally [99]:

- 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 [1] 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 [99].
- 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.

Gay and lesbian, bisexual and transgendered individuals

There is a lack of research into the impact comorbidity has on gay, lesbian, bisexual and transgendered (GLBT) communities in Australia. One recent Swiss study found that gay men had a heightened prevalence of comorbidity compared to wider community findings [279]. The study

found that more than one-quarter of those men who met diagnostic criteria for one of five psychiatric conditions (major depression, specific phobia, social phobia, alcohol dependence, and substance dependence) were comorbid across these categories. This represented 12% of the overall sample. In this comorbid group, the majority were comorbid for either mood or anxiety disorders and AOD use disorders [279]. This study was limited to a select few disorders and individuals were required to meet the DSM-IV-TR [1] diagnostic criteria (i.e., symptomology was insufficient) and therefore represents a conservative estimate of comorbidity amongst this group. A recent UK report indicated that, despite similar levels of social support and physical health, same-sex attracted men and women reported more psychological distress and higher levels of substance misuse than heterosexuals [280]. In Australia, there is some evidence to suggest that a higher incidence of problematic AOD use may occur in gay and bisexually active men and lesbian women than for women and men with exclusively heterosexual relationships [281, 282]. There is also an increased acceptance that same-sex attracted youth are at elevated risk for suicide attempts in particular [283].

Fundamentally, treatment for GLBT individuals is the same as for any other client group and should focus on the specific needs of the client [164]. GLBT clients represent a diverse group of people from varying backgrounds; thus, like all other clients, a holistic view should be adopted considering all aspects of the client's presentation. While all GLBT clients are different, it is important to be aware of the context in which GLBT clients' problems may develop. For instance, the development of a same-sex attracted identity usually occurs within a context of stigma and internal pressure. This can produce feelings of shame, isolation, guilt, lying, maladaptive sexual patterns and loss of social support, among other things, all increasing the risk of mental health and substance use problems. Thus, comorbidity among GLBT individuals is likely to be a consequence of being in a minority group within the community, rather than being same-sex attracted.

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 [283]:

- 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?

Engagement is fundamentally important as well as confidentiality issues. AOD workers should also be aware that, for some clients (especially young clients), issues surrounding gender and sexual orientation may be a principle concern and may demand increased attention during treatment.

Rural/remote communities

People living in rural/remote communities suffer a variety of social, attitudinal, economic, geographic and community barriers which means that they are likely to have difficulties accessing treatments and specialist care [284, 285]. Youth in these communities are at particularly high-risk [286], and alcohol and rural stressors are likely to play a role in high male suicide rate [287]. The lack of specialists in these regions tends to result in heavy reliance on primary and AOD health care providers. However, recently developed self-guided approaches, such as bibliotherapy or computerised treatments, have proven to be effective as have alternatives to face-to-face methods (e.g., telephone, email, internet) where geographical isolation and lack of specialist services are obstacles [288]. For example, Moodgym is a free online CBT self-help program for depression (www.moodgym.anu.edu.au) that has been shown to be effective in treating symptoms of depression [289].

Patterns of substance use and the types of stressors experienced are likely to vary across rural and remote areas. For example, inhalants are a particular problem in some rural areas, especially within Indigenous populations [290]. AOD workers need to be aware of the particular issues related to AOD use in their communities. Professional networking with local health providers, and fostering trust, non-judgemental acceptance and confidentiality with clients may be particularly important in rural/remote communities. In small rural communities, anonymity is very difficult to maintain, presenting a range of additional challenges for the AOD workers. Therefore issues of confidentiality are particularly crucial.

Homeless persons

There tend to be higher rates of mental health and AOD use disorders among homeless people. Being homeless has been found to almost treble a young person's chance of developing a mental disorder [291, 292]. It is important to adopt a holistic and pragmatic view when identifying treatment needs. People who are homeless present with a range of physical, financial, housing, substance, social, and psychological problems. These problems are compounded by having reduced access to services and resources [291]. Attention to their immediate basic needs is often more important than diagnosing a specific condition. It is quite difficult to have successful treatment if basic needs are not met [291]. Do they have access to primary care and from whom? Is the client likely to be able to follow through with treatment and recommendations? Will they seek help in future? Can they afford specific treatments/medications? Thus, treatment should be guided by the perceived needs of the client, as well as AOD worker judgement.

Being homeless involves added stigmatisation to the already marginalising attitudes directed towards individuals with mental health and substance use conditions. It is important to recognise the additional difficulties faced by these clients and be patient and attentive during treatment despite obvious difficulties [293]. It may be useful to try to familiarise yourself with any street outreach programs or resettlement services operating in your area [291]. It can be useful to help the client establish skills and knowledge in obviously deficient areas, as this may provide practical living abilities. It may be necessary to read documents for the client, and assist in the filling out of forms, and other basic tasks due to low literacy levels or other difficulties. Be aware that homeless people are unlikely to attend all appointments or complete homework tasks. AOD

workers need to remain optimistic, non-judgemental, flexible, process-oriented and focused on long-term treatment goals. Engaging with homeless clients' families may be difficult, but where possible and beneficial, encourage clients to consider family relationships [291].

Women

The psychological, social and physical contexts of drug use and mental health are quite different for women as opposed to men [294]. There is increased stigma associated with female AOD use (particularly among those who are pregnant) which is likely to lead to greater guilt and shame [149, 294, 295]. This stigma may lead some women to delay treatment seeking, so that by the time they enter treatment, their AOD problem is quite severe. Childcare consideration and fear of the removal of children have also been identified as barriers for women seeking treatment [292, 295].

Women who misuse substances are more likely than men, or non-misusing women, to have experienced sexual, physical or emotional abuse as children, as well as domestic violence [292, 296-298]. In addition, substance use can often lead to revictimisation via dangerous or risky situations such as unsafe sex and prostitution [292]. Among women engaging in AOD treatment, the rates of depression, anxiety and personality disorders are particularly high [299]. Poor self-esteem and self-image, high rates of suicide attempts and comorbid eating disorders are also particularly common to women with substance use issues [300, 301].

Men

In contrast to women, it is important to be aware that men may be less forthcoming with information concerning mental health. They are likely to find it more difficult to discuss emotion, viewing it as a sign of weakness and vulnerability. Feelings of shame, guilt, and powerlessness are often compounded by the feelings associated with dependency. There is evidence to suggest that men may respond better to more concrete, action-oriented treatment approaches [149]. Therefore, cognitive behavioural techniques are recommended when working with men. For some men, it may also be appropriate to explore such topics as anger management and strategies to avoid domestic violence.

Coerced clients

Clients may be coerced into treatment through a variety of channels, for instance through the judicial system, via family and friends, schools or workplaces or through child protection or other services. However, AOD workers should not assume treatment will be ineffective as a result [302]. In fact, coercion in to treatment may present an opportunity which the client may never have previously considered. It is important for the AOD worker to present it as a positive opportunity from which the client may experience some benefit. A positive attitude on behalf of the AOD worker and efforts in engaging a coerced client are key to a productive outcome. The role of educational and motivational interventions may require more attention. Nevertheless, there are some special considerations that AOD workers ought to be aware of when dealing with coerced clients. First, confidentiality may be complicated and needs to be clarified from the outset of treatment, both with the referrer and the client. Open communication is required regarding the boundaries, rights and obligations concerning confidentiality [149]. Similarly, conflicts of interest

between the views of the AOD worker and the conditions under which the client accesses treatment may arise and should be addressed [9, 284]. Harm reduction is also an important consideration when dealing with coerced clients. This may often be a more satisfactory goal for clients but court orders and familial requests are likely to be based on an expectation of abstinence [9]. The AOD worker, however, can play an important role in clarifying what the realistic goals are for each client. Often, a lack of knowledge and understanding of dependence and treatment results in unrealistic expectations, particularly in relation to the Opioid Treatment Program (methadone/buprenorphine treatment) and the need to be abstinent from all drugs.

Coerced clients may be accessing treatment services for the first time, or may be accessing a different type of service. This provides the opportunity for a thorough assessment which may identify previously undiagnosed comorbid disorders, and present an opportunity for treatment.

Barber [303] suggests in cases of coercion the worker should adopt a negotiation or mediation role and follow six steps in this process. These steps are:

- 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.

When working with justice health specifically, appropriate referrals and consultation with corrective services need to take place. While a client being released from custody should be reviewed to ensure that he/she has all medications post release and that he/she is aware of services, referred to and accepted by service providers where necessary [304].

Youth

A number of epidemiological studies and government initiatives have identified adolescents and young adults as a group at risk for comorbid AOD and mental health conditions [61, 305-308]. The US National Comorbidity Survey reported that the co-occurrence of AOD use disorders and mental illness was highest amongst those aged 15-24 years [309]. In addition, the Australian National Comorbidity Project [75] identified young people as being at increased risk of poor treatment outcomes and social disadvantage as a result of having a comorbid mental health and substance misuse problems [310]. A review of community studies of adolescent substance use, abuse and dependence revealed that 60% of children and youth with an AOD use disorder had a comorbid diagnosis, with conduct disorder and oppositional defiant disorder the most common, followed by depression [307].

An Australian study among substance-abusing youth (aged 16-22 years) attending community drug treatment services found high rates of lifetime and current mental health disorders (69% and 50%, respectively) [61]. Almost half the sample (49%) fulfilled criteria for a current mood or anxiety disorder, and this was more pronounced in female participants (61%). Rates of major depression and PTSD were particularly high, and were both associated with significant morbidity.

Not only does research suggest that there is an increased prevalence of comorbidity among young people but there is evidence to suggest that adolescents with AOD and co-occurring mood and anxiety disorders also display greater severity of substance use and associated problems, including increased disability and suicidal behaviour, and reduced academic performance and social abilities [311-316].

Adolescence and young adulthood can be a difficult, turbulent time for many people, with issues of change, development, identity formation, experimentation, rebellion and uncertainty impacting upon an individual's thoughts, feelings and behaviour [149, 317]. Thus, it is a vulnerable time for mental health and substance use. It is also often the time in which the first presentations of psychosis and symptoms of depression and anxiety emerge [164]. It should be noted that the presentation of mental illness may be different in young people compared to adults. For example, children who have experienced trauma may not have a sense of reliving the trauma, but rather they may engage in repetitive play activities that re-enact the event. AOD workers who work with children or adolescents should refer to the DSM-IV-TR [1] and be aware of possible symptom variations.

It is important to recognise that AOD and mental health problems take place in different physical, attitudinal, psychological and social contexts for young people, and treatment needs to be tailored accordingly [119, 281]. For instance, treatment should be "youth friendly" and include follow-up for missed appointments, ease of access, prompt screening and assessment, drop-in capability, flexibility, strong links to other relevant agencies to ensure holistic treatment, and interventions that recognise different cognitive capacities, and developmental/maturational lags [164]. AOD workers may need to modify the treatment process to avoid client distraction and rebellion (e.g., creating a more active and informal environment) and place special emphasis on engagement (patience and skill is required in addition to the use of appropriate language and questioning and relating to young people on their level).

In regards to confidentiality, most young people would be considered to be "mature minors" by the age of around 14 or 15. In this case there is no obligation to provide information to the parents unless other legal and reporting constraints operate, and confidentiality must be respected [149]. In most circumstances, however, it is helpful to involve families (especially parents or carers) and this should be discussed with the young person at the outset of treatment and his/her consent for involvement sought. Parents and carers may require support, education and empowerment in order to assist with continued care and help prevent client relapse upon discharge [119, 318].

It may be particularly useful to provide young clients with practical and concrete strategies concerning mental health and AOD use (particularly relapse prevention and urge control). For instance, a behavioural treatment program consisting of stimulus control, urge control, social contracting, problem solving, relationship enhancement, anger management and communication skills training has been shown to be particularly effective in continued abstinence in adolescents with AOD issues [319], while cognitive and behavioural therapies have indicated positive outcomes for mental health disorders [320-323]. Towers [324] argues that it is unrealistic to expect many young people to completely cease using all substances and engaging in other risk-taking behaviours (such as driving at high speeds, promiscuity), at least initially.

Therefore, it is particularly important to include harm-reduction strategies when working with young people.

From the above discussion, some useful key strategies to consider when treating young people include [121]:

- 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.

References

REFERENCES

1. American Psychiatric Association. Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington DC: American Psychiatric Association; 2000.
2. McDermott F, Pyett P. Not welcome anywhere: People who have both a serious psychiatric disorder and problematic drug or alcohol use. Melbourne: Victorian Managed Mental Health Services; 1993.
3. Roche A, O'Neill M, Wolinski K. Alcohol and other drug specialist treatment services and their managers: Findings from a national survey. Australian and New Zealand Journal of Public Health. 2004; 28:252-8.
4. Ministerial Council on Drug Strategy (Australia). National Drug Strategic Framework 1998-99 to 2002-03: Building partnerships: A strategy to reduce harm caused by drugs in our community. Canberra: AusInfo; 1998.
5. Commonwealth Department of Health and Aged Care. Second National Mental Health Plan. Canberra: Commonwealth Department of Health and Aged Care; 1998.
6. Jenner L, Kavanagh D, Greenaway L, Saunders JB. Dual Diagnosis Consortium 1998 Report. Brisbane: Alcohol and Drug Training and Research Unit; 1998.
7. Allsop S, Cormack S, Addy D, Ashenden R, Ask A, Beel A. Education and training programs for front-line professionals responding to drug and alcohol problems in Australia: Summary report. Bedford Park: National Centre for Education and Training on Addiction; 1998.
8. Siggins Miller Consultants. Current practice in the management of clients with comorbid mental health and substance use disorders in tertiary care settings. Canberra: Commonwealth Department of Health and Ageing; 2003.
9. Kavanagh DJ, Greenaway L, Jenner L, Saunders JB, White A, Sorban J, et al. Contrasting views and experiences of health professionals on the management of comorbid substance misuse and mental disorders. Australian & New Zealand Journal of Psychiatry. 2000; 34(2):279-89.
10. Saunders B, Robinson S. Co-occurring mental health and drug dependency disorders: Workforce development challenges for the A&D field. Drug and Alcohol Review. 2002; 21:231-7.
11. Hall W, Lynskey M, Teesson M. What is comorbidity and why does it matter? In: Teesson M, Burns L, eds. National Comorbidity Project. Canberra: Commonwealth Department of Health and Aged Care; 2001.
12. National Mental Health Education and Training Advisory Group. National Practice Standards for the Mental Health Workforce. Canberra: Commonwealth Department of Health and Ageing; 2002.
13. Drake RE, Wallach MA. Dual Diagnosis: 15 Years of Progress. Psychiatr Serv. 2000; 51(9):1126-9.
14. Degenhardt L, Hall W. The relationship between tobacco use, substance use disorders and mental disorders: Results from the National Survey of Mental Health and Well-Being. Technical Report. Sydney: National Drug and Alcohol Research Centre, University of NSW; 1999. Report No.: 78.
15. Degenhardt L, Hall W. Patterns of co-morbidity between alcohol use and other substance use in the Australian population. Drug & Alcohol Review. 2003; 22(1):7-13.
16. Trafton JA, Oliva EM, Horst DA, Minkel JD, Humphreys K. Treatment needs associated with pain in substance use disorder patients: Implications for concurrent treatment. Drug and Alcohol Dependence. 2004; 73(1):23-31.
17. Alaja R, Seppä K, Sillanaukee P, Tienari P, Huyse FJ, Herzog T, et al. Physical and mental comorbidity of substance use disorders in psychiatric consultations. Alcoholism: Clinical and Experimental Research. 1998; 22(8):1820-4.

18. Struening EL, Padgett DK. Physical health status, substance use and abuse, and mental disorders among homeless adults. Journal of Social Issues. 1990; 46(4):65-81.
19. Cairney S, Clough A, Jaragba M, Maruff P. Cognitive impairment in Aboriginal people with heavy episodic patterns of alcohol use. Addiction. 2007; 102(6):909-15.
20. Rendell PG, Gray TJ, Henry JD, Tolan A. Prospective memory impairment in "ecstasy" (MDMA) users. Psychopharmacology. 2007; 194(4):497-504.
21. Schrimsher GW, Parker JD, Burke RS. Relation between cognitive testing performance and pattern of substance use in males at treatment entry. Clinical Neuropsychologist. 2007; 21(3):498-510.
22. McGillivray JA, Moore MR. Substance use by offenders with mild intellectual disability. Journal of Intellectual & Developmental Disability. 2001; 26(4):297-310.
23. Taggart L, McLaughlin D, Quinn B, Milligan V. An exploration of substance misuse in people with intellectual disabilities. Journal of Intellectual Disability Research. 2006; 50(8):588-97.
24. Kessler RC, Merikangas KR, Berglund P, Eaton WW, Koretz DS, Walters EE. Mild disorders should not be eliminated from the DSM-V. Archives of General Psychiatry. 2003; 60:1117-22.
25. Khantzian EJ. The self-medication hypothesis of addictive disorders: Focus on heroin and cocaine dependence. American Journal of Psychiatry. 1985; 142(11):1259-64.
26. Khantzian EJ. The self-medication hypothesis of substance use disorders: A reconsideration and recent applications. Harvard Review of Psychiatry. 1997; 4(5):231-44.
27. Raimo EB, Schuckit MA. Alcohol dependence and mood disorders. Addictive Behaviors. 1998; 23(6):933-46.
28. Kavanagh DJ. Psychological management of substance misuse in people with mental disorder. Kelvin Grove: Queensland University of Technology; 2008.
29. Schuckit MA. Comorbidity between substance use disorders and psychiatric conditions. Addiction. 2006; 101(suppl. 1):76-88.
30. Brown S, Schuckit M. Changes in depression amongst abstinent alcoholics. Journal of Studies in Alcohol. 1988; 52:37-43.
31. Teesson M, Degenhardt L, Proudfoot H, Hall W, Lynskey M. How common is comorbidity and why does it occur? Australian Psychologist. 2005; 40(2):81-7.
32. Kessler RC, Foster CL, Saunders WB, Stang PE. Social consequences of psychiatric disorders, I: Educational attainment. American Journal of Psychiatry. 1995; 152(7):1026-32.
33. Lloyd C. Risk Factors for problem drug use: Identifying vulnerable groups. Drugs: Education, Prevention and Policy. 1998; 5(3):217-32.
34. Slade T, Johnston A, Teesson M, Whiteford H, Burgess P, Pirkis J, et al. The Mental Health of Australians 2. Report on the 2007 National Survey of Mental Health and Wellbeing. Canberra: Australian Government Department of Health and Ageing; 2009.
35. Mueser KT, Drake RE, Wallach MA. Dual diagnosis: A review of etiological theories. Addictive Behaviors. 1998; 23(6):717-34.
36. Castle DJ. Anxiety and substance use: Layers of complexity. Expert Review Neurotherapeutics. 2008; 8(3):493-501.
37. Stockwell T, Hodgson R, Rankin H. Tension reduction and the effects of prolonged alcohol consumption. British Journal of Addiction. 1982; 77(1):65-73.
38. Kavanagh DJ, Mueser KT. Current evidence on integrated treatment for serious mental disorder and substance misuse. Journal of the Norwegian Psychological Association. 2007; 44:618-37.

39. Hodgkins DC, el-Guebaly N, Armstrong S, Dufour M. Implications of depression on outcome from alcohol dependence: A three-year prospective follow-up. Alcoholism: Clinical and Experimental Research. 1999; 23:151-7.
40. Kessler RC, Chiu WT, Demler O, Walters EE. Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry. 2005; 62(6):617-27.
41. Begg S, Vos T, Barker B, Stevenson C, Stanley L, Lopez A. The burden of disease and injury in Australia 2003. Canberra: Australian Institute of Health and Welfare; 2007.
42. Andrews G, Issakidis C, Slade T. The clinical significance of mental disorders In: Teesson M, Burns L, eds. National Comorbidity Project. Canberra: Commonwealth Department of Health and Aged Care; 2001.
43. Proudfoot H, Teesson M. Who seeks treatment for alcohol dependence? Findings from the Australian National Survey of Mental Health and Wellbeing. Social Psychiatry & Psychiatric Epidemiology. 2002; 37(10):451-6.
44. Hall W. What have population surveys revealed about substance use disorders and their co-morbidity with other mental disorders? Drug and Alcohol Review. 1996; 15:157-70.
45. Brems C, Johnson ME. Clinical implications of the co-occurrence of substance use and other psychiatric disorders. Professional Psychology - Research & Practice. 1997; 28(5):437-47.
46. Burns L, Teesson M, O'Neill K. The impact of comorbid anxiety and depression on alcohol treatment outcomes. Addiction. 2005; 100(6):787-96.
47. Mills KL, Teesson M, Ross J, Darke S, Shanahan M. The costs and outcomes of treatment for opioid dependence associated with posttraumatic stress disorder. Psychiatric Services. 2005; 56(8):940-5.
48. Ross J, Teesson M, Darke S, Lynskey M, Ali R, Ritter A, et al. The characteristics of heroin users entering treatment: Findings from the Australian Treatment Outcome Study (ATOS). Drug and Alcohol Review. 2005; 24(5):411-8.
49. Topp L, Degenhardt L, Kaye S, Darke S. The emergence of potent forms of methamphetamine in Sydney, Australia: A case study of the IDRS as a strategic early warning system. Drug and Alcohol Review. 2002; 21:341-8.
50. Dawe S, McKetin R. The psychiatric comorbidity of psychostimulant use. In: Baker A, Lee NK, Jenner L, eds. Models of intervention and care for psychostimulant users. Canberra: Commonwealth Department of Health and Ageing; 2004.
51. Baker A, Lee N, Claire M, Lewin TL, Grant T, Pohlman S, et al. Drug use patterns and mental health of regular amphetamine users during a reported "heroin drought". Addiction. 2004; 99:875-84.
52. Mills KL, Teesson M, Ross J, Peters L. Trauma, PTSD, and substance use disorders: Findings from the Australian National Survey of Mental Health and Well-Being. American Journal of Psychiatry. 2006; 163(4):652-8.
53. Kay-Lambkin FJ, Baker A, Lewin TL. The "co-morbidity roundabout": A framework to guide assessment and intervention strategies and engineer change among people with co-morbid problems. Drug and Alcohol Review. 2004; 23(4):407-23.
54. Kavanagh DJ, Mueser KT, Baker A. Management of comorbidity. In: Teesson M, Proudfoot H, eds. Comorbid Mental Disorders and Substance Use Disorders. Canberra: Australian Government Department of Health and Ageing; 2003.
55. Allsop SJ, Helfgott S. Whither the drug specialist? The work-force development needs of drug specialist staff and agencies. Drug & Alcohol Review. 2002; 21(3):215-22.
56. Ouimette P, Goodwin E, Brown PJ. Health and well being of substance use disorder patients with and without posttraumatic stress disorder. Addictive Behaviors. 2006; 31(8):1415-23.

57. Kessler RC. Epidemiology of psychiatric comorbidity. In: Tsuang MT, Tohen M, Zahner GEP, eds. Textbook in Psychiatric Epidemiology. New York: Wiley and Sons; 1995: 179-97.
58. Johnson ME, Brems C, Burke S. Recognizing comorbidity among drug users in treatment. American Journal of Drug & Alcohol Abuse. 2002; 28(2):243-61.
59. Schafer I, Najavits LM. Clinical challenges in the treatment of patients with post traumatic stress disorder and substance abuse. Current Opinion in Psychiatry. 2007; 20(6):614-8.
60. Dickey B, Normand SL, Weiss RD, Drake RE, Azeni H. Medical morbidity, mental illness, and substance use disorders. Psychiatric Services. 2002; 53(7):861-7.
61. Lubman DI, Allen NB, Rogers N, Cementon E, Bonomo Y. The impact of co-occurring mood and anxiety disorders among substance-abusing youth. Journal of Affective Disorders. 2007; 103:105-12.
62. Siegfried N. A review of comorbidity: Major mental illness and problematic substance use. Australian and New Zealand Journal of Psychiatry. 1998; 32:707-17.
63. Center for Substance Abuse Treatment. Substance Abuse Treatment for Persons with Co-occurring Disorders. Treatment Improvement Protocol (TIP) Series 42. DHHS Publication No. (SMA) 05-3922. Rockville, MD: Substance Abuse and Mental Health Services Administration; 2005.
64. Mills KL, Teesson M, Ross J, Darke S. The impact of post-traumatic stress disorder on treatment outcomes for heroin dependence. Addiction. 2007; 102(3):447-54.
65. Cacciola JS, Alterman AI, Rutherford MJ, McKay JR, Mulvaney FD. The relationship of psychiatric comorbidity to treatment outcomes in methadone maintained patients. Drug & Alcohol Dependence. 2001; 61(3):271-80.
66. Mental Health Consumer Outcomes Task Force. Mental Health Statement of Rights and Responsibilities. Canberra: Commonwealth of Australia; 2000.
67. NSW Health. The management of people with a co-existing mental health and substance use disorder. Service delivery guidelines. Sydney: NSW Health Department; 2000.
68. Proudfoot H, Teesson M. Comorbidity and the delivery of services. In: Teesson M, Proudfoot H, eds. Comorbid Mental Disorders and Substance Use Disorders. Canberra: Australian Government Department of Health and Ageing; 2003.
69. Meier PS, Barrowclough C, Donmall MC. The role of the therapeutic alliance in the treatment of substance misuse: A critical review of the literature. Addiction. 2005; 100(3):304-16.
70. Meier PS, Donmall MC, McElduff P, Barrowclough C, Heller RF. The role of the early therapeutic alliance in predicting drug treatment dropout. Drug and Alcohol Dependence. 2006; 83(1):57-64.
71. Barrowclough C, Haddock G, Lowens I, Allott R, Earnshaw P, Fitzsimmons M, et al. Psychosis and drug and alcohol problems. In: Baker A, Velleman R, eds. Clinical handbook of co-existing mental health and drug and alcohol problems. New York: Routledge/Taylor & Francis Group; 2007: 241-65.
72. Phillips P, Labrow J. Dual diagnosis - does harm reduction have a role? International Journal of Drug Policy. 2000; 11(4):279-83.
73. Kavanagh D. Treatment of comorbidity. In: Teesson M, Burns L, eds. National Comorbidity Project. Canberra: Commonwealth Department of Health and Aged Care; 2001.
74. Australian Department of Health and Ageing. Consumer and Carer Involvement in Comorbidity Treatment Planning package. [World Wide Web] Canberra: Australian Department of Health and Ageing; 2007 [updated September 2007; cited 2008 11/06/2008]; Available from:

http://www.health.gov.au/internet/wcms/publishing.nsf/Content/phd-comorbidity-treatment-model#conclusion.

75. Teesson M, Burns L. National comorbidity project. Canberra: Commonwealth Department of Health and Aged Care; 2001.
76. Andrews G. Efficacy, effectiveness and efficiency in mental health service delivery. Australian and New Zealand Journal of Psychiatry. 1999; 33:316-22.
77. Hickie IB, Koschera A, Davenport TA, Naismith SL, Scott EM. Comorbidity of common mental disorders and alcohol or other substance misuse in Australian general practice. Medical Journal of Australia. 2001; 175:S31-S6.
78. WHO. The ICD-10 Classification of mental and behavioural disorders - diagnostic criteria for research. 10th ed: World Health Organization; 1993.
79. Forrest GG. Chemical dependency and antisocial personality disorder: Psychotherapy and assessment strategies. New York: Hawthorne Press; 1991.
80. Darke S, Williamson A, Ross J, Teesson M, Lynskey M. Borderline personality disorder, antisocial personality disorder and risk-taking among heroin users: Findings from the Australian Treatment Outcome Study (ATOS). Drug & Alcohol Dependence. 2004; 74:77-83.
81. Trull TJ, Sher KJ, Minks-Brown C, Durbin J, Burr R. Borderline personality disorder and substance use disorders: A review and integration. Clinical Psychology Review. 2000; 20(2):235-53.
82. Daughters SB, Stipelman BA, Sargeant MN, Schuster R, Bornovalova MA, Lejuez CW. The interactive effects of antisocial personality disorder and court-mandated status on substance abuse treatment dropout. Journal of Substance Abuse Treatment. 2008; 34(2):157-64.
83. Rounsaville BJ. DSM-IV research agenda: Substance abuse/psychosis comorbidity. Schizophrenia Bulletin. 2007; 33(4):947-52.
84. Arseneault L, Cannon M, Poulton R, Murray R, Caspi A, Moffitt TE. Cannabis use in adolescence and risk for adult psychosis: Longitudinal prospective study. BMJ. 2002; 325(7374):1212-3.
85. Dore GM. Psychiatric Comorbidity. In: Latt N, Conigrave K, Marshall J, Saunders J, Nutt D, eds. Oxford Specialist Handbooks: Addiction Medicine. Oxford: Oxford University Press; 2009.
86. Jenner L, Lee N. Treatment approaches to users of methamphetamine: A practical guide for front line workers. Canberra: Australian Government Department of Health and Ageing; 2008.
87. Shand F, Gates J, Fawcett J, Mattick R. The Treatment of Alcohol Problems. Canberra: National Alcohol Strategy; 2003.
88. Myrick H, Brady K. Current review of the comorbidity of affective, anxiety and substance use disorders. Current Opinion in Psychiatry. 2003; 16:261-70.
89. Sim K, Gwee KP, Bateman A. Case Formulation in Psychotherapy: Revitalizing Its Usefulness as a Clinical Tool. Academic Psychiatry. 2005; 29:289-92.
90. Zubin J, Spring B. Vulnerability - a new view of schizophrenia. Journal of Abnormal Psychology. 1977; 86(2):103-24.
91. Roche AM, Pollard Y. Improved services for people with drug and alcohol problems and mental illness. Adelaide: National Centre for Education and Training on Addiction (NCETA); 2006.
92. Croton G. Screening for and assessment of co-occurring substance use and mental health disorders by Alcohol & Other Drug and Mental Health Services. Victoria: Victorian Dual Diagnosis Initiative Advisory Group; 2007.

93. Chan Y-F, Dennis ML, Funk RR. Prevalence and comorbidity of major internalizing and externalizing problems among adolescents and adults presenting to substance abuse treatment. Journal of Substance Abuse Treatment. 2008; 34(1):14-24.
94. Quello SB, Brady KT, Sonne SC. Mood disorders and substance use disorders: A complex comorbidity. Science and Practice Perspectives. 2005; 3:13-24.
95. Hasin D, Trautman K, Endicott J. Psychiatric research interview for substance and mental disorders: Phenomenologically based diagnosis in patients who abuse alcohol or drugs. Psychopharmacology Bulletin. 1998; 34:3-8.
96. Strain EC. Assessment and treatment of comorbid psychiatric disorders in opioid-dependent patients. Clinical Journal of Pain. 2002; 18(4 Suppl):S14-27.
97. Flynn PM, Brown BS. Co-occurring disorders in substance abuse treatment: Issues and prospects. Journal of Substance Abuse Treatment. 2008; 34(1):36-47.
98. Groth-Marnat G. Handbook of psychological assessment. USA: John Wiley & Sons; 2003.
99. NSW Department of Health. Mental health reference resource for drug and alcohol workers. Sydney: NSW Department of Health; 2007.
100. Australian Institute of Health and Welfare. Alcohol and other drug treatment services in Australia 2005-06: Report on the National Minimum Data Set. Drug Treatment Series. No. 7. Cat. No. HSE 53. Canberra: Australian Institute of Health and Welfare; 2007.
101. Elliott D, Bjelajac P, Fallot R, Markoff L, Glover Reed B. Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. Journal of Community Psychology. 2005; 33(4):461-77.
102. Najavits LM. Assessment of trauma, PTSD, and substance use disorder. In: Wilson J, Keane TM, eds. Assessing psychological trauma and PTSD. 2nd ed. New York: Guildford Press; 2004: 466-91.
103. Resick PA, Iverson KM, Artz CE. Participant reactions to a pretreatment research assessment during a treatment outcome study for PTSD. Journal of Traumatic Stress. 2009; 22(4):316-9.
104. Newman E, Walker EA, Gefland A. Assessing the ethical costs and benefits of trauma-focused research. General Hospital Psychiatry. 1999; 21(3):187-96.
105. Walker EA, Newman E, Koss M, Bernstein D. Does the study of victimization revictimize the victims? General Hospital Psychiatry. 1997; 19(6):403-10.
106. Schlenger WE, Jordan BK, Caddell JM, Ebert L, Fairbank JA. Epidemiological methods for assessing trauma and PTSD. In: Wilson JP, Keane TM, eds. Assessing psychological trauma and PTSD (2nd ed.). New York: Guilford Press; 2004: 226-61.
107. Mills KL, Back SE, Teesson M, Brady K, Baker A, Hopwood S, et al. Concurrent Treatment with Prolonged Exposure (COPE) Version II. Unpublished; 2007.
108. Gossop M. Drug addiction and its treatment. Oxford: Oxford University Press; 2003.
109. Myrick H, Brady KT, Malcolm R. New developments in the pharmacotherapy of alcohol dependence. American Journal on Addictions. 2001; 10(Suppl):3-15.
110. Maloney E, Degenhardt L, Darke S, Mattick RP, Nelson E. Suicidal behaviour and associated risk factors among opioid-dependent individuals: A case-control study. Addiction. 2007; 102(12):1933-41.
111. Roy A, Janal MN. Risk factors for suicide attempts among alcohol dependent patients. Archives of Suicide Research. 2007; 11(2):211-7.
112. Kessler RC, Borges G, Walters EE. Prevalence of and risk factors for lifetime suicide attempts in the National Comorbidity Survey. Archives of General Psychiatry. 1999; 56(7):617-26.
113. Gould MS, Marrocco FA, Kleinman M, Thomas JG, Mostkoff K, Cote J, et al. Evaluating iatrogenic risk of youth suicide screening programs: A randomized controlled trial. JAMA. 2005; 293:1635-43.

114. 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.
115. Rudd MD, Joiner T, Rajab MH. Treating Suicidal Behaviour: An effective, time-limited approach. New York: Guilford Press; 2001.
116. Schwartz RC, Rogers JR. Suicide assessment and evaluation strategies: A primer for counselling psychologists. Counselling Psychology Quarterly. 2004; 17(1):89-97.
117. Prochaska J, DiClemente C. Stages and processes of self-change of smoking: Toward an integrative model of change. Journal of Consulting and Clinical Psychology. 1983; 51:390-5.
118. Clancy R, Terry M. Psychiatry and substance use: An interactive resource for clinicians working with clients who have mental health and substance use problems [DVD]. Newcastle, NSW: NSW Health; 2007.
119. Winters K. Screening and assessing adolescents for substance use disorders (Treatment Improvement Protocol (TIP) Series 31). Rockville, MD: Substance Abuse and Mental Health Services Administration; 1999.
120. Ries RK. Assessment and treatment of patients with coexisting mental illness and alcohol and other drug abuse. (Treatment Improvement Protocol (TIP) Series 9.). Rockville, MD: Substance Abuse and Mental Health Services Administration; 1995.
121. Marsh A, Dale A. Addiction Counselling: Content and Process. Melbourne: IP Communications; 2006.
122. Mattick RP, Hall W. A treatment outline for approaches to opioid dependence. Sydney: National Drug and Alcohol Research Centre; 1993.
123. Dawe S, Loxton NJ, Hides L, Kavanagh DJ, Mattick RP. Review of diagnostic and screening for alcohol and other drug use and other psychiatric disorders. Canberra: Commonwealth Department of Health and Aged Care; 2002.
124. Kessler RC. Kessler's 10 Psychological Distress Scale. Boston, MA: Harvard Medical School; 1996.
125. Andrews G, Slade T. Interpreting scores on the Kessler Psychological Distress Scale (K10). Australian and New Zealand Journal of Psychiatry. 2001; 25(6):494-7.
126. Beusenberg M, Orley J. The Self-Reporting Questionnaire. Geneva: World Health Organization; 1994.
127. Lovibond SH, Lovibond PF. Manual for the Depression Anxiety Stress Scales. 2nd ed. Sydney: Psychology Foundation; 1995.
128. Henry JD, Crawford JR. The short-form version of the Depression Anxiety Stress Scales (DASS-21): Construct validity and normative data in a large non-clinical sample. British Journal of Clinical Psychology. 2005; 44:227-39.
129. Prins A, Ouimette P, Kimerling R, Cameron RP, Hugelshofer DS, Shaw-Hegwer J. The primary care PTSD screen (PC-PTSD): Development and operating characteristics. Primary Care Psychiatry. 2003; 9(1):9-14.
130. Kimerling R, Trafton JA, Nguyen B, Kimerling R, Trafton JA, Nguyen B. Validation of a brief screen for Post-Traumatic Stress Disorder with substance use disorder patients. Addictive Behaviors. 2006; 31(11):2074-9.
131. Brewin CR, Rose S, Andrews B, Green J, Tata P, McEvedy C, et al. Brief screening instrument for post-traumatic stress disorder. British Journal of Psychiatry. 2002; 181:158-62.
132. Degenhardt L, Hall W, Korten A, Jablensky A. Use of brief screening instrument for psychosis: Results of a ROC analysis. Technical Report No. 210. Sydney: National Drug and Alcohol Research Centre; 2005.
133. White P, Chant D. The psychometric properties of a psychosis screen in a correctional setting. International Journal of Law & Psychiatry. 2006; 29(2):137-44.

134. Ober C, Schlesinger C. Indigenous Risk Impact Screen (IRIS) user manual. Brisbane: Queensland Health; 2005.
135. Schlesinger CM, Ober C, McCarthy MM, Watson JD, Seinen A. The development and validation of the Indigenous Risk Impact Screen (IRIS): A 13-item screening instrument for alcohol and drug and mental risk. Drug and Alcohol Review. 2007; 26:109-17.
136. Australian Bureau of Statistics. Suicides Australia 1921-1998. No 3309.0. Canberra: Australian Bureau of Statistics; 2000.
137. Tate SR, Brown SA, Unrod M, Ramo DE. Context of relapse for substance-dependent adults with and without comorbid psychiatric disorders. Addictive Behaviors. 2004; 29(9):1707-24.
138. Scott J, Gilvarry E, Farrell M. Managing anxiety and depression in alcohol and drug dependence. Addictive Behaviors. 1998; 23(6):919-31.
139. Baker A, Lee NK, Claire M, Lewin TJ, Grant T, Pohlman S, et al. Brief cognitive behavioural interventions for regular amphetamine users: A step in the right direction. Addiction. 2005; 100(3):367-78.
140. Andrews G, Creamer M, Crino R, Hunt C, Lampe L, Page A. The treatment of anxiety disorders. 2nd ed. Cambridge: Cambridge University Press; 2003.
141. Baillie AJ, Rapee RM. Predicting who benefits from psychoeducation and self-help for panic attacks. Behaviour Research and Therapy. 2003; 42:513-27.
142. Baker A, Dawe S. Amphetamine use and co-occurring psychological problems: A review of the literature and implications for treatment. Australian Psychologist. 2005; 40(2):88-95.
143. Brady KT, Killeen T, Saladen ME, Dansky B, Becker S. Comorbid substance abuse and post traumatic stress disorder: Characteristics of women in treatment. American Journal on Addictions. 1994; 3:160-3.
144. Brown PJ, Wolfe J. Substance abuse and post-traumatic stress disorder comorbidity. Drug and Alcohol Dependence. 1994; 35:51-9.
145. Kofoed L, Friedman MJ, Peck R. Alcoholism and drug abuse in inpatients with PTSD. Psychiatric Quarterly. 1993; 64:151-71.
146. Davies MI, Clark DM. Predictors of analogue post-traumatic intrusive cognitions. Behavioural and Cognitive Psychotherapy. 1998; 26(4):303-14.
147. Dunmore E, Clark DM, Ehlers A. A prospective investigation of the role of cognitive factors in persistent posttraumatic stress disorder (PTSD) after physical or sexual assault. Behaviour Research and Therapy. 2001; 39(9):1063-84.
148. Ouimette P, Brown PJ, eds. Trauma and Substance Abuse. Washington, DC: American Psychological Association; 2003.
149. Marsh A, Dale A, Willis L. A counsellor's guide to working with alcohol and drug users. 2nd ed. Perth: Drug and Alcohol Office, Western Australia; 2007.
150. Sunshine Coast Mental Health Service (SCMHS). Aggression management training, module 1. Nambour: SCMHS; 2004.
151. Malcolm A. Out of harms way. Sydney: National Drug and Alcohol Research Centre; 2007.
152. Rosenthal RN, Miner CR. Differential diagnosis of substance induced psychosis and schizophrenia in patients with substance use disorders. Schizophrenia Bulletin. 1997; 23:187-93.
153. Barlow DH, Durand VM. Abnormal Psychology. Victoria: Thomson Learning; 2005.
154. Corcoran C, Walker, Huot R, Mittal V, Tessner K, Kestler L, et al. The Stress Cascade and Schizophrenia: Etiology and Onset. Schizophrenia Bulletin. 2003; 29(4):671-92.
155. Davison SE. Principles of managing patients with personality disorder. Advances in Psychiatric Treatment. 2002; 8:1-9.

156. Haynes RB, Wang E, Da Mota Gomes M. A critical review of interventions to improve compliance with prescribed medications. Patient Education and Counseling. 1987; 10(2):155-66.
157. Kemp R, Kirov G, Everitt B, Hayward P, David A. Randomised controlled trial of compliance therapy. 18-month follow-up. British Journal of Psychiatry. 1998; 172:413-9.
158. McDowell D, Nunes EV, Seracini AM, Rothenberg J, Vosburg SK, Ma GJ, et al. Desipramine treatment of cocaine-dependent patients with depression: A placebo-controlled trial. Drug & Alcohol Dependence. 2005; 80(2):209-21.
159. Thase ME, Salloum IM, Cornelius JD. Comorbid alcoholism and depression: Treatment issues. Journal of Clinical Psychiatry. 2001; 62(Suppl 20):32-41.
160. SAMHSA/CSAT. Treatment Improvement Protocols 42. (TIP 42) substance abuse treatment for persons with co-occurring disorders: National Information Center on Health Services Research and Health Care Technology.
161. Miller WR, Rollnick S. Motivational interviewing: Preparing people to change addictive behaviour. 2nd ed. New York: Guildford Press; 2002.
162. Baker A, Bucci S, Kay-Lambkin F, Hides L. Cognitive behaviour therapy for people with co-existing mental health and drug and alcohol problems. In: Baker A, Velleman R, eds. Clinical Handbook of co-existing mental health and drug and alcohol problems. London and New York: Routledge; 2007: 55-73.
163. Graham H. Cognitive-behavioural integrated treatment (C-BIT): A treatment manual for substance misuse in people with severe mental health problems. Chichester: Wiley; 2003.
164. NSW Health. Draft: Drug and alcohol psychosocial interventions: Professional practice guidelines. Sydney: NSW Health; 2008.
165. Marlatt GA, Gordon JR, eds. Relapse prevention: Maintenance strategies in the treatment of addictive behaviors. New York: Guilford; 1985.
166. Calderwood K, Christie R. The views of consumers and frontline workers regarding coordination among addiction and mental health services. Mental Health and Substance Use: Dual Diagnosis. 2008; 1(1):21-32.
167. Mueser KT, Pierce SC, Baker A, Velleman R. Group interventions for co-existing mental health and drug and alcohol problems. Clinical handbook of co-existing mental health and drug and alcohol problems. New York: Routledge/Taylor & Francis Group; 2007: 96-113.
168. Modesto-Lowe V, Kranzler HR. Diagnosis and treatment of alcohol-dependent patients with comorbid psychiatric disorders. Alcohol Research & Health: The Journal of the National Institute on Alcohol Abuse & Alcoholism. 1999; 23(2):144-9.
169. Segal ZV, Williams JMG, Teasdale JD. Mindfulness-based cognitive therapy for depression: A new approach to preventing relapse. New York: Guilford Press; 2002.
170. Higgins ST, Petry NM. Contingency management. Incentives for sobriety. Alcohol Research & Health: The Journal of the National Institute on Alcohol Abuse & Alcoholism. 1999; 23(2):122-7.
171. Budney AJ, Higgins ST, Radonovich KJ, Novy PL. Adding voucher-based incentives to coping skills and motivational enhancement improves outcomes during treatment for marijuana dependence. Journal of Consulting & Clinical Psychology. 2000; 68(6):1051-61.
172. Higgins ST, Wong CJ, Badger GJ, Ogden DE, Dantona RL. Contingent reinforcement increases cocaine abstinence during outpatient treatment and 1 year of follow-up. Journal of Consulting & Clinical Psychology. 2000; 68(1):64-72.
173. Saxon AJ, Wells EA, Fleming C, Jackson TR, Calsyn DA. Pre-treatment characteristics, program philosophy and level of ancillary services as predictors of methadone maintenance treatment outcome. Addiction. 1996; 91(8):1197-209.

174. Petry NM, Martin B, Cooney JL, Kranzler HR. Give them prizes, and they will come: Contingency management for treatment of alcohol dependence. Journal of Consulting & Clinical Psychology. 2000; 68(2):250-7.
175. Rounsaville BJ. Treatment of cocaine dependence and depression. Biological Psychiatry. 2004; 56(10):803-9.
176. Gonzalez G, Feingold A, Oliveto A, Gonsai K, Kosten TR, Gonzalez G, et al. Comorbid major depressive disorder as a prognostic factor in cocaine-abusing buprenorphine-maintained patients treated with desipramine and contingency management. American Journal of Drug & Alcohol Abuse. 2003; 29(3):497-514.
177. Milby JB, Schumacher JE, McNamara C, Wallace D, Usdan S, McGill T, et al. Initiating abstinence in cocaine abusing dually diagnosed homeless persons. Drug & Alcohol Dependence. 2000; 60(1):55-67.
178. Brown RA, Evans DM, Miller IW, Burgess ES, Mueller TI. Cognitive-behavioral treatment for depression in alcoholism. Journal of Consulting & Clinical Psychology. 1997; 65(5):715-26.
179. Kay-Lambkin FJ, Baker A, Carr VJ. Depression and drug and alcohol problems. In: Baker A, Velleman R, eds. Clinical handbook of co-existing mental health and drug and alcohol problems. London: Routledge; 2007: 218-40.
180. Hammad TA, Laughren T, Racoosin J. Suicidality in pediatric patients Treated with antidepressant drugs. Archives of General Psychiatry. 2006; 63(3):332-9.
181. Le Fauve CE, Litten RZ, Randall CL, Moak DH, Salloum IM, Green AI, et al. Pharmacological treatment of alcohol abuse/dependence with psychiatric comorbidity. Alcoholism: Clinical & Experimental Research. 2004; 28(2):302-12.
182. Riggs PD, Mikulich-Gilbertson SK, Davies RD, Lohman M, Klein C, Stover SK. A randomized controlled trial of fluoxetine and cognitive behavioral therapy in adolescents with major depression, behavior problems, and substance use disorders. Archives of Pediatrics & Adolescent Medicine. 2007; 161(11):1026-34.
183. Yoon S-J, Pae C-U, Kim D-J, Namkoong K, Lee E, Oh D-Y, et al. Mirtazapine for patients with alcohol dependence and comorbid depressive disorders: A multicentre, open label study. Progress in Neuro-Psychopharmacology & Biological Psychiatry. 2006; 30(7):1196-201.
184. Carpenter KM, Brooks AC, Vosburg SK, Nunes EV. The effect of sertraline and environmental context on treating depression and illicit substance use among methadone maintained opiate dependent patients: A controlled clinical trial. Drug & Alcohol Dependence. 2004; 74(2):123-34.
185. Cornelius JR, Bukstein O, Salloum I, Clark D. Alcohol and psychiatric comorbidity. Recent Developments in Alcoholism. 2003; 16:361-74.
186. Chick J, Aschauer H, Hornik K. Efficacy of fluvoxamine in preventing relapse in alcohol dependence: A one-year, double-blind, placebo-controlled multicentre study with analysis by typology. Drug & Alcohol Dependence. 2004; 74:61-70.
187. Kranzler HR, Burleson JA, Brown J, Babor TF. Fluoxetine treatment seems to reduce the beneficial effects of cognitive-behavioral therapy in type B alcoholics. Alcoholism, Clinical & Experimental Research. 1996; 20(9):1534-41.
188. Dundon W, Lynch KG, Pettinati HM, Lipkin C. Treatment outcomes in type A and B alcohol dependence 6 months after serotonergic pharmacotherapy. Alcoholism: Clinical & Experimental Research. 2004; 28:1065-73.
189. Pettinati HM, Volpicelli JR, Kranzler HR, Luck G, Rukstalis MR, Cnaan A. Sertraline treatment for alcohol dependence: Interactive effects of medication and alcoholic subtype. Alcoholism: Clinical & Experimental Research. 2000; 24:1041-9.

190. Kim T-S, Pae C-U, Yoon S-J, Bahk W-M, Jun T-Y, Rhee W-I, et al. Comparison of venlafaxine extended release versus paroxetine for treatment of patients with generalized anxiety disorder. Psychiatry & Clinical Neurosciences. 2006; 60(3):347-51.
191. Pollack M, Mangano R, Entsuah R, Tzanis E, Simon NM. A randomized controlled trial of venlafaxine ER and paroxetine in the treatment of outpatients with panic disorder. Psychopharmacology. 2007; 194(2):233-42.
192. Stahl SM. Essential Psychopharmacology: The Prescriber's Guide. Cambridge: Cambridge University Press; 2006.
193. Boothby LA, Doering PL, Boothby LA, Doering PL. Acamprosate for the treatment of alcohol dependence. Clinical Therapeutics. 2005; 27(6):695-714.
194. Kranzler HR, Van Kirk J. Efficacy of naltrexone and acamprosate for alcoholism treatment: A meta-analysis. Alcoholism: Clinical & Experimental Research. 2001; 25(9):1335-41.
195. Ooteman W, Koeter MW, Verheul R, Schippers GM, Van Den Brink W. The effect of naltrexone and acamprosate on cue-induced craving, autonomic nervous system and neuroendocrine reactions to alcohol-related cues in alcoholics. European Neuropsychopharmacology. 2007; 17:558-66.
196. Srisurapanont M, Jarusuraisin N. Opioid antagonists for alcohol dependence. Cochrane Database of Systematic Reviews. 2008; (1).
197. Verheul R, Lehert P, Geerlings PJ, Koeter MWJ, van den Brink W. Predictors of acamprosate efficacy: Results from a pooled analysis of seven European trials including 1485 alcohol-dependent patients. Psychopharmacology. 2005; 178(2-3):167-73.
198. Petrakis I, Ralevski E, Nich C, Levinson C, Carroll K, Poling J, et al. Naltrexone and disulfiram in patients with alcohol dependence and current depression. Journal of Clinical Psychopharmacology. 2007; 27(2):160-5.
199. Krystal JH, Gueorguieva R, Cramer J, Collins J, Rosenheck R. Naltrexone is associated with reduced drinking by alcohol dependent patients receiving antidepressants for mood and anxiety symptoms: Results from VA Cooperative Study No. 425, "Naltrexone in the treatment of alcoholism". Alcoholism: Clinical & Experimental Research. 2008; 32(1):85-91.
200. Davidson D, Wirtz PW, Gulliver SB, Longabaugh R. Naltrexone's suppressant effects on drinking are limited to the first 3 months of treatment. Psychopharmacology. 2007; 194(1):1-10.
201. Gerra G, Leonardi C, D'Amore A, Strepparola G, Fagetti R, Assi C, et al. Buprenorphine treatment outcome in dually diagnosed heroin dependent patients: A retrospective study. Progress in Neuro-Psychopharmacology & Biological Psychiatry. 2006; 30(2):265-72.
202. Weiss RD, Najavits LM, Greenfield SF. A relapse prevention group for patients with bipolar and substance use disorders. Journal of Substance Abuse Treatment. 1999; 16(1):47-54.
203. Weiss RD, Griffin ML, Kolodziej ME, Greenfield SF, Najavits LM, Daley DC, et al. A randomized trial of integrated group therapy versus group drug counseling for patients with bipolar disorder and substance dependence. American Journal of Psychiatry. 2007; 164(1):100-7.
204. Vornik LA, Brown ES. Management of comorbid bipolar disorder and substance abuse. Journal of Clinical Psychiatry. 2006; 67 Suppl 7:24-30.
205. Hunot V, Churchill R, Teixeira V, Silva de Lima M. Psychological therapies for generalised anxiety disorder. Cochrane Database of Systematic Reviews. 2008; (1).
206. Pollack MH, Lepola U, Koponen H, Simon NM, Worthington JJ, Emilien G, et al. A double-blind study of the efficacy of venlafaxine extended-release, paroxetine, and placebo in the treatment of panic disorder. Depression & Anxiety. 2007; 24(1):1-14.

207. Gorman JM. Treating generalized anxiety disorder. Journal of Clinical Psychiatry. 2003; 64 Suppl 2:24-9.
208. Snyderman SH, Rynn MA, Bellew K, Rickels K. Paroxetine in the treatment of generalised anxiety disorder. Expert Opinion on Pharmacotherapy. 2004; 5(8):1799-806.
209. Kranzler HR, Burleson JA, Del Boca FK, Babor TF, Korner P, Brown J, et al. Buspirone treatment of anxious alcoholics. A placebo-controlled trial. Archives of General Psychiatry. 1994; 51(9):720-31.
210. Malcolm R, Anton RF, Randall CL, Johnston A. A placebo-controlled trial of buspirone in anxious inpatient alcoholics. Alcoholism: Clinical & Experimental Research. 1992; 16(6):1007-13.
211. Furukawa TA, Watanabe N, Churchill R. Combined psychotherapy plus antidepressants for panic disorder with or without agoraphobia. Cochrane Database of Systematic Reviews. 2008; (1).
212. Schade A, Marquenie LA, van Balkom AJ, Koeter MW, de Beurs E, van den Brink W, et al. The effectiveness of anxiety treatment on alcohol-dependent patients with a comorbid phobic disorder: A randomized controlled trial. Alcoholism: Clinical & Experimental Research. 2005; 29(5):794-800.
213. Randall CL, Thomas S, Thevos AK. Concurrent alcoholism and social anxiety disorder: A first step toward developing effective treatments. Alcoholism: Clinical & Experimental Research. 2001; 25(2):210-20.
214. Brady KT, Tolliver BK, Verduin ML. Alcohol use and anxiety: Diagnostic and management issues. American Journal of Psychiatry. 2007; 164(2):217-21.
215. Thevos AK, Thomas SE, Randall CL. Baseline differences in social support among treatment-seeking alcoholics with and without social Phobia. Substance Abuse. 1999; 20(2):107-18.
216. Stein DJ, Ipser JC, van Balkom AJ. Pharmacotherapy for social anxiety disorder. Cochrane Database of Systematic Reviews. 2008; (1).
217. Back SE, Waldrop AE, Brady KT. Evidence-based time-limited treatment of co-occurring substance use disorders and civilian-related PTSD. Brief Treatment and Crisis Intervention. 2006; 6:283-94.
218. Najavits LM, Ryngala D, Back SE, Bolton E, Mueser KT, Brady KT. Treatment of PTSD and comorbid disorders. Effective treatments for PTSD: Practice guidelines from the International Society for Traumatic Stress Studies (2nd ed.). New York: Guilford Press; 2009: 508-35.
219. Foa EB. Psychosocial treatment of posttraumatic stress disorder. Journal of Clinical Psychiatry. 2000; 61(Suppl 5):43-51.
220. Brady KT, Dansky BS, Back SE, Foa EB, Carroll KM. Exposure therapy in the treatment of PTSD among cocaine-dependent individuals: Preliminary findings. Journal of Substance Abuse Treatment. 2001; 21:47-54.
221. Triffleman E, Carroll K, Kellogg S. Substance dependence post traumatic stress disorder therapy. Journal of Substance Abuse Treatment. 1999; 17:3-14.
222. Back SE, Brady KT, Sonne SC, Verduin ML. Symptom improvement in co-occurring PTSD and alcohol dependence. Journal of Nervous & Mental Disease. 2006; 194(9):690-6.
223. Foa EB, Rothbaum BO. Treating the trauma of rape: Cognitive-behavioral therapy for PTSD. New York: The Guilford Press; 1998.
224. Najavits LM. Seeking safety: A treatment manual for PTSD and substance abuse. New York: The Guildford Press; 2002.
225. Hien DA, Cohen LR, Miele GM, Litt LC, Capstick C. Promising treatments for women with comorbid PTSD and substance use disorders. American Journal of Psychiatry. 2004; 161(8):1426-32.

226. Australian Centre for Posttraumatic Mental Health. Australian guidelines for the treatment of adults with Acute Stress Disorder and Posttraumatic Stress Disorder. Melbourne: ACPMH; 2007.
227. Brady KT, Sonne S, Anton RF, Randall CL, Back SE, Simpson K. Sertraline in the treatment of co-occurring alcohol dependence and post traumatic stress disorder. Alcoholism: Clinical & Experimental Research. 2005; 29(3):395-401.
228. Brady KT, Sonne SC, Roberts JM. Sertraline treatment of comorbid post traumatic stress disorder and alcohol dependence. Journal of Clinical Psychiatry. 1995; 56(11):502-5.
229. Binks CA, Fenton M, McCarthy L, Lee T, Adams CE, Duggan C. Psychological therapies for people with borderline personality disorder. Cochrane Database of Systematic Reviews. 2008; (1).
230. van den Bosch LM, Verheul R. Patients with addiction and personality disorder: Treatment outcomes and clinical implications. Current Opinion in Psychiatry. 2007; 20(1):67-71.
231. Ball SA. Manualized treatment for substance abusers with personality disorders: Dual focus schema therapy. Addictive Behaviors. 1998; 23(6):883-91.
232. Ball SA, Cobb-Richardson P, Connolly AJ, Bujosa CT, O'Neall TW. Substance abuse and personality disorders in homeless drop-in center clients: Symptom severity and psychotherapy retention in a randomized clinical trial. Comprehensive Psychiatry. 2005; 46(5):371-9.
233. Linehan MM, Schmidt H, Dimeff LA, Craft JC, Kanter J, Comtois KA. Dialectical behavior therapy for patients with borderline personality disorder and drug-dependence. American Journal on Addictions. 1999; 8(4):279-92.
234. Alper G, Peterson SJ. Dialectical behavior therapy for patients with borderline personality disorder. Journal of Psychosocial Nursing & Mental Health Services. 2001; 39(10):38-45.
235. Fassbinder E, Rudolf S, Bussiek A, Kroger C, Arnold R, Greggersen W, et al. Effectiveness of dialectical behavior therapy for patients with borderline personality disorder in the long-term course--a 30-month-follow-up after inpatient treatment. Psychotherapie, Psychosomatik, Medizinische Psychologie. 2007; 57(3-4):161-9.
236. Koerner K, Linehan MM. Research on dialectical behavior therapy for patients with borderline personality disorder. Psychiatric Clinics of North America. 2000; 23(1):151-67.
237. Binks CA, Fenton M, McCarthy L, Lee T, Adams CE, Duggan C. Pharmacological interventions for people with borderline personality disorder. Cochrane Database of Systematic Reviews. 2008; (1).
238. Ralevski E, Ball S, Nich C, Limoncelli D, Petrakis I. The impact of personality disorders on alcohol-use outcomes in a pharmacotherapy trial for alcohol dependence and comorbid Axis I disorders. American Journal on Addictions. 2007; 16(6):443-9.
239. Rohsenow DJ, Miranda R, McGeary JE, Monti PM. Family history and antisocial traits moderate naltrexone's effects on heavy drinking in alcoholics. Experimental & Clinical Psychopharmacology. 2007; 15(3):272-81.
240. Leal J, Ziedonis D, Kosten T. Antisocial personality disorder as a prognostic factor for pharmacotherapy of cocaine dependence. Drug and Alcohol Dependence. 1994; 35(1):31-5.
241. Arndt IO, McLellan AT, Dorozynsky L, Woody GE, O'Brien CP. Desipramine treatment for cocaine dependence: Role of antisocial personality disorder. Journal of Nervous and Mental Disease. 1994; 182:151-6.
242. Powell BJ, Campbell JL, Landon JF, Liskow BI, Thomas HM, Nickel EJ, et al. A double-blind, placebo-controlled study of Nortriptyline and Bromocriptine in male alcoholics subtyped by comorbid psychiatric disorders. Alcoholism: Clinical and Experimental Research. 1995; 19(2):462-8.

243. Penick EC, Powell BJ, Campbell J, Liskow BI, Nickel EJ, Dale TM, et al. Pharmacological treatment for antisocial personality disorder alcoholics: A preliminary study. Alcoholism Clinical and Experimental Research. 1996; 20:477-84.
244. Cleary M, Hunt G, Matheson S, Siegfried N, Walter G. Psychosocial interventions for people with both severe mental illness and substance misuse. Cochrane Database of Systematic Reviews. 2008; [computer file] (1):CD001088.
245. Drake RE, Mueser KT, Brunette MF, McHugo GJ. A review of treatments for people with severe mental illnesses and co-occurring substance use disorders. Psychiatric Rehabilitation Journal. 2004; 27(4):360-74.
246. Mueser KT, Torrey WC, Lynde D, Singer P, Drake RE. Implementing evidence-based practices for people with severe mental illness. Behavior Modification. 2003; 27(3):387-411.
247. Kavanagh DJ, Young R, Boyce L, Clair A, Sitharthan T, Clark D, et al. Substance Treatment Options in Psychosis (STOP): A new intervention for dual diagnosis. Journal of Mental Health. 1998; 7(2):135-43.
248. Barrowclough C, Haddock G, Tarrier N, Lewis SW, Moring J, O'Brien R, et al. Randomized controlled trial of motivational interviewing, cognitive behavior therapy, and family intervention for patients with comorbid schizophrenia and substance use disorders. American Journal of Psychiatry. 2001; 158(10):1706-13.
249. Baker A, Bucci S, Lewin TJ, Kay-Lambkin F, Constable PM, Carr VJ. Cognitive-behavioural therapy for substance use disorders in people with psychotic disorders: Randomised controlled trial. British Journal of Psychiatry. 2006; 188:439-48.
250. Tiet QQ, Mausbach B. Treatments for patients with dual diagnosis: A review. Alcoholism: Clinical & Experimental Research. 2007; 31(4):513-36.
251. Polcin DL. Issues in the treatment of dual diagnosis clients who have chronic mental illness. Professional Psychology Research & Practice. 1992; 23(1):30-7.
252. Clemens S, Cvetkovski S, Tyssen E. DirectLine Telephone Counselling and Referral Service. Melbourne: Turning Point Alcohol and Drug Centre Inc; 2006.
253. NSW Department of Health. NSW drug and alcohol withdrawal clinical practice guidelines. Sydney: Mental Health and Drug & Alcohol Office, NSW Department of Health; 2008.
254. Jarvis T, Tebbutt J, Mattick R. Treatment approaches for alcohol and drug dependence. Chichester: John Wiley & Sons; 1995.
255. Perkins JJ, Sanson-Fisher RJ, Blunden S, Lunnay D, Redman S, Hensely MJ. The prevalence of drug use in urban Aboriginal communities. Addiction. 1994; 89:1319-31.
256. Australian Department of Health and Ageing. Alcohol Treatment Guidelines for Indigenous Australians. Canberra: Australian Department of Health and Ageing; 2007.
257. Brady M. Indigenous Australia and alcohol policy: Meeting difference with indifference. Sydney: UNSW Press; 2004.
258. Brady M. Indigenous residential treatment programs for drug and alcohol problems: Current status and options for improvement (Discussion Paper No. 236). Canberra: Centre for Aboriginal Economic Policy Research, Australian National University; 2002.
259. Sheldon M. Psychiatric assessment in remote Aboriginal communities. Australian and New Zealand Journal of Psychiatry. 2001; 35:435-42.
260. Roxbee L, Wallace C. Emotional and social wellbeing: National policy context. Australasian Psychiatry. 2003; 11:S45-S50.
261. Nagel T. The need for relapse prevention strategies in Top End remote Indigenous mental health. Australian e-Journal for the Advancement of Mental Health [serial on the Internet]. 2006; 5(1): Available from: www.auseinet.com/journal/vol5iss1/nagel.pdf.
262. Hunter EM. Aboriginal health and history: Power and prejudice in remote Australia. Melbourne and New York: Cambridge University Press; 1993.

263. Jackson LR, Ward JE. Aboriginal Health: Why is reconciliation necessary? Medical Journal of Australia. 1999; 199: 437-40.
264. O'Shane P. The psychological impact of white colonialism on Aboriginal people. Australasian Psychiatry. 1995; 3:149-53.
265. Armsden GC, McCauley E, Greenburg MT, Burke M. Parent and peer attachment in early adolescent depression. Journal of Abnormal Child Psychology. 1990; 18:683-97.
266. Parker G. Parental overprotection: A risk factor in psychosocial adjustment. Sydney: Grune & Stratton; 1983.
267. Parker G, Barnett B. Perceptions of parenting in childhood and social support in adulthood. American Journal of Psychiatry. 1988; 145:479-82.
268. Swan P, Raphael B. Ways forward: National consultancy report on Aboriginal and Torres Strait Islander mental health. Parts 1 & 2. Canberra: Australian Government Publishing Service; 1995 [5th March 2008]; Available from: http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/mental-pubs/$FILE/wayfor.pdf.
269. Hunter E, Hall W, Spargo R. Alcohol consumption and its correlates in a remote aboriginal population. Aboriginal Law Bulletin. 1991; 2(51):8-10.
270. Prusiak B. Survey of Aboriginal Admissions to Bloomfield Hospital. NSW; 1995.
271. Clough AR, Cairney S, D'abbs P, Parker R, Maruff P, Gray D, et al. Measuring exposure to cannabis use and other substance use in remote Indigenous populations in Northern Australia: Evaluation of a "community epidemiology" approach using proxy respondents. Addiction Research & Theory. 2004; 12:261-74.
272. Li SQ, Measey M, Parker R. Suicide in the Northern Territory 1981-2002. Darwin: Department of Health and Community Services; 2004.
273. Westerman T. Engagement of Indigenous clients in mental health services: What role do cultural differences play? Australian e-Journal for the Advancement of Mental Health [serial on the Internet]. 2004; 3(3): Available from: www.auseinet.com/journal/vol3iss3/westermaneditorial.pdf
274. Davies J. A Manual of Mental Health Care in General Practice. Canberra: Commonwealth Department of Health and Aged Care; 2000.
275. Teasdale KE, Conigrave KM, Kiel KA, Freeburn B, Long G, Becker K. Improving services for prevention and treatment of substance misuse for Aboriginal communities in a Sydney Area Health Service. Drug and Alcohol Review. 2008; 27(2):152-9.
276. Berry SL, Crowe TP. A review of engagement of Indigenous Australians within mental health and substance abuse services. Australian e-Journal for the Advancement of Mental Health (AeJAMH) [serial on the Internet]. 2009; 8(1): Available from: http://www.auseinet.com/journal/vol8iss1/berry.pdf.
277. Alcohol & Other Drugs Unit of the Commonwealth Department of Health and Ageing. Culturally & Linguistically Diverse (CALD) Groups. Canberra: Commonwealth Department of Health and Ageing; 2008.
278. Reid G, Crofts N, Beyer L. Drug treatment services for ethnic communities in Victoria, Australia: An examination of cultural and institutional barriers. Ethnicity & Health. 2001; 6(1):13-26.
279. Wang J, Hausermann M, Ajdacic-Gross V, Aggleton P, Weiss MG. High prevalence of mental disorders and comorbidity in the Geneva gay men's population. Social Psychiatry & Psychiatric Epidemiology. 2007; 42(5):414-20.
280. King M, McKeown E, Warner J, Ramsay A, Johnson K, Cort C, et al. Mental health and social wellbeing of gay men, lesbians and bisexuals in England and Wales: A summary of findings. London: Mind (National Association for Mental Health); 2003.
281. APA. Practice guideline for the treatment of patients with substance use disorders: Second edition. American Journal of Psychiatry. 2006; 163(8):S1-S82.

282. Harcourt J. Current Issues in lesbian, gay, bisexual, and transgender (LGBT) health: Introduction. Journal of Homosexuality. 2006; 51(1):1-11.
283. Howard J, Nicholas J, Brown G, Karaçanta A. Same-sex attracted youth and suicide. In: Rowling L, Martin G, Walker L, eds. Mental Health Promotion in Young People. Sydney: McGraw Hill; 2002.
284. Robertson EB, Donnermeyer JF. Illegal drug use among rural adults: Mental health consequences and treatment utilization. American Journal of Drug and Alcohol Abuse. 1997; 23(3):467-84.
285. Booth BM, Kirchner J, Fortney J, Ross R, Rost K. Rural at-risk drinkers: Correlates and one-year use of alcoholism treatment services. Journal of Studies on Alcohol. 2000; 61(2):267-77.
286. Spoth R, Goldberg C, Neppl T. Rural-urban differences in the distribution of parent-reported factors for substance use among young adolescents. Journal of Substance Abuse. 2001; 13:609-23.
287. Caldwell CH, Kohn-Wood LP, Schmeelk-Cone KH, Chavous TM, Zimmerman MA. Racial discrimination and racial identity as risk or protective factors for violent behaviours in African American young males. American Journal of Community Psychology. 2004; 33(91-105).
288. Kelly B, Kay-Lambkin F, Kavanagh DJ. Rurally isolated populations and co-existing mental health and drug and alcohol problems. In: Baker A, Velleman R, eds. Clinical handbook of co-existing mental health and drug and alcohol problems. East Sussex: Routledge; 2007.
289. Christensen H, Griffiths KM, Jorm AF. Delivering interventions for depression by using the internet: Randomized controlled trial. British Medical Journal. 2004; 328:265-70.
290. Burns CB, Currie BJ, Clough AB, Wuridjal R. Evaluation of strategies used by a remote Aboriginal community to eliminate petrol sniffing. Medical Journal of Australia. 1995; 163:82-6.
291. Velleman R. Homelessness alongside co-existing mental health and drug and alcohol problems. In: Baker A, Velleman R, eds. Clinical handbook of co-existing mental health and drug and alcohol problems. East Sussex: Routledge; 2007.
292. Velleman R. Co-existing problems: From conceptualisation to case formulation. In: Baker A, Velleman R, eds. Clinical handbook of co-existing mental health and drug and alcohol problems. East Sussex: Routledge; 2007.
293. Farhoury W, Murray A, Shepherd G, Priebe S. Research in supported housing. Social Psychiatry & Psychiatric Epidemiology. 2002; 37:301-15.
294. Thomas S. Working with women. In: Helfgott S, ed. Helping change: The addiction counsellors training program. Perth: Western Australian Alcohol and Drug Authority; 1997.
295. Swift W, Copeland J. Treatment needs and experiences of Australian women with alcohol and other drug problems. Drug and Alcohol Dependence. 1996; 40:211-9.
296. Copeland J, Hall W. A comparison of predictors of treatment drop-out of women seeking drug and alcohol treatment in a specialist women's and two traditional mixed-sex treatment services. British Journal of Addiction. 1992; 87:883-90.
297. Miller BA, Downs W, Gondoli DM. Spousal violence among alcoholic women as compared to a random household sample of women. Journal of Studies on Alcohol. 1989; 50(6):533-40.
298. Swift W, Copeland J, Hall W. Characteristics of women with alcohol and other drug problems: Findings of an Australian national survey. Addiction. 1996; 91(8):1141-50.
299. Darke S, Wodak A, Heather N, Ward J. Prevalence and predictors of psychopathology among opioid users. British Journal of Addiction. 1992; 87:771-6.
300. Klee L, Schmidt C, Ames G. Indicators of women's alcohol problems: What women themselves report. International Journal of the Addictions. 1991; 26(8):879-95.

301. Copeland J. A review of the literature on women's substance use, dependence and treatment needs. Brisbane: Queensland Department of Health; 1993.
302. Hall W. The role of legal coercion in the treatment of offenders with alcohol and heroin problems. Australian and New Zealand Journal of Criminology. 1997; 30:103-20.
303. Barber J. Beyond casework. London: MacMillan; 1991.
304. NSW Department of Health. NSW clinical guidelines for the care of persons with comorbid mental illness and substance use disorders in acute care settings. Sydney: NSW Department of Health; 2009.
305. Kandel DB, Johnson JG, Bird HR, Weissman MM, Goodman SH, Lahey BB, et al. Psychiatric comorbidity among adolescents with substance use disorders: Findings from the MECA study. Journal of the American Academy of Child and Adolescent Psychiatry. 1999; 38:693-9.
306. Rohde P, Lewinsohn P, Seeley J. Psychiatric comorbidity with problematic alcohol use in high school students. Journal of the American Academy of Child and Adolescent Psychiatry. 1996; 35:101-9.
307. Armstrong TD, Costello EJ. Community studies on adolescent substance use, abuse, or dependence and psychiatric comorbidity. Journal of Consulting & Clinical Psychology. 2002; 70:1224-39.
308. Godfrey K, Yung A, Killackey E, Cosgrave E, Pan Yuen H, Stanford C, et al. Patterns of current comorbidity in young help-seekers: Implications for service planning and delivery. Australasian Psychiatry. 2005; 13:379-83.
309. Kessler RC, Nelson CB, McGonagle KA, Edlund MJ, Frank RG, Leaf PJ. The epidemiology of co-occurring addictive and mental disorders: Implications for prevention and service utilization. American Journal of Orthopsychiatry. 1996; 66(1):17-31.
310. Szirom T, King D, Desmond K. Barriers to service provision for young people with presenting substance misuse and mental health problems. Canberra: National Youth Affairs Research Scheme; 2004.
311. Grella CE, Hser Y-I, Joshi V, Rounds-Bryant J. Drug treatment outcomes for adolescents with comorbid mental and substance use disorders. Journal of Nervous and Mental Disease. 2001; 189:384-92.
312. Riggs PD, Baker S, Mikulich SK, Young SE, Crowley TJ. Depression in substance-dependent delinquents. Journal of the American Academy of Child and Adolescent Psychiatry. 1995; 34:764-71.
313. Rowe CL, Liddle HA, Dakof GD. Classifying clinically referred adolescent substance abusers by level of externalizing and internalizing symptoms. Journal of Child and Adolescent Substance Abuse. 2001; 11:41-65.
314. Lewinsohn PM, Rohde P, Seeley JR. Adolescent psychopathology: III. The clinical consequences of comorbidity. Journal of American Academy of Child and Adolescent Psychiatry. 1995; 34:510-9.
315. Wittchen HU, Nelson CB, Lachner G. Prevalence of mental disorders and psychosocial impairments in adolescents and young adults. Psychological Medicine. 1998; 28(1):109-26.
316. Andrews G, Slade T, Issakidis C. Deconstructing current Comorbidity: Data from the Australian National Survey of Mental Health and Well-being. British Journal of Psychiatry. 2002; 181:306-14.
317. Spooner C, Mattick R, Noffs T. The nature and treatment of adolescent substance abuse. NDARC Monograph No. 40. Sydney: National Drug and Alcohol Research Centre; 1999.
318. Toumbourou W, Blyth A, Bamberg J, Bowes G, Douvos T. Behaviour exchange systems training: The best approach for parents stressed by adolescent drug problems. Australian and New Zealand Journal of Family Therapy. 1997; 18(2):92-8.

319. Azrin NH, Donohue B, Besalel VA, Kogan ES, Acierno R. Youth drug abuse treatment: A controlled outcome study. Journal of Child and Adolescent Substance Abuse. 1994; 3:1-16.
320. Compton SN, Burns BJ, Egger HL, Robertson E. Review of the evidence base for treartment of child psychopathy: Internalising disorders. Journal of Consulting & Clinical Psychology. 2002; 70:1240-66.
321. Lewinsohn PM, Clarke GN. Psychosocial treatments for adolescent depression. Clinical Psychology Review. 1999; 19(3):329-42.
322. Moak DH, Anton RF, Latham PK, Voronin KE, Waid RL, Durazo-Arvizu R. Sertraline and cognitive behavioral therapy for depressed alcoholics: Results of a placebo-controlled trial. Journal of Clinical Psychopharmacology. 2003; 23(6):553-62.
323. Farmer EM, Compton SN, Burns BJ, Robertson E. Review of the evidence base for treatment childhood psychopathology: Externalising disorders Journal of Consulting & Clinical Psychology. 2002; 70:1267-302.
324. Towers T. Responding to youth drug issues. In: Helfgott S, ed. Helping Change: The addiction counsellors training program. Perth: Western Australian Alcohol and Drug Authority; 1997.
325. Dunn C, Deroo L, Rivara F. The use of brief interventions adapted from motivational interviewing across behavioural domains: A systematic review. Addiction. 2001; 96 (12):1725-42.
326. Martino S, Carroll K, O'Malley S, Rounsaville B. Motivational interviewing with psychiatrically ill substance abusing patients. American Journal on Addictions. 2000; 9:88-91.
327. Baker A, Lewin TJ, Reichler H, Clancy R, Carr VJ, Garrett R, et al. Evaluation of a motivational interview for substance use within psychiatric in-patient services. Addiction. 2002; 87:1329-37.
328. Baker A, Velleman R. Clinical handbook of co-existing mental health and drug and alcohol problems. New York: Routledge/Taylor & Francis Group; 2007.
329. DiClemente C, Velasquez M. Motivational interviewing and the stages of change. In: Miller W, Rollnick S, eds. Motivational interviewing: Preparing people for change. 2nd ed. New York: The Guilford Press; 2002.
330. Martino S, Carroll K, Kostas D, Perkins J, Rounsaville B. Dual diagnosis motivational interviewing: A modification of motivational interviewing for substance abusing patients with psychotic disorders. Journal of Substance Abuse Treatment. 2002; 23:297-308.
331. Goldberg D, Williams P. A user's guide to the General Health Questionnaire. Windsor: NFER-NELSON Publishing Company; 1988.
332. Politi PL, Piccinelli M, Wilkinson G. Reliability, validity and factor structure of the 12-item General Health Questionnaire among young males in Italy. Acta Psychiatrica Scandinavica. 1994; 90(6):432-7.
333. Derogatis LR. Symptom Checklist-90-Revised: Administration, scoring and procedures manual. 3rd ed. Minneapolis: National Computer Systems, Inc; 1994.
334. Horowitz LM, Rosenberg SE, Baer BA, Ureno G, Villasenor VS. Inventory of interpersonal problems: Psychometric properties and clinical applications. Journal of Consulting & Clinical Psychology. 1988; 56:885-92.
335. Mattick R, Oliphant D, Bell J, Hall W, eds. Psychiatric morbidity in methadone maintenance patients: Prevalence, effect on drug use and detection. Substance use and mental illness: Proceedings of the fourth Lingard symposium; 1996; Newcastle Hunter Institute of Mental Health.
336. Dawe S, Mattick RP. Review of diagnostic screening instruments for alcohol and other drug use and other psychiatric disorders. Canberra: Australian Government Publishing Service; 1997.

337. Steer RA, Schut J. Types of psychopathology displayed by heroin addicts. American Journal of Psychiatry. 1979; 136:1463-5.
338. Westermeyer J, Tucker P, Nugent S. Comorbid anxiety disorder among patients with substance abuse disorders. American Journal on Addictions. 1995; 4:97-106.
339. Hedlund JL, Vieweg BW. The Brief Psychiatric Rating Scale (BPRS): A comprehensive review. Journal of Operational Psychiatry. 1980; 11:48 –65.
340. Overall J, Gorham DR. The Brief Psychiatric Rating Scale. Psychological Reports. 1962; 10:799-812.
341. Zimmerman M, Mattia JI. A self-report scale to help make psychiatric diagnoses: The Psychiatric Diagnostic Screening Questionnaire. Archives of General Psychiatry. 2001; 58:787-94.
342. Zimmerman M, Mattia JI. The Psychiatric Diagnostic Screening Questionnaire: Development, reliability and validity. Comprehensive Psychiatry. 2001; 42:175-89.
343. Beck AT, Steer RA, Brown GK. Manual for the Beck Depression Inventory-II. San Antonio, TX: Psychological Corporation; 1996.
344. Beck AT, Steer RA. Beck Depression Inventory: Manual. USA: Harcourt, Brace, Jovanovich; 1987.
345. Beck AT, Steer RA, Garbin MG. Psychometric properties of the Beck Depression Inventory: Twenty five years of evaluation. Clinical Psychology Review. 1988; 8:77-100.
346. Kleinman PH, Miller AB, Millman RB, Woody GE, Todd T, Kemp J, et al. Psychopathology among cocaine abusers entering treatment. Journal of Nervous and Mental Disease. 1990; 178:442-7.
347. Beck A, Steer R. Beck Hopelessness Scale Manual. San Antonio: The Psychological Corporation; 1988.
348. Beck A, Steer R. Manual for the Beck Scale for Suicidal Ideation. San Antonio: Psychological Corporation; 1991.
349. Beck AT, Steer RA. Beck Anxiety Inventory: Manual. USA: Harcourt, Brace, Jovanovich; 1990.
350. de Beurs E, Wilson KA, Chambless Dl, Goldstein AJ, Feske U. Convergent and divergent validity of the Beck Anxiety Inventory for patients with panic disorder and agoraphobia. Depression and Anxiety. 1997; 6(4):140-6.
351. Fydrich T, Dowdall D, Chambless DL. Reliability and validity of the Beck Anxiety Inventory. Journal of Anxiety Disorders. 1992; 6(1):55-61.
352. Spielberger CD. Manual for the State-Trait Anxiety Inventory. Paolo Alto: Consulting Psychologists Press; 1983.
353. Kubany ES, Haynes SN, Leisen MB, Owens JA, Kaplan AS, Watson SB, et al. Development and preliminary validation of a brief broad-spectrum measure of trauma exposure: The Traumatic Life Events Questionnaire. Psychological Assessment. 2000; 12(2):210-24.
354. Read JP, Bollinger AR, Sharkansky E. Assessment of comorbid substance use disorder and posttraumatic stress disorder. In: Ouimette P, Brown PJ, eds. Trauma and substance abuse: Causes, consequences and treatment of comorbid disorder. Washington, DC: American Psychological Society; 2003: 111-25.
355. Green BL. Trauma History Questionnaire. In: Stamm BH, ed. Measurement of stress, trauma and adaptation. Lutherville: Sidran Press; 1996: 366-9.
356. Foa EB, Riggs DS, Dancu CV, Rothbaum BO. Reliability and validity of a brief instrument for assessing posttraumatic stress disorder. Journal of Traumatic Stress. 1993; 6:459-73.
357. Coffey SF, Dansky BS, Falsetti SA, Saladin ME, Brady KT. Screening for PTSD in a substance abuse sample: psychometric properties of a modified version of the PTSD Symptom Scale Self-Report. Journal of Traumatic Stress. 1998; 11(2):393-9.

358. Weathers FW, Litz BT, Herman DS, Huska JA, Keane TM. The PTSD Checklist (PCL): Reliability, validity and diagnostic utility. Annual meeting of the International Society for Traumatic Stress Studies; San Antonio; 1993.
359. Najavits LM, Weiss RD, Reif S, Gastfriend DR, Siqueland L, Barber JP, et al. The Addiction Severity Index as a screen for trauma and posttraumatic stress disorder. Journal of Studies on Alcohol. 1998; 59(1):56-62.
360. McMullin RE. Taking out your mental trash: A consumer's guide to cognitive restructuring therapy. New York: W. W. Norton & Company; 2005.
361. Beck J. Cognitive therapy: Basics and beyond. New York: The Guildford Press; 1995.
362. Gellis ZD, Kenaley B. Problem solving therapy for depression in adults: A systematic review. Research on Social Work Practice. 2008; 18:117-31.
363. Carroll KM. A cognitive-behavioral approach: Treating cocaine addiction. Rockville: U.S. Department of Health and Human Services, National Institute on Drug Abuse; 1998.
364. Mynors-Wallis L. Problem solving treatment for anxiety and depression: A practical guide. Oxford: Oxford University Press; 2005.
365. Street H. Exploring relationships between goal setting, goal pursuit and depression. Australian Psychologist. 2002; 37(2):95-103.
366. Cotterell N. Cognitive therapy of depression during addiction recovery. In: Kantor JS, ed. Clinical depression during addiction recovery: Process, diagnosis and treatment. New York: Marcel Dekker; 1996.
367. Bourne EJ. The anxiety and phobia workbook. California: New Harbinger Publications; 1995.
368. Montgomery B, Morris L. Surviving: Coping with a life crisis. Arizona: Fisher Books; 2000.

Appendices

APPENDIX A: OTHER GUIDELINES

OTHER AUSTRALIAN GUIDELINES
Australian Department of Health and Ageing. (2007). Alcohol treatment guidelines for Indigenous Australians. Canberra: Australian Department of Health and Ageing. www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/426B5656C2395CC3CA2573360002A0EA/$File/alc-treat-guide-indig.pdf.
Australian General Practice Network. (2007). Management of patients with psychostimulant use problems – Guidelines for general practitioners. Canberra: Australian Government Department of Health and Ageing. www.health.gov.au/internet/drugstrategy/publishing.nsf/Content/AC11DD6A037F9ECFCA25717D00811748/$File/psychostimnts_gp.pdf.
Cash, R. & Philactides, A. (2006). Clinical Treatment Guidelines for Alcohol and Drug Clinicians. No. 14: Co-occurring acquired brain injury/cognitive impairment and alcohol and other drug use disorders. Fitzroy, Victoria: Turning Point Alcohol and Drug Centre Inc. www.health.vic.gov.au/drugservices/downloads/abi_ctg.pdf.
Croton, G. (2007). Screening for and assessment of co-occurring substance use and mental health disorders by alcohol & other drug and mental health services. Victoria: Victorian Dual Diagnosis Initiative Advisory Group. www.dualdiagnosis.org.au/home/index.php?option=com_docman&task=doc_download&gid=23&Itemid=27&mode=view.
Gordon, A. (2009). Comorbidity of mental disorders and substance use: A brief guide for the primary care clinician. Canberra: Commonwealth Department of Health and Ageing. www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/FE16C454A782A8AFCA2575BE002044D0/$File/mono71.pdf.
Jenner, L., Baker, A., Whyte, I., & Carr, V. (2004). Psychostimulants – Management of acute behavioural disturbances: Guidelines for police services. Canberra: Australian Government Department of Health and Ageing. www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/16CAC10BAA3E0B7FCA25717E0007E25F/$File/psychostimulant-police.pdf.
Jenner, L. & Lee, N. (2008). Treatment approaches to users of methamphetamine: A practical guide for front line workers. Canberra: Australian Government Department of Health and Ageing.
Marsh, A., Dale, A. & Willis, L. (2007). A counsellor's guide to working with alcohol and drug users (2nd edition). Perth: Drug and Alcohol Office, Western Australia. www.dao.health.wa.gov.au.

OTHER AUSTRALIAN GUIDELINES (CONT.)
McIver, C., McGregor, C., Baigent, M., Spain, D., Newcombe D. & Ali, R. (2006). Guidelines for the medical management of patients with methamphetamine-induced psychosis. Drug & Alcohol Services South Australia. www.dassa.sa.gov.au/webdata/resources/files/Psychosis_guidelines.pdf.
NSW Health Department. (2000). The management of people with a co-existing mental health and substance use disorder service delivery guidelines. Sydney: NSW Health Department. www.health.nsw.gov.au/health-public-affairs/publications/mhsubuse/SDG(Guidelines).pdf.
NSW Department of Health. (2007). Mental health reference resource for drug and alcohol workers. Sydney: NSW Department of Health. www.nada.org.au/images/File/MHRR%20Final%20complete%20resource.pdf.
NSW Department of Health. (2008). NSW Health drug and alcohol psychosocial interventions. Sydney: NSW Department of Health. www.health.nsw.gov.au/policies/gl/2008/pdf/GL2008_009.pdf.
Winstock, A. & Molan, J. (2007). The Patient Journey. KIT2: Supporting GPs to manage comorbidity in the community. Sydney: NSW Department of Health. www.psyborg.com.au/kittest/kit2.pdf.

APPENDIX B: OTHER USEFUL RESOURCES

OTHER USEFUL RESOURCES
Baker, A., Kay-Lambkin, F., Lee, N. K., Claire, M. & Jenner, L. (2003). A brief cognitive behavioural intervention for regular amphetamine users. Canberra: Australian Government Department of Health and Ageing.
Baker, A. & Velleman, R. (2007). Clinical Handbook of co-existing mental health and drug and alcohol problems. London: Routledge.
Clancy, R. & Terry, M. (2007). Psychiatry and substance use: An interactive resource for clinicians working with clients who have mental health and substance use problems [DVD-ROM]. Newcastle: NSW Health.
Graham, H. (2003). Cognitive-behavioural integrated treatment (C-BIT): A treatment manual for substance misuse in people with severe mental health problems. Chichester: Wiley.
Lee, N., Jenner, L., Kay-Lambkin, F., Hall, K., Dann, F., Roeg, S., et al. (2007). *PsyCheck*: Responding to mental health issues within alcohol and drug treatment. Canberra: Commonwealth of Australia.
Miller, W. and Rollnick, S. (2002). Motivational interviewing: Preparing people to change addictive behaviour. New York: The Guildford Press.
Reilly, P. M. & Shopshire, M. S. (2002). Anger management for substance abuse and mental health clients: A cognitive behavioural therapy manual. Rockville: US Department of Health and Human Services.
Mental health first aid. www.mhfa.com.au.
Mental health statement of rights and responsibilities. www.health.gov.au/internet/main/publishing.nsf/Content/1FE72FD78779BB44CA2572060026BC9E/$File/rights.pdf.
National practice standards for the mental health workforce. www.aasw.asn.au/adobe/publications/mental/MH_endorsed_prac_standards.pdf.
National practice standards for social workers. www.aasw.asn.au/adobe/publications/Practice_Standards_Final_Oct_2003.pdf.
NDARC “feeling good?” Answering your questions about alcohol, drugs and mental health. www.health.gov.au.
Streetwize Communications. (2007). Comorbidity worker support kit. Sydney: Streetwize Communications.

OTHER USEFUL RESOURCES (CONT.)		
Agency Name	**Contact**	**Service**
ADCA: Alcohol and other Drugs Council of Australia	www.adca.org.au	The peak, national, non-government organisation (NGO) representing the interests of the Australian AOD sector, provides a number of useful resources.
ADF: Australian Drug Foundation	www.adf.org.au	Information on drugs and services.
ATDC: Alcohol, Tobacco and other Drugs Council of Tasmania Inc	www.atdc.org.au	The peak body representing the NGO, not-for-profit Alcohol, Tobacco and Other Drug (ATOD) sector in Tasmania.
Ausienet – Australian Network for Promotion, Prevention and Early Intervention for Mental Health	www.auseinet.com	Developed to empower young people to address their physical, emotional and social health needs in a way that is relevant, non-judgemental and anonymous.
Australian General Practice Network	www.adgp.com.au	Provides resources to aid the management of comorbidity.
Beyond Blue	www.beyondblue.org.au	A national, independent, not-for-profit organisation working to address issues associated with depression, anxiety and related substance misuse disorders in Australia.
Black Dog Institute	www.blackdoginstitute.org.au	Information on mood disorders.
Can Do Initiative	www.primarymentalhealth.com.au	Includes a range of resources for managing mental health and substance use in general practice.
Co-exist	www.dhi.gov.au/coexist/index.htm	A NSW initiative to assist people from culturally and linguistically diverse (CALD) communities and their families living with comorbidity.
DepNet	www.depnet.com.au	Depression website offering help, support and emergency contacts for mental illness
DrugNet	www.drugnet.bizland.com	Useful drug education website.

OTHER USEFUL RESOURCES (CONT.)		
Agency Name	**Contact**	**Service**
Dual diagnosis Australia and NZ	www.dualdiagnosis.org.au/home	An online community of people interested in contributing to better outcomes for persons with co-occurring substance use and mental health disorders.
Dual diagnosis initiative	www.health.vic.gov.au/drugservices/services/com_dual.htm	Victorian initiative was set up to support the development of better treatment practices and collaborative relationships between drug treatment and mental health services.
Dual Recovery Anonymous	www.dualrecovery.org	An independent, non-professional, 12-step, self-help fellowship organisation for people with a dual diagnosis.
Family Drug Support Australia	1300 368 186 or www.fds.org.au	Assists families throughout Australia to deal with drug issues and achieves positive outcomes.
GROW Fellowship	1800 558 268 www.grow.net.au	A 12-step fellowship for people experiencing mental illness. Services include meetings across Australia and a residential service in Australia.
Headroom	www.headroom.net.au	Information and advice on how to look after the mental health of children and young people. This site is for children, young people, their families and friends and includes information on bullying, stress, problem solving and friendship.
Headspace	www.headspace.org.au	A government-funded youth mental health information site.
Mental Health Association QLD	www.mentalhealth.org.au	Non-government organisation promoting awareness of mental health and advocating for the welfare of people with mental illness in QLD.
The Mental Health Coalition of South Australia	www.mhcsa.org.au	The peak body promoting the interests of non-government organisations supporting people with a psychiatric disability in SA.
Mental Health Community Coalition ACT (MHCC ACT)	www.mhccact.org.au/cms/index.php	The peak body representing the non-profit community mental health sector in the ACT.
Mental Health Coordinating Council (MHCC)	www.mhcc.org.au/home	The peak body for community mental health organisations in NSW.

OTHER USEFUL RESOURCES (CONT.)		
Agency Name	**Contact**	**Service**
Mental Health Council of Australia	www.mhca.org.au	The peak, national NGO representing and promoting the interests of the Australian mental health sector.
Mental Health Council of Tasmania (MHCT)	www.mhct.org/about_us.html	The peak body representing the interests of non-government mental health consumer organisations, carer organisations and service provider organisations.
MoodGym	www.moodgym.anu.edu.au	A CBT self-help training program for depression.
Motivational Interviewing	www.motivationalinterview.org	Motivational Interviewing education.
Multicultural drug and alcohol information services	www.druginfo.adf.org.au/multicultual	Provides translated resources, a multicultural service directory (Victoria only), research and reports.
National Cannabis Prevention and Information Centre	www.ncpic.org.au	Provides information on cannabis to the community, users, their families and the various workforces involved in the delivery of cannabis related interventions.
National comorbidity initiative	www.aihw.gov.au/publications/index.cfm/title/10132	A review of data collections relating to people with coexisting substance use and mental health disorders.
Network of Alcohol and Drug Agencies Inc (NADA)	www.nada.org.au	A peak organisation for the alcohol and drug non-government sector throughout NSW.
Northern Territory Council of Social Service (NTCOSS)	http://www.ntcoss.org.au/	The peak body for the social and community sector in the Northern Territory.
NT Mental Health Coalition	www.ntcoss.org.au/mental-health-coalition	The peak body representing the community-based mental health sector in the NT,
Psychiatric Disability Services of Victoria (VICSERV) Inc	www.vicserv.org.au	The peak body for Psychiatric Disability Rehabilitation and Support Services in Victoria.
Psychiatry online: DSM-IV-TR library	www.psychiatryonline.com/dsmLibrary.aspx	An online resource for the DSM-IV-TR.

OTHER USEFUL RESOURCES (CONT.)		
Agency Name	**Agency Name**	**Agency Name**
Queensland Network of Alcohol and other Drugs Agencies (QNADA)	www.qnada.org.au	The peak organisation for non-government alcohol and drug agencies throughout Queensland.
ReachOut!	www.reachout.com.au	An online service providing information and referrals to young people with a variety of problems including AOD and mental health problems.
SMART recovery Australia	www.smartrecovery.org/australia_website/index.htm	A peer-managed self-help group that assists recovery from AOD dependencies.
Somazone	www.somazone.com.au	Develops, collects and disseminates information on promotion of mental health, prevention of mental disorder, early intervention in mental illness, and suicide prevention.
South Australian Network of Drug and Alcohol Services (SANDAS)	www.sandas.org.au	The peak body for non-government organisations working in the AOD field in South Australia.
Victorian Alcohol and Drug Association Inc. (VAADA)	www.vaada.org.au	The peak body representing AOD services in Victoria.
Western Australian Association for Mental Health (WAAMH)	www.waamh.org.au	The peak mental health representative body in Western Australia for non-government non-profit agencies.
Western Australian Network of Alcohol and Other Drug Agencies (WANADA)	www.wanada.org.au	The peak body for the non-profit AOD sector in Western Australia.
Ybblue	www.beyondblue.org.au/ybblue	Aims to aid young people (as well as their family and friends) in talking about and seeking help for depression.
Youth Coalition for the ACT	www.youthcoalition.net	The peak youth affairs body in the ACT and responsible for representing the interests of people aged between 12 and 25 years of age, and those who work with them.

APPENDIX C: CASE STUDIES

Case Study 1: Cheryl

Cheryl is a 40-year old woman who was referred by her GP for "binge" drinking. She has been drinking to the point of passing out once or twice a week and has had frequent memory lapses ("blackouts") when drinking. Cheryl works part time as a receptionist and was concerned about losing her job because of the increasing absences at work. She lives alone. She has experienced a few relationship break-ups in the last few years which still distress her. She presents as tearful and underweight. She reports frequent crying, poor sleep, and loss of appetite over the last two months. She has sought treatment for her drinking before but discontinued after a few sessions.

Cheryl, one of three children, grew up in a small country town. Her parents drank heavily and argued frequently, at times becoming violent. Cheryl began to drink in her early teens. Alcohol helped her forget her problems and feel "normal". She also began to use amphetamines in her mid twenties. In the last few years, her amphetamine use increased to injecting once or twice a week, usually with her male friend. She does not view this use as a problem and is reluctant to discuss it in detail. Cheryl would like to stop binge drinking and address her financial problems. She reports that she dislikes and avoids crowded places and sees friends mostly at the local hotel. She feels anxious at the thought of leaving the house even to go to the local shops but does not experience full panic attacks.

She is offered treatment for her drinking, depression and anxiety. Following a psychiatric assessment, she commences antidepressant medication (citalopram hydrochloride), and is offered cognitive behaviour therapy for anxiety. In the first three months of treatment, her drinking and depressive symptoms have improved; she has gained weight, is sleeping better and is less anxious. She is spending less time at the pub but is still seeing friends. She has paid off some debts. She is still using amphetamine but less often and is following safer injecting practices.

Case Study 2: Rob

Rob is a 43-year old married man who lives with his wife and has no children. He was referred by his GP for treatment of his alcohol problems, following an admission to hospital for a stomach bleed which was attributed to his drinking. He was drinking two bottles of wine a day and up to three per day on weekends. Rob, who works as a clerk in a law firm, is on extended sick leave from work. He presented to treatment with low mood, frequent crying, flat affect and poor concentration. He reported a loss of interest in most activities including sex. Rob described his wife as supportive. Although they usually "shared a drink" together, in the last few months they had experienced increasing conflict and had talked of separation. Rob thought of suicide at times but had no plan and no history of previous suicide attempts.

Rob began to drink excessively in his late teens, after starting his first job. Heavy drinking was initially associated with sport and parties becoming more frequent over the years. His current pattern began about two years ago, following his father's death. Rob had an ambivalent relationship with his father whom he perceived as critical and rejecting. Since then he has been

also experiencing low mood and frequent ruminative thoughts about his relationship with his father and his perception of himself as a failure.

On enquiry, Rob reveals an episode of severe depression nine years before which lasted several months but responded well to antidepressant medication despite heavy drinking at the time.

Rob is reluctant to stop drinking but accepts a goal of abstinence given his state of physical and mental health. He is offered a psychiatric assessment for depression. He stopped drinking and commenced taking antidepressant medication (Mirtazepine, 30 mg). Within a few weeks, his mood improved and he was able to resume some duties at work. His wife attended a few treatment sessions with Rob to discuss lifestyle changes, especially drinking, that may help Rob attain and maintain his treatment goals. Over the next three months, Rob responded positively to abstinence, antidepressant medication and cognitive behaviour therapy for his ruminative depressive thoughts and inactivity.

Case Study 3: Doug

Doug is a 38-year old man who self-referred because of binge drinking. He works part time as an accountant and is currently living with his ailing elderly mother. Doug presents as a quietly spoken, shy, well-groomed man. During the previous six months, Doug had been drinking a four-litre cask of wine, and occasionally more, between Friday and Sunday nights, then recovering Mondays to return to work on Tuesdays. He expressed concern about his health. After the wine drinking bouts, he had been feeling increasingly unwell, experiencing shaky hands, sweats, and nausea. Between bouts, there was a heightened awareness of thinking, planning and craving for alcohol.

When he presented for treatment, Doug was unhappy with his current situation. He saw little of his friends and would have liked to be in a relationship. He avoided unfamiliar social situations and often felt panicky (tense, racing heart, sweaty, shaky) if they were unavoidable. He was anxious about what people would think if they saw him shaking or blushing. He describes an unhappy, lonely, anxious childhood because of frequent school changes as his parents moved between cities because of work commitments. He began to drink at university and soon realised that alcohol helped him relax and interact with others. He started to drink before going out and soon realised he could not go out without having a few drinks first. Weekend bouts of drinking commenced several years ago when he and his girlfriend broke up.

Doug was offered treatment for his binge drinking and social anxiety. He was started on naltrexone and later also acamprosate to assist with his craving. Over the next few months he was able to reduce but not stop his drinking bouts. As he felt a little better, his anxiety symptoms improved, so he was able to make clear, if slow, progress working through his hierarchy of feared and avoided social situations.

Case Study 4: Jenny

Jenny is a teacher who sought treatment for her drinking. She was drinking a bottle of wine each night and on occasions (once or twice a month), two to three bottles or until she passed out. Jenny lived with her partner of two years with whom she had a volatile and somewhat abusive relationship. Despite a string of such relationships, Jenny strongly feared losing her partner and being alone.

Jenny was one of five children who grew up in a small town. Her father, who was frequently unemployed, was violent and abusive to her mother. He sexually abused Jenny from the age of eight to 14, when she ran away from home and eventually went to live with her maternal aunt. As Jenny had been a good student at school, she was able to complete her studies.

Jenny revealed repeated nightmares and intrusive thoughts about events in her childhood. Sometimes she appeared to "vague out". She reported a pattern of binge drinking that was clearly associated with reminders of her childhood experiences. In particular, conflict with her partner acted as a clear reminder of family conflict during her childhood. After conflict, Jenny would get drunk and consume large quantities of tranquillisers until she passed out. She would sometimes wake up covered in vomit the next day.

These patterns were highlighted to Jenny. She was surprised to hear that she was experiencing symptoms of post traumatic stress disorder. Treatment options were discussed with Jenny. She decided to stop drinking for a period of time and consult a clinical psychologist who was trained and experienced in the treatment of such trauma. Jenny continued to receive treatment for her substance use problems for the duration of her cognitive behaviour therapy for her trauma. Over the next six months, Jenny experienced several lapses to substance use as she worked through her trauma and a difficult relationship at home. Jenny's motivation was strengthened by the reduction in nightmares and growing mastery over severe anxiety symptoms.

Case Study 5: Guido

Guido is a 54-year old farmer from the country who was referred by his GP for depression. On enquiry, it was evident that he drank to excess (a bottle of spirits each day). Guido had the features of alcohol dependence. His GP had prescribed an antidepressant which he had taken in increasing doses but he still felt depressed. His depression steadily worsened over several years, particularly as his relationship with his wife was deteriorating.

He had stopped drinking for six months a year ago and his mood had improved but restarted his drinking. He was not being treated for his alcohol problems. Initially he was keen for a new antidepressant and saw his drinking as a consequence of his depression. The dose of his antidepressant was increased. His GP was encouraged to offer admission to the regional hospital for detoxification, then outpatient counselling and to prescribe acamprosate for him as part of an approach for his alcohol problem. Guido was involved in developing this management plan.

Guido returned home but continued to drink and increased his dose of antidepressant. His depression worsened and several weeks later he was re-assessed. However, in the two weeks leading up to this appointment he began taking the acamprosate and reduced his alcohol intake significantly. His mood lifted slightly; however, he was troubled by impotence. At the review, his successes in reducing his alcohol were re-enforced and relapse prevention strategies employed. He was changed to an antidepressant with less adverse sexual effects in case the medication was causing his impotence. Also the previous antidepressant had not been significantly improving his mood. On review several weeks later Guido had stopped his drinking and was no longer depressed.

Case Study 6: Ian

Ian is 34 years old and lives with his girlfriend and their nine-year old son. He is stable on methadone, via the "take-away" program, and was referred by his caseworker. He has been on methadone for several years with some difficulties. His methadone was dispensed through the clinic for some time and, when he was initially transferred to the community chemist for dispensing, this lasted a very short time because of conflict, arguments and eventually fights with some of the other customers receiving methadone. He often got into conflict with bus drivers who would no longer pick him up and he had alienated the Centrelink officers. This was initially thought to be the result of alcohol use in the presence of a long history of violence and aggression.

Ian denied illicit drug use and diversion of his methadone. His girlfriend and his urine screens confirmed his accounts. Eventual assessment by his caseworker uncovered the fact that his girlfriend did not allow him to sleep at his house and each night after his son went to bed he would take a sleeping bag and spend the night in a local abandoned house. He would return in the morning before his son awoke to maintain the appearance that he was staying in the home. His girlfriend did not feel safe with him being there overnight as she reported that he roamed the house in a restless manner and slept very poorly. Worse still, he would talk to himself. This had occurred periodically throughout the time she had known him, although as he stopped his illicit drug use, it was more noticeable and intrusive on their lives. Ian was reluctant to give details of his problems for fear that he would be "locked away".

After some time of calm and tolerant interviewing by his caseworker, he discussed the auditory hallucinations he experienced. He also stopped his alcohol use. The "voices" had been present for many years and he had never been seen by mental health services. The voices were frequently nasty and derisive as well as providing a commentary on his actions. Over time, Ian had developed the ability to ignore them mostly and to resist what they were telling him to do. Finally he agreed to further psychiatric assessment by the drug and alcohol service and was diagnosed with a psychotic illness, probably schizophrenia.

Ian eventually accepted a trial of an antipsychotic. This had an effect on his symptoms and demeanour, but he remained an unforgiving and at times self-protective individual. His girlfriend was pleased with the changes. Interestingly, he is not so sure he likes the changes, feeling that he became too friendly and somehow vulnerable. This is being monitored and worked through at the drug and alcohol service.

Case Study 7: Lloyd

Lloyd is 23 years old, single and undergoing rehabilitation in a community share house after a residential rehabilitation lasting several months. He had a problem of polydrug abuse from an early age, beginning with cannabis at the age of 12. Lloyd grew up in a house with a strict, over-controlling father who himself had an alcohol problem. He had early conduct problems which worsened in his adolescence as he abused cannabis and smoked cigarettes. He was eventually expelled from school. In his late teenage years, he was involved in a number of situations leading to arrest and charges for various crimes including armed robbery, receiving stolen goods and possession of drugs. Lloyd was heroin dependent from his late teens, using first whilst in prison. Prior to imprisonment he was using large amounts of amphetamine-type stimulants regularly, and developing a tolerance to most of their effects. He smoked cannabis still on a daily basis and whenever available would also take "pills" which included benzodiazepines, stimulants of various types, hallucinogens, and prescription opioids.

His main substance of use in the preceding decade was methamphetamines which he was injecting but he also smoked cannabis and drank alcohol on a daily basis. He eventually decided to stop when a family member confronted him about his state of health. He achieved abstinence from all drug use for several months, but on one planned outing to a busy shopping centre started to have a panic attack. He avoided similar situations from then on, only being able to go out with a companion. When asked, he said that he had been anxious for as long as he could remember in crowded situations and had tended to isolate himself, even when he was using drugs heavily. Now as part of his treatment, Lloyd had been working through the 12 steps in NA and had been able to talk about himself in front of large meetings, although still experiencing some initial discomfort. Over time he has become more comfortable doing this. His fear of crowds was limiting him, but he had changed his life to accommodate his avoidances. He was not depressed, and had no trauma which had precipitated this problem. He had agoraphobia. This was clearly a risk for later relapse to drug abuse. Fortunately, he had been through a long process of working through his problems in a variety of settings and with a variety of styles of therapy. Lloyd was very open to the rationale behind graded exposure as a treatment for his agoraphobia and, with a simple outline of what to do, he worked hard to overcome this problem with great success.

Case Study 8: Kevin

At age 28, Kevin presented to drug and alcohol services with problems with regular heavy cannabis use which he had been doing since age 14. His parents and brother, but not his sister, also used cannabis. Kevin wanted to reduce and cease cannabis, and over the next two weeks he was able to stop, and returned for follow-up appointments. By week three, he reported "paranoia" (people in the street watching him), vague ideas of reference (the radio sends him personal messages), and sleep disturbance. He appeared more confused in his speech than on first presentation. While taking a more in-depth personal and family history, Kevin reported that his father, whom he has not seen for 12 years, may have been diagnosed with schizophrenia. Kevin was a regular smoker. Over time, his confusion worsened and some auditory hallucinations were also evident. He was admitted to the acute care unit and diagnosed as

having “cannabis psychosis”. He was given some depot medication and his symptoms settled. He returned to drug and alcohol services three weeks later saying the voices had been worrying him, so he started to smoke cannabis again as he felt this helped him to sleep, not worry, and maybe concentrate better. His GP negotiated a trial of a low dose antipsychotic, Risperidone. During the next month, Kevin was able to reduce and eventually stop cannabis. Part of the negotiation involved “permission” to use cannabis if needed.

Case Study 9: Brooke

At 33, Brooke, who had been taking 140mg methadone for about 12 years, wanted to get off methadone. During dose reduction, she became more disturbed and started to use benzodiazepines years after ceasing their use. Once reduced to 70mg, she said she wanted to stop the reduction and increase her methadone dose. After attempting to clarify her concerns, she revealed she was starting to be troubled by bad dreams (of childhood sexual abuse), anger and arousal. Her relationship with her partner is now stressed; he says she is emotional and irritable all the time. She has been referred to mental health services, but they are reluctant to treat her while she is using benzodiazepines and methadone. In a conjoint case discussion between AOD and mental health caseworkers, it was agreed the two services would manage her together on the understanding that case workers and doctors involved from both services would need to have regular meetings to discuss her management and progress.

A mental health counsellor experienced in childhood sexual abuse began to see Brooke while AOD clinicians worked closely with her to monitor her substance use. A treatment plan was negotiated with her. She agreed to slow down the methadone reduction while in treatment for trauma. Six months later, Brooke reported considerable progress. She had continued to see her sexual abuse and AOD counsellors; she had reduced her methadone, but was still well maintained by her dose, so she used no illicit substances; her benzodiazepine use had stopped; and she had commenced SSRIs to help with her arousal. She reported less anger, less desire to use substances, and fewer relationship problems. She still experienced nightmares but she was able to discuss and manage these with her counsellor. Over the next six months, Brooke remained stable and continued treatment with both services.

APPENDIX D: MOTIVATIONAL INTERVIEWING

A useful tool in AOD client management is motivational interviewing (MI), irrespective of whether the client suffers co-occurring mental health conditions. MI can be beneficial for clients with comorbidity by increasing treatment motivation, adherence and behaviour change [248, 325, 326], although it may not prove effective in all cases [327]. A number of useful resources for MI are given in Appendix B, including Miller and Rollnick [161], Baker and Velleman [328], and Clancy and Terry [118] from which this section draws upon.

MI is a directive, non-confrontational, client-centred counselling strategy aimed at increasing a person's motivation to change. This strategy assumes equity in the client-counsellor relationship and emphasises a client's right to define his/her problems and choose his/her own solutions. It is, in this sense, a counselling style based on collaboration rather than confrontation, evocation rather than education and autonomy instead of authority, as opposed to a set of techniques [161].

Principles of MI include:

- **Avoid argumentation.** Confrontation is unhelpful to change and is likely to increase resistance.
- **Express empathy, warmth and genuineness** in order to facilitate engagement and build rapport.
- **Support self-efficacy.** Build confidence that change is possible.
- **Roll with resistance.** Arguing, interrupting, negating and ignoring are signs a client is resistant to change.
- **Develop discrepancy.** Generate inconsistency between how the client sees his/her current situation and how he/she would like it to be. This strategy is based on the notion that discomfort motivates change and internal inconsistency or ambivalence is a cause of human discomfort.

Thus MI aims to rouse feelings of ambivalence and discomfort surrounding current behaviour in order to motivate change. To determine where a client stands regarding change it can be useful to consider Prochaska and DiClemente's [117] stages of change discussed in Chapter 6 of these Guidelines. It can be useful to employ existing motivation regarding AOD use treatment to mental health treatment (and vice versa, e.g., Appendix I). It is important to be aware that mental health, medication and cognitive impairments may impact on levels of motivation.

MI can be broken into two phases:

- Building motivation.
- Strengthening commitment.

Building motivation

It is common in the pre-contemplation stage of change to encounter client resistance. DiClemente and Velasquez [329] identify five styles of resistance, and treatment strategies for each group these are outlined in Table 28.

Table 28. Building motivation

Type of Resistance	Strategies
Revelling Those who are having too good a time to change.	• Stimulate concern about the negative consequences. • Raise doubt about their illusory sense of elevated self-efficacy. • Focus on how their behaviour affects others. • Shift focus from problematic issue.
Reluctant Those who are simply unwilling to consider change.	• Counter the hesitance by working through their concerns about changing. • Build confidence in their ability to change. • Use the support of individuals who have made similar changes.
Resigned Those who feel hopeless and helpless, may have a history of failed attempts and do not feel they can change.	• Provide hope. • Share success stories of similar individuals. • Evaluate prior attempts and suggest different. strategies to use.
Rebellious Those who actively resist attempts to encourage change.	• Link autonomy and freedom to change. • Shift high-energy levels from rebellion to change. • Make sure they feel in charge of the change at all times. • Offer choices and options for managing their change.
Rationalising Rationalises why the addictive behaviour does not pose a problem. Appears to have all the answers.	• Continue to make a clear connection between behaviour and consequences. • Do not deride their reasons but try and work with them to your advantage. • Build confidence in their potential to change.

Adapted from Clancy and Terry [118].

Miller and Rollnick [161] suggest the techniques used by an MI therapist can be divided into two categories:

- Microskills.
- Strategies.

Microskills

Open-ended questions

This technique involves a questioning method that does not invite short answers; this increases information flow and trust. Some useful examples of open-ended questions for each stage of change have been provided by Baker and Velleman [328].

Pre-contemplation: Problem recognition

- "What things make you think that this is a problem?"
- "What difficulties have you had in relation to your alcohol/other drug use?"
- "What difficulties have you had in relation to your mood?"
- "In what ways has this been a problem for you?"
- "How has your use of alcohol/other drugs stopped you from doing what you want to do?"

Contemplation: Concern

- "What worries do you have about your use of alcohol/other drugs?"
- "What can you imagine happening to you?"
- "Tell me more about preventing a relapse to using … why is that so important to you … what is it like when you are ill? … What was it like in hospital (if applicable)? … And how about your family – what effect did it have on them? How important are these issues to you?"
- "Can you tell me some reasons why drinking or using may be a health risk? Would you be interested in knowing more about the effects of drinking/using? How important are these issues to you?"
- "What would your best friend/mum say were your best qualities? Tell me, how would you describe the things you like about yourself? ... And how would you describe you the user? ... How do these two things fit together? ... How important are these issues to you?"

Action: Intention to change

- "You seem a bit stuck at the moment. What would have to change to fix this?"
- "What would have to happen for it to become much more important for you to change?"
- "If you were 100% successful and things worked out exactly as you would like, what would be different?"
- "The fact that you are here indicates that at least a part of you thinks it is time to do something. What are the reasons you see for making a change?"
- "What would be the advantages of making a change?"
- "What things make you think that you don't need to worry about changing your alcohol/other drug use?"
- "And what about the other side … What makes you think that it's time to do things a bit differently?"
- "If you were to decide to change what might your options be?"

Maintenance: Optimism

- "What would make you more confident about making these changes?"
- "Are there any ways you know about that have worked for other people? Is there anything you found helpful in any previous attempts to change?"
- "What are some of the practical things you would need to do to achieve this goal? Do any of them sound achievable?"
- "What encourages you that you can change if you want to?"
- "What makes you think that if you did decide to make a change, you could do it?"

In clients displaying symptoms of co-occurring mental health conditions, these questions should be simplified. Compound questioning (two questions in one sentence) should be avoided [330].

Affirming

Affirming involves direct compliments and statements of appreciation and understanding. This helps build rapport, self-efficacy and reinforces open exploration. In clients displaying symptoms of co-occurring mental health conditions, this can be inspiring and build rapport enormously [330].

Examples include:

- "I appreciate that you took a big step in coming here today."
- "That's a great suggestion."

Reflective listening

This technique involves listening to what the client is saying, forming an understanding of what the client is talking about and then giving voice (reflecting) to that understanding. This can be a mere substitution of the client's words, a guess at the unspoken meaning, an observation about the client's emotions or suggesting the next sentence in the client's paragraph (known as continuing the paragraph). The depth of reflection increases with the level of the AOD worker's experience and expertise; however, it is important to slightly understate what the client has said, particularly when a statement is emotionally loaded. For instance:

- "It sounds like you …"
- "And that worries you …"
- "You are …"
- "Would it be correct to say that you …"

In clients displaying symptoms of co-occurring mental health conditions, these statements should be simple, concise and frequent. Avoid repeated reflecting of the client's negative statements and allow him/her time to consider these reflections [330].

Summarising

Summaries are useful in collating, linking and reinforcing information discussed during the interviewing process. This should be done often to promote meaningful relationships and contrasts between statements to enhance motivation to change [330]. Some examples of summarising techniques include:

- Linking – making associations between two parts of the discussion.
- Collecting – gathering a few themes from what the client has said.
- Transitioning – shifting focus from one area to another.

Strategies

In addition to these skills, some key directive strategies have been developed to build intrinsic motivation for change and resolve ambivalence. This is achieved by assisting the client to present his/her own arguments for change in order to [161]:

- Recognise the disadvantages of current behaviour.
- Recognise the advantages of change.

- Express optimism about change.
- Express intent to change.

These strategies include:

Typical day

Often a client deems certain aspects of his/her life irrelevant to treatment or they are insignificant to the client and overlooked and therefore not disclosed during therapy. However, knowing these things can help a worker engage with the client. It can also provide a more holistic view of the person as well as invaluable information concerning daily habits, significant environments, important relationships and people in the client's life. Furthermore, this can highlight to the client aspects of his/her life that he/she had not been aware of (e.g., "I hadn't realised I was drinking that much").

In order to attain this information it can be useful to ask the client to explain how he/she spends an average day. Encourage the client to pick an actual day (e.g., last Wednesday) rather than what they do "most days".

Allow the person to continue with as little interruption as possible. If necessary, prompt with open-ended questions (e.g., "What happened then?" or "How did you feel?"). Review and summarise back to the client after he/she has finished, and clarify that you have summarised accurately.

Once you have a reasonably clear picture of how the client's use (and any co-occurring mental health symptoms) fits into a typical day and any current concerns, ask the client's permission to provide feedback from your assessment (e.g., "I'm getting a feel for what's going on in your everyday life at the moment, you've mentioned several things that are concerning you").

Summarise these problem areas briefly, using those issues raised by the client in the "typical day" discussion (e.g., quality of life, health, mood, drug use).

Decisional balance (good and not so good aspects)

This technique involves a conscious weighing up of the pros and cons of certain behaviours (e.g., drug use). Clients are often aware of the negative aspects involved in certain behaviours but have never consciously assessed them. The decisional balance is a frequently used motivational strategy, particularly when clients are displaying ambivalence regarding their substance use and for when you want to determine their stage of change in regard to their substance use.

Begin by asking questions like:

- "What do you like about your use of …?"
- "Tell me about your drug use. What do you like about it? What's positive about using for you?"

For clients who have difficulty in articulating things they like about using, you may need to offer a menu of options for them to choose from, although you should do this sparingly. Remember you are trying to find out what this client likes about using, not what you think he/she might like about it! Encourage the client to write down these good things (a useful template is included in Appendix V).

Briefly summarise the good aspects of AOD use. Next, ask the client about the not-so-good things about his/her AOD use. Try to avoid using negative words such as the "bad things" or "problems". The AOD worker could ask questions such as:

- "So we have talked about some of the good things about using drugs, now could you tell me some of the less good things?"
- "What are some of the things that you don't like about your drug use?"
- "What are some of the not-so-good things about using?"

Again you may have to offer a menu of options or ask questions (based on collateral information) like "How does your family feel about your using?" but avoid suggesting that an issue should be of concern, and do not put any value judgement on the beliefs of the client by saying something like "Don't you think that getting arrested twice is a bit of a problem?" The success of motivational interviewing rests on the client's personal exploration of his/her AOD use, and the good and not-so-good effects that it has on him/her.

Unlike the good things, the less good things need to be explored in detail. If the client claims AOD use reduces his/her mental health symptoms, explore this in particular detail, for instance enquire about longer-term effects [330]. It is important to remember you are after the client's perspective of the less good things. It can be useful to ask follow up questions such as:

- "How does this affect you?"
- "What don't you like about it?"

Or ask for more detail:

- "Could you tell me a little more about that?"
- "Could you give me a recent example of when that happened?"

It can be particularly useful (especially when not-so-good aspects are not forthcoming) to explore the other side of the positive consequences of using listed. For example, if the high was listed as an advantage, explore the "come-down" that inevitably followed and the length of this crash (which will usually have lasted longer than the euphoria).

It is then useful to assess, through the use of a scale from 1-10, the client's perspective of how important an issue is. Beside each pro and con the client should rate it on the importance it holds for him/her. This ascertains to what extent cons are a concern for the client. Many

counsellors make the mistake of assuming that just because the client acknowledges a not-so-good thing about AOD use, this automatically presents a direct concern for them.

Now give a double-sided, selective summary. For example:

- "You said some of the things you like about using were … and then you said that there was another side to it … you said some of the not so good things about using were …"

Skill is required here in order to emphasise the not-so-good things. It can be useful to give the client a chance to come to his/her own conclusions, for example:

- "Now that you've gone through both sides, where does this leave you? "
- "How do you feel about your drug use now?"

If, despite appropriate emphasis on the not-so-good aspects, the perceived benefits of using still outweigh the perceived costs), continue MI and try to tip the balance in the other direction. If ambivalence is evident, attempt to explore the reasons that underlie this imbalance and re-establish the initial reasons for wishing to quit/cut down. Incorporate information on health and psychological effects of continued use. Guide the client through a rational discussion of issues involved, and carefully challenge faulty logic or irrational beliefs about the process of quitting. Positive reinforcement and encouragement are crucial, but if you encounter resistance from the client, do not push them.

NOTE: Use this strategy with caution for clients with high levels of anxiety or those who are not ready to deal with the pressure of increased ambivalence. In addition, do not leave a depressed client in psychological distress for too long after using the decisional balance strategy [330]. Avoid using this strategy with a client who is currently tempted to use. Distraction is a better strategy to use with someone who is currently tempted rather than to discuss the things they like about using [118].

Elaboration

Once a motivational topic has been raised, it is useful to ask the client to elaborate. This helps to reinforce the theme and to elicit further self-motivational statements. One good way of doing this is to ask for specific examples and for clarification as to why (how much, in what way) this is a concern.

Querying extremes

Clients can also be asked to describe the extremes of their concerns, to imagine worst consequences. For instance you may ask:

- "What concerns you the most?"

- "What are your worst fears about what might happen if you don't make a change?"

- "What do you suppose are the worst things that may happen if you keep on the way you've been going?"

Ask about lifestyle and stresses

This involves discussing routines and day-to-day stresses. Some questions might be:

- "How does your use of drugs affect your

  - Mental health?
  - Physical health?
  - Relationships?
  - Finances?"

Looking back

Sometimes it is useful to have the person remember times before the problem emerged, and to compare this with the present situation. Ask the client what life was like "before": before substance use problems; before legal, work or relationship difficulties; mental health problems etc. Focus on positive memories, hopes, dreams, plans or successes the person may have once had. If the person's history is negative, it may still be useful to explore "what it was like", not necessarily in an attempt to process or resolve issues from that time, but primarily to understand what may have brought about the current situation and behaviours. For example:

- "Do you remember a time when things were going well for you? What has changed and how?"

- "What were things like before you started using?"

- "What were you like back then? What were your plans? What has changed and why?"

- "How has your use of alcohol/drugs influenced things?"

The goal is for the client to obtain some perspective from the immediacy of his or her circumstance and to observe how things have changed over time.

NOTE: In clients with symptoms of a co-occurring depressive condition, this strategy should be avoided or used with caution [330].

Looking forward

Similarly, it can be helpful for clients to visualise the future should they embark on the change or should they remain the same. Some questions might include:

- "What would you like to be doing in two years time?"
- "What do you think will happen if you keep using? How do you feel about that?"
- "If you decided to make a change, what are your hopes for the future?"
- "How would you like things to turn out for you?"
- "I can see that you're feeling really frustrated right now … How would you like things to be different?"
- "What are your options at the moment?"
- "What would be the best results you could imagine, if you make a change?"

NOTE: In clients with symptoms of a co-occurring depressive condition, this strategy should be avoided or used with caution [330].

Exploring goals and values

It can be useful to ask clients about their goals and what is most important to them and compare this to the current situation. Explore the ways in which the problem behaviour is inconsistent with, or undermines important values and goals for them. When the highest or most central values and goals have been defined, you can ask how the problem you are discussing (e.g., drinking/using) fits into this picture. For example:

- "Where do you think your using fits in?"
- "What effect is your current behaviour likely to have on these goals and values?"

Strengthening commitment

After a client commits to the idea of change (to whatever degree), the next phase in MI is to consolidate all the issues raised by the client in the first phase, and build on his/her motivation to change while also negotiating a plan for change. Ambivalence will still possibly be present, and if encountered continue the use of the strategies and microskills outlined above. It can be useful to encourage the client to confront the idea and process of change. For example:

- "Where do we go from here?"
- "What does everything we've discussed mean for your alcohol/drug use?"
- "How would your life be different if …?"
- "What can you think of that might go wrong with your plans?"

Although abstinence is one possible goal, some people may not be ready to stop completely and may opt for reduced or controlled use. In MI, the client has the ultimate responsibility for

change and total freedom of choice to determine his/her goal for treatment. The worker's role is to assist the client to determine treatment goals and guide the realisation of those goals. Goals may often change during the course of treatment, and an initial goal of cutting down may become a goal of abstinence as the client's confidence increases.

In clients with co-occurring mental health conditions, abstinence is the most appropriate goal [330] as mental health symptoms may be exacerbated by AOD use. In particular, those with more severe mental disorders (or cognitive impairment) may have adverse experiences even with low levels of substance use [38]. Those taking medications for mental health conditions (e.g., antipsychotics, antidepressants) may also find that they become intoxicated even with low levels of AOD use due to the interaction between the drugs. Although abstinence is favoured, many people with comorbid conditions prefer a goal of moderation. It is possible to accept a client's decision to use and provide harm reduction information without condoning use.

Explore any fears or obstacles that are identified in the change process and assist the client with problem solving for each of these. Explore any concerns with the management of withdrawal symptoms (e.g., irritability, insomnia, mood disturbances, lethargy and cravings to use) if this is raised. Education and support are essential components of getting through withdrawal.

Finally, when the client begins behaviour change, try manipulating the environment to exaggerate positive outcomes (e.g., involve family, increase social interaction, use encouragers and compliments), particularly in clients with co-occurring mental health conditions in order to strengthen resolve [330].

APPENDIX E: RESEARCH AND INFORMATION ORGANISATIONS

Australian Centre for Addiction Research	www.acar.net.au
Australian Drug Foundation	www.adf.org.au
Australian Hepatitis Council	www.hepatitisaustralia.com
Australian Injecting and Illicit Drug Users League	www.aivl.org.au
Australian Institute of Criminology	www.aic.gov.au
Australian Institute of Health and Welfare	www.aihw.gov.au
Burnet Institute	www.burnet.edu.au
Centre for Accident Research and Road Safety	www.carrsq.qut.edu.au
Centre for Youth Drug Studies	www.adf.org.au/cyds
Drug and Alcohol Services South Australia	www.dassa.sa.gov.au
Menzies School of Health Research	www.menzies.edu.au
National Cannabis Prevention and Information Centre	www.ncpic.org.au
National Centre for Education and Training in Addiction	www.nceta.flinders.edu.au
National Drug and Alcohol Research Centre	www.ndarc.med.unsw.edu.au
National Drug Research Institute	www.ndri.curtin.edu.au
National Centre in HIV Epidemiology and Clinical Research	www.nchecr.unsw.edu.au
National Health and Medical Research Council	www.nhmrc.gov.au
ORYGEN Youth Health	www.orygen.org.au
Queensland Alcohol and Drug Research and Education Centre	www.sph.uq.edu.au/qadrec
Telethon Institute for Child Health Research	www.ichr.uwa.edu.au
The Australian Institute	www.tai.org.au
Turning Point Alcohol and Drug Centre	www.turningpoint.org.au
Youth Substance Abuse Service	www.ysas.org.au

APPENDIX F: MENTAL STATE EXAMINATION

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?

APPENDIX G: ADDITIONAL SCREENING INSTRUMENTS

The **General Health Questionnaire (GHQ)** is a self-report screening instrument which detects the presence of psychological symptoms [331]. It has demonstrated adequate reliability and validity in both the 12- and 28-item forms, on which a client rates each statement on a four-point scale [331, 332]. The GHQ is easy to administer and score and can be used by a range of health professionals; however, this instrument must be purchased. Generally a score of 10 or more on the GHQ is considered indicative of significant psychological distress and the presence of an underlying psychological disorder. However, it has been suggested that approximately 75% of drug users could be expected to obtain scores of 10 or more upon entering treatment; therefore, clients need to be reassessed after entering treatment [149]. If the client continues to score 10 or more, a more in-depth psychological assessment should be conducted.

The **Symptom Checklist-90-Revised (SCL-90-R)** is a 90-item self-report questionnaire measuring symptoms of somatisation, obsessive compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid thoughts, and psychoticism [333]. It has been used with substance abuse populations and has been found to perform better than other general measures of psychological functioning [123]. It has also demonstrated good reliability and validity in clinical and non-clinical populations [334]. The scale provides scores for severity, intensity and extensiveness of symptoms and has been shown to have superior sensitivity to competing scales [335].

Shorter forms of the SCL-90-R have been developed, including the **Brief Symptom Inventory (BSI)** with 53 items and the **Symptom Assessment (SA-45)**, each of which show adequate reliability and validity [336]. However, the long and short forms of the SCL-90-R are copyrighted and must be purchased by registered psychologists [333]. There are both a pen and paper and computerised versions of the SCL-90-R. The former takes 12-15 minutes to complete, is designed for adolescents over the age of 13 years and for adults. A Year 8 reading age is required.

The **Brief Psychiatric Rating Scale (BPRS)** is an 18-item clinician-administered scale measuring a broad range of psychiatric symptoms, as does the SCL-90-R. It has been shown to be effective in various substance use populations [337, 338]. However, the reliability and validity of the scale is dependent upon clinical expertise and specific training and therefore may be less appropriate in the AOD sector [123]. It was initially devised as an instrument to assess the symptoms of schizophrenia on five sub-scales of thought disorder, withdrawal, anxiety/depression, hostility and activity [339, 340].

The **Psychiatric Diagnostic Screening Questionnaire (PDSQ)** consists of 132-items designed to screen for over 13 different DSM-IV-TR [1] Axis I disorders, including alcohol/drug related disorders [341]. Reports have found the questionnaire to have good validity and reliability along with strong sensitivity and high negative predictive value indicating most cases are detected as and most non-cases are indeed non-cases [341, 342]. These psychometric properties are fundamentally important in a screening instrument and suggest the measure might have broad applicability in numerous health care settings including AOD [54].

The **Beck Depression Inventory (BDI or BDI-II)** is a 21-item self-report instrument intended to assess the existence and severity of symptoms of depression [343, 344]. Each item is ranked on a four-point scale. The BDI-II has been shown to be a reliable and valid measure of depression particularly in substance misusing populations [345, 346]. The **Beck Hopelessness Scale (BHS)** is a 20-item scale designed to detect negative feelings about the future and has been found to be a good predictor of suicide attempts [347]. It has been shown to have high internal consistency and test-retest reliability. Instruments such as this can be helpful in ongoing treatment where particular thoughts can continue to be monitored through this and other suicidal thoughts instruments. The **Beck Scale for Suicidal Ideation (BSSI)** is a 21-item scale assessing intention to commit suicide [348]. It has been found to be a valid predictor of admission to hospital for suicidal intention and has high internal consistency and test-retest reliability [123]. The **Beck Anxiety Inventory (BAI)** [349] consists of 21 items, each describing a common symptom of anxiety. The respondent is asked to rate how much he or she has been bothered by each symptom over the past week on a four-point scale. The items are summed to obtain a total score that can range from 0 to 63. The BAI has similarly shown good reliability and validity for the measurement of anxiety symptoms, though discriminant validity has been questioned [349-351]. The Beck scales are quite simple to administer but scoring and interpretation must be supervised by a registered psychologist and the cost is high.

The **Spielberger State Trait Anxiety Inventory (STAI)** also measures anxiety [352] and requires a registered psychologist for scoring, interpretation and the purchasing of the STAI [123]. The reliability and validity are adequate in general populations, but are unknown within AOD sector [123, 352]. The scale consists of 40-items, rated on a four-point scale and takes approximately 10 minutes to complete.

The **Traumatic Life Events Questionnaire (TLEQ)** is a 23-item self-report measure of 22 types of potentially traumatic events including natural disasters, exposure to warfare, robbery involving a weapon, physical abuse and being stalked [353]. For each event, respondents are asked to provide the number of times it occurred (ranging from “never” to “more than 5 times”) and whether fear, helplessness or horror was present (“yes/no”). The TLEQ It has been used successfully within substance-abusing populations. Recent studies have suggested that the psychometric properties of this measure are adequate [354].

The **Trauma History Questionnaire (THQ)** developed by Green [355] is a 24-item self report measure that examines experiences with potentially traumatic events such as crime, general disaster, and sexual and physical assault using a “yes/no” format. For each event endorsed, respondents are asked to provide the frequency of the event as well as their age at the time of the event. The THQ has demonstrated adequate test-retest reliability.

The **PTSD Symptom Scale Self-Report (PSS-SR)** is a screening tool for PTSD which has been used successfully in AOD populations [356, 357]. The modified version of the scale only takes 10-15 minutes to administer and measures both frequency and severity of symptoms [357]. The scale consists of 17 items corresponding to 17 DSM-IV-TR [1] criteria which are rated on a four-point scale of symptom presence.

The **PTSD Checklist** [358] is a self-report scale where respondents rate the extent to which they experience each of the DSM-IV-TR [1] PTSD key symptoms. This checklist has been shown to have strong psychometric properties within AOD populations [359]. It consists of 17 items corresponding to 17 DSM-IV-TR [1] criteria which are rated on a five-point severity scale. This checklist is in the public domain.

APPENDIX H: SUICIDE RISK ASSESSMENT CHECKLIST

Name_____ D.O.B._____ Date_____

Questions used to complete this assessment might include [149]:

- 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 risk level:

[Non-existent----------Mild/low----------Moderate----------Severe/high----------Extreme/very high]

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 et al. [114], Rudd et al. [115], and Schwartz et al. [116].

APPENDIX I: INTEGRATED MOTIVATIONAL ASSESSMENT TOOL (IMAT)

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

Source: NSW Department of Health. (2007). *Mental health reference resource for drug and alcohol workers*. Sydney: NSW Department of Health.

APPENDIX J: KESSLER PSYCHOLOGICAL DISTRESS SCALE (K10)

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.

APPENDIX K: THE 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.				

* Regardless of the client's total score on the SRQ, consider intervention or referral if in significant distress.

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: □ **Mental health worker** Name: Contact details: Role: □ **Other – specify:** Name: Contact details: Role:	□ **Psychologist** Name: Contact details: Role: □ **General practitioner** 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

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

Self reporting questionnaire (SRQ)

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):	

Source: Lee, N., Jenner, L., Kay-Lambkin, F., Hall, K., Dann, F., Roeg, S., Hunt, S., Dingle, G., Baker, A., Hides, L., & Ritter, A. (2007). *PsyCheck: Responding to mental health issues within alcohol and drug treatment*. Canberra: Commonwealth of Australia.

APPENDIX L: 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.

DASS-21 Scoring Template

Sum scores for each scale. Multiply total for each scale by 2.

D = Depression

A = Anxiety

S = stress

S
A
D
A

D
S
A
S
A

D
S
S
D
S

A
D
D
S
A

A
D

APPENDIX M: 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.

APPENDIX N: 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.

APPENDIX O: 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

APPENDIX P: 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	

Source: Schlesinger, C. M., Ober, C., McCarthy, M. M., Watson, J. D., & Seinen, A. (2007). The development and validation of the Indigenous Risk Impact Screen (IRIS): A 13-item screening instrument for alcohol and drug and mental risk. *Drug and Alcohol Review, 26*, 109-117.

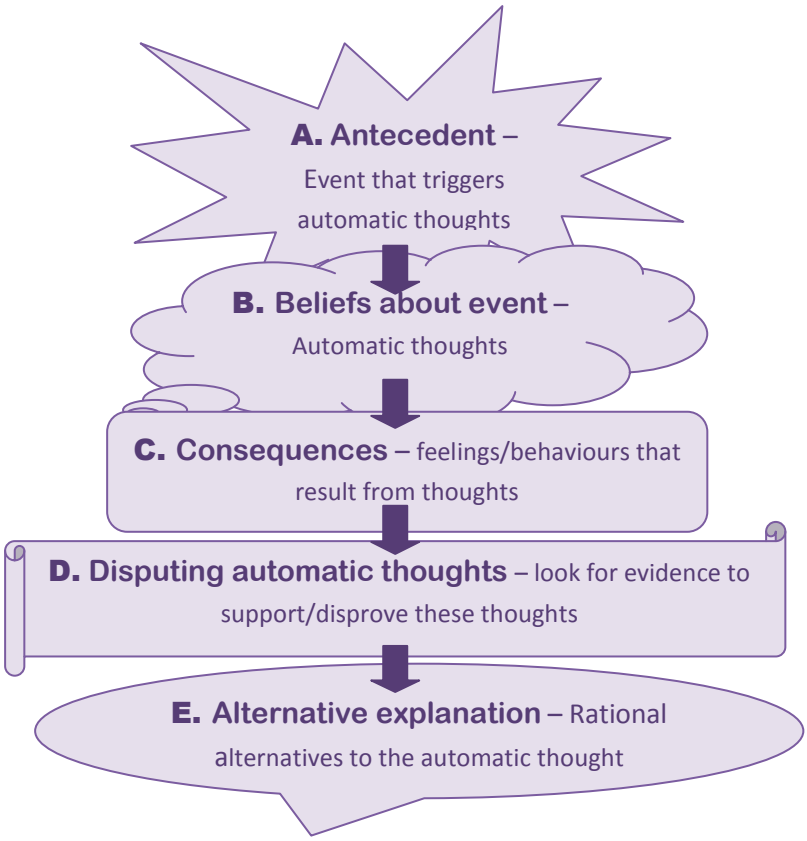
APPENDIX Q: COGNITIVE BEHAVIOURAL TECHNIQUES

Cognitive behavioural therapy (CBT) has been identified as one of the most effective ways of treating co-occurring depression and substance use difficulties [114, 139]. A number of simple CBT-based strategies are useful in managing clients with these symptoms, including:

- Cognitive restructuring.
- Pleasure and mastery events scheduling.
- Goal setting.
- Problem solving.

Cognitive restructuring

Cognitive restructuring is a useful method for controlling symptoms of depression (and anxiety) and is based on the premise that what causes these feelings is not the situation itself but, rather, the interpretation of the situation [360]. The idea is that our behaviours and feelings are the result of automatic thoughts which are related to our core (deeply held) beliefs. Therefore, feelings and behaviours of anxiety, depression, relapse etc. are the result of negative thoughts and beliefs that can be modified. A simple process of recognition and modification of these thoughts and beliefs can be conducted with clients using the A – E model depicted below.



In this model there is an initial event (*the antecedent*) which leads to automatic thoughts (*beliefs about the event*). These thoughts have resulting feelings and behaviours (*consequences*). Because these thoughts are automatic and often negative, they are rarely based on any real-world evidence – it is therefore necessary to look for evidence either supporting or disproving evidence (*dispute automatic thoughts*). Finally, developing rational alternative explanations to automatic thoughts can result in a new interpretation of the antecedent (*alternative explanation*). This process allows the client to stop and evaluate the thought process and realise how he/she comes to feel that way. A client worksheet is included in Appendix W to walk clients through the thought recognition and modification process.

Some common negative automatic thoughts and beliefs which can be challenged by using cognitive restructuring exercises include:

All or none (black and white) thinking

"If I fail partly, it means I am a total failure."

Mental filter

Interpreting events based on what has happened in the past.

"I can't trust men, they only let you down."

Overgeneralisation

Expecting that just because something has failed once that it always will.

"I tried to give up once before and relapsed. I will never be able to give up."

Catastrophising

Exaggerating the impact of events – imagining the worst case scenario.

"I had an argument with my friend, now they hate me and are never going to want to see me again."

Mistaking feelings for facts

People are often confused between feelings and facts.

"I feel no good, so therefore I am no good."

Should statements

Thinking in terms of "shoulds", "oughts" and "musts". This kind of thinking can result in feelings of guilt, shame and failure.

"I must always be on time."

Personalising

People frequently blame themselves for any unpleasant event and take too much responsibility for the feelings and behaviours of others.

"It's all my fault that my boyfriend is angry, I must have done something wrong."

Discounting positive experiences

People often discount positive things that happen.

"I stayed clean because I didn't run into any of my using mates."

(Adapted from Beck [361] and Jarvis et al. [254])

A client information sheet on common negative thoughts is provided in Appendix X. A client information sheet on cognitive restructuring is included in Appendix Y.

Structured problem solving

Structured problem solving is also a useful means to manage the symptoms of anxiety/depression as these symptoms are often the result of an inability (or perceived inability) to deal effectively with problems [362]. Some simple steps suggested by Carroll [363] and Mynors-Wallis [364] can be a useful guide in assisting the client:

- Identify the problem (try to break it down) and define it.
- Step back from the problem and try to view it as an objective challenge.
- Brainstorm possible solutions (realistic and unrealistic).
- Think about each solution in practical terms, and evaluate the pros and cons.
- Decide on the best solution (and a second, "back-up" solution).
- Put the solution into action.
- Evaluate how effective it was and whether it can be improved.

A problem-solving worksheet for clients is included in Appendix Z.

Goal setting

Goal setting is a useful strategy to help clients with both AOD treatment as well as depression/anxiety symptom management. For example, one goal might be to spend more time partaking in rewarding activities each week.

Goal setting can keep therapy on track and also enables progress to be measured over time. It allows the client to experience feelings of control and success, which may counter common feelings of hopelessness and worthlessness. Goal setting also ensures that therapy remains client-focused which increases motivation and helps the therapist ascertain what the client's central concerns are. However, it is important that the focus is on the process of goal pursuit

rather than outcome and expectations of achievement; it is important that happiness is not conditional upon goal achievement or else failure may exacerbate depressive symptoms [365].

According to Marsh et al. [149] goals should be:

- geared towards the client's level of motivation and concern (client's stage of change – see Chapter 6 of these Guidelines);
- negotiated between client and AOD worker;
- specific and achievable – it is important that the client begins to gain a sense of mastery by achieving his or her goals;
- based on process rather than outcome;
- short term – break down overall goals into shorter-term ones in order to increase motivation and feelings of success; and
- described in positive rather than negative terms – for example, the goal to "decrease feelings of apprehension and worry at parties" is expressed in negative terms. The same goal, expressed in positive terms is "I will try to relax and enjoy myself at parties".

A goal setting worksheet is provided in Appendix AA.

Pleasure and mastery events scheduling

Individuals with depressive symptoms often stop engaging in behaviours that give them a sense of pleasure and achievement. This can lead to a cycle in which they become very inactive, leading to more negative feelings and lower mood and energy, which then leads to even less engagement in activities, and so on [149, 366].

Pleasure and mastery events scheduling is a behavioural technique to help clients engage in activities that give them a sense of pleasure and achievement in a structured way. It can be very difficult for clients to simply resume previous levels of activity, so this strategy enables clients to use a weekly timetable in which they can schedule particular activities. It is important for clients to start with activities that are simple and achievable.

Clients might be encouraged to think of just one activity they can do for achievement and one for pleasure each day. Each week more activities can be added to form a list. A worksheet is provided in Appendix BB for clients to complete; it also includes a list of possible starting points. Clients may also need to be reminded of the fact that they deserve to feel good and that motivation generally follows activity rather than the reverse and, thus, the key is initiation of such activity. The gradual pattern of experiencing the emotional and physical benefits of pleasure and achievement can break the negative thought cycle.

APPENDIX R: ANXIETY MANAGEMENT TECHNIQUES

Relaxation techniques are also a common means to manage the distressing and distracting symptoms of anxiety [140]. Some useful relaxation methods include:

- Progressive muscle relaxation.
- Controlled or abdominal breathing.
- Calming response.
- Visualisation and imagery.
- Grounding.

Each method works best if practiced daily by clients for 10-20 minutes, but again, not every technique may appropriate for every client.

Progressive muscle relaxation

Progressive muscle relaxation involves tensing and relaxing of different muscle groups in succession. It is particularly useful for clients with intrusive thoughts. Before starting, make sure the client is sitting in a quiet and comfortable place. Ask the client that when they tense a particular muscle group, they do so strongly and hold the tension for 10 seconds. Encourage the client to concentrate on the feelings in his/her body of tension and release. Tell the client when relaxing muscles to feel the tension draining out of his/her body and enjoy the sensation of relaxation for 15 seconds. Isolate each muscle group at a time, allowing the other muscle groups to remain relaxed. The following instructions are based on Bourne [367]. A client copy is also available in Appendix CC.

1. Take three deep abdominal breaths, exhaling slowly each time, imagining the tension draining out of your body.

2. Clench your fists. Hold for 10 seconds (counsellors may want to count to 10 slowly), before releasing and feeling the tension drain out of your body (for 15 seconds).

3. Tighten your biceps by drawing your forearms up toward your shoulders and make a muscle with both arms. Hold, then relax.

4. Tighten your triceps (the muscles underneath your upper arms) by holding out your arms in front of you and locking your elbows. Hold, then relax.

5. Tense the muscles in your forehead by raising your eyebrows as high as you can. Hold, then relax.

6. Tense the muscles around your eyes by clenching your eyelids shut. Hold, then relax. Imagine sensations of deep relaxation spreading all over your eyes.

7. Tighten your jaws by opening your mouth so widely that you stretch the muscles around the hinges of your jaw. Hold, then relax.

8. Tighten the muscles in the back of your neck by pulling your head way back, as if you were going to touch your head to your back. Hold, then relax.

9. Take deep breaths and focus on the weight of your head sinking into whatever surface it is resting on.

10. Tighten your shoulders as if you are going to touch your ears. Hold, then relax.

11. Tighten the muscles in your shoulder blades by pushing your shoulder blades back. Hold then relax.

12. Tighten the muscles of your chest by taking in a deep breath. Hold, then relax.

13. Tighten your stomach muscles by sucking your stomach in. Hold, then relax.

14. Tighten your lower back by arching it up (don't do this if you have back pain). Hold, then relax.

15. Tighten your buttocks by pulling them together. Hold, then relax.

16. Squeeze the muscles in your thighs. Hold, then relax.

17. Tighten your calf muscles by pulling your toes towards you. Hold, then relax.

18. Tighten your feet by curling them downwards. Hold, then relax.

19. Mentally scan your body for any left over tension. If any muscle group remains tense repeat the exercise for those muscle groups.

20. Now imagine a wave of relaxation spreading over your body.

Controlled or abdominal breathing

When tense, a person's breathing is rapid and shallow, which can lead to hyperventilation or panic attacks. Hyperventilation is a process where shallow breathing gets rid of too much carbon dioxide which can lead to light-headedness, breathlessness, feeling of suffocation, blurred vision, and numbness or tingling in hands or feet as well as a hot, flustered feeling. Mild hyperventilation can lead to increased perpetual anxiety and apprehension.

When teaching clients breathing retraining, it is important they understand and feel the difference between shallow, chest-level breathing and controlled, abdominal breathing. A good way to do this is to ask clients to practice each type of breathing. However, it is important to inform clients who are extremely anxious that they may experience trouble breathing deeply and may need to try this when feeling less anxious (some clients may always have trouble with this). Encourage clients to increase their breathing speed. Ask them to place their hand gently on their abdomen and feel how shallow and rapid their breathing is, only the chest moves up and down. Compare this with abdominal breathing based on the following instructions for the client provided by Lee et al. [114]:

1. Rate your level of anxiety on a scale from 1 to 10.
2. Sit as comfortably as possible in a chair with your head, back and arms supported, free legs and close your eyes (if you like).
3. Place one hand on your abdomen right beneath your rib cage
4. Inhale deeply and slowly, send the air as low and deep into your lungs as possible. If you are breathing from your abdomen you should feel your hand rise, rather than your chest.
5. When you have taken a full breath, pause before exhaling. As you exhale imagine all of the tension draining out of your body.
6. Do 10 slow abdominal breaths. Breathe in slowly counting to four, before exhaling to the count of four (four seconds in, four seconds out). Repeat this cycle 10 times. Hold final breath for 10 seconds, then exhale.
7. Now re-rate your level of anxiety and see if it has changed.

Controlled breathing techniques can help reduce overall levels of tension and are a useful strategy to use when faced with high-anxiety or high-risk situations when relapse is likely. A client worksheet for abdominal breathing is included in Appendix DD.

Calming response

This is a quick skill developed by Montgomery and Morris [368] to reduce the discomfort of unwanted feelings. The basic steps involve the client mentally detaching from the situation and thinking "clear head, calm body" as they take one slow deep breath. As they exhale they relax.

Visualisation and imagery

This relaxation technique might be only useful for a select few clients and should not be used where a client finds the process difficult or has unpleasant affects as a result [367].

1. Sit comfortably in a chair, close your eyes and breathe deeply. Clear your mind of all thoughts and images.

2. Imagine a place where you feel safe and relaxed; this could be a real or imaginary place. Think in as much detail as possible: What are the sounds? What are the smells? What do you feel? What do you see?

3. Think about how your body feels in this place (e.g., are your muscles relaxed? Is it warm? Is your breathing and heart rate slow or fast?).

4. Stay in this relaxed state for a moment and remember how it feels so you can return to it when you need to.

5. Slowly clear your mind again and return to the "here and now" and the sounds around you. Stretch your arms and legs and when you are ready, open your eyes.

A client worksheet for visualisation in provided in Appendix EE.

Grounding

For most clients suffering anxiety symptoms, most breathing and relaxation techniques are effective; however, for sufferers of panic or trauma some relaxation and breathing strategies can occasionally trigger flashbacks, intrusive memories, panic, fear and dissociation. AOD workers can assist these clients and reduce traumatic and panic reactions by focusing the attention of these clients on the outside world rather than the internal trauma. This process is known as "grounding" (or distraction, centering, or healthy detachment) [224].

There are different forms of grounding outlined below; different strategies work best for different clients and it is important to use a strategy appropriate to the individual. The examples of grounding techniques provided below are adapted from Najavits [224].

Examples of mental grounding:

- Describe objects in your environment in detail using all your senses.
- Describe an every day activity, such as eating or driving to work, in detail.
- Use a grounding statement. "I am Jo, I am 23 years old, I am safe here, today is ...".
- Say the alphabet slowly.
- Counting backwards from 20.

Examples of physical grounding:

- Run cool or warm water over your hands.
- Press your heels into the floor.
- Touch objects around you as you say their names.
- Jump up and down.
- Change your posture to a more upright one.
- Stretch.
- As you inhale say "in", and when you exhale say "out" or "calm" or "easy" or "safe".

Examples of soothing grounding:

- Rub nice smelling hand cream slowly into hands and arms and notice the feel and smell.
- Say encouraging statements to yourself such as "You're okay, you'll get through this".
- Think of favourites of any kind of object (e.g., cars) or animal.
- Think of a place where you felt calm and peaceful, describe where you were, what was around you and what you were doing.
- Plan something nice for yourself such as a bath or a good meal.
- Think of things you look forward to doing in the next few days.

APPENDIX S: COMMON REACTIONS TO TRAUMA

After a traumatic event, it is common to experience a range of reactions. These might include:

Feelings of sadness/depression

It is common to:

- experience feelings of hopelessness and despair;
- have thoughts of suicide;
- have an altered perception of yourself (e.g., I am a bad person); and/or
- lose interest in once pleasurable activities.

Feeling a loss of control or trust

It can be common to feel as though the traumatic event has left you with a lack of control, or as though you cannot trust anyone.

Feelings of anger

Sometimes you might find yourself experiencing anger and even directing it towards your loved ones.

Feelings of guilt and shame

These feelings are a common reaction to trauma survival. You might find yourself second-guessing your reactions or blaming yourself.

Re-experiencing the event

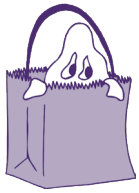
This includes:

- Flashbacks – feeling the trauma is re-occurring.
- Intrusive thoughts – memories that you can't control.
- Nightmares about the event.

Physical arousal

This includes difficulty falling asleep or an interrupted sleep, irritability, finding it hard to concentrate, getting startled easily or feeling constantly on edge, sweating or a racing heartbeat.

Avoidance reactions



You may find yourself avoiding all reminders of the trauma (e.g., places, people) or even the memories of, and feelings associated with the traumatic experience itself.

Although these reactions can be overwhelming and distressing, it is important to remember they are a normal response when someone has experienced a traumatic event.

APPENDIX T: COMMON REACTIONS TO GRIEF AND LOSS

There is a multitude of different sources of grief and loss and not all involve death. Individuals experiencing grief from a loss may choose a variety of ways of expressing it. No two people will respond to the same loss in the same way. However, some frequent reactions include:

Changed behaviours:

- Seeking solitude, withdrawal
- Change in social activities
- Inappropriate behaviour (e.g., laughing)
- Absent mindedness
- Crying

Sleep and energy disturbances:

- Feeling fatigued, restless, lethargic
- Sleep difficulties

Other physical symptoms:

- Changed eating habits
- Gastro-intestinal complaints
- Decreased interest in pleasurable activities
- Decreased sex drive

A range of troubling emotions:

- Feelings of denial, disbelief, numbness, shock, panic, or sadness
- Feelings of isolation
- Mood fluctuations
- Anger, guilt, frustration, hostility, blaming

Cognitive difficulties such as forgetfulness, confusion or a lack of concentration

Spiritual emptiness and pessimism

Constant thought about the deceased or a feeling of their presence

Although these reactions can be overwhelming and distressing it is important to accept and not to avoid them. It is also useful to remember your reactions are common and natural and you are not alone.

APPENDIX U: REFERRAL PROFORMA

Patient identified with possible Mental Health Disorder

Date:

Referral from:

PATIENT DETAILS

Name: _____ Year of Birth:_____

Address: _____ Postcode:_____

Aboriginal/TSI: Yes ☐ No ☐

Patient lives: Alone ☐ With Carer / Family ☐

Patient Contact Details:

Phone _____

Patient may be contacted at this number	Yes ☐ No ☐
Patient 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: ……

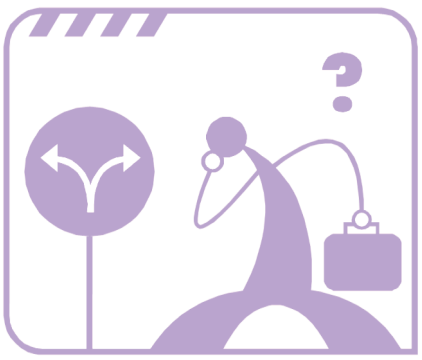
PROVIDE RELEVANT CLINICAL INFORMATION

CURRENT MEDICATIONS

RISK ASSESSMENT

Within 2 weeks ☐ within 1 month ☐

APPENDIX V: GOOD THINGS & NOT-SO-GOOD THINGS WORKSHEET

Good things about current behaviour	Not-so-good things about current behaviour
Good things about change	Not-so-good things about change 

APPENDIX W: COGNITIVE RESTRUCTURING WORKSHEET

	A ⇨ B ⇨ C			Challenge negative thoughts		
	Activating event/trigger	Beliefs/thoughts/ interpretations	Consequences: feelings/ behaviours			
Date	What happened?	What were you thinking?	What were you feeling? What did you do?	What is the evidence for and against your thoughts?	Is there any other way of looking at this situation?	What do you think now?

APPENDIX X: IDENTIFYING NEGATIVE THOUGHTS

It can be useful to categorise your negative thoughts in order to identify the process that is occurring. Some common negative automatic thoughts and beliefs which can be challenged by using cognitive restructuring exercises include:

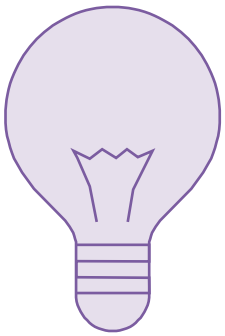
All or none (black and white) thinking	*"If I fail partly, it means I am a total failure."*
Mental filter	Interpreting events based on what has happened in the past. *"I can't trust men, they only let you down."*
Overgeneralisation	Expecting that just because something has failed once that it always will. *"I tried to give up once before and relapsed. I will never be able to give up."*
Catastrophising	Exaggerating the impact of events – imagining the worst case scenario. *"I had an argument with my friend, now they hate me and are never going to want to see me again."*
Mistaking feelings for facts	People are often confused between feelings and facts. *"I feel no good, so therefore I am no good."*
Should statements	Thinking in terms of "shoulds", "oughts" and "musts". This kind of thinking can result in feelings of guilt, shame and failure. *"I must always be on time."*
Personalising	People frequently blame themselves for any unpleasant event and take too much responsibility for the feelings and behaviours of others. *"It's all my fault that my boyfriend is angry, I must have done something wrong."*
Discounting positive experiences	People often discount positive things that happen. *"I stayed clean because I didn't run into any of my using mates."*

Sources: Beck, J. (1995). *Cognitive therapy: Basics and beyond.* New York: The Guildford Press.
Jarvis, T., Tebbutt, J., & Mattick, R. (1995), *Treatment approaches for identifying unhelpful thoughts, alcohol and drug dependence.* Chichester, UK: John Wiley & Sons.

APPENDIX Y: COGNITIVE RESTRUCTURING

Unhelpful thoughts produce negative emotions and behaviours and often these thoughts can be extreme and inaccurate. However, this automatic process can be broken through awareness and thought restructuring.

Step 1: Identification of negative/inaccurate thoughts

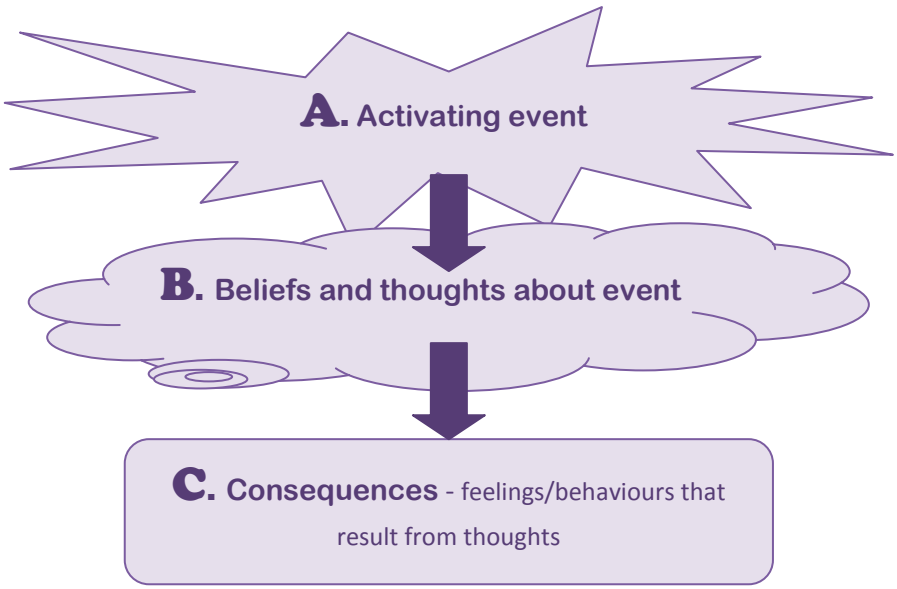


Thoughts are often automatic, but you can learn to identify and alter these negative thoughts through monitoring.

The more aware you are of the way you think and the things you say to yourself in stressful circumstances, the better prepared you will be to think differently.

Step 2: Notice how thoughts cause feelings and motivate behaviour

A good way to think of the relationships between thoughts and behaviours is through the "ABC" model:



Step 3: Challenging and replacing negative thoughts

After you become aware of the thoughts and their resulting feelings and behaviours, you should examine and challenge those thoughts for evidence and accuracy.

- REALITY TESTING:
  - What is the evidence for and against my thinking being true?
  - What unhelpful thinking patterns are operating?
  - What are facts and what are my feelings?

- ALTERNATIVE EXPLANATIONS:
  - Are there any other possible reasons to explain this?
  - Is there another way I could think about this?
  - Is there a more helpful way of thinking about this?
  - What would others think if they were in this kind of situation?

- PUTTING IT INTO PERSPECTIVE:

  - Is it as bad as I'm making out?
  - Is there anything good about this situation?
  - How likely is it that the worst will happen?
  - What is <u>most</u> likely to happen?

- GOAL-DIRECTED THINKING
  - Are my thoughts helping me to achieve my goals?
  - What can I do that will help me deal with the problem?
  - How can I minimise the negative effects?
  - How can I think about this in a way that will help me to feel good about my life and myself?
  - If it is something that has already happened, how could I do better next time?

Once you have challenged your unhelpful or negative thought, the **final step is to replace the thought with more logical, positive or realistic ones.** Check to see if there are new consequences (thoughts and beliefs) for your new thought.

For example, when you are bored you may say to yourself, *"I'm all alone, life is awful"*. This leads to feelings of uselessness, worthlessness and sadness, and even less motivation to do anything. Once you examine the thought you may find you have "catastrophised" the situation and come to an overly negative conclusion. There is evidence of friends and family but you just haven't called them. Try thinking "I've got friends I can call them now or I can just enjoy doing something by myself". This might help you feel a bit more positive and in control, and motivated to act. We call these new thoughts **alternate interpretations.**

APPENDIX Z: STRUCTURED PROBLEM-SOLVING WORKSHEET

1. What is the problem?

(Break it down into manageable smaller problems)

_____

_____

_____

2. Step back and view problem objectively and without emotion, as if it were happening to someone else.

3. What can I do?

(Brainstorm a list of possible solutions, good and bad, real and unreal)

Solution	*Pros*	*Cons*

4. Cross out any silly or impossible options. *With those that remain, write down the short-term and long-term consequences and the pros and cons.*

5. Write down your favourite three.

1. _____

2. _____

3. _____

6. Put it into action!

(What do you need to do to implement it? Did it work? Why/why not? Would another solution work better?)

APPENDIX AA: GOAL SETTING WORKSHEET

I want to …

(e.g., stop smoking)

For these reasons …

(e.g., to prove that I can, to improve my health)

The obstacles stopping me are …

(e.g., routine)

I can overcome these by …

(e.g., avoiding situations where I am tempted)

These people can help …

(e.g., family)

By …

(e.g., providing support)

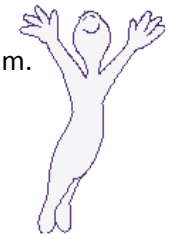
I will start working towards this goal …

(e.g., today)

I know I will have achieved this goal because …

(e.g., I no longer crave)

APPENDIX BB: PLEASURE AND MASTERY WORKSHEET



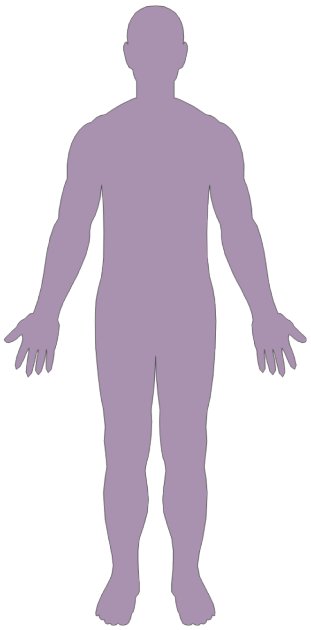
Create a list of activities you do for pleasure or you get a sense of achievement from.
Try to think of more each day and add to the list.
Make note of how each activity makes you feel.
Find time to complete some of these tasks every day.
A list of examples is included on the next page to help start you off.

TASK	HOW I FEEL

Examples of fun activities

1. Listening to music
2. Playing soccer
3. Playing golf
4. Having a bath
5. Going for a swim
6. Going for a job
7. Watching a movie
8. Watching favourite TV show
9. Going shopping
10. Going bowling
11. Working on car/bike
12. Sex
13. Reading poetry
14. Cooking
15. Surfing
16. Playing video games
17. Have coffee at a café
18. Riding bike
19. Playing pool/billiards
20. Looking at photos
21. Bushwalks
22. Playing volleyball
23. Picnics
24. Playing cards
25. Discussing politics
26. Playing with pets
27. Woodworking
28. Getting a massage
29. Watching a sporting event
30. Hobbies (e.g., collecting things)
31. Going horse riding
32. Lying in the sun
33. Talking to others
34. Camping
35. Going on holiday
36. Going to the beach
37. Going fishing
38. Having a relaxed evening
39. Debating
40. Going to the zoo/aquarium
41. Eating
42. Going to the gym
43. Playing cricket
44. Playing hockey
45. Driving
46. Doing jigsaws
47. Buying things
48. Playing basketball
49. Doing martial arts
50. Playing netball
51. Yoga
52. Playing squash
53. Playing tennis
54. Going surfing
55. Photography
56. Surfing the net
57. Getting hair done
58. Kissing
59. Going to museums and galleries
60. Going to church/synagogue/ temple/mosque
61. Throwing parties
62. Going to parties
63. Exercise
64. Having a meal with friends
65. Singing
66. Going sailing
67. Praying
68. Going to concerts or plays
69. Sewing
70. Working
71. Reading books
72. Playing board games
73. Volunteering
74. Having a BBQ
75. Eating out
76. Acting
77. Cleaning
78. Meditating
79. Playing with children
80. Sleeping
81. Gardening
82. Going canoeing
83. Painting/drawing
84. Skating
85. Skiing
86. Writing
87. Reading newspaper
88. Dancing
89. Rock climbing
90. Doing crosswords/word games

APPENDIX CC: PROGRESSIVE MUSCLE RELAXATION



1. Take three deep abdominal breaths, exhaling slowly each time, imagining the tension draining out of your body.
2. Clench your fists. Hold for 10 seconds, before releasing and feeling the tension drain out of your body (for 15 seconds).
3. Tighten your biceps by drawing your forearms up toward your shoulders and make a muscle with both arms. Hold, then relax.
4. Tighten your triceps (the muscles underneath your upper arms)by holding out your arms in front of you and locking your elbows. Hold, then relax.
5. Tense the muscles in your forehead by raising your eyebrows as high as you can. Hold, then relax.
6. Tense the muscles around your eyes by clenching your eyelids shut. Hold, then relax. Imagine sensations of deep relaxation spreading all over your eyes.
7. Tighten your jaws by opening your mouth so widely that you stretch the muscles around the hinges of your jaw. Hold, then relax.
8. Tighten the muscles in the back of your neck by pulling your head way back, as if you were going to touch your head to your back. Hold, then relax.
9. Take deep breaths and focus on the weight of your head sinking into whatever surface it is resting on.
10. Tighten your shoulders as if you are going to touch your ears. Hold, then relax.
11. Tighten the muscles in your shoulder blades by pushing your shoulder blades back. Hold then relax.
12. Tighten the muscles of your chest by taking in a deep breath. Hold, then relax.
13. Tighten your stomach muscles by sucking your stomach in. Hold, then relax.
14. Tighten your lower back by arching it up (don't do this if you have back pain). Hold, then relax.
15. Tighten your buttocks by pulling them together. Hold, then relax.
16. Squeeze the muscles in your thighs. Hold, then relax.
17. Tighten your calf muscles by pulling your toes towards you. Hold, then relax.
18. Tighten your feet by curling them downwards. Hold, then relax.
19. Mentally scan your body for any left over tension. If any muscle group remains tense, repeat the exercise for those muscle groups.
20. Now imagine a wave of relaxation spreading over your body.

Bourne, E.J. (1995). *The anxiety and phobia workbook.* California: New Harbinger Publications.

APPENDIX DD: CONTROLLED ABDOMINAL BREATHING

1. Rate your level of anxiety on a scale from 1 to 10.

2. Sit as comfortably as possible in a chair with your head, back and arms supported, free legs and close your eyes (if you like).

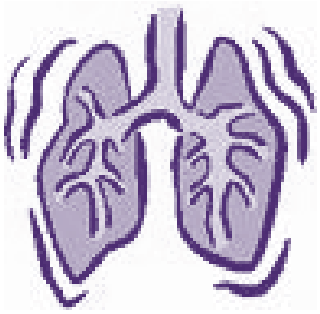
3. Place one hand on your abdomen right beneath your rib cage.

4. Inhale deeply and slowly, send the air as low and deep into your lungs as possible. If you are breathing from your abdomen, you should feel your hand rise, rather than your chest.

5. When you have taken a full breath, pause before exhaling. As you exhale, imagine all of the tension draining out of your body.

6. Do 10 slow abdominal breaths. Breathe in slowly counting to four, before exhaling to the count of four (four seconds in, four seconds out). Repeat this cycle 10 times. Hold final breath for 10 seconds, then exhale.

7. Now re-rate your level of anxiety and see if it has changed.

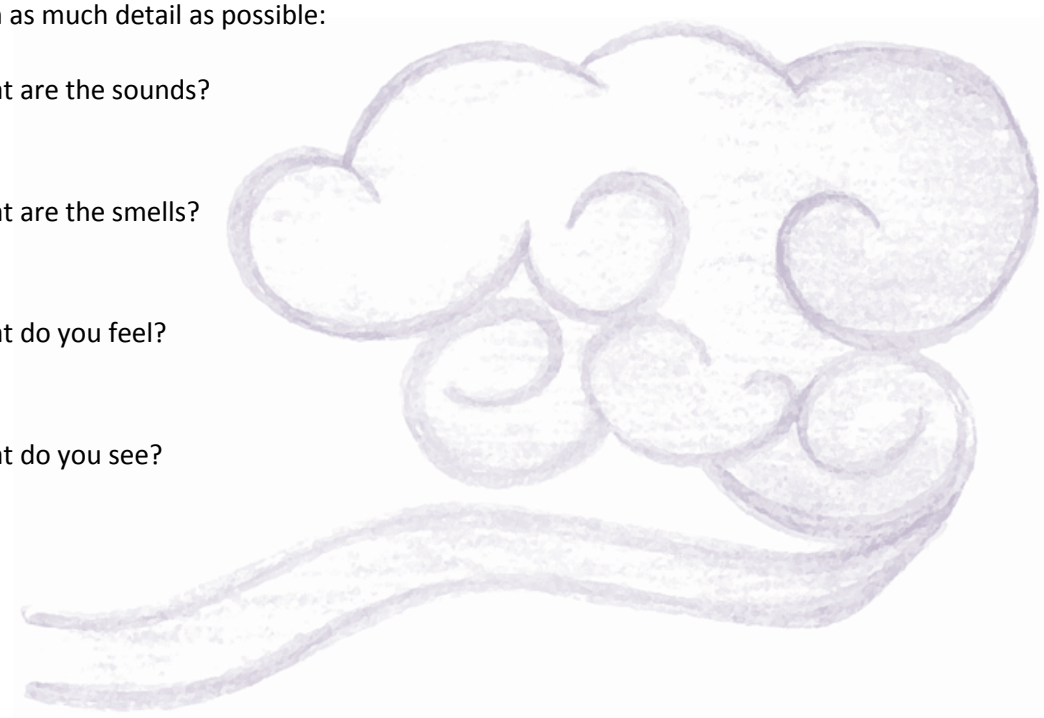


APPENDIX EE: VISUALISATION AND IMAGERY

1. Sit comfortably in a chair, close your eyes and breathe deeply. Clear your mind of all thoughts and images, like a blank page.

2. Imagine a place where you feel safe and relaxed – this could be a real or imaginary place. Think in as much detail as possible:

   - What are the sounds?
   - What are the smells?
   - What do you feel?
   - What do you see?



3. Think about how your body feels in this place:

   - Are your muscles relaxed?
   - Is it warm?
   - Is your breathing and heart rate slow or fast?

4. Stay in this relaxed state for a moment and remember how it feels so you can return to it when you need to.

5. Slowly clear your mind again and return to the "here and now" and the sounds around you. Stretch your arms and legs and when you are ready open your eyes.