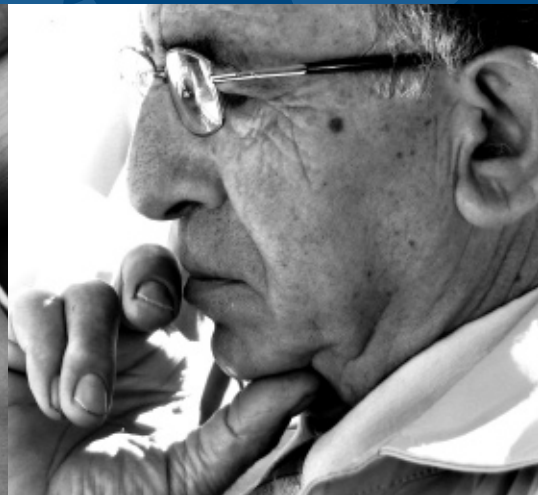
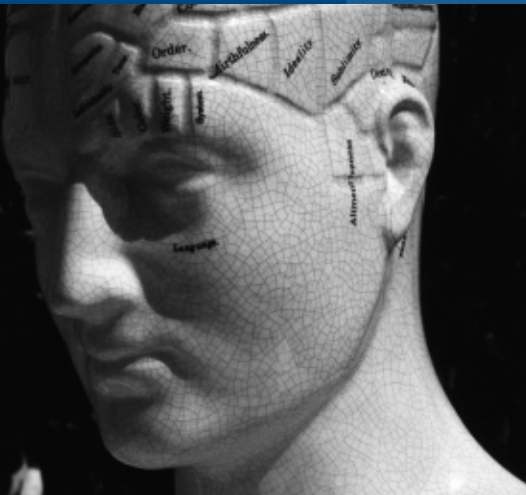


Mental health reference resource

for drug and alcohol workers



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Introduction

Forward

It is estimated that mental illness affects more than one in five people in the Australian community and people with a mental illness are at very high risk of developing problematic drug and alcohol use. For many reasons, these people do not always seek assistance from specialist mental health services. This means other health professionals who do not necessarily have knowledge or skills in mental health care usually interact with them.

Drug and Alcohol Services are increasingly interacting with clients affected by mental health issues. These clients are predominately affected by anxiety and mood disorders as well as personality disorders and acute psychotic episodes. Alcohol and other drug (AOD) workers need to be able to respond appropriately to these clients, according to their responsibilities and skills.

The Centre for Drug and Alcohol (CDA) commissioned the development of this resource through the Network of Alcohol and other Drugs Agencies (NADA). The development of this resource was undertaken by Jenny Melrose/JEMECO Psychology and designed by Jeremy Gordon.

This resource has been developed to assist those workers who do not necessarily specialise in mental health work to increase their understanding about how to support clients affected by mental illness. It is not a training manual in techniques, but does give a brief explanation of the strategies AOD workers can seek training in to build further skills and knowledge.

The opportunity for feedback on the resource was provided to the following committees:

- NSW Health Drug and Alcohol Council
- NSW Health Mental Health Coordinating Council
- The Aboriginal Health and Medical Research Council of New South Wales
- NSW Health Quality in Treatment Council
- NSW Health Clinical Advisory Council (Mental Health)
- NSW Health Comorbidity Subcommittee (Mental Health and Substance Use)
- NSW Health Quality in Treatment Sub Committee
- NSW Health Nursing Advisory Committee
- NSW Health Allied Health Workers Committee
- NSW Health Prevention Sub Committee
- Aboriginal Leadership Group
- Transcultural Mental Health Service
- STARTTS – NSW Services For The Treatment and Rehabilitation of Torture and Trauma Survivors

We would like to express our sincere gratitude and appreciation to all of the above individuals and organisations who have contributed to this important document.

About this resource

This resource aims to:

- Provide information in an accessible format to support drug and alcohol staff working with clients with mental illness
- Improve the confidence and skills of drug and alcohol staff working with clients with mental illness.

The resource provides practical and relevant information about:

- Types of mental health illness, services available and interventions
- Information on comorbidity, and
- Suggested tools and interventions for drug and alcohol workers to utilise when working with clients with co-occurring mental illness.

How to use this resource

This resource has been designed for rapid referral. Key sections have been bookmarked down the page edge for ease of reference. The contents of this resource have been separated into 6 major sections and several subsections for ease of use.

Section 1: Overview of mental illness contains a brief background on mental illness, government policies, and classifications.

Section 2: Mental health plans and protocols provides an in-depth look at current government policies regarding mental health.

Section 3: Classifications of mental health details the various forms and diagnosis of mental illness.

Section 4: Mental health services: how they work examines similarities and differences between the AOD and mental health service sectors.

Section 4A: Mental health interventions lists the various methods used to help those with mental illness.

Section 5: Comorbidity analyses the links between mental health and substance use issues, and how they affect each other.

Section 6: Working with clients with mental health issues in an AOD setting outlines the stages of treatment specific to working with clients affected by mental illness in an alcohol and other drug service.

Section 6A: Working with clients with commonly occurring mental illness symptoms provides practical strategies and resources dealing with comorbidity in clients.

Section 6B: Working with clients from particular populations raises key issues to remember with interacting with various populations.

Section 6C: Referral lists various organisations that can assist in the treatment and care of clients

Section 6D: Worker self-care provides strategies to care for the wellbeing of AOD workers

Overview of mental illness

This section provides background information on mental illness including definitions, causes, prevalence and the issue of stigma. It provides a brief overview of the National and State plans and protocols on mental health and the classifications used to diagnose mental illness.

Mental health and mental illness

The concepts of mental health and mental illness are related to the beliefs and values of the society in which the person lives. In Western society mental health is generally defined as a positive state in which people are responsible, self-directed, self-aware, reasonably worry-free and can cope with general daily chores and tensions. Three factors influence the development of mental health:

- biological factors
- psychological factors
- sociocultural factors

Biological factors include genetic predisposition, physical health, neurobiology and physiology. Psychological factors include nurturing during childhood, family interactions, intelligence, self-concept, skills, talents, creativity, emotional development level and exposure to trauma. Sociocultural factors include family stability, child rearing patterns, economic resources, housing, religious beliefs and values.

When people are mentally unwell or ill they are generally unable to carry out their normal roles in society. Mental illness may be defined as a set of behavioural or psychological responses that interfere with or inhibit a person's ability to comfortably or effectively meet their needs and function within their culture. The American Psychiatric Association's definition of mental illness (called a mental disorder) is:

A clinically significant behavioral or psychological syndrome or pattern that occurs in an individual and that is associated with present distress (e.g. a painful symptom) or disability (i.e. impairment in one or more important areas of functioning) or with a significantly increased risk of suffering death, pain, disability, or an important loss of freedom. In addition, this syndrome or pattern must not be merely an expectable and culturally sanctioned response to a particular event (APA, 2000, pxxx).

Despite the number of public awareness campaigns aimed at educating the general public about mental illness, stigma remains a significant issue in the mental health sector. Stigma is experienced as social, vocational and recreational barriers in the community due to widespread ignorance and misunderstanding that reinforces shame and isolation. It is very important that workers are aware of the feelings of shame and isolation people with mental illness can feel and thus the reluctance they may have in discussing their difficulties.

Prevalance

The World Health Organisation (2001) note that internationally mental and behavioural health disorders are common, affecting more than 25% of people at some time during their lives. It is also estimated that by 2020 depression alone will constitute one of the largest health problems worldwide (Murray & Lopez 1996).

Estimates confirm that mental disorders are also the leading cause of disability burden in Australia. In 1996 mental disorders were responsible for nearly 30% of the non-fatal disease burden with depression the top-ranking cause (Mathers, Vos, Stevenson and Begg, 2000). Three million Australians will experience a major depressive illness during their lifetime (National Media and Mental Health Group, 2004).

Adults who lived in the most socioeconomically disadvantaged areas experience a higher prevalence of mental or behavioural problems (16%) compared with people who live in the least socioeconomically disadvantaged areas (9%).

In Australia the 2004-5 National Health Survey (ABS, 2006) showed that the prevalence of mental or behavioural problems generally increased with age until the 35-44 year age group then declined in people aged 75 years and over. Females were more likely than males to report a long-term mental or behavioural problem and were also more likely to report high/very high levels of psychological distress than men. However men are at greater risk of suicide, particularly among young men and rural populations.

Specifically in NSW, a snapshot of mental health conducted by NSW Health (2006a) showed that approximately 1.1 million people experienced a mental illness in 2005/6. In 2004-5 mental health units in NSW provided approximately 26,000 overnight admissions and community mental health services provided 2.3 million interventions.

Mental health plans and protocols

National action plan on mental health 2006-2011

The Council of Australian Governments (COAG) agreed to a five-year National Action Plan on Mental Health following its meeting in February 2006. The Plan provides a strategic framework that emphasises coordination and collaboration between government, private and non-government providers. This is in order to deliver a more seamless and connected care system, so that people with mental illness are able to participate in the community. Each jurisdiction is undertaking different actions as part of an Individual Implementation Plan.

To see the National Action Plan on Mental Health 2006-2011 and the Individual Implementation Plan on Mental Health - New South Wales, go to:

- http://www.coag.gov.au/meetings/140706/docs/nap_mental_health.pdf

National mental health plan 2003 - 2008

The current National Mental Health Plan is an ongoing agenda for services and the community. It is the third plan, the first of which was published in 1992 as an initial attempt to coordinate mental health care reform nationally. The broad aims of the plans have been to:

- promote the mental health of the Australian community
- where possible, prevent the development of mental disorder
- reduce the impact of mental disorder on individuals, families and the community
- assure the rights of people with mental disorder.

The principles underpinning the plan are:

- All people in need of mental health care should have access to timely and effective services, irrespective of where they live
- The rights of consumers, their families and carers must shape reform
- Mental health care should be responsive to the continuing and differing needs of consumers, families and carers, and communities
- The quality and safety of mental health care must be ensured
- A recovery orientation should drive service delivery
- Investment in the workforce is essential
- Innovation must be strongly encouraged and supported
- Sustainability of effective interventions must be ensured
- Resources for mental health must recognise the impacts of mental health problems and mental illness
- Mental health reforms must occur in concert with other developments in the broader health sector
- Mental health reforms require a whole-of-government approach.

The four priority themes for this plan are:

1. Promoting mental health and preventing mental health problems and mental illness
2. Increasing service responsiveness
3. Strengthening quality
4. Fostering research, innovation and sustainability.

National standards for mental health services

The National Standards for Mental Health Services document was produced to provide standards for mental health services across Australia. The guiding principles for the standards are:

- the promotion of optimal quality of life for people with mental disorders and/or mental health problems
- a focus on consumers and the achievement of positive outcomes for them
- an approach to consumers and carers that recognises their unique physical, emotional, social, cultural and spiritual dimensions
- the recognition of the human rights of people with mental disorders as proclaimed by the United Nation's Principles on the Protection of People with Mental Illness and the Australian Health Minister's Mental Health Statement of Rights and Responsibilities
- equitable access to appropriate mental health services when and where they are needed
- community participation in mental health service development
- informed decision making by individuals about their treatment
- continuity of care through the development of intersectoral links between mental health services and other organisations
- a mental health system that emphasises comprehensive, coordinated and individualised care
- accountability to consumers, carers, staff, funders and the community

- adequate resourcing of the mental health system
- equally valuing the various models and components of mental health care.

— AHMAC National Mental Health Working Group (1996).

To view the National mental health plans and protocols go to:

- <http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/mental-pubs>

NSW – a new direction for mental health 2006 - 2010

This document outlines a five year programme of additional expenditure on new and existing initiatives across a range of key focus areas in NSW:

- Promotion, prevention and early intervention
- Integrating and improving the care system
- Participation in the community and employment, including accommodation
- Increasing workforce capacity

NSW Mental Health Act

The Mental Health Act establishes the legislative framework within which care, control and treatment can be provided for people with a mental illness in NSW. The Act acknowledges that although people with mental illness need to have the same rights as everyone else in NSW, there are times in which mental illness results in behaviour that leads to those rights being curtailed. The Act sets out the circumstances in which these rights can be curtailed and ensures that the interference to the client's rights is kept to a minimum.

The Act makes provisions for the care of people who:

- are admitted to hospital voluntarily
- are admitted to or detained in hospital against their wishes
- are required to receive treatment in the community
- have committed an offence and are mentally ill (i.e. forensic clients).

The Mental Health Act lists a number of ways in which an involuntary admission to hospital can be initiated:

1. A medical practitioner (or in regional areas an accredited mental health practitioner) completes a particular form, this is called Schedule 2
2. Police can take a person appearing to be at risk of causing themselves serious bodily harm to hospital
3. (In remote areas only) a request by a relative or friend, along with a written request by a medical superintendent of the hospital
4. An order of the court
5. An accredited person or welfare officer
6. A magistrate can authorise a doctor with backup from the police to schedule a person (this is rarely used).

Clients may be placed on a Temporary Order for up to three months or a Community Order (either a Community Treatment Order or Community Counselling Order).

The Mental Health Review Tribunal has the following responsibilities under the Act:

- Renewing and approving Community Orders
- Looking into the care of voluntary clients who have been hospitalised for a year
- Accessing applications for Electro-Convulsive Therapy (ECT).

The Mental Health Act is currently being reviewed. Due to its complexity it is advisable to access more detailed information from the local Area Mental Health Services regarding the application of the Act in each area. Information about the Mental Health Review Tribunal can also be accessed at <http://www.mhrt.nsw.gov.au/>

To view the NSW Health mental health publications go to:

- <http://www.health.nsw.gov.au/pubs/>

Classifications of mental illness

This section contains background information to the different classifications of mental illness including anxiety, mood, psychotic and personality disorders. Each of these classifications is examined in detail including the criteria mental health professionals use to assess these illnesses in clients.

Classification is vital to the correct treatment of mental illness although there is the possible misuse of diagnostic labels and the stereotyping of individuals. Classification was developed within the field of psychiatry and is used to group various disorders on the basis of their similarities and differences. It is important because it:

- makes for effective communication between mental health professionals, clients and families
- provides a framework for the study of the mental illness, which provides information to clients and families on what to expect
- allows for prediction of the effects of treatment and helps clients to understand why one treatment is chosen over another
- facilitates scientific research into possible causes of psychiatric disorders and their treatment.

Disorders are described as a mixture of signs (what is objectively visible about the client, e.g. muscle tremor) and symptoms (what the client describes, e.g. flat mood). The combination of signs and symptoms is called a syndrome. If a particular cluster of symptoms and signs occur regularly and show a distinct pattern of progression and response to treatment then this syndrome is called a disorder.

There are two main classification systems.

The Diagnostic and Statistical Manual of Mental Disorders is published by the American Psychiatric Association (APA) and is in its fourth edition, text revised (DSM-IV-TR). It uses the term mental disorders rather than mental illness. The DSM is the classification system predominantly used within NSW and thus is the system which is utilised and cited within this document. The second system is the *International Classification of Diseases and Related Health Problems* published by the World Health Organisation and is in its tenth edition (ICD-10). It groups disorders into neurotic disorders (anxiety and depression) and psychotic disorders (the schizophrenic spectrum).

Both systems classify people as being mentally unwell by listing a variety of signs and symptoms called criteria. A certain number of criteria needs to be met within a certain time frame for the person to be diagnosed as having a disorder. There are exclusion criteria related to each category which preclude diagnosis as they are deemed as possibly causing the signs and symptoms instead of the disorder. Preclusion criteria include the person having a medical condition or substance use issue.

Only a qualified medical practitioner can make a clinical diagnosis. It is therefore unethical for non-trained workers to use the diagnoses in clinical notes unless they have received written confirmation of diagnosis from someone qualified to make such a diagnosis. Instead, generic workers are encouraged to note signs and symptoms without labelling the client as having a specific disorder.

Anxiety disorders

Having an anxiety disorder is not just a matter of being too anxious. Anxiety is considered a disorder when a person's symptoms of fear or worrying are grossly disproportionate to reality. The symptoms restrict and hamper the person's normal life, don't lessen with reassurance and may be accompanied by thoughts and actions that are exaggerated.

There are many anxiety disorders described in the DSM. Common to most anxiety disorders are:

- Panic symptoms or "attacks" such as shortness of breath, hyperventilation, heart palpitations or chest tightness, light headedness, sweating, shaking, nausea and/or vomiting. Panic attacks, although common amongst many of the anxiety disorders, are not a specific mental illness
- Fearfulness, distress, agitation, restlessness and/or sleep disturbance.

Please note the following regarding how mental health services would diagnose anxiety disorders:

- general medical conditions, intoxication with or withdrawal from drugs or alcohol precludes diagnosis
- anxiety or worry related to another disorder precludes diagnosis
- significant distress or impairment of the person experiencing the symptoms is required for a diagnosis.

Table 3.1 Symptoms of anxiety disorders

Anxiety Disorder	Symptoms
Generalised Anxiety Disorder	Excessive anxiety or worry felt for at least 6 months that is difficult to control and focuses on a number of events or activities. Symptoms include feeling restless, fatigue, difficulty concentrating, irritability, muscle tension and sleeping problems
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. The person recognises that his/her obsessions and/or compulsions are excessive and they cause distress or anxiety, are time consuming or interfere with the person's normal routine
Panic Disorder (with or without Agoraphobia)	This disorder involves the person having unexpected panic attacks followed by persistent concern or worry about having and the implications of having another attack. As a result the person changes their behaviour in relation to the attacks. Panic disorder is sometimes accompanied by agoraphobia which 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. Symptoms involve the person avoiding such situations, or if such situations are endured there is considerable distress or anxiety, or a need for a companion
Social Phobia	Social phobia involves a marked and persistent fear of social or performance situations, exposure to unfamiliar people, possible scrutiny of others or fear of acting in a way that will be humiliating or embarrassing. Exposure to these things causes anxiety and/or panic attacks and hence the person usually avoids the situations. The avoidance may make this disorder appear to be agoraphobia but the feared event differs
Specific Phobia	This phobia is related to marked, persistent and excessive 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 aeroplanes, lifts or enclosed spaces
Post Traumatic Stress Disorder	PTSD results from the person having experienced a traumatic event where they perceived they (or others) are in threat of loss of life or physical integrity leading to intense fear, helplessness or horror. Following the event, for at least one month, the person re-experiences the event in ways such as having dreams or recollections that increase arousal (e.g. causing sleep problems, anxiety, anger, difficulty concentrating, hypervigilance). The person thus avoids situations reminding them of the event or may become numb
Acute Stress Disorder	This disorder is similar to PTSD but lasts for less than a month

Mood disorders

The Mood disorders, sometimes called the affective disorders, are characterised by a disturbance in mood. The most common in Australia is depression and is frequently seen in clients with chronic problems such as illness, pain or disability. A recent study from the National Drug and Alcohol Research Centre (NDARC) showed that of heroin users entering treatment one in four had current major depression.

The word 'depression' is now used regularly by many people, often to describe sadness or feeling 'flat'. Depression in terms of a disorder involves more severe symptoms:

- Psychological symptoms such as feeling worthless, hopeless, distress, lacking motivation and/or loss of interest in what was previously interesting and being withdrawn
- Physical symptoms such as fatigue, sleep disturbance, headaches, gastro-intestinal disturbances, aches and pains, loss of appetite and weight loss
- Suicidal ideation or thoughts of self-harm

The mood disorders involve having 'episodes' of dysfunction. Episodes themselves are not diagnosable mental illnesses. They are included to aid understanding of the disorders.

Table 3.2 Symptoms of mood disorders

Anxiety Disorder	Symptoms
Major Depressive Episode	Involves at least a two week period in which the person regularly (nearly every day) experiences some of the following: 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 ideation, attempts or plans
Manic Episode	Involves at least one week of abnormally or persistently elevated, expansive or irritable mood where the person experiences some of the following: inflated self-esteem; decreased need for sleep; increased talkativeness, distractability and/or agitation; racing thoughts and/or excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g. buying sprees, sexual indiscretions)
Mixed Episode	In a mixed episode criteria are met for both a manic episode and major depressive episode for at least one week
Hypomanic Episode	A hypomanic episode is the same as a manic episode but can be noted after four days but unlike a manic episode does not require the episode to be severe enough to cause impairment in social or occupational functioning

Each of the mood disorders are listed separately and are split into depressive (unipolar) disorders and bipolar (a mixture of episode types) disorders. Please note the following regarding how mental health services would diagnose these disorders:

- general medical conditions, intoxication with or withdrawal from drugs or alcohol precludes diagnosis
- mood changes related to another disorder precludes diagnosis
- significant distress or impairment of the person experiencing the symptoms is required for a diagnosis.

Table 3.3 Symptoms of depressive disorders

Depressive Disorder	Symptoms
Major Depressive Disorder	Is characterised by one or more major depressive episode/s
Dysthymic Disorder	Dysthymic disorder is a milder more persistent form of depression which is diagnosed after the person has experienced symptoms for at least two years. It can not be diagnosed if any episodes have occurred

Table 3.4 Symptoms of bipolar disorders

Bipolar Disorder	Symptoms
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. The presence of a manic or mixed episode precludes diagnosis of this disorder
Cyclothymic Disorder	Cyclothymic disorder is a chronic (at least two years) fluctuating mood disturbance involving numerous periods of hypomanic and depressive symptoms. The presence of symptoms that meet major depressive, manic or mixed episodes precludes diagnosis of this disorder

Psychotic disorders

The term psychosis refers to the inability to distinguish external reality from internal fantasy. The psychotic disorders are characterised by distortions of thinking and perception, a disorganisation of thought and behaviour, cognitive impairment, disturbances in communication and social and functional impairment. It is usual for people with these disorders to have a sense of being a unique, self-directed individual however they also lack insight and thus may not realise that there is anything wrong with their mental state or behaviour.

The most common of the psychotic disorders is schizophrenia. The symptoms of schizophrenia are grouped within two types: positive and negative. Positive symptoms reflect an excess or distortion of normal functioning and include:

- hallucinations (seeing, hearing, smelling, sensing or tasting things that others can't)
- delusions (false beliefs involving the misinterpretation of perceptions or experiences and may involve persecutory, religious or grandiose themes)

- disorganised speech (not staying on the topic; tangentiality; incomprehensible or thought disturbances such as the person believing that thoughts are being inserted into or withdrawn from the mind or are being broadcast to others)
- motor manifestations such as grossly disorganised behaviour (can include agitation, silliness, difficulty in performing activities of daily living) or catatonia (decreased reactivity to the environment sometimes to the extreme of complete unawareness, maintaining a rigid or inappropriate posture).

Negative symptoms reflect a loss of normal functioning and include:

- avolition (restricted initiation of goal-directed behaviour)
- flat affect (restricted range and intensity of emotional expression)
- alogia (restricted fluency and productivity of thought and speech)
- anhedonia (loss of interest or pleasure).

Schizophrenia has been conceptualised as occurring in three phases:

1. **Prodromal phase** which is often described as 'something is not quite right'. This phase includes subtle changes characterised by general loss of interest; depressed mood; avoidance of social interactions; avoidance of work or study; anxiety, irritability or oversensitivity and odd beliefs and behaviours (such as superstitiousness). These symptoms can be hard to distinguish from normal adolescent behaviour. The prodrome phase does not occur in all people, when it does occur its length is extremely variable.
2. **Acute phase** is when the person experiences positive symptoms along with strong feelings such as distress, anxiety, depression and fear. Risk of suicide increases at this stage, especially during the early years of the disorder. Without treatment this stage may resolve spontaneously or may continue indefinitely, with treatment the symptoms are usually brought under control.

3. **Residual phase** is the period where symptoms are reduced, although they may still be experienced with less severity than in the previous stage. There is significant variability in this phase between one person and the next: some will function well while others will remain considerably impaired.

The latter two phases frequently cycle with repeated acute episodes of illness interspersed by periods of residual negative symptoms of varying degrees of severity. While full remissions from schizophrenia do occur, the majority of people have at least some residual symptoms of varying severity. It is important to recognise that people may be well functioning between episodes although they may have some residual negative symptoms.

Table 3.5 Symptoms of psychotic disorders

Anxiety Disorder	Symptoms
Schizophrenia	A mixture of positive and negative symptoms <i>most of the time</i> for at least one month (shorter if successfully treated) with some signs of the disorder for at least six months. These signs and symptoms are associated with marked social or occupational functioning
Schizophreniform Disorder	Characterised by a symptomatic presentation that is equivalent to 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	A disturbance involving acute symptoms of schizophrenia along side a mood episode (depression, mania or a mixture of the two). This disorder may thus be divided into two types: bipolar (mania or mixed episode) and unipolar (depressive episode)
Delusional Disorder	Characterised by at least a month of non bizarre delusions. There is a relative absence of hallucinations or other positive symptoms of schizophrenia
Brief Psychotic Disorder	A disturbance when positive psychotic symptoms are present for less than a month
Shared Psychotic Disorder	Develops in an individual who is influenced by someone else who already has a psychotic disorder with prominent delusions of a similar content

Personality disorders

Generally people with personality disorders seem to be different from the “norm” in the way that they relate to others, moderate their behaviour and emotions and the way they think about the world. The personality disorders involve deeply ingrained and enduring patterns of behaviour manifested as inflexible responses to a wide range of social and personal situations. It is common for people with personality disorders to present with the following symptomatology:

- Inflexible, maladaptive responses to stressful circumstances
- Significant impairments in loving, working and relating
- Impulsivity in most areas of their lives
- Difficulty in accommodating other people’s needs
- Difficulty in accepting responsibility for their own behaviour
- A history of pervasive and persistent anger and resentment
- Concrete thought processes
- A belief in personal uniqueness, deserving special attention and consideration
- Tendency to misperceive feelings as facts or realities
- A pervasive sense of boredom, nothingness or emptiness
- Lack of problem solving ability
- Hypersensitivity to perceived put downs, persistent fear of being discovered as worthless or a nobody.

To be diagnosed with a personality disorder using the DSM-IV-TR the client must have a pervasive and enduring pattern of inner experience and behaviour that deviates from the expectations of the individual’s culture. This pattern must lead to distress or impairment and be stable and of long duration, with onset traced back to at least adolescence or early adulthood. Personality disorders tend to develop in adolescence or early adulthood and are generally lifelong.

It is important to note that even though many individuals may display the traits listed above it is only when these traits are inflexible, maladaptive, persistent and cause significant functional impairment or subjective distress that they constitute a personality disorder. For a formal diagnosis to be made, specific criteria must be met and an evaluation of the individual’s long-term patterns of functioning must be undertaken.

The personality disorders are grouped into three clusters. People with cluster A personality disorders often appear to be odd or eccentric, have significant impairment but relatively infrequently seek out help.

People with cluster B personality disorders tend to be dramatic, emotional and erratic and are generally significantly impaired and 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.

People with cluster C personality disorders tend to be anxious and fearful and are generally less impaired than cluster B.

Table 3.6 Symptoms of personality disorders

Cluster A Disorders	Symptoms
Paranoid Personality Disorder	Is a pattern of distrust and suspiciousness such that others' motives are interpreted as malevolent
Schizoid Personality Disorder	Is a pattern of detachment from social relationships and a restricted range of emotional expression
Schizotypal Personality Disorder	Is a pattern of acute discomfort in close relationships, cognitive or perceptual distortions and eccentricities of behaviour
Cluster B Disorders	Symptoms
Antisocial Personality Disorder	Is a pattern of disregard for and violation of the rights of others. They are aggressive, unlawful and impulsive
Borderline Personality Disorder	Is a pattern of instability in interpersonal relationships, self-image and feeling states with marked impulsivity and chaoticness
Histrionic Personality Disorder	Is a pattern of excessive emotionality including being dramatic, attention seeking and seductive
Narcissistic Personality Disorder	Is a pattern of grandiosity and self-centredness and thus lacking empathy for others
Cluster C Disorders	Symptoms
Avoidant Personality Disorder	Is a pattern of social inhibition with feelings of inadequacy and hypersensitivity to negative evaluation. They 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 a pattern of submissive and clinging behaviour related to an excessive need to be taken care of. They tend to be indecisive and fear abandonment
Obsessive-Compulsive Personality Disorder	Is a pattern of preoccupation with orderliness, perfectionism and control, thus they are rigid and inefficient

Mental health services: how they work

This section of the resource examines the similarities and differences between the AOD and mental health service sectors. It also gives background to the roles of different mental health services and describes the interventions used in mental health care work. There is also a special section on the types of medications commonly used in these interventions.

AOD and mental health sectors: The similarities and differences

There are several similarities between the AOD and mental health sectors. Both AOD and mental health sectors employ a highly skilled and committed workforce. Unfortunately however, both clients and staff working in these are often stigmatised and the workforces tend to be under recognised, under valued and under resourced. Clients within both these sectors have chronic, relapsing illnesses and experience a marked impact on behavioural and social functioning. Hence, both workforces tend to be very effective in dealing with client crises and emotional distress. What is important to note is that mental health services and AOD workers are often dealing with the same or similar clients.

There is also a range of differences between and within the two sectors. For clients with AOD issues there are a variety of organisations that provide services. These can include medical model pharmacotherapy services such as opiate treatment programs, harm reduction services such as needle syringe programs, diversion programs such as drug courts and Magistrates Early Referral into Treatment (MERIT), counselling services and non-government residential and support services. The AOD workforce

is thus made up of a variety of workers with a range of skills and models (i.e. life-experience based workers, TAFE trained workers and university trained workers). Workers in the AOD sector generally work from the concept of harm minimisation and thus may not focus on abstinence unless abstinence is the client-goal. Generally AOD services call the people that they provide services to 'clients' although medical model pharmacotherapy programs may use the word 'patient'. Generally too referrals to the AOD sector are only accepted if the client is willing to attend, thus client motivation needs to be high.

In the mental health sector medication is often an essential component of treatment and thus psychiatric nurses are a major section of the workforce. Allied health professionals and psychiatrists also play an essential role. In government services care is usually based on a multidisciplinary team working within a case management model. Non-government services also provide residential, support and drop-in services. Generally the mental health sector calls the people they provide a service to 'patients' (if in hospital) or 'consumers' (if in the community). Some organisations use mental disorder diagnosis as criteria for service provision. These organisations are often restricted in their capacity to manage clients who are using drugs since drug or alcohol intoxication or withdrawal are exclusion criteria in mental illness diagnosis. As lack of motivation and insight are often a part of mental illness, the mental health sector tends to assertively follow-up their consumers. Thus, the Mental Health Act allows for a consumer to be admitted to a mental health unit on an involuntary basis if they are acutely unwell and are a risk to themselves or others.

The Act also allows for people to be discharged to the community on a Community Treatment Order which obliges them to stay on medication and have regular follow-up. In mental health care, consumers' families and carers are more often actively involved in the consumers' care plan and may be provided with education and support from the sector.

Due to the different methodologies used by the alcohol and other drugs and mental health sectors there are often difficulties in engaging with clients with both issues and developing an effective treatment approach. There often tends to be a lack of collaboration between the sectors and thus they traditionally have worked in isolation from each other. Due to the high rates of comorbidity between mental illness and alcohol and other drug issues it is suggested that the two sectors increase their collaboration despite their differences.

The role of different mental health services

The role of mental health services differs across area health services depending on population need and the resources available. The following provides a general overview of what the main components of mental health services provide. However, it is important to liaise with local services to find out the specifics of service provision including intake procedures, hours of service delivery and specific methodology utilised.

MH-OAT

The suite of Mental Health Outcome and Assessment Tools (MH-OAT) is a NSW Health initiative to strengthen the mental health assessment and clinical documentation skills of clinical staff in mental health. MH-OAT has a number of clinical modules addressing the consumer journey from assessment through to discharge.

Each mental health service has implemented standard documentation, assessment and outcome measurement using the MH-OAT clinical modules. This has led to a significant improvement in the consistency, accuracy and quality of information which is collected and allows for much improved tracking of the consumer's progress.

The content and format of MH-OAT reflects the input of clinicians, managers, consumers and other key stakeholders obtained through consultation.

Acute care

Together, emergency departments, crisis teams and inpatient services deliver 24-hour, 7 days a week access to mental health services. Services have been developed according to local need and within available resources, and hence vary between different areas.

Staff in emergency departments are generally able to request assessments and care from mental health staff for the following presenting problems:

- Violent behaviourally disturbed (threat to self or others)
- First presentation of mental health disorder or behavioural disturbance
- Patients presenting with intentional self harm including overdose
- Patients requiring immediate physical assessment or intervention.

In some areas crisis teams are available with extended hours to provide triage and short-term case management while in other areas these services are provided within business hours. The teams typically operate out of community mental health centres and/or hospital emergency departments.

Inpatient services provide assessment and assertive management of people with acute psychiatric symptoms. As inpatient services are located within hospitals they are based on a medical model and thus patients are usually medicated so that symptomatology is reduced. Depending on resources available, brief interventions for mental health may be provided.

Ongoing care

Community mental health teams are based in the local community, usually within Community Health Centres. In most areas there are both adult Community Mental Health Teams and Child and Adolescent Mental Health Services. For older people with mental health problems each Area has a SMHSOP coordinator (Specialist Mental Health Services for Older People) who provides links with both generalist Aged Care Services and Psychogeriatric (Aged care psychiatry) Services. In some Areas these coordinators are colocated with community mental health teams.

Ongoing care is provided by the appropriate component of the mental health service in each Area. Consumers will be designated a case manager who will continue assertive follow-up for the period of time the consumer requires it and coordinate the different services the person requires based on individual needs. Community teams are usually multi-disciplinary, made up of psychiatrists, psychiatric nurses, psychologists, occupational therapists and social workers to provide a holistic service to the consumers.

The key features of effective community mental health services are:

- Working with primary care services (e.g. GPs) to provide a clear point of entry into the service
- Comprehensive assessment
- A multidisciplinary team approach
- Regular review, including multidisciplinary and multi-agency review
- A range of evidence based interventions and continuing care
- Access to psychosocial rehabilitation from the earliest entry point to the system
- Partnerships with consumers, their families and carers, other parts of the health system, other government agencies and NGOs
- Provision of discharge and transfer arrangements.

NGO service providers and support groups

NSW Health recognises the vital role non-government organisations (NGOs) play in mental health care (NSW Health, 1998). NGOs play an important role in building local communities, involving consumers in the delivery and management of their services and providing community services across all aspects of care – including children’s services, Aboriginal services, youth services, women’s services, telephone help lines, education, employment, housing, and services for people with a disability, ex prisoners, and refugees. Many NGOs draw on volunteers and donations. NGOs provide people with a mental illness with a range of psychosocial rehabilitation and support services, including social and emotional support, practical support to live at home, support in employment, social activities, helping link people with services and advocating on their behalf.

Depending on the region there are a variety of self help groups and organisations for people with mental health issues. It is important to check local availability. The following provides a brief introduction to some of the support groups within NSW:

- GROW Fellowship: a 12-step fellowship (i.e. Alcoholics Anonymous-like model) for people experiencing mental illness. Services include meetings across Australia and a residential service in Austral. Phone 02 9569 5566
- Schizophrenia Fellowship of NSW provides a telephone support line from Monday to Friday, 9am to 5pm: 02 9879 2600 and monthly support groups across NSW for people with a mental illness and their carers along with a variety of other services. <http://www.sfnsw.org.au/>
- The Richmond Fellowship of NSW is a statewide service and provides residential, rehabilitation and support services for people experiencing mental illness along with their families and friends. For more information on the Richmond Fellowship call the head office on 02 9701 3600 or view their website for specific services in metropolitan, regional and rural areas: <http://www.rfnsw.org.au/>
- ARAFMI (Association for the Relatives and Friends of the Mentally Ill) offers support for relatives, friends and carers of the mentally ill. NSW ARAFMI offers support groups, including those for younger people (Young ARAFMI) in regional and inner NSW. For more information call NSW ARAFMI on (02) 9887 5897 or Toll Free on 1800 655 198 <http://www.arafmi.org/>
- Anxiety Disorders Alliance runs a variety of support groups for people with obsessive-compulsive disorder, agoraphobia, panic disorder and anxiety. For more information contact (02) 9570 4126 or Toll free 1800 626 077 <http://www.ada.mentalhealth.asn.au/index.html>
- Lifeline’s Just Ask: Rural Mental Health Information Service is Australia-wide and available on 1300 13 11 14 <http://www.justask.org.au/>, Lifeline staff are also available for counselling on 13 11 14

Mental health interventions

Mental wellness: a strengths perspective

The commonly held view in education, medicine, psychology and many other disciplines has been a deficit and problem-oriented paradigm. The emphasis within this paradigm has been on risk factors that define what is wrong, missing or abnormal. Viewing people through this deficit lens prohibits seeing their strengths, resources and capabilities and it is difficult to instil hope from this basis.

An alternative view is that of the strengths-based approach. The strengths-based approach recognises that everyone has talents, abilities, interests, achievements, capabilities, dreams and wishes and thus resilience. Everyone has existing resources and resourcefulness that can be opened up to provide opportunities, inspire confidence and hope in themselves.

In the deficits perspective, individuals are typically seen as hopeless and without resources. In the strengths perspective it is presumed that people are able to make significant positive steps when their own strengths and abilities are identified, emphasised, and built upon within the context of adverse conditions.

— Adapted from Utesch (n.d.)

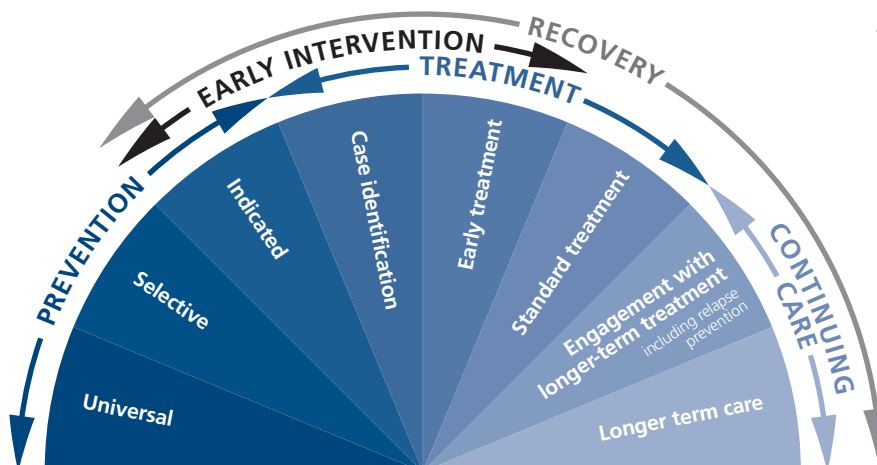
Mental health intervention spectrum

The mental health intervention spectrum describes a framework for identifying appropriate interventions for different stages in the development of mental illnesses and disorders.

The spectrum comprises promotion, prevention, early intervention, treatment and continuing care. The model has been widely adopted in the Australian mental health field.

MENTAL HEALTH INTERVENTIONS

Table 4A.1: Mental health intervention spectrum



— Adapted from Mrazek and Haggerty, 1994

Mental health promotion is any action taken to maximise mental health among populations and individuals. It aims to protect, support and sustain the emotional and social well being of the population. It is applicable across the entire spectrum of mental health interventions and is focused on the promotion of well being rather than illness prevention or treatment.

Prevention is made up of interventions that occur before the initial onset of a disorder with the aim to prevent the development of disorder. Prevention focuses on reducing the risk factors for mental disorder and enhancing protective factors. Prevention interventions can be universal, targeted at the general population, selective for population subgroups or individuals with a higher risk of developing mental disorder, or indicated for those with low levels but detectable signs or symptoms, which do not meet diagnostic levels.

Early intervention refers to interventions targeting people displaying the early signs and symptoms of a mental health problem. These interventions occur shortly after signs and symptoms have been displayed and aim to reduce distress, shorten the episode of care and minimise the level of intervention required. Early interventions include indicated prevention interventions.

Treatment is made up of early intervention, assessment and treatment for diagnosed disorders. Treatment involves the application of effective, evidence-based treatments for individuals with diagnosed disorders.

Continuing care comprises interventions for individuals whose disorders continue or recur. The aim is to provide clinical treatment and rehabilitation and support services in order to prevent relapse or the recurrence of symptoms, and to maintain optimal functioning to promote recovery. Ongoing mental health promotion, the reduction of risk factors and the enhancement of protective factors are still relevant at this end of the spectrum.

Relapse prevention refers to interventions in response to the early signs of recurring mental disorder for people who have already experienced a mental disorder. It differs from early intervention; the factors which influence the first onset of a disorder may be quite different factors from those which lead to relapse and recurrence of a disorder and the treatments may also differ.

— Adapted from Commonwealth Department of Health and Aged Care (2000).

Assertive follow-up

In most AOD services clients are voluntary and therefore are expected to be motivated to engage in treatment. In comparison, mental health services often engage in what is known as 'assertive-follow-up'. This is an acknowledgement that difficulties engaging with clients may not only be due to the clients' denial or resistance to treatment. Some clients, especially those with severe problems such as suicidality or psychosis, usually lack motivation to attend treatment or may lack insight into their degree of illness but need treatment to improve (or to prevent death). In these cases, the mental health sector is responsible to engage the client so that they remain in treatment.

A significant component of assertive follow-up is also brokering treatment client-centred services for clients. This means that when possible mental health services provide extended services. This policy is often adopted with an acknowledgement that mental health clients may have crisis out of normal working hours.

However, for comorbid clients assertive follow-up is rendered more difficult by increased rates of mobility and homelessness while engagement and retention in treatment is often a significant challenge.

For more information on considerations regarding discharge planning when patients are discharged from hospital into the community please download:

- ***<http://www.health.nsw.gov.au/pubs/> NSW Health Policy Directive PD2006_054 Discharge Planning Responsive Standards from <http://www.health.gov.au/policies/>***

Involving families and carers in treatment

Compared to AOD services mental health services engage more with the families and carers of people with mental illness. This can be through the provision of education and information, support or through engagement in the client's care or discharge planning. In some services, families and carers are involved in advisory groups for the mental health service, thus providing feedback and recommendations to the mental health service on its service provision. Likewise, some services engage families and carers on their internal committees to encourage feedback and participation.

When families and carers are provided assistance by the mental health service the core principles of this style of intervention are:

- Ensuring that relevant information is accessible and provided in user-friendly formats and languages
- Providing access to independent advocacy where appropriate with the aim of ensuring that clients, their families and carers understand the treatment being provided, available options and are enabled to express their opinions and preferences
- Giving regular feedback on actions suggested by clients so that they know their views are taken seriously
- Encouraging clients to participate in decision making about their own treatment as well as the service from which they are receiving treatment
- Developing a culture within the service that recognises and encourages the rights of clients to participate as fully as possible in decisions about their care and evaluate the services they receive.

Understanding medication

Research has shown that many mental illnesses are associated with changes in brain chemistry. Certain medications assist the brain to restore its usual chemical balance, which reduces symptoms so that the person feels better. Medications are usually taken as tablets, by injection or as a syrup. For people who have difficulty remembering to take their medication a depot injection, which slowly releases medication for more extended periods is often suggested. In the mental health sector medication is often one of the predominant forms of treatment for those with mental illness. Medication prescribers and case managers should always provide their clients with education on:

- The specific medication they are being prescribed
- The expected results of the medication
- The medication's time course (i.e. expected time to start reducing symptoms, which can be some weeks)
- Possible side effects
- Expected results of combining medication and other AOD use
- The importance of complying with medication prescription (i.e. not complying with prescription often makes the medication ineffective).

Side effects can reduce medication compliance and/or increase the use of recreational drugs to self-medicate. Therefore clients should be encouraged to report back to their prescriber any side effects that they are finding unpleasant or disruptive as an alternative medication may be better suited to them.

Antipsychotic medication

The aim of antipsychotic medication prescription is to minimise the symptoms of psychosis and minimise the risk of having another episode of psychosis by restoring the chemical imbalances in the brain. It is not a cure although recent research is indicating that if clients stay on antipsychotic medication for three years they only have a 20 – 30% chance of relapse (as compared to one year and 90% relapse risk). Research indicates that early and aggressive (higher dose) treatment works most effectively.

Like all of the medications, antipsychotics produce side effects. The most common effects are drowsiness, weight gain, changes in menstrual cycle in women, drop in blood pressure and dizziness. The less common side effects can be: parkinsonism (stiffening and weakening of muscles, a shuffling), akathisia (severe sense of restlessness) and/or dystonia (spasms in the muscles). Fortunately the newer antipsychotics have fewer unwanted effects than the traditional (older) medications.

Table 4A.2 Antipsychotic medications

Newer antipsychotics		Traditional antipsychotics	
Drug name	Brand name	Drug name	Brand name
clozapine	Clozaril	chlorpromazine	Largactil
olanzapine	Zyprexa	droperidol	Droleptan
quetiapine	Seroquel	fluphenazine	Anatenzol, Modecate
risperidone	Risperdal	flupenthixol	Fluanxol
amisulpride	Solian	haloperidol	Haldol, Serenace
		pericyazine	Neulactil
		pimozide	Orap
		thioridazine	Aldazine, Melleril
		thiothixene	Navane
		trifluoperazine	Stelazine
		zuclopenthixol	Clopixol

Mood stabilisers

The mood stabilisers are usually used to treat bipolar disorder. The aim of their prescription is to reduce the frequency of depression and manic symptoms. Their side effects include fine tremor, thirst, muscular weakness and memory problems. Also, they can cause harmful effects to the thyroid, kidney and central nervous system so medical checks are needed regularly.

Lithium initially increases psychomotor activity, insomnia and pressure speech however with time it diminishes manic symptoms. The anticonvulsants (carbamazepine and valproic acid) may also be prescribed for 'flashbacks' related to PTSD and are often used when lithium has failed.

Table 4A.3 Mood stabiliser medications

Mood stabilizer

Drug name	Brand name
carbamazepine	Tegretol, Teril
lithium carbonate	Lithicarb
sodium valproate	Epilim, Valpro
gabapentin	Neurontin

Antidepressants

Antidepressants are a treatment for people with debilitating and incapacitating depressive symptoms and work for 60-70% of people with major depressive disorder. They may also be prescribed to people with anxiety disorders if the client is prone to panic and those with psychotic disorders if symptoms include significant depression and/or anxiety. Antidepressant medication can provide symptom relief and allow participation in activities of daily living or to enable someone to stabilise enough to engage in other forms of treatment.

There are several classes of antidepressants in Australia, the main ones being: tricyclics (e.g. amitriptyline), selective serotonin reuptake inhibitors (SSRIs) (e.g. Prozac), serotonin antagonists (e.g. Serzone), serotonin and noradrenaline reuptake inhibitors (e.g. Efexor), reversible inhibitors of monoamine oxidase A (RIMAs) (e.g. Aurorix), tetracyclics (e.g. mianserin) and monoamine oxidase inhibitors (MAOIs) (e.g. phenelzine and tranylcypromine).

The tricyclics have been available for a number of years, are highly effective but have more side effects, are dangerous in terms of overdose and can be fatal because of their effects on the heart and propensity to reduce seizure threshold. Other side effects include: sexual dysfunction, weight gain, precipitation of mania, dry mouth, blurred vision, constipation and sedation (especially if mixed with depressant recreational drugs such as alcohol). However, they tend to be relatively quick acting compared to the newer antidepressants.

Compared to the tricyclics the SSRIs are newer, just as effective, have fewer side effects and minimal cardiac effects but often take between a week (e.g. Aropax and Zoloft) and a month (e.g. Prozac) to take effect. Side effects include nausea, diarrhoea, headache, tremor, agitation, sexual dysfunction (especially delayed ejaculation) and anxiety. A benzodiazepine might be prescribed to take at night in the first two weeks to improve sleep.

The MAOIs take about two weeks to work effectively but their use is limited because they can cause serious side effects and they have dangerous interactions with other drugs and some foods (e.g. matured cheeses, aged meat or liver products, soy products, products with banana flavour, vegemite and several other products containing brewer's yeast or beef extracts). Other common side effects include drug mouth, blurred vision, constipation, sexual dysfunction, arousal and insomnia or sedation.

The other types of antidepressants are used less frequently and also have side effects.

Table 4A.4 Antidepressant medications

Newer antidepressants		Traditional antidepressants	
Drug name	Brand name	Drug name	Brand name
citalapram	Cipramil	amitriptyline	Endep, Trptanol
fluoxetine	Prozac	clomipramine	Tryptine
fluvoxamine	Luvox	desipramine	Anafranil
moclobemide	Aurorix	dothiepin	Pertofran
nefazodone	Serzone	doxepin	Dothep, Prothiaden
paroxetine	Aropax	imipramine	Deptran, Sinequan
sertraline	Zoloft	mianserin	Melipramine, Tofranil
venlafaxine	Efexor	nortriptyline	Lerivon, Lumin, Tolvon
mirtazepine	Avanza	phenelzine	Allegron
		tranylcypromine	Nardil
		trimipramine	Parnate

Anti-anxiety medications

Benzodiazepines are used in the treatment of anxiety disorders, as sedative hypnotics and as adjuncts to antipsychotics in the treatment of agitated psychotic patients. They are also effective as anticonvulsants and muscle relaxants.

Unfortunately, tolerance to benzodiazepines is produced fairly quickly, benzodiazepines have reinforcing effects, leading to increased use, and dependency is not uncommon. Therefore these drugs are not recommended for long term use. However, stopping these drugs can cause withdrawal symptoms including anxiety which often leads to reinstatement of use. Withdrawal from high dose benzodiazepine use is very dangerous and should be done gradually under the supervision of a doctor.

Table 4A.5 Anti-anxiety medications

Anti-anxiety medication

Drug name	Brand name
chlordiazepoxide	Librium
diazepam	Valium, Ducene, Propam, Antenex
nitrazepam	Mogadon, Alodorm, Dormicum, Nitepam
oxazepam	Serepax, Benzotran, Murelax, Alepam
flunitrazepam	Rohypnol
temazepam	Euhypnos, Normison

For further resources on mental health medications go to:

- **Sane Australia:**
<http://www.sane.org/Information/Information/Factsheets.html>
- **DepressionNet:**
<http://depressionnet.com.au/>
- **Mental Health Council of Australia:**
<http://www.mhca.org.au>
- **Black Dog Institute (mood disorders):**
<http://www.blackdoginstitute.org.au/>
- **Beyond Blue (anxiety and depression):**
<http://www.beyondblue.org.au/>
- **Consumer versions of the Clinical Practice Guidelines from the Royal Australian and New Zealand College of Psychiatrists:**
<http://www.ranzcp.org/publicarea/cpg.asp#cc>

Comorbidity

This section focuses on information on the comorbidity between mental illness and substance use issues. It provides an overview of comorbidity in Australia including the differences in comorbidity presentations. It discusses the interactions between drug use and mental illness including the effects of the use of alcohol and other drugs on prescribed medications for mental illness.

Overview of comorbidity in Australia

Within this document the word comorbidity refers to a co-occurrence of mental disorder and substance use disorder. Comorbidity of mental disorders and substance use disorders is common in Australia. Studies have shown comorbidity rates to be between 20% and 75% of those examined in mental health care and similar rates have been found amongst AOD using populations. Marginally women experience more comorbidity than men. Anxiety and depression and the use of tobacco are mostly commonly connected to comorbidity.

Mental illness complicates substance disorders and visa versa. Those with more than one disorder report significantly higher levels of disability, distress and service utilisation and as the number of disorders increases so too does the level of disability. Compared to clients with one disorder comorbid clients:

- often experience more severe and chronic medical, social and emotional problems such as:
 - increased rates of hospitalisation with longer admissions, shorter remissions and higher rates of sectioning
 - increased rates of housing instability, homelessness and unemployment
 - increased rates of violence
 - increased rates of criminal behaviour and imprisonment
 - increased rates of non-compliance with treatment
 - poorer treatment access
 - poorer outcome in both psychiatric and AOD treatment
 - increased service use, especially acute care services.
 - increased rates of suicidal behaviour
- are more vulnerable than people with only one disorder to AOD relapse and a worsening of the psychiatric disorder
- often experience worsening of mental illness symptoms when experiencing AOD relapse
- often experience AOD relapse when psychiatric problems worsen
- require longer treatment and progress more gradually in treatment
- experience more crises.

Types of comorbidity

When comorbidity is discussed it is often separated into different types. These types aim to attribute which symptoms came first (i.e. primary) and thus caused (i.e. secondary) other symptoms. Thus, the types are often summarised as:

Primary substance use disorder with psychiatric consequences

This occurs when either use of or abstinence from a drug causes psychiatric problems

Primary psychiatric disorder with secondary substance misuse

This includes 'self medication' whereby the person with a psychiatric disorder misuses substances in an attempt to relieve distressing psychological symptoms

Dual primary disorders

This is having both a mental illness and a substance use disorder coexist, although they are not necessarily related to or caused by each other

Common aetiology

This means not necessarily having a diagnosable problem, but the person experiences symptoms from both problems, e.g.. someone who is mildly anxious using cannabis regularly to reduce the anxiety.

1. Primary and secondary disorders

The first two types of comorbidity attribute a direct causal relationship between substance use and mental illness. However, establishing primary diagnosis is difficult in that:

- AOD use can prompt the development, provoke the re-emergence or worsen the severity of psychiatric symptoms
- AOD use can mask psychiatric symptoms and disorders by hiding or changing the character of psychiatric symptoms
- AOD withdrawal can cause psychiatric symptoms and mimic psychiatric syndromes

It can take significant time for primary diagnosis to be clear – especially as several weeks may need to pass following cessation of substance use before symptoms relating to the substance use abate. There are debates that residual effects of drugs may continue for many months or even a year, especially if the substance/s had been used for a long time.

Table 5.1: urine screen: length of time urine remains positive after last use**Anti-anxiety medication**

Drug	Detection window after use
Cannabis	3 days-6 weeks
Heroin	2-3 days
Methadone	7-9 days
LSD	1 day
Stimulants	1-3 days

A careful and prolonged assessment needs to be carried out to indicate which symptoms occurred first. Although this sounds straightforward, not all clients can provide a clear history, may not be aware of certain symptoms occurring and if both psychiatric symptoms and substance use commenced at an early age it is often unclear which came first. A family history of mental illness should be considered due to the possibility of a genetic component of some mental disorders. Sometimes if the client has a history of multiple treatment failures in standard AOD or mental health services, this can indicate the possibility of comorbid problems. Needless to say, it is very important that quick diagnoses and decisions are not made if the situation is unclear.

The 'self-medication' hypothesis is reported frequently as an indication of primacy (i.e. a person with a mental illness self-medicates by using a substance to reduce mental illness symptoms). This is a simplistic idea that does not fully explain the chronic and destructive patterns of substance use that some people with mental illness develop and there is little evidence that specific drugs are used

to self-medicate specific mental illness symptoms. An alternative theory, the 'anxiety (or tension) reduction' theory attributes causality to people with anxiety difficulties using substances, particularly alcohol to reduce their fear or worrying. Although there is a high comorbidity between alcohol use and anxiety, causality is not clear. Individual genetic make-up and differences in symptomatology and substance use (i.e. amount, frequency, tolerance etc) make it very difficult for a consistent finding of causality in research.

Likewise, a common misconception is that cannabis use causes schizophrenia. This misconception has probably arisen due to the fact that schizophrenia tends to develop in late adolescence around the same time that cannabis use is peaking. However, as high numbers of people with schizophrenia also smoke tobacco, it would be just as incorrect to attribute development of schizophrenia to tobacco use. It is also notable that rates of schizophrenia have not increased while cannabis use has. Thus any connection between cannabis use and schizophrenia is likely to be a correlation rather than causal.

In conclusion, from a practical point of view, the issue of primary diagnosis isn't that important unless picked up at early stages of the disorders. By later stages the two diagnoses are enmeshed and mutually reinforcing.

2. Common aetiology

While there are often difficulties in attributing causality or primacy between mental illness and substance use, what is often more clear is that there are common risk factors in the development of both mental illness and substance use disorders.

The social and environmental risk factors that have often been related to comorbidity include:

- negative emotional states
- a lack of self-esteem and self-efficacy
- impaired social and coping skills
- neglect, emotional, physical and/or sexual abuse
- the absence of protective childhood factors such as a loving and supportive family environment
- the absence of positive life experiences such as success at school or in sport
- poverty and poor access to good education

Some studies have indicated that there are common physiological factors such as neurotransmitter function and genetic factors that might explain comorbidity. Other studies have found that individual factors such as temperament, especially those with high rates of neuroticism (anxious, worrying, depressed and moody) can be related to comorbidity.

It is important to note that there is increasing evidence to suggest that simple causal hypotheses for the development of comorbidity do not adequately explain the association between mental illness and substance use.

How drug use and mental illness affect each other

It is well known that clients with AOD disorders have an increased risk for mental disorders and clients with mental disorders have an increased risk for AOD disorders. This section highlights the association of particular mental illness symptoms associated with drug use and also provides an overview of the substance-induced mental disorders as defined in the DSM.

Depression

- Long-term use of stimulants depletes serotonin and dopamine neurotransmitters which can aggravate or create episodes of anhedonia (loss of interest or pleasure) and lethargy potentially leading to depression
- Sedative effects of cannabis and opioids can exacerbate and simulate the cognitive psychomotor features of depression
- Long-term use of cannabis can produce what is known as ‘amotivational syndrome’ – a loss of interest and involvement in normal activities and responsibilities which can mimic depression
- Benzodiazepines can reduce insomnia, but exacerbates lack of energy through disturbing deep sleep. Long-term use worsens depressive symptoms
- Depression may occur as a direct result of the pharmacological effects of alcohol as well as during withdrawal and post-withdrawal
- Different studies have found high rates (10-25%) of suicide attempts amongst individuals who are alcohol dependent.

Substance-induced mood disorder

In substance-induced mood disorder the disturbance in mood is related to the use of a substance, either during intoxication or withdrawal. Symptomatology may resemble that of a major depressive, manic, mixed or hypomanic episode.

This disorder may occur during intoxication of substances such as alcohol, amphetamine-type substances, hallucinogens, inhalants, opioids and benzodiazepines. It can also occur during withdrawal from alcohol, amphetamine-type substances and benzodiazepines.

Anxiety

- High numbers of clients who use amphetamine-type substances report symptoms such as anxiety, depression, paranoia, mental confusion and panic attacks during intoxication
- Cannabis and hallucinogens can cause anxiety in some people during intoxication, especially with higher doses
- Some people use cannabis, benzodiazepines, opiates and alcohol as self-medication for anxiety or tension
- Benzodiazepines, although an effective short term treatment for anxiety, in the longer term exacerbate the symptoms of anxiety disorder (known as the “rebound effect”)
- During intoxication stimulants usually make anxiety worse and during withdrawal are likely to cause a rebound effect.

Substance-induced anxiety disorder

In substance-induced anxiety disorder the anxiety symptoms are deemed to be due to the physiological effects of a substance, either during intoxication or withdrawal and are required to be in excess of those normally experienced during intoxication or withdrawal. Symptoms may resemble that of panic disorder, generalised anxiety disorder, social phobia, or obsessive-compulsive disorder.

This disorder can occur in association with intoxication with alcohol, amphetamine-type substances, caffeine, cannabis, hallucinogens, inhalants and withdrawal from alcohol, cocaine and benzodiazepines.

Psychosis

- Some research has found that cannabis can increase the frequency and intensity of psychosis and paranoia, shorten the period of time between psychotic episodes and increase the rate of hospitalisation. However, some research has also found that cannabis use has resulted in improving symptoms, with a lowering of anxiety, agitation and hospitalisation rates in those psychosis sufferers who continue to use cannabis, and are actively case-managed and medication compliant, when compared to cohorts who use other substances, or no substances at all. The general view is that cannabis is likely to exacerbate psychosis and may precipitate it in vulnerable individuals but does not cause it per se
- The current view is that there is no distinct ‘cannabis psychosis’ although panic attacks, paranoia, depersonalisation, derealisation, hallucinations and psychotic states have been reported with acute intoxication of cannabis
- Mental health symptoms reported with the use of alcohol include auditory hallucinations, often derogatory or command, fragments of conversation or music and there may be secondary delusions. These symptoms may be highly distressing and can result in violent suicide. The onset of such psychotic symptoms is rarely chronic although the reinstatement of drinking often results in the return of symptoms. However, some people with psychosis report that using alcohol makes their symptoms easier to deal with
- High doses of methamphetamine may lead to a temporary psychotic state that is clinically indistinguishable from paranoid schizophrenia except in that it remits within a few days

- Smoking related diseases are related to high levels of illness and death amongst people with schizophrenia for whom rates of cigarette smoking are very high
- Opiates increase sedation. This can be problematic when mixed with antipsychotic medication and could increase overdose risk
- Benzodiazepines reduce positive symptoms but exacerbate negative symptoms
- Generally for those with psychosis, any substance use increases the risk of a psychotic episode and suicide attempts (the general rate of suicide for people with schizophrenia is 15%, with substance use this rate increases to 30%)
- Newer research recommends no non-prescribed drug use for those with schizophrenia.

Substance-induced psychotic disorder

In substance-induced psychotic disorder the signs and symptoms of psychosis are diagnosed as being directly attributable to the consequence of drug use including medication or toxin exposure. In general, acute substance-induced psychotic symptoms tend to be positive symptoms. This disorder can be associated with drug intoxication of alcohol, amphetamine type substances, hallucinogens and opioids and withdrawal from sedatives including alcohol and benzodiazepines.

When amphetamine type substances or cannabis induce psychotic disorder persecutory delusions are common although cannabis induced psychotic disorder is rare. Psychotic disorder induced by amphetamine type substances can sometimes persist for weeks after withdrawal is complete which may make it difficult to distinguish from other psychotic disorders.

Personality disorders

- Substance use is very common for borderline personality disorder and antisocial personality disorder as a way of managing interpersonal difficulties
- Cannabis and opiates may be used within polydrug context to relieve distress
- Drug use generally, although especially alcohol use, exacerbates symptoms of personality disorders
- Alcohol causes disinhibition and leads to more acting out (e.g. violence or self harm)
- Use of stimulants may exacerbate impulsivity, may act as symptom control or improve recreation
- Benzodiazepines can reduce impulse control, disinhibition and increase violence
- People with both alcohol dependence and borderline personality disorder who live alone are at very high risk of suicidal behaviour.

Drug and medication interactions

This section provides some of the interactions between drugs and alcohol and prescribed medication. It is not exhaustive. It is also important to note that many recreational drug users are polydrug users and hence it is often hard to have clarity regarding potential drug interaction. Similarly, many drugs available, especially the amphetamine-type substances contain multiple substances, which again make drug interaction potential difficult to assess.

Depressants

The central nervous system (CNS) depressants include drugs such as alcohol, benzodiazepines and the opiates such as heroin. Antipsychotics are also depressants. Antidepressants however work by changing hormone levels in the brain and do not formally sit in the 'depressant' category.

- The tricyclic antidepressants are toxic when combined with the CNS depressants, especially alcohol, the MAOIs can also be problematic
- The antipsychotics and antidepressants lower the seizure threshold and thus increase the potential for seizures during alcohol and benzodiazepine withdrawal
- Alcohol intoxication and withdrawal disturbs the fluid electrolyte balance in the body. This can lead to lithium toxicity for those with bipolar disorder who are prescribed lithium carbonate
- Mixing the depressant drugs with antipsychotics, antidepressants and anti-anxiety medication can significantly increase the chance of overdose
- Benzodiazepines in particular have a long half-life, which means it stays in the person's body for a long time (sometimes up to 24 hours)
- Alcohol worsens the sedative effects of benzodiazepines and some antidepressants and can reduce the effects of prescription medications.

Stimulants

The CNS stimulants include drugs such as amphetamine-type substances, tobacco, caffeine and cocaine. MDMA also acts as a stimulant although it is often placed in a separate category of 'entactogens':

- The interaction between the stimulants and MAOI antidepressants can lead to a hypertensive crisis, potentially causing death
- The stimulants can inhibit the effects of some of the anti-depressants
- Stimulants can offset the effects of antipsychotic medications and thus increase sexual drive but precipitate acute psychosis in high doses
- Tobacco can reduce side effects of antipsychotic medication.
- Methylendioxyamphetamine (MDMA, 'Ecstasy') can adversely interact with antidepressant medication and may lead to too much serotonin. High levels of serotonin is linked with having hallucinations, mania and "serotonin syndrome" (hypertension, tachycardia, hyperthermia, nausea, muscle rigidity, tremor and ataxia).

Cannabinoids

The cannabinoids are made up of the drugs from the plant cannabis sativa, that is cannabis (marijuana, pot, grass), hash and hash oil. Although many clients experience cannabis as a depressant it also has hallucinogenic properties, especially in higher doses and sometimes some stimulant qualities:

- The interaction between cannabis and antipsychotics can increase the intensity and frequency of psychosis but can also reduce the side effects of antipsychotic medication
- Cannabis increases the sedative effects of benzodiazepines and tricyclic anti-depressants
- Cannabis can also cause symptoms of mania, confusion, depersonalisation (a feeling of unreality concerning oneself or the immediate environment) and psychosis when used with some of the newer antidepressants.

For resources on comorbidity for both health workers, clients and their families go to:

- *NSW Office of Drug and Alcohol Policy has various publications and resources on dual diagnosis: http://www.druginfo.nsw.gov.au/information_&_resources/dual_disorders*
- *Dual Diagnosis Australia and New Zealand <http://www.dualdiagnosis.org.au/> (go to fact sheets)*
- *MIDAS (Mental Illness with Problematic Drug or Alcohol Use) <http://www.swsahs.nsw.gov.au/areaser/midas/default.asp>*
- *Teesson, M. and Proudfoot, H. (Eds.) (2003). *Comorbid Mental Disorders and Substance Use Disorders: Epidemiology, Prevention and Treatment*. Commonwealth Department of Health and Ageing. <http://www.health.gov.au/pubhlth/publicat/mono.htm>*
- *National Drug Strategy: Feeling Good? Answering your Questions about Alcohol, Drugs and Mental Health <http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/feeling-good>*
- *National comorbidity initiative: a review of data collections relating to people with coexisting substance use and mental health disorders <http://www.aihw.gov.au/publications/index.cfm/title/10132>*
- *Sane Australia: <http://www.sane.org/Information/Information/Factsheets.html>*
- *Mental Health Association NSW: <http://www.mentalhealth.asn.au/resources/facts.htm>*
- *Mental Health Council of Australia: <http://www.mhca.org.au>*
- *DrugNet: <http://www.drugnet.bizland.com/Specialty/coexist/coexisting.htm>*
- *Evans, K. and Sullivan, J.M. (1990). *Dual Diagnosis: Counseling the Mentally Ill Substance User*. New York: Guildford Press.*
- *Australian General Practice Network provides resources to developed for their *Managing the Mix: Your mental health and alcohol program* <http://www.adgp.com.au/>*
- *Kathleen Sciacca's Dual Diagnosis website (American website) <http://users.erols.com/ksciacca/>*

Working with clients with mental health issues in an AOD setting

This section outlines the stages of treatment specific to working with clients affected by mental illness in an alcohol and other drug service. It covers the approaches and principles to the stages of engagement, enhancing motivation, active treatment and relapse prevention. There is also a resource section on screening tools that AOD practitioners can use with clients and a focus on particular interventions that can be used with clients with different mental illnesses and from different target groups.

Stages of treatment

Stage 1: Engagement

The first step to working effectively with all clients, especially those with mental health issues is to engage them in the process of treatment. The basis of engagement is building an effective therapeutic relationship. This is an ongoing process rather than something that develops in the first interaction with a client.

Sometimes people find it difficult to acknowledge their mental health problems. Hence many clients in AOD settings do not admit any mental illness symptoms to workers. Engagement therefore usually involves establishing what the client wants, what they understand as being the problem or issue to be addressed and to support the client to develop their own goals, rather than the goals of the worker. Sometimes engagement involves supporting clients to meet their basic needs such as housing, medical, nutritional or relationship needs. AOD workers are generally very skilled at engagement with their clients and the same processes and strategies often work with clients with mental health issues as those with AOD issues.

Coercion into treatment may interrupt the engagement process. For example, some clients have had a Protective (Guardianship) Order placed on them. State Guardians are appointed if a client is experiencing, or at risk of, exploitation due to their mental health condition. In these cases the State Guardian appointed to them is given the responsibility of controlling the client's funds and individual affairs. Likewise, mental health treatment is sometimes mandated through the Mental Health Act. Some of these instances involve hospitalisation so as to medicate and stabilise a client, in others the client may be placed under a Community Treatment Order (CTO) to ensure that they take, or are given, medication prescribed.

Some suggested methods to improve engagement include:

- Maintain the attitude that the client is a person of goodness, dignity and strength worthy of courtesy, respect, acceptance and time
- Maintain the belief that the client will benefit from the relationship even when the relationship takes time to develop and the importance of the relationship is not acknowledged by the client
- Improvement may be exceedingly slow and thus it is important to accept that the client is 'where they are at'
- Use people's names and make appropriate eye contact
- Do not use technical language or jargon
- Do not patronise or 'talk down' to clients
- If the client is angry, acknowledge the anger but do not take it personally
- If the client is acting seductively be aware of your boundaries and do not encourage or engage in reciprocal behaviour. Likewise, do not be rejecting, punishing or rude.
- If the client is being overly demanding outside of reasonable behaviour, state clearly what you can and can not do while being empathic to the client's feelings. Provide alternatives so the client has some sense of control (Treatment Protocol Project, 2004).

Due to the stigma associated with mental illness trust is a very important issue for most clients. Discussing confidentiality and its limitations are therefore very important. It is good practice to obtain consent from the client before sharing any information to family or other stakeholders. The client's confidentiality should only be overridden where there is a legal requirement.

Stage 2: Motivation

This stage is about building motivation and working towards change if the client is ready to do so. It often utilises both the stages of change model and motivational interviewing.

Stages of change

Although the stages of change model (Prochaska, DiClemente and Norcross, 1992) was originally developed for use within the AOD context it has more recently been utilised with clients with mental health issues and those with comorbidity. The following provides an adapted overview of the different stages of change along with the recommended treatment approaches.

Table 6.1 Stages of change and treatment approaches

Stage of change	Possible treatment approach
<p>Precontemplation:</p> <ul style="list-style-type: none"> • Those not concerned about what others may consider to be a 'problem' e.g. drug or mental health problem • Positives for not changing outweigh the negatives 	<ul style="list-style-type: none"> • Harm reduction strategies • Raise consciousness by increasing client's perception of risks • Provide information and feedback • Don't assume it's a problem
<p>Contemplation:</p> <ul style="list-style-type: none"> • Large proportion of people • Enjoy benefits of staying the same but are conscious of the increasing costs of doing so • Ambivalent about change • Can become 'resistant' if pushed into changing 	<ul style="list-style-type: none"> • Aim is to tip balance in favour of change • Elicit reasons for change and risks of not changing • Acknowledge positives of staying the same and perceived negatives of change • Avoid too much focus on 'Action'
<p>Determination/preparation:</p> <ul style="list-style-type: none"> • "Window of Opportunity" • Ripe for change • Costs outweigh benefits • Planning for change • Change is imminent BUT may not happen 	<ul style="list-style-type: none"> • Help client to determine best course of action • Match approach to client needs • Practical assistance • Support self-efficacy • Don't under-estimate ambivalence, i.e. the chance of the person not changing
<p>Action:</p> <ul style="list-style-type: none"> • Person is resolved to change and taking steps towards change • Trying out change 	<ul style="list-style-type: none"> • Assist with coping skills • Ongoing education and information • Possible 'loss and grief' issues for loss of lifestyle or comfort-zone • Relapse prevention strategies in case of future relapse
<p>Maintenance:</p> <ul style="list-style-type: none"> • Successful change for approximately six months • Possible ongoing attachment to previous behaviour and lifestyle 	<ul style="list-style-type: none"> • Ongoing relapse prevention strategies • Assist if person experiences slips or lapses • Support in trying new situations • Self-help groups
<p>Relapse:</p> <ul style="list-style-type: none"> • Can be lapse (mistake, slip) or full relapse (return to original behaviour) • Resolution breakdown 	<ul style="list-style-type: none"> • Distinguish between a lapse and relapse • Help to minimise harm from relapse • Assist client to renew resolution for change • Explore lessons learned

Generally assessment of clients based on the stages can be done by clarifying their readiness to change. Readiness can be summarised as:

- Precontemplative: I’m basically satisfied with my life at the moment and do not plan to change
- Contemplative: I’ve thought about changing but I don’t think I’ll be doing it in the next 30 days
- Determined: I think I will change sometime in the next 30 days
- Action: I am changing
- Maintenance: I changed 6 months or more ago

When working with co-morbid clients the stages of change need to be assessed for readiness to participate in treatment for both AOD use and mental health. For example, a client may be in determination stage for their alcohol use (i.e. planning what exactly to do to achieve abstinence from alcohol) while only contemplating addressing their issues of anxiety (i.e. considering telling their AOD worker about the degree to which their anxiety is linked with their alcohol use).

Using the stages of change in this way enables workers to develop interventions specifically for the individual client. It is client-centred in that it does not assume that clients are at the same stage of change for all of their issues.

Table 6.2: The motivation matrix

		Motivation regarding AOD treatment				
		Precontemplation	Contemplation	Determination	Action	Maintenance
Motivation regarding psychiatric treatment	Precontemplation					
	Contemplation					
	Determination					
	Action					
	Maintenance					

Motivational interviewing

Motivational interviewing is a therapeutic approach that is directive and client-focused. It involves presenting factual information in a non-judgemental way and inviting clients to give their views about this information. The worker takes the role of an active listener who reflects back the clients' responses. Motivational interviewing aims to help clients to explore and resolve the ambivalence they have towards engaging in treatment. It utilises clients' readiness to change.

There are five general principles to motivational interviewing:

1. Expressing empathy – reflective listening is essential to showing the client acceptance. As ambivalence about change is often high, empathy, not coercion is very important.
2. Developing discrepancy – discrepancy between continuing the present behaviour and important goals can motivate change. Thus the worker needs to help the client develop awareness of the consequences of their behaviour but allow the client to present arguments for change rather than instruct the client of them.
3. Avoiding arguments – arguing with the client is counterproductive as it breeds defensiveness and reduces rapport. Using confrontational methods with cause further defensiveness.
4. Rolling with resistance – client resistance is often an indication that the worker needs to change strategies. Working through resistance can highlight new perspectives or solutions.
5. Supporting self-efficacy – as the client is responsible for choosing and carrying out personal change, their belief in themselves can be a powerful motivator.

Motivational interviewing was originally developed by Miller and Rollnick for use with AOD clients and it is now being used with a variety of other clients, for example, those with comorbidity, mental illness, gambling problems, eating disorders and domestic violence. When applying motivational interviewing to clients with comorbidity may include:

- Writing down summaries of the key aspects of discussions to help clients who are unable to hold information for and against change in mind simultaneously
- Discussion of new alternative goals and activities may need to occur as many people with severe mental illness may not be able to carry out activities done before the illness developed
- Ensuring the client sets achievable goals, especially those that have been achieved in the past (i.e. supporting self-efficacy).

For more information on the stages of change and motivational interviewing:

- ***Miller, W. and Rollnick, S. (2002). **Motivational Interviewing: Preparing People to Change Addictive Behaviour.** New York: Guildford Press.***
- ***Motivational Interviewing website <http://www.motivationalinterviewing.org/>***
- ***DrugNet <http://www.drugnet.bizland.com/intervention/motivati.htm>***

Stage 3: Active treatment

After assessing the client's stage of change and carrying out motivational interviewing it will be clearer to both the client and the worker how ready the client is to address their AOD use and/or mental illness symptoms. From this point a treatment plan can be developed and strategies put in place to support the client. This stage is called active treatment and will vary depending on client readiness to change and individual difference.

Goal setting

At this stage goals are negotiated with the client and will vary depending on each individual. It is important that any goals decided upon are clear, measurable and realistic. Goals also need to be broken down into short-term targets to encourage clients' self-efficacy and sense of achievement.

Please note that setting quit dates for all clients can be very stressful unless the client is in determination stage. This is particularly relevant to many people with schizophrenia who can feel very intimidated by inflexible quit dates.

Education and awareness

Clients may need to be provided with information about what their diagnosis means and informed about what medication they are on (if medication is prescribed). Clients need to be empowered so that they can ask questions so that they become more involved in their care. It is also useful to provide education and awareness to the families and/or carers of clients as these people are often very helpful in identifying the early signs of decline in the client, whether it be mental illness or substance use problems.

Improving support networks

People with comorbidity frequently face problems with living conditions, employment, homelessness, housing instability and loss of social support systems. Individuals living in the community may need to be encouraged to get assistance from various community welfare organisations as well as to work on improving or maintaining their relationships with partners, friends and family.

For more information on types of active treatment please see:

- ***The sections in this resource on working with clients with mental health issues in an AOD setting and how mental health services work***
- ***Treatment Protocol Project (2004). Management of Mental Disorders. 4th ed. World Health Organisation Collaborating Centre for Evidence in Mental Health Policy. Sydney: WHO.***

Stage 4: Relapse prevention and management

Relapse needs to be anticipated for both substance use and mental illness as they are both known as 'chronic relapsing disorders'. For psychotic disorders especially, long-term observation is required to assess for the emergence of paranoia and other psychotic symptoms. Changes in daily routine, irritation with friends and rejection of help are all potential indications of a relapse.

Strategies for relapse prevention and management for mental illnesses are similar to those used within the AOD sector. For instance, it is important that both the worker and the client see lapses or relapses as opportunities to learn and develop more effective preventative strategies. Identifying high risk situations that cause vulnerability of relapse need to be planned for in that certain actions can be used to prevent or reduce the relapse.

Relapse prevention needs to be client-focused and can include several interventions such as cognitive-behavioural therapy, assertiveness training and relaxation techniques. If necessary it is also helpful to encourage the client to develop alternative activities and social supports such as voluntary or paid work, sport, hobbies, support groups etc

For more information on relapse prevention please see:

- ***The section in this resource on working with clients with mental health issues in an AOD setting***
- ***Treatment Protocol Project (2004). Management of Mental Disorders. 4th ed. World Health Organisation Collaborating Centre for Evidence in Mental Health Policy. Sydney: WHO.***

Screening tools

This section provides an overview of some tools that AOD workers can use to screen for mental illness symptoms in their clients. These screening tools are designed to highlight the existence of symptoms, not to diagnose clients with a mental illness.

Kessler Psychological Distress Scale (K10)

The K10 is widely recommended as a simple measure of psychological distress and as a measure of outcomes following treatment for common mental health disorders. The K10 is in the public domain and is promoted on the Clinical Research Unit for Anxiety and Depression website (<http://www.crufad.org>) as a self report measure to identify need for treatment.

The K10 uses a five value response option for each question – all of the time, most of the time, some of the time, a little of the time and none of the time which can be scored from five through to one. The maximum score is 50 indicating severe distress, the minimum score is 10 indicating no distress.

For all questions, please circle the answer most commonly related to you, then add up all your scores. The maximum score is 50 indicating severe distress, the minimum score is 10 indicating no distress. Questions 3 and 6 are not asked if the proceeding question was ‘none of the time’ in which case questions 3 and 6 would automatically receive a score of one.

Table 6.3: The K10 questionnaire

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:					

— Taken from Andrews and Slade (2001)

Modified CAGE

The CAGE questionnaire is a useful screening tool for alcohol abuse. It has been adapted for AOD professionals to screen for mental health problems but has not been evaluated.

Table 6.4: Modified CAGE questionnaire

In the past four weeks:	No	Yes
1. Have you ever tried to cut down or increased your alcohol or other drug use because you felt very depressed, anxious, elated or suspicious?		
2. Do you get more irritable, angry, depressed or annoyed when you are drinking or using other drugs?		
3. Do you drink or use drugs to help you deal with feelings of guilt or shame?		
4. Do you ever take a drink or drug "the day after the night before" to steady your nerves or because you're hung over?		
5. Does drinking or drug taking interfere with taking your prescribed medication?		
6. Do you take medications for reasons they were not intended for?		
7. Do drugs help you stop people knowing what you are thinking or from putting thoughts in your mind?		
8. Do you use alcohol or other drugs to help you cope with suicidal thoughts, paranoid feelings or voices which other people say they can't hear?		

— Adapted from MIDAS (n.d.)

Mental state examination

The Mental State Examination is designed to obtain information about specific aspects of the individual's mental experiences and behaviour at the time of interview. It is a useful tool for AOD workers to know about as it is one of the main tools mental health workers utilise to assess their clients. Therefore, if AOD workers write their client notes using the mental state examination format and make referrals to mental health services using this format, it may improve referral efficacy. The mental state examination thus allows for rapid communication between practitioners and can be used to follow a client's status over time.

Appearance and behaviour

Appearance: How does this 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
- Stigmata of drug or alcohol use – flushed, dilated/pinpoint pupils, track marks

Behaviour: How is the client behaving?

- Motor activity – immobile, pacing, restless, hyperventilating
- Abnormal movements – tremor, dyskinetic movements, abnormal gait
- Bizarre/odd/unpredictable actions
- Sleep – Has the client recently experienced disrupted, excessive or minimal sleep?

Behaviour: How is the client reacting to the current situation and examiner?

- Angry/hostile towards interviewer/others
- Uncooperative
- Over familiar/inappropriate/seductive
- Fearful, guarded, hyper vigilant

Speech

How is the client talking?

- Rate – rapid, uninterruptible, slow, mute
- Tone/volume – loud, angry, quiet, whispering
- Quality – clear, slurred
- Anything unusual about the client's speech

Mood and affect

Mood: How does the client describe their emotional state?

- Down/depressed
- Angry/irritable
- Anxious/fearful
- Highly/elevated

Affect: What do you observe about the person's emotional state?

- Depressed – flat, restricted, tearful, downcast
- Anxious – agitated, distressed, fearful
- Labile – rapidly changing
- Inappropriate – inconsistent with content (e.g. laughs when talking about mother's death or setting fire to the house)
- High/elevated – excessively happy or animated

Consistency between mood and affect:

Do the patient's emotions, posture, facial expression seem natural for their present situation?

Form and content of thought

This component is an assessment of the amount of thought and its rate of production. It includes whether the person's thoughts have a logical order of flow, e.g. do they lose their train of thought, as well as any disturbances in language such as the use of words that do not exist or conversations that do not make sense.

How does the client express himself/herself?

- Incoherence/illogical thinking (word salad: communication is disorganised and senseless and the main ideas can not be understood)
- Derailment (unrelated, unconnected or loosely connected ideas shift 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)
- Thought blocking (abrupt interruption to flow of thinking so that thoughts are completely absent for a few seconds or irretrievable)

What is the client thinking about?

- Bizarre/delusional thoughts
- Paranoid thoughts
- Depressive thoughts
- Anxious thoughts
- Suicidal thoughts
- Homicidal thoughts
- Pre-occupations, obsessions or overvalued ideas

Does the client believe that his/her thoughts are being broadcast out to others or that someone/thing is disrupting or inserting their own thoughts?

Perception

Is the client experiencing any misinterpretations of sensory stimuli?

Does the client report:

- Auditory, visual, olfactory or somatic hallucinations?
- Illusions?

Do you observe the client responding to unheard sounds/voices/unseen people/objects?

Cognition

Level of consciousness:

- Is the client alert, oriented, or in their attention or concentration?
- Is the client attentive during the interview (drowsy, stupor, distracted)?
- Does their attention fluctuate during the interview?
- Are they able to recall recent events (memory and simple tasks e.g. Calculation)?
- Is the client's concentration impaired?
- Are they able to make judgments about their situation?
- Does the client present as confused?

Memory:

- Can the client remember why they are with you? (immediate)
- Can the client remember what they had for breakfast? (recent)\
- Can the client remember what they were doing around this time last year/last decade? (remote)

Orientation:

- Does the client know who they are?
- Does the client know who you are?
- Does the client know where they are?
- Does the client know why they are with you now?

Insight

- How aware is the client of what others consider to be their current difficulty?
- Is the client aware that of any symptoms that appear weird/bizarre or strange?

An example: notes from a consultation with a client with schizophrenia

Joe presented to the session looking dishevelled and unkempt with poor personal hygiene (dirt under fingernails and on face, smelling of old sweat). He was dressed with two pairs of shorts, three layers of bright tee-shirts, a tie, a beret, odd socks and shoes.

Throughout the interview Joe appeared to be agitated. After brief eye contact he continually returned his gaze to a spot in the corner of the room and three times suddenly turned his head to this spot gesturing to be quiet (finger up to lips, eye contact at spot). At these times Joe's agitation appeared to increase.

Joe frequently changed the topic and seemed to have difficulty following what the counsellor said. At times he gave excessive detail to small questions ("what did you have for breakfast") while at other times sentence structure did not make sense ("can't you see the... isn't it a funny...red is a lovely colour...how are your kneecaps?") Joe seemed to be unaware that his behaviour was unusual.

Joe was able to correctly identify himself, the counsellor and the centre but was unaware that it was 9am or a Tuesday morning (he thought it was 11pm of Sunday).

There are a number of other tools that can be used for screening mental illness although many of them are copyrighted and therefore can not be reproduced in this publication. For more information on assessment and screening:

- *Kavanagh, D.J., Mueser, K.T. and Baker, A. (2003). Management of comorbidity. In Teesson, M. and Proudfoot, H. (Eds.), Comorbid Mental Disorders and Substance Use Disorders: Epidemiology, Prevention and Treatment. Commonwealth Department of Health and Ageing. <http://www.health.gov.au/pubhlth/publicat/mono.htm>*
- *Dawe, S. and Mattick, R.P. (1997). Review of Diagnostic Screening Instruments for Alcohol and Other Drug Use and Other Psychiatric Disorders. Canberra: Commonwealth Department of Health and Ageing. <http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/alc-diagrev>*
- *Lovibond, S.H. & Lovibond, P.F. (1995). Manual for the Depression Anxiety Stress Scales. (2nd. Ed.) Sydney: Psychology Foundation. <http://www.psy.unsw.edu.au/Groups/Dass/>*
- *Treatment Protocol Project (2004). Management of Mental Disorders. 4th ed. World Health Organisation Collaborating Centre for Evidence in Mental Health Policy. Sydney: WHO.*
- *Goldberg, D. and Williams, P. (1988). A User's Guide to the General Health Questionnaire. Windsor: NFER-NELSON Publishing Company*

Working with clients with commonly occurring mental illness symptoms

This section looks at the common types of mental illness occurring in clients who present to alcohol and other drug services. It provides a general guide to strategies that can be used when working with depression, anxiety, personality disorders, psychotic clients, clients at risk of suicide and aggressive clients. AOD workers should seek further training in the specific interventions and support from their employer before putting these into practice.

Anxious and/or depressed clients

Anxiety disorders are the most common form of mental illness amongst clients who present to AOD services. As described in section on Classifications of Mental Illness clients with anxiety often find it hard to relax, concentrate or sleep. They may experience tension and muscle pain, hyperventilation, indigestion and headaches. Anxiety and depression often co-occur. For example, in some clients, because their anxiety has been untreated, their distress and feeling of powerlessness over their anxiety has led to a depressive illness. Anxiety and depression commonly co-occur with the use of alcohol, cannabis, psychostimulants, opioids and the benzodiazepines.

There are several interventions that alcohol and other drug workers can use with clients to address their symptoms of anxiety and depression. These include: providing education, teaching relaxation techniques, discussing hyperventilation and sleeping patterns as well as carrying out some cognitive-behavioural strategies. For more information about these interventions please see the 'For more information' box at the end of this chapter.

Education

For both anxiety and depression the first intervention that workers should carry out is to provide information to clients about the nature of the disorders and their symptoms. This knowledge can give clients greater control over their disorders and reduce feelings of helplessness. A range of fact sheets and brochures have been listed at the end of this section that can aid in the delivery of this intervention.

For clients experiencing severe anxiety, especially panic attacks, an explanation of the symptoms of the fight-or-flight response can be especially enlightening. It is important to explain that anxiety is a normal reaction to danger but can become a problem when no real danger exists or the reaction is excessive. Anxiety creates a series of changes in the body making it prepare to 'fight' or flee ('flight') from whatever danger is occurring. It is also important to emphasise that this response is useful in the short term, especially when in real danger, however it is of no use in the long term and is of little use in most stressful situations.

For clients with depression it can be important to emphasise that depression is an illness, not a character flaw or sign of weakness and that recovery is the rule, not the exception. Clients should be aware that treatment is effective, and there are many options available, but that the rate of recurrence is quite high.

Relaxation techniques

Clients can work to prevent anxiety by reducing the stressful nature of their life experiences. This can be achieved through relaxation and there are a variety of useful techniques that can be practised regularly.

1. **Calming response:** The calming response is a quick coping skill developed by Montgomery and Morris (2000). It is helpful when strong feelings rise up quickly and is most effective if used as soon as uncomfortable feelings arise. It is best practiced regularly, a couple of minutes each day. The steps are for clients to mentally detach from the situation and smile inwardly yourself. They then think “clear head, calm body” and take in one slow, deep breath. As they breathe out they relax.
2. **Abdominal breathing:** Breathing reflects the level of tension in our bodies. Under tension, breathing becomes shallow and rapid, high in the chest sometimes causing hyperventilation. When relaxed we breathe more fully, deeply and from the abdomen. Encouraging clients to practise abdominal breathing exercises can lead to deep relaxation and reduce the symptoms of anxiety.
3. **Progressive Muscle Relaxation:** Progressive muscle relaxation involves tensing and relaxing, in succession, the different muscle groups of the body. Although it is easier to do this exercise when lying down it can be adapted to sitting up. It needs to be practised for 20 minutes a day, although twice a day is better. It is good to do this at the same time each day and on an empty stomach. The idea of this exercise is to tense each muscle group separately working from the hands, through to the neck and then down to the feet.

Tensing needs to be hard without straining for 7-10 seconds concluded by suddenly letting go or relaxing. After tensing each muscle it is important to take a 15-20 second break to notice how the muscle group feels when relaxed. If one group of muscles is not sufficiently relaxed, they should be tensed a second time after a twenty second break. All other muscles should be relaxed while working on a particular muscle group.

4. **Reducing Hyperventilation:** When people become anxious they set off an emergency or alarm reaction which may lead to an increase in the speed and decrease in the depth of breathing called ‘hyperventilation’. When people hyperventilate they get rid of too much carbon dioxide. This worsens the light-headedness and breathlessness and may lead to choking or a sense of smothering, blurred vision, tingling sensations or numbness in the hands, arms or feet and cold, clammy hands. As over breathing is hard physical work it can lead to clients being tired and feeling hot, flushed and sweaty.

In many cases hyperventilation can be very subtle, especially if the individual has been slightly over-breathing for a long period of time. Mild hyperventilation can cause an individual to remain in a state of perpetual apprehension and anxiety. It is important to accurately identify what the problem is rather than become stuck on dealing with the symptoms. For many clients worry and anxiety are due to an inability to solve their problems.

Improving sleep

Many people with anxiety and/or depression experience sleeping problems. Clients may experience difficulty getting to sleep or staying asleep, may sleep for too long, have abrupt awakening or sleep walk. Assisting clients to develop regular sleep patterns and to address insomnia are important strategies to help manage depression and anxiety. These include not taking naps during the day, maintaining regular sleep hours and avoiding using the bed for other activities, for example watching TV.

Cognitive restructuring strategies

One of the major strategies used with people with anxiety and depression is cognitive behavioural treatment (CBT). CBT is based on the premise that what causes our feelings is not the situation itself, but how we interpret and think about the situation. The idea behind CBT is that negative thoughts are identified and challenged so clients are better able to develop a sense of control and bounce back from difficulties. A typical CBT approach has the following elements:

1. Identifying triggers: Careful assessment identifying what triggers unhelpful thinking or interpretations of the situation.
2. Become aware of unhelpful thinking patterns: Connected to the person's triggers are their negative thinking patterns or self-talk. Self-talk is an internal monologue that is often automatic and subtle and anticipates the worst before it happens. This can manifest as catastrophising, overgeneralisation, unrealistic expectations, mind reading and labelling. Clinicians work closely with clients to identify negative thinking patterns and how these thinking patterns cause problems in their lives.
3. Thought stopping: Once clients have identified when they use negative self-talk they are encouraged to use thought stopping. This consists of mentally saying "Stop, slow down!" and taking time out to analyse what is going on in the situation. Some people picture a stop sign or traffic lights as they do this.
4. Challenging thoughts: Clients are then encouraged to talk back to their negative thinking. They are given techniques to challenge their way of thinking including looking at their thoughts more objectively and realistically.
5. Replacing negative thoughts: Clients are assisted to replace negative thoughts with more helpful thoughts.
6. Behavioural Modification: Behaviour modification aims to identify and change aspects of behaviour that cause or exacerbate anxiety or depression. This is often done by exposing clients to the thing they fear or teaching them new strategies to deal with their thoughts and feelings. All behaviour modification techniques need to be practised regularly and require significant time and effort to master depending on the degree of reaction the client experiences. For clients with significant phobic reactions it is advised that a referral to a specialist health professional or Psychologist is made. There is also some evidence that if alcohol use continues during behaviour modification treatment, the use of alcohol retards the treatment process. Different styles of behaviour modification include:

- a. Exposure to the symptoms of panic: This technique involves doing activities to bring on some of the symptoms of anxiety and panic and then to use relaxation and breathing to bring the symptoms under control. This can teach the client that panic attacks are not a serious threat to their physical or mental well-being.
- b. Visualisation/imagery desensitisation: This technique involves imagining the feared thing or situation so that the client becomes desensitised to it.
- c. Graded real-life exposure: This technique involves real-life exposure to the feared thing or situation so that the client becomes desensitised to it.
- d. Activity scheduling: People with depression often become inactive because they tire easily and lack motivation. Encouraging clients to increase their level of activity improves their sense of control over their lives, acts as a distraction from their thoughts and problems, reduces tiredness, motivates further activity and improves thought processes. Despite the benefits of activity it is often difficult for people with depression to become more active due to their negative thinking.
- e. Structured Problem Solving: Some clients with anxiety and/or depression feel this way because they are unable to deal with their problems. Teaching them problem solving techniques can help change their behaviour and therefore reduce their anxious or depressed symptoms. An example includes the seven step process which walks clients through identifying the problem and brainstorming solutions:
 - Identify the problem: Write down exactly what the client believes the main problem to be. Try to break a big problem into smaller pieces to help define the problem better.
 - Write down all possible solutions, including any solutions that are unrealistic or impossible.
 - Think about each solution in practical terms: Delete any obviously impractical strategies and discuss the pros and cons of each option including the short and long-term consequences of each.
 - Encourage the client to choose the most practical solution after weighing up all the factors. Pick the second best option as a 'fall back' option.
 - Plan how to will carry that solution out. Plan exactly how, where, when, and with whom to will implement the solution.
 - Put the solution into action
 - Evaluate the results. Think about whether the selected option resolved the problem totally or only in part. If it was unsuccessful, try the second option or return to the brainstorming process.

For more information on depression and anxiety and their interventions:

- **NSW Health:** <http://www.health.nsw.gov.au/living/mental.html>
- **MoodGym: A CBT self-help training program for depression** <http://moodgym.anu.edu.au/>
- **NSW Health:** <http://www.health.nsw.gov.au/pubs/>
- **Sane Australia:** <http://www.sane.org/Information/Information/Factsheets.html>
- **Mental Health Association NSW:** <http://www.mentalhealth.asn.au/resources/facts.htm>
- **Australian Department of Health and Ageing:** <http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/mental-pubs>
- **DepressionNet:** <http://depressionnet.com.au/>
- **Mental Health Council of Australia:** <http://www.mhca.org.au>
- **Black Dog Institute (mood disorders)** <http://www.blackdoginstitute.org.au/>
- **Lifeline's Just Ask: Rural Mental Health Information Service** <http://www.justask.org.au/>
- **Beyond Blue (anxiety and depression)** <http://www.beyondblue.org.au/>
- **Clinical Research Unit for Anxiety and Depression (St Vincent's Hospital and University of NSW) provides resources for clinicians and clients on anxiety and depression** <http://www.crufad.com>
- **Consumer versions of the Clinical Practice Guidelines from the Royal Australian and New Zealand College of Psychiatrists** <http://www.ranzcp.org/publicarea/cpg.asp#cc>
- **MentalHelp.Net (an American site):** <http://mentalhelp.net/>
- **Treatment Protocol Project (2004)** provides various handouts to provide information and interventions about anxiety and depression
- **Useful books include:**
 - Greenberger, D. and Padesky, C.A. (1995). *Mind over Mood*. Guildford Press <http://www.mindovermood.com/> (there is also a clinician's guide for the book)
 - Bourne, E. J. (2000). *The Anxiety and Phobia Workbook*. Oakland: New Harbinger Publications
 - Morawetz, D. (1994). *Sleep Better ...without Drugs!* <http://www.sleepbetter.com.au/>
 - Aisbett, B. (1993). *Living with It: A Survivor's Guide to Panic Attacks*. Harper Collins Publishers
 - Aisbett, B. (2000). *Taming the Black Dog: A Guide to Overcoming Depression*. Harper Collins Publishers
 - Tanner, S. and Ball, J. (1991). *Beating the Blues*. Doublebay.

Psychotic clients

The disorders involving psychosis include schizophrenia, schizo-affective disorder, bipolar disorder, drug-induced psychosis and to some extent borderline personality disorder (please see the section on Classification of Mental Illness for more information). Drug or alcohol using clients with psychotic symptoms are considered to have special needs due to the severity of their symptoms, distorted thinking and general disorganisation both psychologically and socially. People with psychosis tend to use a variety of substances; however cannabis and alcohol are the most commonly used. Psychosis can also be drug-induced, although usually this is an acute or short term symptomatology (see the comorbidity section for more information).

There are several interventions that alcohol and other drug workers can use with clients to address their psychotic symptoms. These include: managing an acute psychotic episode, supporting the client after an acute episode and providing ongoing care. For more information about these interventions please see the 'For more information' box at the end of this chapter.

Management of an acute episode

During an acute episode of psychosis, for example during the active stage of schizophrenia, a person's behaviour is likely to be disruptive. It is important to ask questions of the client to clarify and understand the severity and degree of their symptoms such as their experience of delusions and hallucinations.

If a client is persistently talking in a confused way it is important not to encourage this by listening nor arguing about any delusional statements. It may be necessary to point out to the client that what they are experiencing doesn't make sense to you or to change the topic. If however the person seems to be trying to express a feeling or talks strangely when upset it can be helpful to show understanding of the feeling by asking for more details about what has upset them.

As psychotic clients may experience thought disturbance it is important to speak clearly and remain calm. Ask only one question at a time waiting for an answer for each question before going onto the next one. Similarly, if giving instructions, only give one set of directions at a time. When asking someone to do something it is best not to give choices and to be clear and direct.

Like most people, people with schizophrenia often respond negatively to being criticised. However, there may be times that it is important to give a psychotic client feedback regarding their behaviour, especially in relation to the effect of their behaviour on other people's (including workers') feelings.

There are several dos and don'ts about interacting with someone with psychosis, such as:

- Do point out the consequences/effects of the other person's behaviour. Be specific (e.g. when you do the shopping it gives me more time to prepare meals)
- Don't be vague (e.g. it's fantastic when you go shopping)
- Do try to express your feelings. It is best to do this when not upset, angry or overwhelmed
- Don't wait too long before expressing your feelings. Otherwise you might say things out of anger or another emotion
- Do distract the person if you can. You could offer them something to look at or involve them in doing something.
- Don't try to figure out what the person is talking to or about
- Don't laugh (or let others laugh) at the person
- Don't act horrified or panic
- Do ignore strange or embarrassing behaviour if you can, especially if it's not serious

Maximising safety

During an acute episode of schizophrenia it is important that workers assess the safety of the client and others. It may be necessary to carry out a suicide assessment as unfortunately suicide rates amongst people with schizophrenia are relatively high. Risk of harm to others also needs to be assessed as acutely psychotic people can be paranoid, believing that others (including organisations or bureaucracies) are persecuting them. This can lead to homicidal thoughts, especially if the person experiences commanding hallucinatory voices. If the individual is responsible for caring for others, such as children, he or she may inadvertently cause them harm through neglect of physical or emotional needs.

Organising treatment and support

Sometimes the person may be aware that he or she is unwell and will voluntarily seek help, others may lack insight into their symptoms and refuse help. Active phase schizophrenia requires medication and hence the mental health service need to be accessed. If the person is at all at risk to themselves or others the mental health service must be advised, whether the client wants such a referral to be made or not.

During an active episode social stressors may develop or existing stressors may worsen. Social stressors may include accommodation, taking leave from work, finances, legal problems, child care or lack of support from family, friends or others. Providing support and practical assistance with these difficulties is especially important. During this stage the person's family and carers will need to be provided with reassurance and support. They may need to be provided with some education and information on how to deal with the person during active phase schizophrenia.

After an acute episode

After a person has had an acute episode of psychosis they often feel confused, distressed, afraid and lack confidence. These feelings can last for quite some time after an episode. This is because they have been through a period where they have lost control of their thoughts and feelings, they may have had frightening ideas that someone is persecuting or talking to or about them. This is often quite a shock to the system and the person will need some rest and time to recuperate. After leaving hospital a person with schizophrenia will often need to:

- Sleep long hours every night, often for 6 – 12 months after the episode
- Be quiet and alone more often than other people
- Be inactive and not feel that they can do very much.

It is best therefore to expect this period of recovery. Individuals and families will need some time to adjust after an episode.

Ongoing care

Ongoing care needs to include:

- Psychosocial rehabilitation using targeting interventions such as vocational issues and living skills
- Development of strategies to deal with residual symptoms and developing adaptive coping
- Addressing any physical health issues
- Development of medium to longer term goals
- Interventions with the family and carers
- Coordination of care through the use of a case management model
- Planning for relapse/acute episodes
- The formation of social support and networks to reduce social isolation, e.g. consumer/support/self-help groups.

The prevention interventions listed within the anxiety and depression section may also be of use to clients with psychosis within the residual phases. Obviously, use of these interventions during active phase will not be helpful.

For resources on the psychotic disorders for both health workers, clients and their families go to:

- **NSW Health:** <http://www.health.nsw.gov.au/living/mental.html>
- **Sane Australia:** <http://www.sane.org/Information/Information/Factsheets.html>
- **Mental Health Association NSW:** <http://www.mentalhealth.asn.au/resources/facts.htm>
- **Australian Department of Health and Ageing:** <http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/mental-pubs>
- **Schizophrenia Fellowship of NSW:** <http://www.sfnsw.org.au/>
- **Mental Health Council of Australia:** <http://www.mhca.org.au>
- **Consumer versions of the Clinical Practice Guidelines from the Royal Australian and New Zealand College of Psychiatrists** <http://www.ranzcp.org/publicarea/cpg.asp#cc>
- **MentalHelp.Net (an American site):** <http://mentalhelp.net/>
- **Treatment Protocol Project (2004) provides various handouts to provide information on and interventions for schizophrenia.**

People with personality disorders

Clients with personality disorders present relatively frequently to alcohol and other drug services, particularly those with antisocial, borderline, histrionic, narcissitic, dependent and obsessive-compulsive personality disorders. Symptoms displayed by these clients include inappropriate and intense anger, difficulty regulating emotions, impulsive behaviour and poor social skills (please see the section on Classification of Mental Illness for more details). Clients with personality disorders are most likely to present with interpersonal problems that result from their habitual patterns of interacting with others. It is quite common for people with these disorders to use alcohol and other drugs and many tend to be poly-drug users.

Diagnosis of clients with personality disorders is difficult and since intense resistance to change and chronic inability to accept responsibility are typical symptoms of the personality disorders treatment is also difficult, usually long-term and has varying effectiveness. Thus 'treatment' of personality disorders is not usually within the scope of alcohol and other drug workers without more specialised training such as in Dialectical Behaviour Therapy (DBT, a relatively new treatment for borderline personality disorder).

Generally some of the interventions to utilise with clients with personality disorders include:

- Develop a therapeutic relationship with clear boundaries and a limit setting approach
- Listen to and evaluate the client's concerns
- Accept but do not confirm the client's beliefs
- Do not reward inappropriate behaviour (such as demanding, aggressive, suicidal, chaotic or seductive behaviour)
- Plan clear and mutual goals while maintaining clear limits
- Explain everything clearly and concretely to the client
- Take careful notes
- Establish a team approach
- Help with the 'here and now' problems the client presents with rather than trying to establish causes or exploring past problems
- Unless the client has a high level of self-awareness avoid referral into group programs unless the programs are specifically designed for clients with personality disorders (such as DBT groups)
- Address any worker personal reactions to the client (including frustration, anger, dislike, attraction or enmeshment) by organising clinical supervision.

Other sections of this resource are appropriate to be used with clients with personality disorders. As these clients often experience significant anxiety and depression, the interventions listed within the 'Working with anxious and/or depressed clients' section might be useful. Some personality disordered clients, especially those with borderline personality disorder, have high rates of suicidal behaviour thus the 'Working with suicidal clients' may be useful. Some clients with borderline and schizotypal personality disorder display psychotic symptoms where the interventions listed in the section on 'Working with psychotic clients' may be relevant. Unfortunately, clients with personality disorders, especially those with cluster B symptoms have an increased potential of aggressive behaviour, hence the 'Working with aggressive clients' interventions may be of use.

For resources on the Personality Disorders for both health workers, clients and their families go to:

- ***Sane Australia: <http://www.sane.org/Information/Information/Factsheets.html>***
- ***Mental Health Association NSW: <http://www.mentalhealth.asn.au/resources/facts.htm>***
- ***Borderline personality disorder Information and Support <http://www.bpdcentral.com/>***
- ***Marsha Linehan's website on Dialectic Behaviour Therapy for borderline personality disorder <http://faculty.washington.edu/linehan/index2.html>***
- ***MentalHelp.Net (an American site): <http://mentalhelp.net/>***
- ***Treatment Protocol Project (2004) provides information on the personality disorders.***

Suicidal clients

In 2000 the Centre for Mental Health produced a suicide data report for NSW. The report highlighted that on average more than 700 people suicide in NSW annually and the majority of these have a mental illness. The majority of suicide victims are men and the rates for young and rural men are increasing. For males the predominant method of suicide is hanging, for females it is overdose. It is important to note that for every person who commits suicide, 30 to 40 make an attempt. Admissions to hospital for intentional self-injury are about 10 times as common as completed suicides (National Media and Mental Health Group, 2004).

Recent research from the National Drug and Alcohol Research Centre (NDARC) has shown that about 10% of deaths of dependent drug users are through suicide. Contrary to popular belief the methods of suicide is typically not through the drug of choice.

Assessing suicide

In 2004 NSW Health produced a Framework for Suicide Risk Assessment and Management. This framework states that clients of NSW Health with possible suicidal behaviour must receive preliminary suicide risk assessment and where possible a more thorough mental health assessment. The framework has the following key elements:

1. Establish rapport and maximise engagement as much as possible. Remember that suicidal acts are attempts at solving problems in the person's life
2. Suicide screening: Carry out a brief psychiatric assessment that may include a mental state examination. Screening questions may include:
 - Have things been so bad lately that you have thought you would rather not be here?
 - Have you had any thoughts of harming yourself?
 - Are you thinking of suicide?
 - Have you ever tried to harm yourself?
 - Have you made any current plans?
 - Do you have access to firearms or any other lethal means?
3. Immediate management. A client who seems to be of high risk should not be left alone. Those with a suicide risk need to be referred to a specialist service provider for a more comprehensive assessment as suicidal behaviours are often symptoms of underlying mental health problems.
4. Assess the client's risk and protective factors through carrying out a comprehensive suicide assessment.
5. Assign the client to one of four categories of risk and provide appropriate interventions:

- High risk: the clinician must ensure that the client is in an appropriately safe and secure environment and organises a re-assessment within the next 24 hours while also developing a contingency plan for rapid re-assessment if the client's distress escalates. Note: if suicide risk is identified in an intoxicated person they need to be given a high risk until sober
- Medium risk (significant but moderate risk of suicide): the clinician organises a re-assessment within the next week while also developing a contingency plan for rapid re-assessment if the client's distress escalates
- Low risk (definite but low suicide risk): the clinician organises review of the client at least monthly and provides the client with written information on suitable 24-hour access to clinical care
- No (foreseeable) risk indicates that the person has no thoughts of suicide or a history of attempts and has good social networks, thus interventions are not required.

Dos and don'ts

Do:

- ensure the client has no immediate means of self-harm; remove weapons and potentially dangerous objects.
- listen to and validate the person's feelings
- point out that there is help available
- validate the person's feelings and that he/she has spoken with you
- contact the local mental health crisis team if suicidal ideas persist
- try to find a way to help the person's feeling of isolation (if that is a predominant issue)
- consider what stresses can be removed which might be triggering the person's depression

Don't:

- use platitudes or 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. Many people have these feelings and it is a positive thing for them to talk about them
- be afraid of asking about suicidal ideation where risk of self-harm is suspected.

For resources on working with suicidal people go to:

- ***NSW Health: <http://www.health.nsw.gov.au/pubs> to download **Suicide Risk Assessment and Management Protocols for NSW Health Staff*****
- ***Sane Australia: <http://www.sane.org/Information/Information/Factsheets.html>***
- ***Suicide Prevention Australia <http://www.suicidepreventionaust.org/>***
- ***Living Works in Australia <http://www.livingworks.org.au/>***
- ***Borderline personality disorder resources <http://www.bpdresources.com/>***
- ***Mental Health Association NSW: <http://www.mentalhealth.asn.au/resources/facts.htm>***
- ***Australian Department of Health and Ageing: <http://www.health.gov.au/internet/wcms/Publishing.nsf/Content/mental-pubs>***

Aggressive clients

One of the reasons that there is stigma associated with mental illness is that there is a commonly held belief that people with mental disorders are dangerous and aggressive. In general this is a myth, psychiatric diagnosis is a poor predictor of violence. However, people with schizophrenia are about two to five times more likely to commit acts of violence than the rest of the population, which is the same rate as that for young men in general (Davies, 2000).

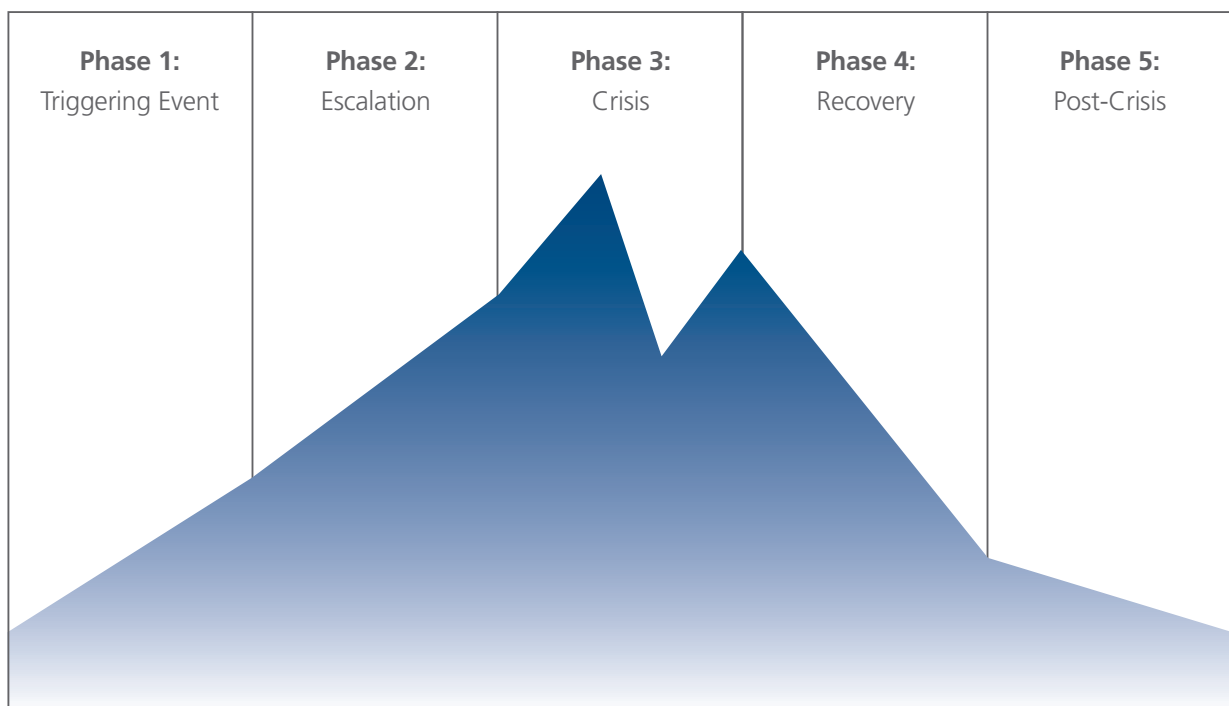
Signs of potential violence include:

- Physical appearance: being intoxicated; bizarre, bloodstained, dishevelled or dirty appearance; carrying anything that could be a potential weapon

- Activity levels and posture: pacing, restlessness, agitation, inability to sit still; clenching of jaw or fists; difficulty controlling actions; hostile facial expressions with sustained eye contact; standing up frequently and entering 'off-limit' areas uninvited
- Mood: angry, irritable, short-tempered, anxious, tense, distressed, not in control of emotions
- Speech: loud; slurred; speech content is sarcastic, swearing or threatening
- Worker's reaction: fear, anger, anxiety, frustration, uneasiness or avoidance.

When dealing with aggressive clients, knowledge of the assault cycle can help to explain what happens during a crisis and in what ways to intervene:

Table 6A.1: Phases of aggression



Phase 1 is when there is a triggering event of some sort. This can be any event that the individual perceives as an immediate threat to them. Some interventions that may prevent violence may include:

- Inform the client of anticipated delays
- Avoid excess stimulation
- Maintain minimal eye contact (direct eye contact is confronting)
- Allow the client to have adequate personal space (up to 6 metres)
- Keep your hands visible and maintain an open body posture
- Do not stand if the client is sitting
- Use general counselling skills such as trying to see the client's point of view, maintain respect, allow the client to talk
- Set clear limits

Phase 2 is the escalation phase. The individual displays increasing signs of distress or conflict. Unless this phase is recognised, acknowledged and addressed the result could be an aggressive act. Common signs include pacing, fidgeting, dilated pupils, tense appearance, abusive and derogatory remarks and clenched fists. It is important during this stage to use communication using the LASSIE model to deescalate the situation:

- L** Listen actively: allow the person to run out of steam before you talk
- A** Acknowledge the problem/situation, validate the feelings
- 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 choices to alleviate the situation
- E** Encourage to try options: assist the person to follow through

To help reduce escalation the following may also be of use:

- Try to maintain a quiet, non stimulating environment for the client (excessive noise or people may contribute to aggression)
- The presence of a familiar person may help to calm and reassure the client
- A client's previous negative experience or their experience of being coerced into presenting for treatment may contribute to aggressive behaviour
- Be warm, friendly and non-judgmental
- Provide a safe environment for the client, yourself and others
- Take notice and care of your feelings, know your limitations and refer if necessary
- Offer reassurance and information
- Anticipate problems, but respond to how the person is
- Stay focused on the present
- Carefully monitor the physical and psychological condition of the client
- If the client's behaviour escalates, withdraw and seek assistance immediately
- Remember not all aggressive behaviour is associated with mental illness.

Phase 3 is the crisis phase, in many senses the fight or flight stage of anxiety. At this stage the client reacts with impulsive physical aggression at the perceived threat, property or self-harm. It is best for workers to remove themselves and any clients during this stage unless the service has other policies on evasive self-defence and/or restraint.

Phase 4 is the recovery phase. The client appears to relax and tension reduces. If this phase is not dealt with in a supportive manner it is likely that phase 3 re-occurs at an even higher level of escalation. It is best to be supportive and empathic to the client at this stage, but generally give them some space. It is important that workers be given the opportunity to debrief. Any violence should be documented in the client's file.

Phase 5 is the post-crisis depression stage. At this point the client's body becomes exhausted following the escalation and crisis phases and the client appears to be fatigued. The client may also feel a sense of depression and guilt having lost control of themselves. Support may be required from workers during this stage.

Adapted from SCMHS (2004)

General Dos and Don'ts when working with aggressive people

Don't:

- turn your back on the person
- yell, even if the person is yelling at you
- say angry or critical things which will escalate the aggression
- argue
- 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
- try and battle it out alone (i.e. don't be a hero)

Do:

- stay calm
- adopt a passive and non-threatening body posture (e.g. hands by side with empty palms facing forward, body at 45 degrees angle to the aggressor)
- let the person talk
- ensure a safe escape route
- 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)

Working with clients from particular populations

This section explores the importance of developing understanding, skills, knowledge and expertise in working with clients from different backgrounds including culturally and linguistically diverse populations, Aboriginal and Torres Strait Islander peoples, young people, older people and families. These groups face unique challenges in accessing mental health and alcohol and other drug services.

Clients of transcultural backgrounds

People from different cultures have different views on what constitutes mental illness. The DSM makes it clear that diagnoses can only be made if the person's behaviour is abnormal within their culture. While there are similarities in the forms of illnesses across different cultures the specific symptoms and signs are different for different societies. For example, a man in Australia with schizophrenia may have delusions that his thoughts are influenced by laser beams, while a man in Fiji with schizophrenia may complain that black magic is interfering with his thoughts. It is also not uncommon for people from some cultures (particularly South-East Asian countries) to express psychological distress through somatic (physical) symptoms.

There are several differences between cultures in how they attribute the causes of mental illness and how they provide treatment. Thus, the way clients present and expect treatment will depend on their cultural beliefs. Often in Western medicine mental illness is attributed to a physical cause and thus medication is prescribed. Some allied health workers attribute mental illness to disturbances in thinking and thus provide counselling and psychotherapy. However, in some societies, mental illness is attributed to problems relating to a spiritual dimension and thus a spiritual healer is required for treatment.

The Western concept of mental illness locates the 'problem' as emanating from the individual while in many non-Western cultures, including amongst Aboriginal and Torres Strait Islander populations, the problem is seen as belonging to the community as a whole. Hence, when working with clients with a non-Western viewpoint, treating them in isolation from their family or community is often not what they desire. Usually including the client's community to whatever extent he or she prefers improves the prognosis.

Migration is also a significant cause of distress and may precipitate mental illness. This is even more the case for refugees, especially those who have been traumatised by war or experiences of torture. Even for migrants from Westernised, English-speaking countries, the idiosyncrasies of the Australian culture can be confusing and changes in environment, jobs, social supports and lifestyle can create stress. Migrants may experience a loss in social and occupational status if their qualifications are not recognised in Australia. Immigrants may face issues such as high unemployment levels, overcrowded living conditions, poverty, racial discrimination and family conflict.

Clients of culturally and linguistically diverse backgrounds

When working with clients of culturally and linguistically diverse (CALD) backgrounds consider the following points to improve assessment:

- 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 as describing symptoms, especially feelings, can be very difficult when English is a second language. Make sure you do not use a family or community member to interpret, as a professional interpreter will not edit what you or the client say. The Translating and Interpreting Service (TIS) can be contacted on 131 450, with further information available at the Department of Immigration and Multicultural Affairs website <http://www.immi.gov.au/>
- Ask the person what his or her preferred form of address is. Do your best to pronounce the name correctly
- Where possible, involve the family in treatment if the client wants this. Allow the client to pick who from their family or community participates
- Keep what you know about mental illness in mind but ensure that you try to understand the client's cultural understanding of their problems
- 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

For more information on working with clients from CALD backgrounds:

- ***Transcultural Mental Health Centre*** <http://www.dhi.gov.au/tmhc/>
- ***Mental Health Co-ordinating Council (MHCC)*** <http://www.mhcc.org.au/> (factsheets)
- ***NSW Health Multicultural Health Communication Service*** http://www.mhcs.health.nsw.gov.au/mhcs/topics/Mental_Health_Illness.html
- ***Multicultural Mental Health Australia*** <http://www.mmha.org.au/>

Aboriginal and Torres Strait Islander people

The standards of physical and mental health among Aboriginal and Torres Strait Islander peoples are poor in comparison with the wider Australian community. Life expectancy is 20 years less than for non-Indigenous people. Suicide rates, especially among Aboriginal men are significantly higher than non-Aboriginal people. Rates of alcoholism, incarceration, anxiety and depression are higher than in non-Indigenous communities. There are high rates of grief and loss as Aboriginal people are faced with death and serious illness within their extended family more often than non-Aboriginal people and at a younger age. This severe social disadvantage in which Aboriginal and Torres Strait Islander people live may partly explain the high rates of mental disorders.

When working with Aboriginal and Torres Strait Islander clients it is important to note that many have a holistic concept of health embracing physical, psychological, social, cultural and spiritual health. Health (including mental health) problems in the individual are viewed as not just about that individual but reflect difficulties in the entire community and the land they inhabit. Unwell people are usually cared for by their families. Traditional healers often play a vital role in the care of the individual as severe mental health problems are often attributed to spiritual problems.

When working with Aboriginal and Torres Strait Islanders with apparent psychotic symptoms it is important to clarify the cultural appropriateness of such symptoms. For example, it is not unknown for some Aboriginal and Torres Strait Islander people to hear recently departed relatives and see spirits representing ancestors. It is not uncommon for other family members to also share this experience which is usually seen as reassuring. This spiritual experience is completely culturally valid and is usually not a symptom of psychosis thus prescription of antipsychotic medication would be inappropriate. If possible, and consented to by the client, engaging the services of a local Aboriginal and Torres Strait Islander community member or health professional to assist in assessment and ongoing care may be useful.

Davies (2000) lists the following guidelines to consider when working with Aboriginal and Torres Strait Islander clients:

- Set aside extra time as the consultation may take longer
- Be clear about your role and the types of things you would like to cover in the consultation
- Remember that you may be viewed as a member of a culture that has caused damage to Aboriginal and Torres Strait Islander culture. The history of white 'colonisation' of Australia is perceived as an 'invasion' by many Aboriginal and Torres Strait Islander people. Therefore, anticipate the client perceiving you with anger, resentment and/or suspicion

- Be conscious that anxiety may be created by interviewing an Aboriginal and Torres Strait Islander person within an enclosed space
- Reduce direct questioning as it can be perceived as being threatening and intrusive
- Watch the client's body language and mirror it if possible. For instance, direct eye contact is often viewed as impolite in Aboriginal and Torres Strait Islander communities and is often avoided. Speaking softly with brief answers may indicate that the person is shy or being polite
- 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)
 - not criticising an elder: older people are treated with great respect
 - confiding personal information to a member of the opposite sex – men's and women's business are usually kept separate (this may create difficulties if the worker is of the opposite sex from the client)
 - appearing to criticise members of the extended family as family loyalties are strong

For more information on working with Aboriginal and Torres Strait Islander people:

- ***AUSINET Aboriginal and Torres Strait Islander mental health issues*** <http://auseinet.flinders.edu.au/atsi/index.php>
- ***Mental Health Co-ordinating Council*** <http://www.mhcc.org.au/> (factsheets)
- ***Mental Health Council of Australia:*** <http://www.mhca.org.au>
- ***Australian Indigenous HealthInfoNet:*** <http://www.healthinfonet.ecu.edu.au/index.htm>

Young people

In 2000 a report was released to describe the Child and Adolescent Component of the National Survey of Mental Health and Well-Being. This report provided the following information relating to mental illness of young people in Australia:

- Fourteen percent of children and adolescents in Australia have mental health problems
- There is a higher prevalence of child and adolescent mental health problems among those living in low-income, step/blended and sole-parent families
- Children and adolescents with mental health problems have a poorer quality of life than their peers
- There are a limited number of trained clinicians in child and adolescent mental health
- Only one in four of young people with mental health problems receives professional help
- Adolescents with mental health problems report a high rate of suicidal ideation and other health-risk behaviour, including smoking, drinking and drug use.

In 2001 NSW Health published *Getting in Early – A Framework for Early Intervention and Prevention in Mental Health for Young People in NS*. This report highlights that the onset of psychosis, anxiety, depression and substance abuse generally occurs in the mid-late adolescent or early-adult years. For example, about 800 young people will experience first episode psychosis each year and it is not uncommon for young people to develop more than one

mental illness. As adolescence and early adulthood is a time of significant development of self, relationships, career and social life mental illness can lead to significant disabling effects for young people, as well as impacting on their families.

Unfortunately, there is often a 1-2 year delay between first symptoms and receiving treatment and the longer the delay in treatment the worse the outcome for young people. There are many reasons why this delay occurs: mental health services may not be culturally or youth friendly; it is at times difficult to distinguish between emerging mental health problems and 'normal' adolescent difficulties and the stigma and discrimination related to mental illness may limit help seeking behaviour. Instead it is common for young people to present to generic services. This provides opportunities for early recognition, intervention and referral in services that are prepared to work holistically with young people.

Engagement is critical when providing early intervention to young people with emerging mental health problems. Engagement provides a supportive response to lessen the effects of stressors related to symptoms, building competence and strengths and is an ongoing process. It involves developing a therapeutic relationship with young people and their families through rapport building, being interested and respectful, as well as providing information and building trust.

Engaging young people can be difficult because they are usually brought into treatment by a parent or other caregiver. Engagement therefore requires patience and skill. The engagement approach used needs to be adjusted to the age of the young people. Providing information and support is a useful way to improve engagement as young people can often feel confused by their symptoms. Providing information and support to parents on what to expect and what they can do to assist is also important. Working with the family is essential. The younger the child the more critical family or carer involvement becomes. With young people, as with adults, confidential and its limits should be explained in detail.

It is important to realise that mental illness in young people can present differently than it does with adults, and therefore, treatment may be different. In all cases early intervention is crucial.

When assessing young people information should be obtained from a variety of sources. Young children may be less able to verbalise feelings. It is important to ask questions at an age appropriate level, use language the child understands and to check that they have understood what you have told them. It is vital to systematically assess all potential areas of difficulty as comorbidity is common and emotional problems are often overlooked in the presence of aggressive and disruptive behaviour.

At assessment, it is important to consider the safety, welfare, and well-being of any children. Health care workers have a duty under the NSW Children and Young Persons (Care and Protection) Act 1998 to notify the Department of Community Services whenever they suspect that a child may be at risk of harm through abuse or neglect. When necessary, this duty overrides the duty to maintain client confidentiality. For further information, refer to:

- NSW Health Policy Directive PD2005_299: Protecting children and young people
- NSW Health Frontline Procedures for the protection of children and young people 2000.

Mood disorders

Getting early support and treatment can help prevent problems from becoming serious, long term issues. This is especially important for children and young people. Early intervention with depression can lessen the length of depressive episodes and reduce relapse and improve psychosocial outcomes. Unfortunately the degree of depression in young people tends to be underestimated and therefore often goes unrecognised or untreated. Young people who experience depression often appear cranky, grouchy and irritable rather than sad or unhappy. They may not experience weight loss but rather fail to make expected weight gains.

In children depression may be displayed through somatic (bodily) symptoms rather than specific mood changes. In fact the commonest diagnosis for children is dysthymic disorder rather than major depression. Although the symptoms are less severe for dysthymic disorder the level of disability such as poor school performance and problems with peers and family is often high. Psychosocial interventions should target: enhancing good peer and parental relationships; improving employment and strengthening individual resilience through positive and optimistic thinking styles. In some areas referrals can be made to specialised programs that support children and young people.

Anxiety disorders

Although fears are common during childhood and adolescence an anxiety disorder is likely if fears are intensive or long lasting and cause significant impairment in functioning. Unfortunately, the anxiety disorders are common in young people who tend to display similar symptoms as experienced by adults. Anxiety disorders are however difficult to recognise because young people usually know their fears are not realistic and therefore may not speak about them out of shame.

Interventions for anxiety often include education and counselling to help the person understand their thoughts, emotions and behaviours associated with anxiety.

Psychotic disorders

Different types of psychoses include schizophrenia, bipolar mood disorder and drug induced psychoses. In first onset psychosis early intervention should ideally occur during the 'something is not quite right' prodrome stage where pre-psychosis negative symptoms such as social withdrawal and changes in behaviour occur.

Unfortunately it can be difficult to distinguish between the depressive and psychotic disorders and they can be further complicated by behavioural or developmental issues and/or substance use. Referral to specialist services or consultancy staff is advised.

For more information on working with young people:

- *The Australian Network for Promotion, Prevention and Early Intervention for Mental Health (Auseinet) <http://auseinet.flinders.edu.au/>*
- *Early Psychosis Prevention and Intervention Centre (EPPIC) <http://www.eppic.org.au/>*
- *Reach Out! <http://www.reachout.com.au/> (factsheets)*
- *Getting in Early – A Framework for Early Intervention and Prevention in Mental Health for Young People in NSW can be downloaded from <http://www.health.nsw.gov.au>*
- *Treatment Protocol Project (2004) provides information on the child and adolescent disorders*
- *The report prepared for the National Youth Affairs Research Scheme (NYARS) titled *Barriers to Service Provision for Young People with Presenting Substance Misuse and Mental Health Problems*, downloadable from: <http://www.facs.gov.au/internet/facsinternet.nsf/aboutfacs/programs/youth-nyars.htm>*
- *The NSW Association for Adolescent Health report *Caught in the Gap: Dual Diagnosis and Young People: A Report on the Issues*, downloadable from <http://www.naah.org.au>*
- *Department of Health and Ageing publications and resources on young people and mental health from <http://www.health.gov.au> and <http://www.mentalhealth.gov.au>*

Older people

The proportion of 'older people' in the Australian community is increasing for a variety of reasons: increased life expectancy, better health care and declining infant mortality. There is an increasing need for workers to be knowledgeable about the presentation and management of the more common mental illnesses in older people and the way in which they differ from those of the younger population.

Mental illness in older Australians is more difficult to diagnose and treat due to their comorbidity with physical illnesses and disabilities. As with working with young people it may be advisable to gain collateral information from carers and close relatives as it can be difficult to assess how different the client is from his or her normal level of functioning. In contrast to younger people, older people generally have more complex social backgrounds that can increase risk factors for developing mental illness, for example: bereavement, loss of social roles due to retirement or ill health, increasing social isolation, economic concerns, diminishing cognitive function and a reduced ability to look after their own affairs.

As detailed in the NSW Service Plan for Specialist Mental Health Services for Older People (SMHSOP), a small but significant cohort of older people, predominantly men, is affected by substance use disorders. A 1998 ABS study of mental health and wellbeing of adults found

that 2.1 per cent of older men and 0.2 per cent of older women suffered from substance use disorders. However, it should be noted that there are limitations to prevalence information regarding substance use disorders in older people because the diagnostic criteria were developed and validated on young and middle-aged adults. Some of these people are currently living in boarding houses or supported accommodation in the community. Some are homeless or at risk of homelessness. They may have developed dementia and have behavioural and psychological symptoms, complicated by their substance use disorder. They may be difficult to place in residential aged care facilities when they require high levels of nursing and physical care.

Another important group is those who are dependant upon prescription drugs or suffering from significant side effects from inappropriate prescribing of psychotropic medication. Older people in nursing homes are particularly at risk in this regard, especially if they have dementia. Specialist medical practitioners in mental health services for older people have an important role to play in reviewing medication regimes and advising on appropriate prescribing for older people. This is also true for older people with substance use disorders and a coexisting mental illness, for whom assessment and management planning are likely to be further complicated, especially where there is cognitive impairment.

The statewide framework for Specialist Mental Health Services for Older People (SMHSOP) is currently in early stages of implementation. The Service Plan for SMHSOP can be accessed from the NSW Health website www.health.nsw.gov.au.

Depression is easily overlooked in older people and suicide can be difficult to assess as it is recognised that depressed older people may deny suicidal ideation. Thus direct questioning may have to be utilised during suicide assessments. Older people who are isolated and lack social networks and supports are at higher risk of depressive disorders. For example, in residential aged care settings depressive symptoms and disorders are more common. All treatment interventions used for younger people are effective in older clients.

Dementia is a syndrome that is of specific concern to those working with older Australians. The most common and well known cause of dementia is Alzheimer's disease. The first signs of dementia are usually noticed by carers and close relatives while the older person generally only notices symptoms when they become more severe. The major sign of dementia is memory loss while there can also be difficulties with activities of daily living. Management of dementia requires a long-term multidisciplinary partnership between the client, the doctor and other health professionals such as occupational therapists, community nurses, social workers and physiotherapists.

Delirium is also an under-diagnosed syndrome that is more common in elderly people. Delirium is an acute impairment in consciousness creating a confusional state. It has a sudden onset with fluctuating symptoms and usually lasts for less than four weeks although it can last for up to six months. The commonest causes of delirium are infections and adverse reactions to drugs. The main intervention is to identify and treat the underlying cause of the delirium. A detailed physical examination is required and treatment is usually managed by medical professionals.

For more information on working with older people:

- ***Treatment Protocol Project (2004) provides information on the mental disorders in older people***
- ***NSW Health has produced a fact sheet on dementia that is available in a variety of languages <http://www.health.nsw.gov.au/health-public-affairs/publications/dementia/>***
- ***Alzheimer's Australia: <http://www.alzheimers.org.au/>***

Families and carers

Working with the families is integral to successful outcomes for clients. With support and understanding from family members, clients are more likely to have a successful and lasting recovery.

Families usually experience serious tension and conflict around the client's substance use, difficult behaviour and mental illness symptoms. Family members may have difficulty accepting the problems the client is having and may experience a number of difficult feelings such as confusion, guilt, shame, grief, depression, anxiety and a sense of loss. They may find that their caring for the client has replaced their own routines and activities and may lose touch with their own network of friends.

Families therefore need support from workers as much as clients do. The stages of treatment described earlier can be adapted to working with families. During the engagement stage, workers can establish a good working relationship by reaching out to families, providing them with practical assistance and giving them information about both substance use and mental illness and treatment options. During the motivation stage workers can provide motivational interviewing to help family members recognise the impact of comorbidity on the client and family members. Families can play an important role in relapse prevention by noticing the early warning signs of relapse and supporting recovery in other areas of functioning.

Children and young people affected by parents who have mental illness and substance misuse problems require particular attention and support.

Workers can assist families to access parenting programs, play groups, child care and suitable health services as appropriate. By identifying families early and providing them with support, it can be possible to assist them to cope with parental dual diagnosis and ensure children are properly cared for.

For more information on working with families:

- **NSW Health has produced the Family Help Kit which can be downloaded from <http://www.health.nsw.gov.au/health-public-affairs/familyhelpkit/>**
- **ARAFMI (Association for the Relatives and Friends of the Mentally Ill) offers support for relatives, friends and carers of the mentally ill. NSW ARAFMI offers support groups, including those for younger people (Young ARAFMI) in regional and inner NSW. For more information call NSW ARAFMI on (02) 9887 5897 or Toll Free on 1800 655 198 <http://www.arafmi.org/>**
- **Sane Australia has fact sheets for family members: <http://www.sane.org/Information/Information/Factsheets.html>**
- **Patterson, J & Clapp, C. (2004). *Working with Families: Clinical Treatment Guidelines for Alcohol and Drug Clinicians*, no 11. Turning Point Alcohol and Drug Centre, Fitzroy: Victoria. <http://www.turningpoint.org.au>**
- **Carers NSW <http://www.carersnsw.asn.au/>**
- **Department of Communities (DoCS) website <http://www.community.nsw.gov.au>**

Referral

It is not expected that AOD workers develop specialised expertise in providing mental health interventions with their comorbid clients. The interventions provided within this resource should only be utilised if workers feel confident in carrying them out. Further education and training in all the interventions would be beneficial to ensure they

are utilised appropriately. Otherwise, clients should be referred to an alternative service to carry out appropriate interventions whilst the client continues to receive AOD interventions as required.

The following table lists 24-hour contact numbers in NSW Area Mental Health Services:

AREA HEALTH SERVICE

CENTRAL INTAKE NUMBER

Greater Southern Area Health Service

Greater Murray	1800 800 944 / 02 9425 3923
Southern	1800 809 423

Greater Western Area Health Service

Far West	1800 665 066 / 08 8080 1556
Macquarie	1800 092 881 / 02 6841 2360
Mid Western	1300 887 000

Hunter / New England Area Health Service

Hunter	02 4923 2060
New England	1300 660 059

North Coast Area Health Service

Mid North Coast	1300 662 263
Northern Rivers	02 6620 7612

Northern Sydney / Central Coast Area Health Service

North Sydney	1300 889 788
Central Coast	4394 488

South Eastern Sydney / Illawarra Area Health Service

South East Sydney	02 9113 4444
Illawarra	1300 652 226

Sydney South West Area Health Service

South West Sydney	02 9616 8586
Central Sydney	02 9515 6311

Sydney West Area Health Service

Wentworth	02 4734 1333
Western Sydney	02 9840 3355

Other useful contacts and resources are:

The Alcohol and other Drugs Council of Australia (ADCA)

PO Box 269
WODEN ACT 2606
Telephone: 02 6281 0686
Email: adca@adca.org.au

Alcohol and Drug Information Service (ADIS)

24hr hotline
Telephone: 02 9361 8000
Toll free number: 1800 422 599

Australian Drug Information Network (ADIN)

PO Box 818
North Melbourne, VIC 3051
Telephone: 03 9278 8100
Email: adin@adf.org.au,
Website: www.adin.com.au

The Australasian Professional Society on Alcohol & Other Drugs (APSAD)

PO Box 73
Surry Hills NSW 2010
Telephone: 02 9331 7747
Website: www.apsad.org.au

Drug and Alcohol Nurses of Australasia (DANA)

The Secretary
PO Box 5095
Warrnambool VIC 3280
Telephone: 1300 557 594
Website: www.danaonline.org

The Drug and Alcohol Specialist Advisory Service (DASAS)

Telephone - Country: 1800 023 687
Telephone - Sydney: 9361 8006

Family Drug Support Head Office

PO Box 7363
Leura NSW 2789
Telephone: 1300 368 186
Website: www.fds.org.au

National Centre for Education and Training on Addiction (NCETA)

Flinders University
GPO Box 2100
Adelaide SA 5001
Telephone: 08 8201 7535
Website: www.nceta.flinders.edu.au

National Drug and Alcohol Research Centre (NDARC)

University of New South Wales
Sydney NSW 2052, Australia
Telephone: (02) 9385 0333
Website: <http://ndarc.med.unsw.edu.au/>

The National Drug Research Institute (NDRI)

GPO Box U1987
Perth WA 6845
Telephone: 08 9266 1600
Website: www.ndri.curtin.edu.au

NSW Department of Health

73 Miller Street

North Sydney NSW 2060

Telephone: 02 9391 9000

Website: www.health.nsw.gov.au

The Hepatitis C Council of NSW

Telephone: 02 9332 1599

Freecall: 1800 803 990 (country)

Email: hccnsw@hepatitisc.org.au

**The Network of Alcohol and Drug Agencies Inc
(NADA)**

PO Box 2345

STRAWBERRY HILLS NSW 2012

Telephone: 02 9698 8669

Website: www.nada.org.au

The Quitline Service

(A telephone-based service designed to help smokers quit smoking)

Telephone: 13 7848 (13 QUIT)

Worker self-care

Working in the drug and alcohol field can be a rewarding and satisfying experience. The opportunity to work directly with clients, to share their journey and to witness their recovery can be professionally fulfilling.

On the other hand workers can often experience high levels of stress and in some cases burnout. Work related stress relates to psychological, physical and behavioural responses over a short-term period of time. Burnout is the term used to describe long-term process that is characterised by a negative and cynical attitude towards clients and work in general.

A range of undesirable consequences result from work related stress and burnout that may include:

- reduced job satisfaction,
- low job performance
- higher absenteeism and
- higher staff turnover

To reduce the incidence of stress and burnout workers need to pay special attention to their level of self-care. Ways this could be done include:

- reflecting on your lifestyle and make changes where necessary
- ensuring that you have a balanced and regular diet
- allowing time each day for breaks, lunch and physical exercise
- scheduling regular holidays and other breaks away from work such as conferences, education sessions and clinical supervision

- avoiding professional isolation by keeping in contact with peers
- maintaining a balance between family, personal and work commitments
- being aware of your own alcohol and other drug use
- learning and using relaxation skills
- using the problem-solving technique in this resource when feeling stuck

Clinical Supervision

Clinical supervision is a method in which workplace stress and burnout can be reduced. The definition of clinical supervision differs across groups and settings but generally it has three meanings:

- quality assurance
- a method to improve clinical practice such as the worker learning new skills, solving problems effectively and obtaining suggestions for practice improvement
- professional support (Ask and Roche, 2005).

Evidence suggests that clinical supervision:

- is commonly valued by managers and practitioners
- can facilitate the acquisition of complex clinical skills
- is associated with higher levels of job satisfaction or morale, where it is perceived to be of high quality
- can support staff retention.

For workers, clinical supervision can provide a mechanism for support, debriefing and for managing workplace stress. It provides an opportunity for coaching and professional guidance, enhancing skills, identifying new ways to work with clients as well as a mechanism to validate existing clinical skills and increase job satisfaction.

In 2006 NSW Health produced clinical supervision guidelines for drug and alcohol services. The Guidelines are generic and intended to be applicable across disciplines to all workers in D&A services who have responsibility for the provision of direct services to clients, either individually or in groups. The intent of the Guidelines is to allow for flexibility. They are not prescriptive, but rather make suggestions about what constitutes good practice. There is no single recommended model of clinical supervision, and services need to have flexibility to implement programs and processes appropriate to the local context, and within the available resources. The Guidelines are intended to provide a framework for, and support to, local operations and to encourage a degree of consistency across the state.

For more information on worker self-care:

- ***The NSW Health Drug and Alcohol Clinical Supervision Guidelines: <http://www.health.nsw.gov.au>***
- ***National Centre for Education and Training on Addiction (NCETA) publications downloadable from <http://www.nceta.flinders.edu.au>:***
 - ***Clinical Supervision Resource Kit for the Alcohol and Other Drugs Field***
 - ***Mentoring: An Age Old Strategy for a Rapidly Expanding Field, A What, Why and How Primer for the Alcohol and Other Drugs Field***
 - ***Stress and Burnout: A Prevention Handbook for the Alcohol and Other Drugs Workforce.***
- ***DrugNet has several resources on supervisory practice and guidelines <http://www.drugnet.bizland.com/standards/supervision.htm>***
- ***Hawkins, P. and Shoheit, R. (2000). Supervision in the Helping Professions. Milton Keynes: Open University Press.***
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