NSW Clinical Guidelines

For the Care of Persons with Comorbid Mental Illness and Substance Use Disorders in Acute Care Settings

NSW HEALTH

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SECTION 1

About the guidelines

1.1 Background

The high prevalence of coexisting mental health and drug and alcohol disorders is well established in both clinical practice and throughout the literature. Clients with a comorbid mental health and substance use disorder (SUD) are more likely to have highly complex and complicated illness courses, a high dependence on clinical services and poorer long-term prognoses.[1]

In 2007/8, the Mental Health and Drug and Alcohol Office (MHDAO) of the NSW Department of Health developed a Comorbidity Framework for Action.[2] This document acknowledged four specific areas for action:

1. Focus on workforce planning and development
2. Improved infrastructure and systems development
3. Improved response in priority settings for priority clients
4. Improved promotion, prevention and early intervention strategies.

In order to address priority area number one, MHDAO identified the need to develop resources for practitioners. A lack of guidelines for the care and treatment of clients who presented in public sector health care settings with mental health and drug and alcohol comorbidity was noted, as was the need to refine and revise the existing Mental Health and Substance Use Disorder Service Delivery Guidelines, published in 2000.[3] The need for clinical guidelines has resulted in the development of this resource which will be supported by an implementation plan, communication strategy and evaluation program.

1.2 Rationale

The complex presentations, illness trajectory and poor outcomes for people with comorbid mental health and substance use disorders has led to the need to identify and develop a set of guidelines to provide direction for the care and treatment of this client population. The goal of these guidelines is to improve client care and outcomes.

The extent of comorbid mental health and substance use disorders within Australia was documented in the 1997 National Survey of Mental Health and Wellbeing, conducted by the Australian Bureau of Statistics. The survey included 10,641 respondents between the ages of 18 and 90. Results indicated that slightly less than 1 in 5 Australian adults had an anxiety, affective disorder or substance use disorder in the past year or approximately 2.3 million Australians.[4,5] Approximately 50% of those with a mental health disorder had more than one.

There is a commitment and awareness of the need to address the challenges of comorbid mental health and substance use disorders. This is evidenced by national and state based policy initiatives to address these complex problems. Information about the latest initiatives is available on State and Commonwealth websites.

1.3 Audience

These guidelines have been written for practitioners working in the drug and alcohol and/or mental health sectors who provide care for people with comorbid mental health and substance use disorders and who work in the following environments:

- Acute
- Non acute
- Community settings
- Hospitals
- Government
- Non-government.

It is acknowledged that these guidelines will be useful for those practitioners providing care to people with comorbid mental health and substance use disorders in a variety of other clinical settings including: emergency departments, justice health, general wards and general practice. Information specifically relevant to each of these clinical settings has been included within the guidelines.

1.4 Scope

The guidelines aim to provide practitioners working with clients who have comorbid mental health and substance use disorders with information to guide care.

This document does not intend to replace expert clinical knowledge; rather it seeks to serve as a resource supporting practitioners in providing care to their clients. Although the guidelines recommend a range of interventions, at no time does it endorse or suggest that a practitioner and/or a service, practice at a level that extends beyond their skills/ experience and available resources.

1.5 No wrong door

This document has been drafted based upon the principle that all clients should receive care that addresses the full spectrum of their illness(es), regardless of where they present (i.e. there is no wrong door).

This 'no wrong door' principle clarifies that the responsibility of providing care that addresses the range of client needs is the responsibility of the care provider/service where the client presents. It is acknowledged that this requires services to provide care, and/or facilitate access to service delivery that falls beyond their specific focus. It removes the onus of negotiating different services and providers from the client and thereby aims to reduce the incidence of clients 'falling through the cracks' of a complex service delivery system.[6]

1.6 Existing guidelines

This document is based on the premise that best quality care should be provided to every client in line with existing best care principles. These guidelines seek to provide clinical guidance that is specifically relevant to people with comorbid mental health and substance use disorders. Where other credible clinical treatment guidelines exist, they are referenced and the reader directed accordingly.

1.7 Kettil Bruun Process

The Kettil Bruun process was implemented to develop the content included within these guidelines. Kettil Bruun was a Finnish alcohol researcher (1924–1985) who is acknowledged as a pioneer in alcohol and social research. He was the Director of the Social Research Institute of Alcohol Studies in Helsinki and was well regarded for his ability to collaborate with diverse groups of people in order to reach consensus on difficult subjects.7

The Kettil Bruun process aims to promote social and epidemiological research that fosters a comparative understanding of the social aspects of alcohol use and alcohol problems and across different sub-populations. The first step in the process was to develop Trigger Papers based on a review of the best available evidence. Each paper was prepared by a subject matter expert and was completed voluntarily.

The Trigger Papers were then provided to expert clinicians who reviewed the paper and evidence, identified key implications and information gaps from the papers and provided recommendations regarding the content to be included in the guidelines. This review took place on an individual basis or through a collective review process which included a facilitated meeting of clinical specialists.

The resulting materials were presented to 27 workshop delegates who participated in a facilitated discussion reviewing all available evidence. The outcomes of this meeting and the evidence outlined in the papers were then collectively used to prepare the NSW Health Clinical Comorbidity Guidelines. Widespread consultation was conducted in an effort to develop guidelines reflecting clinical consensus.

1.8 Levels of evidence

A review of available evidence was used to inform the development of the guidelines. Where there was an identified paucity of clinical evidence, consensus from the experts who participated in the one-day workshop was used to inform the guideline development.

The recommended NHMRC grading for assessing levels of evidence was used to weigh the evidence. However, at the time this document was prepared the NHMRC grading for levels of evidence was under review. For this reason, the 1999 grades with some modifications were recommended.[8]

1.9 Language

It is acknowledged that some language used by mental health and drug and alcohol sectors is different, as is the language used across different clinical settings. For the purposes of these guidelines, the following terms have been used in order to develop shared meaning and understanding of the content.

It is understood that these terms are not the preferred language of all service providers. These guidelines do not attempt to, nor recommend, change to the language used within individual services and practice however this 'shared language' may be useful when communicating between services and will be a valuable resource when providing care for a client with a comorbidity (i.e. during case conferences and client transition(s)).

In particular instances, there are terms which have different cross-sectoral meanings. For example, the terms 'recovery' and 'rehabilitation' have significantly different meanings for drug and alcohol practitioners than what they do for mental health practitioners. When these terms are used in this document, their meaning will be defined and explained.

These guidelines acknowledge that although a specific mental health diagnosis is not required to meet the criteria for a comorbid mental health and substance use disorder, the terms used in the Diagnostic and Statistical Manual of Mental Disorders (DSM *IV* TR) multi-axial classification system are referenced throughout the document.[9] This classification system provides a framework for approaching mental illness. It is not necessary for a reader to be intimately familiar with the content of the DSM *IV* TR to use the guidelines.

CLIENT: Person receiving care/treatment for a comorbid mental health and substance use disorder
MENTAL HEALTH DISORDER: The existence of a set of symptoms or behaviours which impair an individual's cognitive, affective and/or relational abilities
PRACTITIONER: Person working in a drug and alcohol or mental health service
SUBSTANCE USE DISORDER (SUD): Dependence, reliance or addiction to a substance

1.10 Definition of comorbidity

In general medical language, comorbidity refers to the simultaneous presence of two or more diseases in the same person.[10] There is significant discourse regarding the use of language to accurately describe comorbid mental health and substance use disorders. A definition must consider the breadth of diagnoses, the possible inability of some disorders to meet diagnostic criteria and the fluidity of the problems faced by an individual as they relate to the diagnosis.

For the purposes of these guidelines, comorbidity will refer to:

Situations where people have problems related both to their use of substances (from hazardous through to harmful use and/or dependence) and to their mental health (from problematic symptoms through to highly prevalent conditions, such as, depression and anxiety, to the low prevalence disorders such as psychosis).[11]

Although acknowledged as a significant health problem, nicotine dependence is not considered within the structure of this document. Further information about this subject is available from the NSW Department of Health website.

1.11 Impact of comorbidity

The impact of a comorbid mental health and substance use disorder for a client is significant. This client population is faced with an increased risk of illness and injury (including self harm and suicide), poorer psychiatric and physical outcomes, increased risk of side effects and less efficacious treatment. The challenges of the problems that clients face impede on their ability to attend appointments and adhere to medication regimes, thereby increasing the likelihood of relapse.[12] This picture can often be further complicated with poly-substance use.

Family members and carer(s) may also feel the impact of comorbidity, sometimes working with the client to help navigate through the system. This may include trying to address the broader consequences of these problems which can include challenges with housing, social networks, finances, employment amongst others.

1.12 The similarities and differences between Drug and Alcohol, and Mental Health sectors

Drug and alcohol and mental health services employ a highly skilled and committed workforce. The workforce in both sectors provide complex and supportive care for clients. The client population in both sectors are frequently stigmatised, commonly have chronic, relapsing illnesses and experience illnesses which have a marked impact on behavioural and social functioning. Therefore, both workforces tend to be very effective in dealing with complex client presentations.

It is important to note that practitioners in each sector have provided care for clients with comorbid mental health and substance use disorders within former and existing service delivery frameworks and are therefore aware of the challenges and unique needs of this population.

Drug and Alcohol and Mental Health practitioners and services are both required to comply with many of the same legislative requirements. These include:

- Mandatory reporting requirements under the Children and Young Persons Care and Protection Act. For further information please view The *NSW Interagency Guidelines for Child Protection Interventions 2006* available at http://www.health.nsw.gov.au/pubs/2006/iag_childprotection.html

- The legal obligations outlined within the NSW Health Policy for Identifying and Responding to Domestic Violence available at http://www.health.nsw.gov.au/policies/pd/2006/pdf/PD2006_084.pdf

- The NSW Health Code of Conduct http://www.health.nsw.gov.au/policies/pd/2005/PD2005_626.html

- The local Area Health Service Code of Conduct (where applicable)

- Local service ethical codes and requirements under funding agreements for NGO's

- NSW Health Privacy Act

- Mental Health Act

There are also a range of differences between and within the two sectors.

The workforces in each sector are made up of practitioners who have different skills, training and experience. Drug and Alcohol sector practitioners may include life-experience based workers, vocationally trained workers, registered nurses, enrolled nurses, social workers, occupational therapists, psychologists, medical officers and addiction specialists. The mental health workforce is largely comprised of vocationally trained workers, registered nurses, enrolled nurses, social workers, occupational therapists, psychologists and psychiatrists.

The treatment philosophies between the sectors vary, as do those within each sector. For instance the care and treatment priorities and paradigms vary between acute and community care services.

The motivations for clients at each service may also differ. A client seeking treatment at a drug and alcohol service may be required to demonstrate a commitment to attend therapy, demonstrating their motivation for compliance with treatment. A lack of motivation and insight may be a part of a mental health problem. The mental health sector approach accounts for this and has strategies to care for clients if they are acutely unwell and are a risk to themselves (e.g. a mental health unit on an involuntary basis).

A description of the legislation that governs care in either sector is available at Appendix 1.

1.13 Misconceptions about working with clients who have a comorbid mental and substance use disorder

Mental health practitioners are not able to help clients with substance use problems

The high prevalence of people with comorbid mental and substance use disorders within the Australian population indicates that many mental health practitioners have been providing care and treatment to people with comorbid mental and substance use disorders within the course of their practice for many years. Although it is essential that no practitioners practice beyond their scope of practice, the suggested competencies for practitioners and services are detailed in the Service Delineation Section. Please refer to this section of the guidelines for information about what you can do to help someone.

Drug and alcohol practitioners are not able to help clients with a mental health problem

The high prevalence of people with comorbid mental health and substance use disorders within the Australian community indicates that many drug and alcohol workers have been providing care and treatment to people with a comorbid mental health problem within the course of their practice. Although it is essential that no practitioners practice beyond their scope of practice, the suggested competencies for practitioners and services are detailed in the Service Delineation Section. Please refer to this section of the guidelines for information.

A Mental Status Exam (MSE) can not be conducted on a client when they are intoxicated

A Mental Status Examination may be conducted on anyone who is conscious, including those who are intoxicated.[13] The state of intoxication is likely to influence the outcomes of exam and should be noted. The practitioner should remain cognisant of the fact that the outcomes of the exam will change when it is repeated at a time when the client is not intoxicated.

Care and treatment for people with mental health problems can only be provided if the client is not continuing to use

For many clients the aim of drug and alcohol treatment may be to reduce the use of a substance rather than to completely cease use. If this is the case, a practitioner may address the symptoms of a mental health problem. Please refer to the chapters addressing specific mental health problems for more detailed information.

SECTION 2

Client engagement

2.1 Communication and approach

Client-centered approach

The focus of any intervention for clients with comorbid mental health and substance use disorders needs to concentrate upon empowering the person to manage their own lives to their full potential. Some people take longer than others to trust practitioners and services. People are more likely to enter into a relationship where they are assisted in identifying and expressing their own needs and can set goals and objectives to achieve them.[14]

2.2 Confidentiality

Confidentiality is an important element in the provision of services to all clients presenting to drug and alcohol and/or mental health services.

Key Practice Tips for Confidentiality

All clients must have their confidentiality defined and explained to them. Explain to the client:

- instances in which legislation limits the confidentiality of disclosed information (for example, mandatory reporting of child abuse, risk of suicide or homicide.
- any sharing of their personal information with other clinical teams will be discussed with the client as appropriate.
- clinical records can be subpoenaed by courts of law.or to court by law.
- the purpose for seeking information is to assist in the provision of their health care and not for a forensic investigation.
- information can only be provided to third parties (in most cases) on the behalf of a client if they have provided specific written permission for this to occur.[15,16]

Be aware of potential breaches of confidentiality when posting, faxing and emailing information

2.3 Non-judgmental approach

Incorrect beliefs and inaccurate information can lead to continued stigmatisation of people with comorbid mental health and substance use disorders. This ultimately results in clients being increasingly reluctant to seek help. For practitioners to be effective and clients to feel comfortable, both issues need to be viewed and approached as health issues rather than moral issues.[17]

2.4 Strengthening motivation

When a client approaches a mental health or drug and alcohol service for assistance, it is with at least some awareness regarding the existence of either a mental health and/or drug and alcohol problem. They may not however be aware that they have a comorbid disorder. The degree to which a person may be aware of the extent of their problems, and their desire and readiness to change and/or seek help is directly related to their recognition that a problem exists.

Practitioners working with clients who have a comorbid mental health and substance use disorder have the ability to positively influence a person's understanding and readiness to consider the issues and the possibility for change.

A thorough assessment is a critical process of information-sharing between client and practitioner and an important step towards engaging in more in-depth care or referral if required.[18]

2.5 Stages of Treatment

Osher & Kofoed, and Mueser et al describe a staged treatment model for clients with a comorbid mental health and substance use disorder that matches interventions to the client's readiness to address treatment.[19,20]

The stage of treatment model includes the following stages:

Engagement

A client who is engaged in treatment feels that the service provider has something positive to offer. The focus of the engagement stage is to build this therapeutic alliance.

Persuasion

Once engaged, the client is more prepared to be gently challenged regarding their substance use and is open to persuasion. Psycho-educational and motivational strategies are used to persuade the client to consider active treatment options.

Active Treatment

A client actively participates in treatment collaborating with clinicians in setting treatment goals. Treatment may include face-to-face sessions or pharmacotherapy.

Relapse Prevention

The client has achieved the goals of treatment for a period of time and implements strategies to maintain these changes and avoid relapse.[21]

SECTION 3

Principles of practice

Several principles can be used to guide the care and treatment of a client with a comorbid mental health and substance use disorder. All practitioners working with this client group should use these principles as a guide to their service delivery.

1. Recognise the frequency of people presenting with comorbid mental health and substance use disorders and screen each client for each disorder.[22]

2. Recognise that the service where the client presents is the primary care coordinator, until such time as another service agrees to accept the primary responsibility for coordinating the care for the client and this arrangement is acceptable to the client.

3. Identify and familiarise with a system for classifying clients' diagnoses, incorporating this into the assessment process of your work team.[23]

   a) One practical classification of comorbid mental health and drug and alcohol presentations defines mental health diagnoses as:

      - mental health conditions as defined by DSM *IV* TR, and
      - mental health symptomatology, not severe enough to warrant a definitive diagnosis.**
      - drug and alcohol dependence as defined by the DSM IV TR, and
      - drug and alcohol problems not severe enough to warrant a definitive diagnosis.**

   b) The systematic classification of both clinical problems implies a need to plan management so that the more severe (either in acuity or immediacy) problems take priority over those identified as less severe or urgent.

   c) Attention to one aspect of their problem may lead to an amelioration of the other for example, stopping alcohol excess will lead to a reduction in depressive symptomatology in many clients.

4. Make a full assessment of all new clients over a number of visits (wherever possible).

5. Make a full list of symptoms and/or a diagnostic list. Complete this list after each visit and modify it as new information becomes available. Include mental health, psychosocial, drug and alcohol and medical/surgical diagnoses and/or symptoms.

6. Take reasonable steps to identify and involve family members and significant others (with client consent) at several points in the management process.

7. Consider the relationship between the conditions diagnosed by asking five key questions:

   1. Where did the problem start (What might have been the primary problem, the second problem, the third problem etc)?
   2. What needs to be addressed now?
   3. What services are currently required for optimal care?
   4. What services are available?
   5. What does the client want?

   Ask these questions repeatedly when a client presents to you and during their care journey.

8. Identify those conditions that require immediate attention and act.

9. Establish a management plan for each of the complex but defined conditions.

   a) This may include an initial intervention with subsequent actions dependent on the response to that intervention.

   b) This may also include the initiation of two or three interventions immediately because several issues require immediate attention.

10. Involve other clinicians (as relevant) at an early stage of management planning.

    a) This may include other mental health or addiction medicine clinicians or specialists from other disciplines.

11. Ensure that all clients have their physical health care needs assessed and addressed, preferably with involvement of a primary care practitioner where possible.

12. Do not attempt to work beyond one's level of expertise.

13. Ensure continuity of care by facilitating transitions/ collaboration/coordination between services including thorough communication with other providers and sharing of information (consistent with privacy requirements).

14. Follow up clients in accordance with a synchronised management plan involving the key services providing care to the client (General Practitioners, Drug and Alcohol and Mental Health Services and their carer(s), where appropriate).

15. Provide care to address the range of client needs regardless of how they access the health care system ensuring there is 'no wrong door'.[24]

Key practice tips

The following key practice tips will ensure that practitioners manage the comorbid client to maximise the best possible outcomes in terms of recovery and/or quality of life.

- Be aware. Know your field and when there are known comorbid conditions that commonly occur.
- Become accomplished in handling these comorbid conditions or have a mechanism established to ensure consultation can be obtained in a timely fashion.[25]
- Recognise that clients will select the service to which they present, guided by an awareness of a problem and what the services offer.[26]
- Spend time with the client and relevant carers to ensure all care delivery is coordinated and focused on the same outcome.
- Get a full history.
- Do not hurry the assessment process. These clients have multiple reasons for being unable to give an accurate history including fear, lack of trust, confusion, intoxication, mental health diagnoses causing delirium, withdrawal symptoms.
- Seek information from other units involved in the client's care while complying with confidentiality and privacy laws/regulations, including seeking the client's consent.
- Do not rush to make a diagnosis. It is important to take the time to identify all the symptoms that are relevant.

Adapted from Batey, R. (2008). *What are the Basic Principles of Management of People with Comorbid Conditions?* Trigger Paper 01.

SECTION 4

Service Delineation

A set of minimum expectations has been established for practitioners and services in both drug and alcohol and mental health sectors in order to address the needs of clients with comorbid mental health and substance use disorders. Adherence to these expectations will result in a shared understanding of the reasonable expectations for service provision in each sector.

The guidelines do not intend to encourage or require practitioners or services to operate beyond the scope of their programs or services. Rather, these guidelines seek to clarify and improve how sectors can work together. It is important to note that only qualified practitioners can make a clinical diagnosis. Other practitioners are responsible for assessing, identifying and recording signs and symptoms that a client may display without labelling the client with a disorder. These practitioners are never expected to make diagnoses – this would be unsafe and unethical.

4.1 Expectations for Drug and Alcohol Practitioners and services

The list below outlines the expectations for service delivery from drug and alcohol practitioners when a client with a comorbid mental health and substance use disorder presents to a service. Where any expectation is beyond the scope of a practitioner, it is the responsibility of the service to seek additional capacity to ensure the criteria listed below are met.

- Every client is screened for a possible mental illness (please refer to page 25 for further information).
- A thorough risk assessment is completed including assessment of:
  - harm to self and others
  - acute medical illness
  - child protection
  - domestic violence.
- A list of diagnostic symptoms and/or a rudimentary diagnosis of the symptoms of mental illness that a client displays is prepared.
- Supportive therapies which address a client's mental health symptoms are provided (in consultation with a mental health service where required).
- Secondary prevention of mental illness is provided via early intervention (where possible) and the provision of psycho-education regarding the symptoms of mental illness and the impact of ongoing substance use.
- Mental health services and General Practitioners are involved where appropriate (consultation/case conferencing).
- The drug and alcohol service serves as the primary care coordinator for each client who has accessed the service until such time as an alternative service accepts the client. See Principles of Practice on page 15.

4.2 What is a Drug and Alcohol Practitioner/Service NOT required to complete?

A drug and alcohol practitioner/service is **not required** to provide a mental illness diagnosis. Only qualified practitioners can make a clinical diagnosis and where this is an option, this should occur. Other drug and alcohol practitioners should focus on the assessment, identification and documentation of any signs and symptoms that a client may display without labelling the client with a specific disorder.

It is acknowledged that a drug and alcohol practitioner/service is **not** expected to deliver specialised mental health treatment. This includes the following:

- The management/coordination of care during a prolonged, acute psychotic episode.
- The sole management/coordination of care for a client experiencing their first psychotic episode (this should be managed in conjunction with a mental health service).

The drug and alcohol service remains the primary care coordinator for the client until another service has agreed to accept the client. Please see Principles of Practice on page 15.

4.3 Expectations for Mental Health Practitioners and services

- Every client is screened for a possible drug and alcohol disorder (please refer to page 25 for further information).

- A thorough risk assessment is completed including assessment of:
  - harm to self and others
  - acute medical illness
  - child protection
  - domestic violence.

- A list of diagnostic symptoms and/or a rudimentary diagnosis of the symptoms of a drug and alcohol disorder that a client displays is prepared.

- Supportive therapies that address a client's drug and alcohol disorder are provided (in consultation with a drug and alcohol service where required). These may include:
  - motivational interviewing
  - cognitive behaviour therapy
  - simple withdrawal management
  - medications for relapse prevention.

- Secondary prevention of drug and alcohol substance use is provided via early intervention (where possible) and the provision of psycho-education regarding the harms and dangers of ongoing substance use.

- Drug and alcohol treatment services and General Practitioners are involved where appropriate (consultation/ case conferencing).

- The mental health service remains as the primary care coordinator for each client who has accessed the service until such time as an alternative service accepts the client. See Principles of Practice on page 15.

4.4 What is a Mental Health Practitioner/Service NOT required to complete?

A mental health practitioner/service is not required to provide a diagnosis of a substance use disorder. Only qualified practitioners can make a clinical diagnosis. Other mental health practitioners should focus on the assessment, identification and recording of any signs and symptoms that a client may display without labelling the client with a specific disorder.

It is acknowledged that a mental health practitioner is **not** expected to deliver specialised drug and alcohol treatment. This includes the following:

- Initiation of Opiate Substitution Therapy

  Clients requiring initiation of this therapy should be referred to a drug and alcohol service.

  The mental health service remains the primary care coordinator for the client until another service has agreed to accept the client. Please see Principles of Practice on page 15

- Management of complicated withdrawal

  Mental health services have the skills to effectively manage withdrawal in its early stages. Proper management during this time can effectively reduce or prevent a progression to complicated withdrawal. For information about withdrawal management please refer to page 39.

  Complicated withdrawal may be life threatening due to accidental injury, dehydration, electrolyte imbalance, seizures, delirium tremens, or the negative impact on other concurrent disorders, including acute infection, renal disease or diabetes. The care and treatment of a client experiencing acute, complicated withdrawal symptoms should be conducted in consultation with a drug and alcohol specialist service.

- Long term Drug and Alcohol Counselling

  If the need of the client includes the provision of longer term drug and alcohol specific counselling which is outside the scope of the mental health service, the client should be referred to drug and alcohol services with the specialised skills to provide this.

SECTION 5

Service delivery frameworks

There are several possible models of service care delivery for people with comorbid mental illness and substance use disorders. The provision of care depends upon a number of contributing factors including, client acceptance and preference of care deliverer, expertise of services and availability of service provision.

People severely disabled by mental health problems and disorders and adversely affected by problematic substance use disorders would generally be the primary responsibility of mental health services with extra support and assistance provided by drug and alcohol services as required.

CASE STUDY – DIANE

Diane is a 32 year old sole parent with two children, 8 and 10. She suffers from major depression. Her first episode of depression followed the birth of her oldest child. She has had many inpatient admissions to the local mental health unit, usually following a serious suicide attempt whilst intoxicated. Diane admits to drinking 4–6 glasses of wine each day but staff suspect that she minimises her use and drinks more, especially when she is depressed. She has always refused contact with drug and alcohol services and denies that her drinking is a problem. Her psychiatrist believes that she uses alcohol to self-medicate when she is depressed and that her alcohol use is exacerbating her depressive illness.

During her last inpatient admission to the mental health unit, Diane required treatment for alcohol withdrawal. This was the first time she had had withdrawal symptoms during an admission. Her children (who stay with their grandmother when Diane is in hospital) told the mental health social worker that sometimes their mother is too drunk to cook dinner for them and they go to bed hungry. The social worker is obligated to make a notification to the Department of Community Services (DOCS) because she is concerned about the welfare of the children. The social worker discusses Diane's alcohol use at the ward's multidisciplinary team meeting. The team expresses their concern about Diane and the safety of the children. A plan is developed for the community mental health team to follow up Diane's case after she is discharged from the unit.

Diane's Community Mental Health Case Manager (MH CM) decides to seek advice from the local Drug and Alcohol Service about how the mental health team could best assist Diane. Diane still refuses to have contact with D&A services but has agreed to weekly appointments with the MH CM. They decide that the best approach is to have the MH CM focus on engagement with Diane to develop a therapeutic relationship. When this had been established, the MH CM could offer some psycho education to Diane concentrating on the harmful effects of alcohol, the effects of alcohol use on depression and the positive effects of ceasing use.

The D&A service provided brochures to assist with this education. They also suggested that Diane's mother could visit their family counsellor to learn some strategies to support Diane. If Diane does become contemplative about ceasing her alcohol use, the D&A service are willing to offer a more structured service as required.

People severely disabled by substance use disorders and adversely affected by mental disorders are generally the responsibility of drug and alcohol services with input from specialist mental health services as required.

CASE STUDY – MELISSA

Melissa is a 26 year old woman with a cocaine dependence. She has been using regularly cannabis monthly since the age of 18 and started experimenting with cocaine last year. Originally her use was primarily at parties and social gatherings however her dependence has escalated quickly and she has been using almost daily for the past 5 months. She has been hiding her use from her friends and family, however they have noticed changes in her behaviour. She is becoming increasingly isolated and is spending most of her time with her boyfriend who is also a heavy user. Melissa is currently at risk of losing her job as a personal assistant due to poor attendance and a decreased ability to meet her role expectations.

Melissa attends her local General Practitioner after repeated requests from her parents and concerned friends. She admits that she has been feeling 'off her game' and feels better when high, so increases her use to compensate for these feelings.

Melissa is admitted an inpatient unit where her withdrawal symptoms are managed. She is then referred to a drug and alcohol community case manager. At their first meeting the case manager identifies the need to focus on issues relating to relapse prevention and underlying self esteem and relationship issues. She is concerned however when Melissa speaks to her case manager about how she is feeling quite flat and depressed. The case manager contacts the local mental health service for advice.

The mental health caseworker discusses some strategies that the drug and alcohol case manager could implement to help support Melissa and agrees that if Melissa's feelings did not alleviate a referral to the service could be arranged.

People severely disabled by comorbid mental health and substance use disorders will require a coordinated, integrated approach by both mental health and drug and alcohol services. Joint case management or an identified service provider with responsibility as care coordinator from the service most able to meet the current needs of the client will ensure continuum of care.

CASE STUDY – ROBERT

Robert is a 34 year old man with chronic schizophrenia, cannabis dependence and alcohol abuse problems, He lives with his mother in the western suburbs. Since the age of 18, Robert has been admitted to a psychiatric hospital for management of psychosis 11 times. The involvement of Robert's mother is viewed as quite supportive although she has become verbally abusive to staff on several occasions stating that the system has failed her son.

Robert is allocated to a new case manager with the community mental health team after his previous case manager left the service. He has had no contact with AOD services. The new case manager takes the opportunity to review Robert's history and current situation. She notes that Robert drinks 5-10 standard drinks on average, three days per week and also smokes 4-10 cones of "hydro" each day. Robert sees no problem with this and is not interested in changing his behaviour. Robert also has no insight into his illness and only takes his antipsychotic medication at his mother's insistence.

Attempts to raise the issue of substance use in a non-confrontational manner and engage Robert in discussion about his feelings regarding his substance use are not successful. Unfortunately, Robert makes no change. A referral to AOD services would be futile at this point because of Robert's lack of motivation and pronounced negative symptoms of schizophrenia – he would be very unlikely to attend an appointment.

Robert's case manager makes contact with a clinician from drug and alcohol clinical services for advice. The case manager is informed that the approach they are taking was appropriate, and advised not to rush things at this point of the therapeutic relationship. A plan is developed for Robert's case manager to continue with more engagement strategies such as providing practical assistance, engaging Robert's mother and offering her some motivational tips to use with Robert. After the case manager is better engaged, it is hoped that Robert will be more accepting of a joint assessment or at least be prepared to receive some more persuasion stage interventions such as more focused educational and motivational interventions.

After several months, Robert's case manager feels that the she has engaged with Robert well enough to start motivational interventions. The case manager is aware that working with Robert on his substance use and mental health issues is likely to be a long term process and that good clinical supervision can help maintain focus over time.

People mildly to moderately disabled by comorbid mental health and substance use disorders may access both mental health and drug and alcohol services from time to time, but the primary care provider would in most cases be the general practitioner. At the milder end of the spectrum, this group represents the majority of people affected by dual disorders.

CASE STUDY – JULIAN

Julian is a 30 year old, heavy smoker who lives with his long-time girlfriend in a house in Wollongong.

Julian presents to his General Practitioner with a severe chest infection. In completing an assessment the GP enquires about Julian's drug and drinking history. Julian reports that he has been drinking an average of 6 drinks a day with a binge on the weekend for the past few months. He acknowledges that this is more than 'his usual' amount and that he has begun drinking more than many of his mates.

Julian reveals that one of his mates had recently told him that he thought that he was overdoing it with the drinking and that his girlfriend has threatened to end their nine year relationship unless he cuts down. He also has reported that he has been feeling less optimistic about his life and feeling more stressed in recent months.

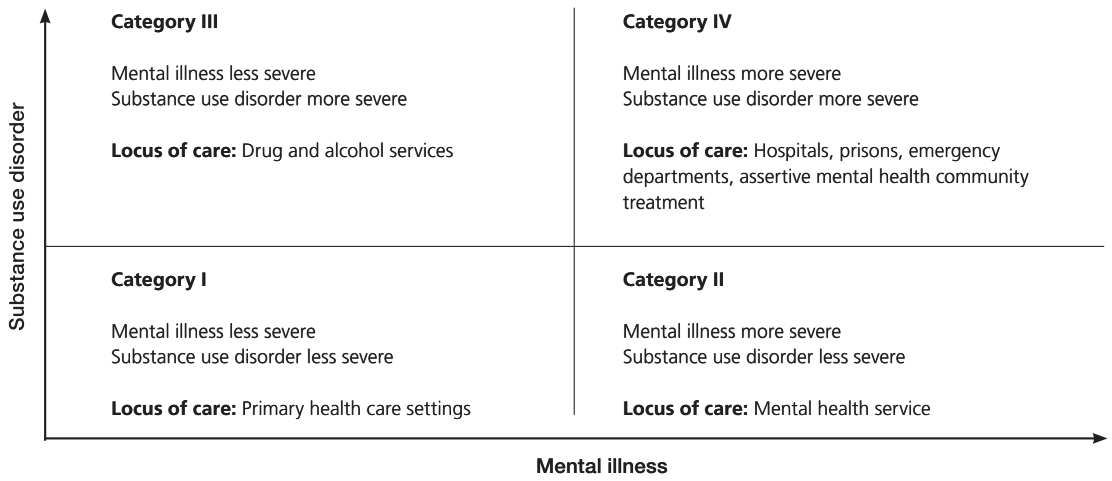
The GP conducts a brief intervention on alcohol and discusses with Julian some strategies to help reduce his drinking. He is provided with some written information about alcohol and risky levels of drinking. Julian is also referred to a psychologist to address his depressed mood and feelings of hopelessness. The GP asks Julian to check back in to see how he is going with his drinking in the next few weeks.

Remember Principle Number One – the service where a client presents is responsible for the primary coordination of client care until such time as another service agrees to accept care.

5.1 Level of Care Quadrants

The diagram below clearly illustrates the different Level of Care Quadrants between which a client may transition. A client may require more intensive intervention than others and the nature of the intervention required is determined by their placement within each specific quadrant.

A comprehensive assessment is required in order to determine an individualised care plan approach for each client that considers their preferences, needs, specific diagnosis, phase of recovery/change, level or severity of impairment and their level of engagement.27



Adapted from Center for Substance Abuse Treatment. *Substance Abuse Treatment for Persons With Co-Occurring Disorders. Treatment Improvement Protocol* (TIP) Series 42. DHHS Publication No. (SMA) 05-3992. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

5.2 What is Integrated Care?

Integrated care is defined as the provision of mental health and substance use treatment by one clinician or within one service where clinicians assume responsibility for synthesising information and ensuring that a client moves toward recovery with a consistent approach and consistent information.

Integrated service provision may take many forms. One framework is that of a designated specialist service; however integrated care may also occur at any mental health or drug and alcohol facility where programs and practitioners target both issues concurrently.

The Australian Commonwealth Government National Comorbidity Project summarised the body of literature on integrated treatment using NHMRC guidelines and concluded that "evidence suggests that an integrated mental health and drug and alcohol treatment for people with a range of dual diagnoses is beneficial across both mental health and substance use outcomes".[28]

Although described as the 'preferred model' for care delivery, the evidence in support of its continued use is modest and further study is required.[29]

5.3 Parallel and Sequential care

Parallel and sequential care may be appropriate in instances where skilled clinicians are happy to provide treatment and act as primary coordinator for care of an individual.

Sequential or serial care

Serial treatment is where one disorder is treated initially before the client is "handed over" to the team responsible for treating the other disorder. There are two distinguishing features of the serial treatment model:

- the treatment of the substance use and mental health problems are managed by different clinicians at different services
- each disorder is handled separately at a different time point.

This fragmentation of services in the past has lead to many clients being 'lost' to treatment due to the restrictions or criteria that a client was required to meet prior to service acceptance. This has been referred to as "ping-pong therapy", ultimately resulting in no treatment.

Parallel treatment

This approach involves mental health and drug and alcohol workers working with the client at the same time.

While parallel treatment offers some advantages over serial treatment in terms of dealing with both problems, there are some risks and limitations. Fragmentation of treatment can occur resulting in clients receiving conflicting information from service providers. Clients often have difficulty navigating a complex system of care delivery. This may result in the client not engaging with either service. Success is dependent on both sectors maintaining good communication.

5.4 Service delivery

To assess your service's ability to provide care for clients with a comorbid condition, consider using the Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index or the Dual Diagnosis Capability in Mental Health Treatment (DDCMHT) Index tools.

These resources are available for download from:
DDCAT – http://www.vaada.org.au/resources/items/2008/08/226803-upload-00001.pdf
(this version has been adapted for use in the Australian context)

DDCHMHT – http://www.adp.state.ca.us/cod/pdf/ddcat_ddcmht_desription.pdf
(this version has not been adapted for use in Australian context)

SECTION 6

Screening

Given the prevalence of clients with comorbid mental health and substance use disorders, it is important that all clients are screened for each condition. This will alert the practitioner to the potential presence of problems allowing for proper intervention at the earliest opportunity.

6.1 What is screening?

Screening is a component of assessment. Screening is a brief method of determining whether a client has a specific problem (such as a mental health or substance use disorder). A positive screen indicates the need for a more detailed assessment of the condition – it does not confirm its presence.[30]

Conversely, a negative screen does not totally rule out the possibility of a comorbid disorder. A negative screen may be the result of a flaw in the tool being used or the questions being asked. It is therefore important to screen every client during different interactions.

It is recommended that screening for a comorbid mental health or substance use disorder is brief. This reduces the risk of interfering with the relationship that is being formed between the practitioner and the client during the first few interactions. A formal tool can be used or a service can decide to integrate a standard set of questions that are asked of every client during their initial consultation.

6.2 What screening tools should be used?

The decision regarding what type of screening tool to use is dependent on the purpose of the screen.[31]
The appropriateness of a tool is selected based upon a number of characteristics including:

Reliability: the ability of a screening test to show consistent results between tests

Validity: how accurate the screening tool is at detecting a disorder

Sensitivity: the proportion of people who are correctly identified as having a disorder by the screening tool

Specificity: the proportion of people who are correctly identified as not having a disorder by the screening tool

Availability: the availability of the tool in the public domain

Ease of use: the ease with which it can be used (is it completed by a client or a clinician?)

Appropriateness: the usefulness of the tool in detecting the disorder in the population you are working with (e.g. has it been shown to be appropriate for detecting drug and alcohol disorders or mental health symptoms?)

Acceptability: the acceptability of the tool to your organisation, colleagues, partner agencies etc.

6.3 Screening to detect a comorbid mental illness or substance use disorder

Screening tools and the use of specific clinical questions

A number of screening tools exist to detect mental health and substance use disorders. These include formal tools that are administered and rated by a clinician, those that are self-administered and those which are more generally integrated into one's practice. Clinical questioning is a useful screening technique that can be introduced into the first contact made with a client and into subsequent interactions. It is non-intrusive, uses the skills of the practitioner to elicit information and has minimum interference with the engagement of the client.

6.4 Questions to screen for a possible mental health problem

The following questions may assist a drug and alcohol practitioner to screen clients for the possible presence of a mental health problem.

- Have you ever seen a doctor or psychiatrist for emotional problems or problems with your 'nerves'/anxieties/ worries?
- Have you ever been given medication for emotional problems or problems with your 'nerves'/anxieties/ worries?
- Do you currently have a mental health worker, psychiatrist, psychologist, general practitioner or other health provider?
- Are you having any difficulties sleeping? Can you tell me about that?
- Have you experienced any changes in your appetite? Are you eating more or less than is normal for you?
- Are you experiencing any changes in your ability to concentrate or complete a task?

6.5 Questions to screen for a possible SUD

The following questions may assist a mental health practitioner to screen clients for the possible presence of a substance use disorder.

- Have you ever used drugs or alcohol?
- When did you last use drugs or alcohol?
- What drug did you last use?
- How frequently do you use?
- How much drug(s) did you or do you use?
- Is this a normal amount for you?
- Have you increased or decreased your use lately?
- Please elaborate….

Language used for different drugs

If a mental health practitioner is unfamiliar with the language used to describe drugs the table below may provide assistance.

The language used can vary significantly depending on location, age and experience of a client however familiarity with some of the terms may help to reduce unease when conducting a screen/assessment[17].

DRUG	STREET NAMES
Alcohol	grog, piss, cans, six pack, long necks, slabs, casks
Benzodiazepines	benzos, pills, jack & jills, downers, seras, rowies
Heroin	smack, hammer, h, gear
Methadone syrup Physeptone tablet	'done
Morphine, Oxycodone, Oxycontin	oxy
Buprenorphine	bupe
GHB (gamma-hydroxybutyrate)	fantasy, grievous bodily harm, liquid ecstasy, liquid e
Cannabis/marijuana *Bush: medium strength Hydro: high strength*	grass, pot, ganja, reefer, joint, yarndi *Implements:* bong, cone
Amphetamine/methamphetamine powder	speed, goey, uppers, whiz, velocity
Methamphetamine base (stronger than powder)	base, paste, wax, pure, point,
Methamphetamine ice (stronger than base)	crystal, crystal meth, shabu, yaabaa, point
Cocaine	coke, c, snow, nose candy, okey-doke, crack, free base
Ecstasy/MDMA (methylenedioxymethamphetamine)	xtc, eccy, E, pills
LSD (lysergic acid diethylamide)	trips, acid
Magic mushrooms	golden top mushrooms, magic mushies
Ketamine	special k, k, vitamin k
PCP (phencyclidine)	angel dust, super weed, killer weed

6.6 Biochemical measures for screening purposes

At certain times, biochemical measures may also be considered for screening purposes, for example when a client is unable to provide information in Emergency Departments and/or inpatient settings where a client is substantially confused or presents with cognitive impairment. This information may be essential to ensure proper care is provided during medical crises. When the client is able and symptoms have resolved, the client may provide more detailed information to assist in care planning.

These biochemical markers are expensive and often insensitive. Evidence suggests that the presence of routine urine screen results in inpatient records does increase the number of substance use disorder diagnoses assigned. In addition, it is thought that biochemical tests can reduce the trust between agencies and clients therefore inhibiting engagement. For these reasons, it is not recommended that biochemical measures be used as a standard screening tool to detect substance use disorders.[32]

Sourced from the NSW Department of Health (2008) *NSW Drug and Alcohol Withdrawal Clinical Practice Guidelines*. North Sydney: NSW Health.

SECTION 7

Assessment

An assessment is a process rather than a discrete point in time. It requires attention and time in order to:

- confirm whether the condition or disorder is present
- assess the severity, impact and relevance of a condition (including the clients' physical needs and conditions which may require attention)
- assess a client's perceptions, attitudes and beliefs about the condition or disorder
- use this information to inform and develop integrated treatment planning around the disorder (in dual diagnosis, around both disorders)
- use information from collateral sources (family, file history etc).[33]

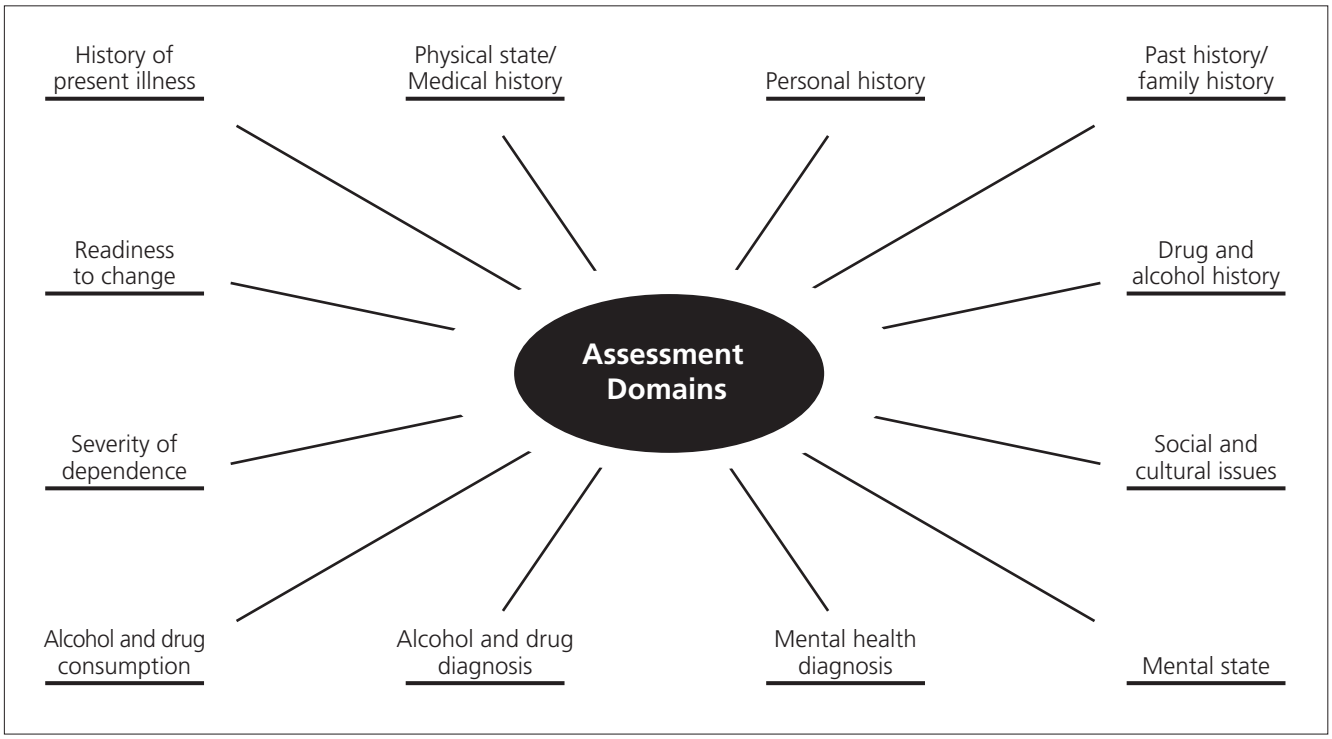
7.1 Domains for assessment

In addition to the assessment that would regularly be completed by either sector, mental health services are required to complete a drug and alcohol assessment and a drug and alcohol service is required to complete a mental health assessment.

7.2 Assessment Tools for use by Drug and Alcohol Practitioners to assess mental health

The Mental Health Clinical Documentation Suite (formerly MHOAT)

It is mandatory for all government mental health services within NSW to implement the Mental Health Clinical Documentation Suite (previously known as MH-OAT).[34]



The assessment module within this suite of documents provides a framework for documenting a mental health assessment on first contact and/or at other times where a comprehensive assessment is indicated.

The assessment tools implemented by a drug and alcohol service's policies and procedures may have previously addressed some of the domains assessed within this framework. A copy of the assessment proforma is available at Appendix 2.

Mental state examination (MSE)

Within the Mental Health Clinical Documentation Suite assessment from a MSE is recommended. As psychoactive drugs and mental illness may affect cognition, emotions and behaviour, the conduct of a MSE helps to provide insight into the status of a client. A MSE involves assessing the following:

- Appearance and behaviour (e.g. physical description, level of personal hygiene and grooming)
- Behaviour during interview (e.g. rapport, engagement, psychomotor activity, interactions at assessment)
- Affect (appropriate emotional responses e.g. appropriate, restricted, flattened)
- Mood (reported feeling or emotion e.g. depressed, angry, euphoric or distressed)
- Speech (e.g. quantity, rate, volume, tone, unusual characteristics)
- Thought form (e.g. logical, tangential, blocked, concrete)
- Thought content (e.g. obsessions, delusions, suicidal or homicidal ideation, view of future, for children consider play and fantasy)
- Perception (e.g. auditory, visual or somatic hallucinations)
- Cognition and intellectual functioning (e.g. orientation to time/place/person, memory, attention/concentration, planning)
- Insight and judgement.

A MSE can be performed on a client who appears intoxicated.

Other Assessment Tools

Other assessment tools including components of the PsyCheck (Appendix 3) and validated assessment tools can also be used once endorsed by the service.[35] These guidelines do not mandate the use of any particular tool.

7.3 Assessment tools for Mental Health Services to assess drug and alcohol use

The Mental Health Clinical Documentation Suite (formerly MHOAT)

The Mental Health Clinical Documentation Suite (previously known as MH-OAT) is required within NSW Health and Area mental health services.

A specific substance use assessment module is available within the MH-OAT. This module, developed in consultation with the NSW Health Drugs and Alcohol Quality in Treatment Advisory Group, provides a structured format for the documentation of drug and alcohol use. It is appropriate for use in both inpatient and community settings and should be completed at first contact and at other times where further assessment is indicated. A copy of the assessment proforma is available at Appendix 4.

The Alcohol, Smoking and Substance Involvement Screening Test – ASSIST

Alternatively, a practitioner and/or a service may favour the use of a standardised tool to assist in the screening of all clients attending a service. In this instance, the ASSIST tool is recommended.

The ASSIST tool was developed by the World Health Organisation and is appropriate for use in a wide variety of health care settings including general ward settings, emergency departments, psychiatric settings and drug and alcohol services amongst others. It is appropriate for administration by a mental health practitioner[36] and requires approximately 10 – 20 minutes.

ASSIST assesses the following items:

1. substance use (ever and recently)
2. problems related to substance use
3. risk of harm
4. dependence
5. IV drug use.

A copy of the assessment proforma is available at Appendix 5.

The Alcohol Use Disorders Identification Test – AUDIT

The AUDIT tool was developed by a WHO collaborative study conducted in six countries. This brief screen is used for a range of alcohol consumption problems and harms. It is suitable for use in a wide variety of settings and can be administered by a practitioner or completed by a client.

The AUDIT tool is located at Appendix 6.

Taking a retrospective consumption history

An important aspect of assessment is developing an understanding of the frequency and patterns of use. The following steps provide guidance as to how to collect this information from a client in a systematic and useful manner.

- Always ask about each drug group (e.g. tobacco, alcohol, opioids, benzodiazepines, cannabis, amphetamines, cocaine, ecstasy and related drugs).
- Start with most recent use. Ask, "When did you last have anything to drink/use?"
- Ascertain how much was consumed at that time.
  - Inquire back through that day: "What about during the day?"
- Link consumption to activities. "What were you doing during the day?" Then, for example, "How much did you drink/use when you went to your friends' house?"
- Examine consumption through each day for the past week.
- Ask if that was a typical week's pattern. If not, ask specifically how it differed (i.e. how much more or less of each drug than usual).
- Recording a complete consumption history is not always practical because of the context of the presentation, including the physical and mental state of the person.

NOTE: A common drug combination that should be noted is alcohol and benzodiazepines. These drugs produce cross-tolerance and regular use of both can make withdrawal more severe and/or protracted.

Reproduced from the NSW Department of Health *Drug and Alcohol Withdrawal Clinical Practice Guidelines,* 2008.

7.4 Suicide risk

In addition to screening for mental illness and/or drug and alcohol disorders, it is essential to screen for risk of suicide for every client. This brief screen provides an opportunity to intervene early.

Screening questions for suicide risk:

- 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 a firearm or access to other lethal means?

Concern about the safety of the client should result in immediate action.

Interventions to deal with suicide risk

The NSW Department of Health has issued Policy Guidelines for the Management of Patients with Possible Suicidal Behaviour for NSW Health Staff and Staff in Private Hospital Facilities PD2005_121. These guidelines outline the appropriate standards for the treatment and care of clients with suicidal behaviour in treatment settings within NSW.

A key component of this circular is the Framework for Suicide Risk Assessment and Management for NSW Health staff. This document provides detailed information on conducting suicide risk assessments and specific information on the roles and responsibilities of services to guide both the assessment and management processes. This document is available at: http://www.health.nsw.gov.au/pubs/2005/pdf/suicide_risk.pdf

People displaying possible suicidal behaviours must receive a comprehensive mental health assessment including a detailed suicide risk assessment. The goal of a suicide risk assessment is to determine the level of suicide risk at a given time in order to provide the appropriate clinical care and management.

It is recognised that there are circumstances where drug and alcohol practitioners and services will be required to conduct comprehensive suicide risk assessments and be responsible for the ongoing management of people at risk of suicide. The type and level of services provided will depend on the skill and competency of the health worker. Clients with a suicide risk will not all require mental health services.

The Commonwealth government has supported the development of The Living Is For Everyone (LIFE) Framework. The goal of the strategy is to reduce suicide attempts, loss of life through suicide and the impact of suicidal behaviour. The website below is Australia's national resource for the National Suicide Prevention Strategy: http://www.livingisforeveryone.com.au/LIFE-Framework.html

Key considerations for managing clients at risk for suicide

Detection – assess all clients for potential suicide risk.

Safety – use principle of safety to guide care (ensure appropriate observation and supervision).

Consultation – treatment should include collaboration between the client, family, general practitioner and other care providers including senior staff members where required.

Referral – where the needs of the client are beyond the scope of practice for the service, provide a coordinated referral to an appropriate service provider.

Information – provide information about suicide risk to both the client and carers or significant others including appropriate printed resources (see table below).

7.5 Key resources for the management of clients at risk of suicide

Policy Guidelines for the Management of Patients with Possible Suicidal Behaviour for NSW Health Staff and Staff in Private Hospital Facilities	http://www.health.nsw.gov.au/policies/PD/2005/pdf/PD2005_121.pdf
Suicide Risk Assessment and Management Protocols for the following settings:	
Community Mental Health Service	http://www.health.nsw.gov.au/pubs/2004/community_mental_hlt.html
Emergency Department	http://www.health.nsw.gov.au/pubs/2004/emergencydept.html
General Community Health Service	http://www.health.nsw.gov.au/pubs/2004/general_community.html
General Hospital Ward	http://www.health.nsw.gov.au/pubs/2004/general_hosp_ward.html
Justice Health Long Bay Hospital	http://www.health.nsw.gov.au/pubs/2004/justice_longbay.html
Mental Health In-Patient Unit	http://www.health.nsw.gov.au/pubs/2004/inpatient_unit.html
Suicide: We can all make a difference. NSW Suicide Prevention Strategy	http://www.health.nsw.gov.au/pubs/1999/pdf/suicide.pdf
Framework for Suicide Risk Assessment and Management for NSW Health Staff	http://www.health.nsw.gov.au/pubs/2005/pdf/risk_assessment.pdf
The revised Living Is For Everyone (LIFE) framework	http://www.livingisforeveryone.com.au/LIFE-Framework.html
LIFE reference card	http://www.livingisforeveryone.com.au/IgnitionSuite/uploads/docs/lifereferencecard.pdf
LIFE Fact Sheets (a series of 24 fact sheets for suicide and self harm prevention)	http://www.livingisforeveryone.com.au/LIFE-Fact-sheets.html

SECTION 8

Acute Crisis Management

Managing an acute crisis

The principles for the management of client in an acute crisis are essentially the same regardless of whether the client presents with a mental health crisis or acutely intoxicated.

The key actions include addressing the presenting (behavioural disturbance) symptoms by:

- assessing the client in a safe environment
- attempting to de-escalate and/or distract the client with a focus on engagement
- considering the legal issues impacting care (seek consent if available/possible)
- providing medication/sedation if required
- using physical restraints (manual and/or mechanical) if required
- calling for security or police assistance if there is any danger to the client or others
- considering possible serious acute medical illness.

Often a combination of these means will be necessary.[37]

Note:

Physical threat of immediate injury to the client or others should be treated as an emergency requiring immediate intervention.

Clients who have carried out an act of violence prior to arrival should be considered very high risk even if they appear calm on initial presentation.

Detailed information on the strategies regarding the management of clients with a comorbid disorder who are experiencing an acute crisis are included with the *NSW Health, Mental Health for Emergency Departments – A Reference Guide* (2008).

This resource will be accessible via the NSW Health website when complete.

SECTION 9

Withdrawal

9.1 What is withdrawal?

Withdrawal occurs in drug-dependent people who stop or considerably reduce their drug use. When a person is dependent on a drug, withdrawal of the drug carries risks of physical harm, psychological trauma and (rarely) death.

It is best to assume that any person who has consumed alcohol and other drugs excessively on a daily basis over a significant period of time (weeks) can experience some withdrawal symptoms on ceasing or reducing their intake.

Drug withdrawal may occur in a number of different clinical settings. For example, in a controlled, predictable manner on a withdrawal unit, unexpectedly in an acute care setting following an unplanned admission or in the community.

The severity of withdrawal symptoms can differ depending on the person, the drug(s) used, duration of use, past experience(s) of withdrawal, other psychological and physical conditions (e.g. nutrition, hydration) or illness. Severity is not clearly or directly linked to the quantity of drugs consumed.

The aim of withdrawal management is to minimise the risks associated with withdrawal. [38]

9.2 The diagnosis of dependence

A diagnosis of dependence is generally required to understand and manage drug withdrawal.

According to the DSM *IV* TR substance dependence is defined as a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. Tolerance, as defined by either of the following:
   a) a need for markedly increased amounts of the substance to achieve intoxication or desired effect
   b) markedly diminished effect with continued use of the same amount of the substance.
2. Withdrawal, as manifested by either of the following:
   a) the characteristic withdrawal syndrome for the substance
   b) the same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms
3. The substance is often taken in larger amounts or over a longer period than was intended
4. There is a persistent desire or unsuccessful efforts to cut down or control substance use
5. A great deal of time is spent on activities necessary to obtain the substance, use the substance, or recover from its effects
6. Important social, occupational or recreational activities are given up or reduced because of substance use
7. The substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

9.3 General principles of withdrawal management for a client with a comorbid mental health and substance use disorder

- The primary goal of withdrawal must be client safety, rather than long-term abstinence
- The objectives of withdrawal management are to:
  – interrupt a pattern of heavy and dependent use,
  – reduce the severity of withdrawal symptoms,
  – avoid complications during withdrawal,
  – promote engagement in treatment.

In order to effectively coordinate care and provide equitable and accessible care for clients with a comorbid disorder during this time, a primary care coordinator for each client must be identified at all times (Please refer to Principles of Practice on page 15).

A client may request to continue treatment where they initially presented. If this occurs then the treatment must remain within the first service as long as it is safe, with case conferencing and consultation in order to provide the best care possible[39,40].

9.4 Recognising withdrawal

Active withdrawal states can produce symptoms that mimic psychiatric disorders, including major depression, anxiety states and psychosis. Substance use and withdrawal can also result in disturbances of mood and behaviour that may resemble states seen with personality disorders. See the table below.

Drug/Alcohol	Onset	Duration	Features
Alcohol	As blood alcohol falls; depends on rate of fall and hours after last drink	3-7 days (up to 14 in severe withdrawal)	Anxiety, agitation, sweating, tremor, nausea, vomiting, abdominal cramps, diarrhoea, anorexia, craving, insomnia, elevated blood pressure, pulse and temperature, headache, confusion, perceptual distortions, disorientation, hallucinations. Seizures may occur and be life-threatening
Benzodiazepines	1-10 days (depending on half-life of the drug)	3-6 weeks (may be longer)	Anxiety, headache, insomnia, muscle aching and twitching perceptual changes, feeling of unreality, depersonalization. Seizures may occur and be life-threatening
Opioids	6-24 hours (may be longer with long acting opioids)	Peaks 2-4 days, ceases 5-10 days (more prolonged for longer acting opioids)	Anxiety, craving, muscle tension, muscle and bone ache, muscle cramps and sustained contractions, sleep disturbance, sweating, hot and cold flushes, piloerection, yawning, lacrimation and rhinorrhea, abdominal cramps, nausea, vomiting, diarrhoea, palpitations, elevated blood pressure and pulse, dilated pupils.
Cannabis	Within 24 hours	1-2 weeks	Insomnia, shakiness, irritability, restlessness, anxiety, anger, aggression
Psychostimulants	6-12 hours (cocaine); 12-24 hours (amphetamines)	Several weeks for withdrawal phase, then months for extinction	3 phases. Crash: fatigue, flat affect, increased sleep, reduced cravings. Withdrawal: fluctuating mood and energy levels, cravings, disturbed sleep, poor concentration. Extinction: persistence of withdrawal features, gradually subsiding.

Adapted from NSW Department of Health. (2006). *Opioid Treatment Program: Clinical Guidelines for methadone and buprenorphine treatment*. North Sydney: NSW Health.

9.5 Management of withdrawal focuses on the following:

- assessment of withdrawal risk (past history of severe withdrawal including seizures or delirium tremens (DTs)
- early recognition of withdrawal
- assessment of psychoses and/or suicidal intent
- anxiety management
- documenting and reporting withdrawal symptoms
- preventing withdrawal complications where possible
- preventing progression to severe withdrawal
- decreasing risks of any injury to self or others
  - eliminating risk of dehydration, electrolyte or nutritional imbalance
  - minimising risk of seizures
  - identifying concurrent illness that masks, mimics or complicates withdrawal
  - providing supportive care
  - discharge planning for after-care and referral.

Adapted from the NSW Department of Health. *Clinical guidelines for nursing and midwifery practice in NSW: Identifying and responding to drug and alcohol issues.* North Sydney: NSW Health.

9.6 Assistance or referral

The Drug and Alcohol Specialist Advisory Service (DASAS) advises on the clinical diagnosis and management of patients with alcohol and other drug related problems. The telephone service is free and is available 24 hours a day, 7 days a week.

Drug and Alcohol Specialist Advisory Service (DASAS)
Phone: 02 9361 8000
Free call: 1800 023 687 (outside Sydney)

The NSW Department of Health Drug and Alcohol Withdrawal Clinical Practice Guidelines provide the most up-to-date knowledge and current level of best practice for the treatment of withdrawal from alcohol and other drugs.

Further information and advice is available from:

Drug and Alcohol Withdrawal Clinical Practice Guidelines

http://www.health.nsw.gov.au/policies/gl/2008/GL2008_011.html

SECTION 10

Anxiety

10.1 What is an anxiety disorder?

Anxiety is considered a disorder when a person's symptoms of fear or worry are grossly disproportionate to reality, the symptoms restrict and hamper the person's normal life, do not lessen with reassurance and may be accompanied by thoughts and actions that are exaggerated.

There are many anxiety disorders described in the DSM-*IV*-TR. 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 diagnose anxiety disorders:

- general medical conditions which contribute to an anxiety disorder, 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.

Referenced from NSW Department of Health. *Mental Health Reference Resource for drug and alcohol professionals*, 2007.

Key features of specific anxiety disorders

Panic Disorder with or without agoraphobia
Recurrent unexpected panic attacks in situations where most people would not be afraid. Client may actively avoid situations in which panic attacks are predicted to occur. Intolerance of physical symptoms of anxiety.

Social Anxiety disorder (SAD) and (or) social phobia
Excessive or unrealistic fear of social or performance situations. Intolerance of embarrassment or scrutiny by others.

Specific phobia
Excessive or unreasonable fear of a circumscribed object or situation, usually associated with avoidance of the feared object (for example, an animal, blood, injections, heights, storms, driving, flying, or enclosed places).

Obsessive Compulsive Disorder (OCD)
Presence of obsessions; recurrent, unwanted, and intrusive thoughts, images, or urges that cause marked anxiety (for example, thoughts about contamination, doubts about actions, distressing religious, aggressive, or sexual thoughts). Compulsions; repetitive behaviours or mental acts that are performed to reduce the anxiety generated by the obsessions (for example, checking, washing, counting, or repeating).

Generalised Anxiety Disorder (GAD)
Uncontrollable and excessive worry occurring more days than not, about a number of everyday, ordinary experiences or activities. Often accompanied by physical symptoms (for example, headaches or upset stomach). Intolerance of uncertainty.

Post Traumatic Stress Disorder (PTSD)
Occurs after a traumatic event to which client responds with intense fear, helplessness, or horror; clients relive the event in intrusive memories, avoid reminders of the event, and experience emotional numbing and symptoms of increased arousal.

Adapted from DSM-IV-TR (1) and referenced from Clinical practice guidelines for the management of anxiety. (2006). *Canadian Journal of Psychiatry.* Vol 51(Supplement 2).

10.2 Key points for consideration

- It can be difficult to distinguish between substance-induced anxiety and an underlying anxiety disorder
- A 4 week period of abstinence is required for a new, definitive diagnosis. Exceptions to this rule include:
  – risk of harm to self/others,
  – a previous history of anxiety disorder
- You can treat symptoms of anxiety without a diagnosis
- Psychosocial support and therapy is recommended
- Benzodiazepines should largely be avoided except in the context of withdrawal
- Selective serotonin reuptake inhibitors are indicated for the treatment of OCD and panic disorder in line with best practice guidelines
- Cognitive Behaviour Therapy (CBT) may be appropriate.

10.3 Clinical care considerations for clients with comorbid anxiety and substance use disorders

Findings from a number of multiple large-scale epidemiological surveys confirm high rates of comorbidity between anxiety disorders and substance abuse[41 42].

Time lapse before definitive diagnosis

The relationship between anxiety and substance use disorders is complex and bi-directional. As a result, it is often difficult to distinguish between the two disorders. Observing the client over time, particularly during times of abstinence and/or periods of stability on a maintenance medication can assist in a definitive diagnosis. In general, a reasonable time prior to making a definitive diagnosis is approximately 4 weeks.

Clients who agree to cease using may go through a withdrawal period. For information regarding how to manage withdrawal, please refer to the section on withdrawal on page 27.

This may not be appropriate for all clients, as some will elect not to cease using. It is appropriate to treat the symptoms experienced by these clients. Please refer to the section titled 'Working with clients who do not cease using' for further information.

The timeframe of abstinence provides an opportunity to observe the client's symptoms and distinguish between those caused by the substance use and those resulting from an anxiety disorder. If a client demonstrates sustained anxiety symptoms despite a 4-week period of abstinence, it is likely they have a co-existing anxiety disorder, which requires treatment in its own right.[43]

Certain 'warning signs' such as a family history of anxiety disorders and previous symptoms may assist in the early identification or suspicion that a client has a comorbid anxiety disorder.[44] It is important to note that only qualified practitioners can make a clinical diagnosis. Other practitioners are responsible for assessing, identifying and documenting signs and symptoms which a client may display, without labelling the client with a specific disorder.

Exceptions to the waiting period

The need for a waiting period prior to a definitive diagnosis is not absolute. If any of the criteria listed below are met, a waiting period to definitive diagnosis is not recommended and interventions can be initiated immediately:

- The client is a significant risk of harm to themselves or others – intervention should be immediate,
- There is evidence from assessment that a diagnosis is present (e.g. the client is receiving active care from a mental health professional to address a diagnosed illness).

Working with clients who are continuing to use

For many clients the aim of their drug and alcohol treatment may be to reduce the amount of a substance that is used rather than to completely cease using. If this is the case then the practitioner can address the symptoms of the anxiety disorder and initiate harm reduction strategies with the client in the following manner.

What is harm reduction?

Harm reduction is a public health philosophy which seeks to prevent and/or reduce the harm associated with potentially risky activities, not on preventing people from performing those activities. Harm reduction is a pragmatic concept that recognises the reality of drug use. The harm reduction approach acknowledges that it can be more effective for individuals and communities to reduce the harms associated with drug use than to support attempts to eliminate drug use altogether.

Engagement

Engagement refers to the client relationship with a counsellor and the dedication/motivation to participate in treatment. It is a critical part of substance abuse treatment and an important element of the care for clients with comorbid disorders specifically, since remaining in treatment for an adequate length of time is essential to achieving behavioural change.[45]

Important elements of engagement include:

- universal access
- empathic detachment
- person-centred assessment
- cultural sensitivity
- trauma sensitivity.

Motivational Interviewing

The goal of motivational interviewing is to explore ambivalence regarding ongoing substance use and encourage patients to explore and express their reasons for change. The five general principles for motivational interviewing include:

- express empathy,
- develop discrepancy between current behaviour and future goals,
- avoid arguments,
- roll with resistance,
- support self-efficacy.[46]

Psycho-Education

This would include working with the client to identify:

- the potential harms associated with ongoing substance use
- the possible advantages of ceasing use
- the impact of ongoing substance use on anxiety symptoms

If no progression in condition occurs, a clinical review is warranted.

Psychosocial therapies

There is strong evidence supporting the use of Cognitive Behaviour Therapy (CBT), with or without pharmaco-therapy, for treatment of a variety of anxiety disorders in the general population. This therapy should also be considered for clients with comorbid anxiety and substance use disorders.

Benzodiazepines

Benzodiazepines are effective anxiolytic medications with significant risk of dependence.

Caution should be taken and the use of benzodiazepine should be avoided for treatment of clients with a comorbid disorder due to the high risk of addiction/abuse and its synergistic interaction with alcohol and opioids.

Evidence suggests that a substantial proportion of clients who are treated with benzodiazepines will develop some form of dependence.

The exception to this rule would be in the following two circumstances:

- The client is benzodiazepine dependent in this situation the client would be managed in accordance with best practice withdrawal recommendations with appropriate gradual withdrawal and interventions to manage supportive care needs (sleep, hygiene, depression, etc.)

- Benzodiazepines are being utilised for a client to withdraw from another substance and benzodiazepines are required in this situation benzodiazepines could be administered in accordance with the NSW Drug and Alcohol Withdrawal Clinical Practice Guidelines available at: http://www.health.nsw.gov.au/policies/gl/2008/pdf/GL2008_011.pdf 31

Selective Serotonin-Reuptake Inhibitors (SSRIs)

Selective serotonin reuptake inhibitors are a class of anti-depressants used for the treatment of depression and anxiety.

There is some evidence supporting the use of SSRIs for clients with comorbid anxiety and substance use disorders. Treatment should be considered carefully and in accordance with existing best practice guidelines.[47] [48] See Existing Resources on page 45.

10.4 Existing resources for the care of a person with an anxiety or substance use disorder

A number of clinical treatment guidelines exist to guide the management of separate anxiety and substance use disorders. Some of the key guidelines are listed below.

Guidelines	Author
Mental Health Resources	
Australian and New Zealand clinical practice guidelines for the treatment of panic disorder and agoraphobia http://www.ranzcp.org/images/stories/ranzcp-attachments/Resources/Publications/CPG/Clinician/CPG_Clinician%20Full_Panic_Disorder_Agoraphobia.pdf	Royal Australian and NZ College of Psychiatrists
Australian Guidelines for the Treatment of Adults with Acute Stress Disorder and Posttraumatic Stress Disorder http://www.acpmh.unimelb.edu.au/resources/resources-guidelines.html#1	Australian Centre for Posttraumatic Mental Health
Benzodiazepines – clinical guidelines http://www.racgp.org.au/guidelines/benzodiazepines	Royal Australian College of General Practitioners
Clinical Practice Guidelines: Management of anxiety disorders http://publications.cpa-apc.org/media.php?mid=440&xwm=true	Canadian Psychiatric Society
Mental Health Reference Resource for drug and alcohol professionals. http://www.health.nsw.gov.au/pubs/2007/pdf/mh_resource.pdf	NSW Department of Health
Practice Guideline for the Treatment of Patients with Acute Stress Disorder and Posttraumatic Stress Disorder http://www.psychiatryonline.com/pracGuide/loadGuidelinePdf.aspx?file=ASD_PTSD_05-15-06	American Psychiatric Association
Practice Guideline for the Treatment of Patients with Panic Disorder http://www.psychiatryonline.com/pracGuide/loadGuidelinePdf.aspx?file=Panic_05-15-06	American Psychiatric Association
Psychotropic Electronic Therapeutic Guidelines – CIAP www.ciap.health.nsw.gov.au	NSW Department of Health
PTSD clinical treatment algorithm http://www.racgp.org.au/guidelines/ptsd	Royal Australian College of General Practitioners
Client resources	
Clinical Research Unit for Anxiety and Depression – Self Help Section http://www.crufad.com/site2007/selfhelp/shindex.html	St Vincent's Hospital, The University of NSW
Moodgym: http://moodgym.anu.edu.au/welcome	The Australian National University
Panic disorder and agoraphobia: Australian Treatment Guide for Consumers and Carers http://www.ranzcp.org/images/stories/ranzcp-attachments/Resources/Publications/CPG/Australian_Versions/AUS_Panic_disorder.pdf	Royal Australian and NZ College of Psychiatrists
Clinical Research Unit for Anxiety and Depression http://www.crufad.com/cru_index.html	St Vincent's Hospital, The University of NSW

Guidelines	Author
Drug and Alcohol Resources – General	
Clinical guidelines for nursing and midwifery practice in NSW: Identifying and responding to drug and alcohol issues http://www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007_091.pdf	NSW Department of Health
Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines http://www.health.nsw.gov.au/policies/gl/2008/pdf/GL2008_009.pdf	NSW Department of Health
NSW Drug and Alcohol Withdrawal Clinical Practice Guidelines http://www.health.nsw.gov.au/policies/gl/2008/pdf/GL2008_011.pdf	NSW Department of Health
Drug and Alcohol Resources – Alcohol	
Alcohol Practice guideline: For Practitioners Helping Veterans with Alcohol Problems http://www.therightmix.gov.au/pdfs/2005_Alcohol_Practice_Guidelines_Intro_Rationale_and_Methodology.pdf	Australian Government Department of Health and Ageing – Commonwealth
Alcohol treatment guidelines for Indigenous Australians http://www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/426B5656C2395CC3CA2573360002A0EA/$File/alc-treat-guide-indig.pdf	Australian Government Department of Health and Ageing – Commonwealth
Treating Alcohol Problems: Guidelines for Alcohol and Drug Professionals http://www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/AAG13	National Drug and Alcohol Research Centre
Drug and Alcohol Resources – Other drugs	
Clinical guidelines and procedures for the use of methadone in the maintenance treatment of opioid dependence http://www.health.vic.gov.au/dpu/downloads/guidelines-methadone.pdf	Australian Government Department of Health and Ageing – Commonwealth
Clinical guidelines and procedures for the use of naltrexone in the management of opioid dependence http://www.dasc.sa.gov.au/webdata/resources/files/NDS_naltrexone_cguide.pdf	Australian Government Department of Health and Ageing – Commonwealth
Opioid Dependent Persons Admitted to Hospitals in NSW – Management http://www.health.nsw.gov.au/policies/pd/2006/PD2006_049.html	
Opioid Treatment Program: Clinical Guidelines for Methadone and Buprenorphine Treatment http://www.health.nsw.gov.au/policies/gl/2006/GL2006_019.htm	NSW Department of Health
Psychostimulant Users – Clinical Guidelines for Assessment and Management http://www.health.nsw.gov.au/policies/gl/2006/pdf/GL2006_001.pdf	NSW Department of Health
Rapid Detoxification From Opioids – Guidelines http://www.health.nsw.gov.au/policies/GL/2005/pdf/GL2005_027.pdf	NSW Department of Health
Treatment Options for Heroin and other opioid dependence http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/3972807722EB6F7ECA25717D000655EB/$File/opioid_workers.pdf	National Drug and Alcohol Research Centre

SECTION 11

Mood disorders

11.1 What is a mood disorder?

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. 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
- Mood disorders include the following diagnoses: Major depressive disorder, Dysthymic disorder, Bipolar I Disorder, Bipolar II Disorder and Cyclothymic Disorder (see table below).

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.

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, distractibility 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.
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 that is diagnosed after the person has experienced symptoms for at least two years. It can not be diagnosed if any episodes have occurred
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

Referenced from NSW Department of Health. *Mental Health Reference Resource for drug and alcohol professionals*, 2007.

11.2 Key points for consideration

- Depressive illness is highly prevalent in substance using populations and it can be difficult to distinguish a temporal relationship
- A 4 week period of abstinence is recommended for a new, definitive diagnosis
- Exceptions to this rule include:
  - risk of harm to self/others
  - a previous, documented history of a mood disorder
  - episodes of mania
- Symptoms of a mood disorder can be treated without a definitive diagnosis
- Psychosocial therapies are highly recommended
- Clients who continue to use can be treated using harm minimisation principles however be alert for:
  - potential interactions particularly with Opiate Substitution Therapy, SSRIs and Tricyclics
  - increased risk of suicide
  - the potential need to invoke an involuntary treatment order.

11.3 Clinical care considerations for clients with comorbid mood and substance use disorders

Evidence demonstrates that clients with substance use disorders report increased levels of depression with high numbers meeting the criteria for a major depressive illness. Depressive symptoms are often transient in clients with substance use disorders. This may be related to the substance intoxication, withdrawal, and/or many psychosocial stressors, which are associated with the individual's lifestyle. Detoxification often leads to an improvement in mood, as does maintenance therapy for opioid dependence or it may reveal an underlying depression.[49]

Time lapse before definitive diagnosis

It can be difficult to distinguish the temporal relationship between the substance use and the depressive symptoms. A key question for practitioners to consider is whether the drugs are causing the depressive symptoms or rather are the depressive symptoms causing the client to try and self-medicate.

Observing the client during a period of abstinence of approximately 4 weeks duration is considered appropriate prior to assessing the client against the criteria for a depressive illness and therefore making a definitive diagnosis. The symptoms however of depressive disorder can be treated without a definitive diagnosis.

It is important to note that only qualified practitioners can make a clinical diagnosis. Other practitioners are responsible for assessing, identifying and documenting signs and symptoms which a client may display, without labelling the client with a specific disorder.

Clients who agree to cease using may/will go through a withdrawal period. For information regarding how to manage withdrawal, please refer to the section on Withdrawal on page 36.

Exceptions to the waiting period

The need for a waiting period prior to a definitive diagnosis of a mood disorder is not absolute. If any of the criteria listed below are met, a waiting period is not recommended:

- there is evidence from outset that a diagnosis is present (ie. pre-established diagnosis)
- there is significant risk of harm to self or others
- a client presents in a manic state.

The latter two items require an immediate clinical intervention.

Working with clients who are continuing to use

Some clients may identify that the aim of drug and alcohol treatment is to reduce the amount of a substance that is used rather than to cease using. Others will continue to use and not moderate usage. If this is the case then a practitioner can address the symptoms of the mood disorder with the client and initiate harm reduction strategies with the client in the following manner.

Engagement

Engagement refers to the client relationship with a practitioner and dedication/motivation to participating in treatment.

It is a critical part of substance abuse treatment and an important element of the care for clients with comorbid disorders specifically, since remaining in treatment for an adequate length of time is essential to achieving behavioural change.

Important elements of engagement include:

- universal access
- empathic detachment
- person-centred assessment
- cultural sensitivity
- trauma sensitivity.[50]

Motivational interviewing

The goal of motivational interviewing is to explore ambivalence regarding ongoing substance use and encourage patients to explore and express their reasons for change.

The five general principles for motivational interviewing include:

- express empathy
- develop discrepancy between current behaviour and future goals
- avoid arguments
- roll with resistance
- support self efficacy[51]

Psycho-education

This would include working with the client to identify:

- the potential harms associated with ongoing substance use
- the possible advantages of ceasing use
- the impact of ongoing substance use on depressive symptoms

Psychological therapies

Psychological therapies are considered front-line therapy for the treatment of a client with comorbid mood and substance use disorder. The type of a therapy may vary depending upon the needs of the client and expertise of the practitioner however it may include: cognitive behavioural therapies (CBT), motivational interviewing, interpersonal therapies, psychodynamic, dialectical behaviour, and narrative therapy.

- Increased risk for suicide
  There is evidence for a need to monitor a client with a comorbid mood and substance use disorder for an ongoing high risk of suicide. Regular assessments are necessary.

- There may be a need for an involuntary treatment order
  Where a client is at increased risk to self or others there may be a need to utilise the Mental Health Act in order to provide involuntary treatment. Please refer to appendix 1 for further information.

Provide medical therapy and be cognisant of potential interactions

There are a number of possible interactions between medical therapies prescribed to treat mood disorders and substance use. Particularly, special awareness is required for clients who are being treated with:

- **Opiate Substitution Therapy (OST)**
  Possible drug interactions may occur when clients are receiving methadone or buprenorphine. The combination of methadone and other sedative drugs (opioids, alcohol, benzodiazepines, tricyclic antidepressants, major tranquilisers and sedating antihistamines) can be fatal[52]. A detailed list of drugs which interact with methadone including fluvoxamine and other SSRI's is available at Appendix 7.

  The combination of buprenorphine and sedative drugs, including opioids, alcohol, benzodiazepines, tricyclic antidepressants, and major tranquilisers and sedating antihistamines can be dangerous (deaths have been reported)[41]. A detailed list of drugs which interact with buprenorphine is available at Appendix 8.[41]

  Please refer to the NSW Department of Health 'Opioid Treatment Program: Clinical Guidelines for methadone and buprenorphine treatment' for further information.

- **Tricyclics**
  There is an increased risk of overdose therefore these drugs are not recommended as first line treatment for people with comorbid disorders and should be administered with caution.

- **Selective Serotonin Reuptake Inhibitors (SSRI)**
  There is a risk of the development of a serotonin syndrome with the concurrent administration or active use of stimulants, monoamine oxidase inhibitors (MAOI), tryptophan, lithium or other drugs which limit the reuptake of serotonin[53].

  SSRIs are contraindicated when a client is being treated with Tramadol.

11.4 Existing resources for the care of a person with a mood or substance use disorder

A number of clinical treatment guidelines exist to guide the management of separate mood and substance use disorders. Some of the key guidelines are listed below.

Guidelines	Author
Mental Health Resources	
Australian and New Zealand clinical practice guidelines for the treatment of bipolar disorder http://www.ranzcp.org/images/stories/ranzcp-attachments/Resources/Publications/CPG/Clinician/CPG_Clinician_Full_Bipolar.pdf	Royal Australian and NZ College of Psychiatrists
Australian and New Zealand clinical practice guidelines for the treatment of depression http://www.ranzcp.org/images/stories/ranzcp-attachments/Resources/Publications/CPG/Clinician/CPG_Clinician_Full_Depression.pdf	Royal Australian and NZ College of Psychiatrists
Clinical Research Unit for Anxiety and Depression http://www.crufad.com/cru_index.html	St Vincent's Hospital, The University of NSW
Psychotropic Electronic Therapeutic Guidelines – CIAP www.ciap.health.nsw.gov.au	NSW Department of Health
Treating depression: the beyondblue guidelines for treating depression in primary care http://www.mja.com.au/public/issues/176_10_200502/ell10082_fm.html	Beyondblue
Client Resources	
Bipolar Disorder: Australian Treatment Guide for Consumers and Carers http://www.ranzcp.org/resources/clinical-practice-guidelines.html	Royal Australian and NZ College of Psychiatrists
Depression: Australian Treatment Guide for Consumers and Carers http://www.ranzcp.org/resources/clinical-practice-guidelines.html	Royal Australian and NZ College of Psychiatrists
Clinical Research Unit for Anxiety and Depression – Self Help Section http://www.crufad.com/site2007/selfhelp/shindex.html	St Vincent's Hospital, The University of NSW
Mood gym : http://moodgym.anu.edu.au/welcome	The Australian National University
The Black Dog Institute – Resources for the public http://www.blackdoginstitute.org.au/	The Black Dog Institute
Drug and Alcohol Resources – General	
Clinical guidelines for nursing and midwifery practice in NSW: Identifying and responding to drug and alcohol issues http://www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007_091.pdf	NSW Department of Health
Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines NSW Department of Health http://www.health.nsw.gov.au/policies/gl/2008/pdf/GL2008_009.pdf	
NSW Drug and Alcohol Withdrawal Clinical Practice Guidelines http://www.health.nsw.gov.au/policies/gl/2008/pdf/GL2008_011.pdf	NSW Department of Health
Drug and Alcohol Resources – Alcohol	
Alcohol Practice guideline: For Practitioners Helping Veterans with Alcohol Problems http://www.therightmix.gov.au/pdfs/2005_Alcohol_Practice_Guidelines_Intro_Rationale_and_Methodology.pdf	Australian Government Department of Health and Ageing – Commonwealth
Alcohol treatment guidelines for Indigenous Australians http://www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/426B5656C2395CC3CA2573360002A0EA/$File/alc-treat-guide-indig.pdf	Australian Government Department of Health and Ageing – Commonwealth
Treating Alcohol Problems: Guidelines for Alcohol and Drug Professionals http://www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/AAG13	National Drug and Alcohol Research Centre

Guidelines	Author
Drug and Alcohol Resources – Other drugs	
Clinical guidelines and procedures for the use of methadone in the maintenance treatment of opioid dependence http://www.health.vic.gov.au/dpu/downloads/guidelines-methadone.pdf	Australian Government Department of Health and Ageing – Commonwealth
Clinical guidelines and procedures for the use of naltrexone in the management of opioid dependence http://www.dasc.sa.gov.au/webdata/resources/files/NDS_naltrexone_cguide.pdf	Australian Government Department of Health and Ageing – Commonwealth
Opioid Dependent Persons Admitted to Hospitals in NSW – Management http://www.health.nsw.gov.au/policies/pd/2006/PD2006_049.html	NSW Department of Health
Opioid Treatment Program: Clinical Guidelines for Methadone and Buprenorphine Treatment http://www.health.nsw.gov.au/policies/gl/2006/GL2006_019.html	NSW Department of Health
Psychostimulant Users – Clinical Guidelines for Assessment and Management http://www.health.nsw.gov.au/policies/gl/2006/pdf/GL2006_001.pdf	NSW Department of Health
Rapid Detoxification From Opioids – Guidelines http://www.health.nsw.gov.au/policies/GL/2005/pdf/GL2005_027.pdf	NSW Department of Health
Treatment Options for Heroin and other opioid dependence http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/3972807722EB6F7ECA25717D000655EB/$File/opioid_workers.pdf	National Drug and Alcohol Research Centre

SECTION 12

Psychosis

12.1 What is psychosis?

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 cannot)
- 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, 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 that 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 over sensitivity and odd beliefs and behaviours (such as superstitiousness). The prodromal 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.

Referenced from NSW Department of Health. *Mental Health Reference Resource for drug and alcohol professionals.* 2007

12.2 Key Points for consideration

- Determine temporal relationship of conditions
- Beware of an early diagnosis of drug induced psychosis
- Use principle of safety to guide care for clients experiencing a psychotic episode
- Clients who chose to continue to use can be treated using harm minimisation principles and should be provided with psycho-education and motivational interviewing techniques
- Be alert for potential contraindications, medication tolerance and/or toxicity
- Mental health services must be involved in every diagnosis of first episode psychosis and where a client is experiencing a prolonged, acute psychotic episode.

12.3 Clinical care considerations for clients with comorbid psychotic and substance use disorders

Exacerbation of psychosis

There is clear evidence supporting the relationship between the onset of psychotic symptoms and the use of substances, particularly cannabis. Psychotic symptoms are twice as common (even correcting for confounding influences in young people who use cannabis).[54] Recent literature reviews indicate that cannabis does play a causal role in schizophrenia, and doubles the risk in the long term.

Safety

During an acute psychotic episode, safety is the guiding principle of care. Due to high risk of suicide, clients should be assessed frequently. The safety of staff and others needs to also be considered. Particular attention should be paid to a client's social environment, roles and responsibilities (for instance if s/he is a carer for children, has elderly parents etc) and how the psychosis is affecting their safety.

Interacting with someone with psychosis

DO point out the consequences/effects of the person's behaviour. Be specific.

DO distract the person if you can – try to offer them something to look at or involve them in doing something

DO ignore strange or embarrassing behaviour if you can, especially if it is not serious

DO NOT try to figure out what the person is talking to or about

DO NOT laugh or let others laugh at the person

DO NOT act horrified or panic.

Adapted from NSW Department of Health. *Mental Health Reference Resource for drug and alcohol professionals.* 2007 [24]

Determine temporal sequence

Analysis of the temporal sequence between psychotic illness and substance use disorder begins with a thorough examination of the history of both disorders in an attempt to identify if one disorder preceded the other.[38] This information can assist in the formulation of a treatment plan.

Drug induced psychosis

Beware of an early diagnosis of drug induced psychosis as this concept should be regarded with caution. When schizophrenia and a substance use disorder co-exist, it has been found that in about half of the cases the original diagnosis was of a drug-induced psychosis, which may have delayed treatment for schizophrenia.[38]

Duration and complexity

The nature of the intervention and ability of a service to assist a client with psychosis will depend upon the skills of the service where the client attends. If a client presents with a complex and/or persistent psychotic episode or if a service is not equipped to provide safe and adequate care for that client, a mental health service should be engaged for case consultation and/or referral.

First onset psychosis

Non-affective psychosis and substance abuse are both disorders with onset in adolescence or early adulthood. On this basis alone a certain degree of co-occurrence is to be expected. However the rate of substance abuse among

populations experiencing their first episode of psychosis is higher than expected. [55]

As mentioned above, the symptoms of a psychosis need to be addressed in the first instance using the principle of safety to guide the care of the client by the practitioner.

Mental Health services should be engaged in all instances where a client is presenting with a first onset psychosis. This can be determined by asking the client, their carers and through their client case record. The management of this episode has long-term impacts for the health of a client and subsequent psychotic episodes.

Interventions which may be appropriate for treatment of clients with first onset psychosis depending upon the client's stage of recovery include:

- Motivational enhancement
- Psychoeducation regarding the risks of chronic psychosis with continuing drug use should be discussed with the client. A client who has experienced at least one psychotic episode is at increased risk of having further episodes in the future.
- Skills training and support

Psycho-education

The evidence indicates that clients who experience a psychotic episode are at increased risk for ongoing episodes. Psycho-education that aims to increase awareness of the increased risk of psychosis, the harms of ongoing substance use and the advantages of cessation is an important element of care provision.

Medications

Choice of medication for those with psychotic illnesses should be chosen with the aim of minimising positive symptoms, enhancing compliance and potentiating psychosocial interventions, whilst minimising side effects and the motivation for substance use. At present, atypical antipsychotics appear to be the first line among this group.[37]

Contraindications

Caution is required when administering methadone to clients who are taking conventional antipsychotics, such as chlorpromazine and some atypical antipsychotics such as risperidone as they may enhance the hypotensive and sedative effects of these drugs.

Tolerance and toxicity

Cannabis has been shown to affect the metabolism of some classes of medication including antipsychotics. Cannabis users may therefore require higher doses of antipsychotics due to this effect. [56] This increased dosage may result in an increase in risk of tardive dyskinesia, already elevated to due to use of cannabis. The selection of medication, dosing schedule and its preparation is therefore important.[57]

Accurate monitoring of the impact of cannabis cessation is imperative as this may inadvertently result in toxicity.

12.4 Existing resources for the care of a person with a psychotic or substance use disorder

A number of clinical treatment guidelines exist to guide the treatment and care of clients with psychotic disorders or substance use disorders. Some of the key guidelines are listed in the table below:

Guidelines	Author
Mental Health Resources	
Clinical practice guidelines for the treatment of schizophrenia and related disorders http://www.ranzcp.org/images/stories/ranzcp-attachments/Resources/Publications/CPG/Clinician/CPG_Clinician_Full_Schizophrenia.pdf	Royal Australian and NZ College of Psychiatrists
International Clinical Practice Guidelines for Early Psychosis http://bjp.rcpsych.org/cgi/content/full/187/48/s120	International early psychosis association writing group
Client Guidelines	
Schizophrenia: Australian Treatment Guide for Consumers and Carers http://www.ranzcp.org/resources/clinical-practice-guidelines.html	Royal Australian and NZ College of Psychiatrists

Guidelines	Author
Drug and Alcohol Resources – General	
Clinical guidelines for nursing and midwifery practice in NSW: Identifying and responding to drug and alcohol issues http://www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007_091.pdf	NSW Department of Health
Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines http://www.health.nsw.gov.au/policies/gl/2008/pdf/GL2008_009.pdf	NSW Department of Health
NSW Drug and Alcohol Withdrawal Clinical Practice Guidelines http://www.health.nsw.gov.au/policies/gl/2008/pdf/GL2008_011.pdf	NSW Department of Health
Drug and Alcohol Resources – Alcohol	
Alcohol Practice guideline: For Practitioners Helping Veterans with Alcohol Problems. http://www.therightmix.gov.au/pdfs/2005_Alcohol_Practice_Guidelines_Intro_Rationale_and_Methodology.pdf	Australian Government Department of Health and Ageing – Commonwealth
Alcohol treatment guidelines for Indigenous Australians http://www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/426B5656C2395CC3CA2573360002A0EA/$File/alc-treat-guide-indig.pdf	Australian Government Department of Health and Ageing – Commonwealth
Treating Alcohol Problems: Guidelines for Alcohol and Drug Professionals http://www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/AAG13	National Drug and Alcohol Research Centre
Drug and Alcohol Resources – Other drugs	
Clinical guidelines and procedures for the use of methadone in the maintenance treatment of opioid dependence http://www.health.vic.gov.au/dpu/downloads/guidelines-methadone.pdf	Australian Government Department of Health and Ageing – Commonwealth
Clinical guidelines and procedures for the use of naltrexone in the management of opioid dependence http://www.dasc.sa.gov.au/webdata/resources/files/NDS_naltrexone_cguide.pdf	Australian Government Department of Health and Ageing – Commonwealth
Opioid Dependent Persons Admitted to Hospitals in NSW – Management http://www.health.nsw.gov.au/policies/pd/2006/PD2006_049.html	NSW Department of Health
Opioid Treatment Program: Clinical Guidelines for Methadone and Buprenorphine Treatment http://www.health.nsw.gov.au/policies/gl/2006/GL2006_019.html	NSW Department of Health
Psychostimulant Users – Clinical Guidelines for Assessment and Management http://www.health.nsw.gov.au/policies/gl/2006/pdf/GL2006_001.pdf	NSW Department of Health
Rapid Detoxification From Opioids – Guidelines http://www.health.nsw.gov.au/policies/GL/2005/pdf/GL2005_027.pdf	NSW Department of Health
Treatment Options for Heroin and other opioid dependence http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/3972807722EB6F7ECA25717D000655EB/$File/opioid_workers.pdf	National Drug and Alcohol Research Centre

SECTION 13

Personality disorders

13.1 What is a personality disorder?

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 (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. 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.

Referenced from NSW Department of Health. Mental Health Reference Resource for drug and alcohol professionals. 2007

13.2 Key points for consideration

It is likely that a number of clients with undiagnosed personality disorders are being treated in health settings across NSW:

- Clients with comorbid personality and substance use disorders are likely to benefit from a structured approach with firm boundaries.
- Personality disorders are treatable.
- Evidence suggests that a number of psychosocial therapies includes psychodynamic, Cognitive Behaviour Therapy and Dialectical Behaviour Therapy can assist.

13.3 Clinical care considerations for people with comorbid personality and substance use disorders

The incidence of comorbid personality disorders and substance use disorders is high and it is likely that clients who have an undiagnosed personality disorder are being treated in various settings across NSW. A diagnosis of a personality disorder should not be rushed, rather, careful consideration must be given to the impact of ongoing substance use to the ability to make a clear diagnosis.

Comorbid personality and substance use disorders place a client at a high risk for suicide, engaging in other high-risk behaviours and a poorer prognosis.[58]

The elements of some drug and alcohol treatment approaches, including engagement and rapport building, structure and firm boundaries result in enhanced clinical outcomes for clients with personality disorders.[49]

These clients will benefit from being treated like all other clients. However, it is important to continually identify the need to engage other services (eg. Case conferencing) where appropriate to develop a comprehensive care and treatment plan.

Evidence does exist for the use of a variety of psychosocial therapies including Cognitive Behaviour Therapy (CBT), psychodynamic therapy and trauma informed therapies. An increasing evidence base is available for the use of Dialectical Behaviour Therapy (DBT). DBT treatment is available in some specialist centres in NSW.

Discharge/treatment termination

Clients with personality disorders may struggle with the discharge and treatment termination stage of treatment. The following key practice tips may assist in this transition:

Provide clear identification of upcoming date/times for termination and/or discharge -

- discuss the upcoming date/times in advance where possible

Set clear boundaries with the client -

- work with the client to establish clear expectations regarding the limitations or requirement in behaviour which will guide the transition period

Develop a plan and structured approach for how the client is expected to behave/react -

- develop a plan based upon experience with the client. What might they find particularly distressing or difficult? What steps may be taken to help to minimise this distress?

Develop with the client a clear plan for future crisis management -

- work with the client to identify a plan regarding how they may manage situations which may arise in the future. Consideration of advanced directives can be given at this time.

Ensure that all practitioners interacting with the client provide a common message and approach to care and treatment with the client

13.4 Existing resources for the care of a person with a personality disorder or substance use disorder

A number of clinical treatment guidelines exist to guide the treatment and care of clients with personality disorders or substance use disorders. Some of the key guidelines are listed opposite:

Guidelines	Author
Mental Health Resources	
Practice Guideline for the Treatment of Patients With Borderline Personality Disorder http://www.psychiatryonline.com/pracGuide/loadGuidelinePdf.aspx?file=BPD_05-15-06	American Psychiatric Association
Drug and Alcohol Resources – General	
Clinical guidelines for nursing and midwifery practice in NSW: Identifying and responding to drug and alcohol issues http://www.health.nsw.gov.au/policies/pd/2007/pdf/PD2007_091.pdf	NSW Department of Health
Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines http://www.health.nsw.gov.au/policies/gl/2008/pdf/GL2008_009.pdf	NSW Department of Health
NSW Drug and Alcohol Withdrawal Clinical Practice Guidelines http://www.health.nsw.gov.au/policies/gl/2008/pdf/GL2008_011.pdf	NSW Department of Health
Drug and Alcohol Resources – Alcohol	
Alcohol Practice guideline: For Practitioners Helping Veterans with Alcohol Problems. http://www.therightmix.gov.au/pdfs/2005_Alcohol_Practice_Guidelines_Intro_Rationale_and_Methodology.pdf	Australian Government Department of Health and Ageing – Commonwealth
Alcohol treatment guidelines for Indigenous Australians http://www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/426B5656C2395CC3CA2573360002A0EA/$File/alc-treat-guide-indig.pdf	Australian Government Department of Health and Ageing – Commonwealth
Treating Alcohol Problems: Guidelines for Alcohol and Drug Professionals http://www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/AAG13	National Drug and Alcohol Research Centre
Drug and Alcohol Resources – Other drugs	
Clinical guidelines and procedures for the use of methadone in the maintenance treatment of opioid dependence http://www.health.vic.gov.au/dpu/downloads/guidelines-methadone.pdf	Australian Government Department of Health and Ageing – Commonwealth
Clinical guidelines and procedures for the use of naltrexone in the management of opioid dependence http://www.dasc.sa.gov.au/webdata/resources/files/NDS_naltrexone_cguide.pdf	Australian Government Department of Health and Ageing – Commonwealth
Opioid Dependent Persons Admitted to Hospitals in NSW – Management http://www.health.nsw.gov.au/policies/pd/2006/PD2006_049.html	NSW Department of Health
Opioid Treatment Program: Clinical Guidelines for Methadone and Buprenorphine Treatment http://www.health.nsw.gov.au/policies/gl/2006/GL2006_019.html	NSW Department of Health
Psychostimulant Users – Clinical Guidelines for Assessment and Management http://www.health.nsw.gov.au/policies/gl/2006/pdf/GL2006_001.pdf	NSW Department of Health
Rapid Detoxification From Opioids – Guidelines http://www.health.nsw.gov.au/policies/GL/2005/pdf/GL2005_027.pdf	NSW Department of Health
Treatment Options for Heroin and other opioid dependence http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/3972807722EB6F7ECA25717D000655EB/$File/opioid_workers.pdf	National Drug and Alcohol Research Centre

SECTION 14

Specific Populations

Access and equity are two key issues for all people with a comorbid mental health and substance use disorder. Some client populations face specific challenges regarding these issues. This chapter discusses key considerations relevant for the care of these specific client populations.

Although the suggested recommendations can largely be extrapolated for all groups, the intention is to raise awareness of particular considerations that may improve client care.

14.1 Young people

Like those with adult disorders, youth comorbidity is associated with a more severe pathology, significant challenges in terms of service delivery and poorer treatment outcomes[59].

Australian burden of disease and injury statistics illustrate the breadth of the problem of mental and substance use disorders for young people. Of young people aged 15–24, eight out of ten of the causes of burden for young women were related to mental or substance use disorders and nine out of ten for males. The disease burden in this group is largely the result of substance use disorders and/or mental health problems as illustrated in the table below (Mathers & Vos, 1999). Comorbidity of these disorders is high with over 50% having comorbid disorders.[60]

Males	Females
road traffic accidents	depression
alcohol dependence	bipolar affective
suicide	alcohol dependence
bipolar affective	eating disorders
heroin dependence	social phobia
schizophrenia	heroin
depression	asthma
social phobia	road traffic accidents
borderline personality	schizophrenia
generalised anxiety disorder	generalised anxiety disorder

Sourced from Teeson M. and Proudfoot H. 2003 "Responding to comorbid mental disorders and substance use disorders", in *Comorbid mental disorders and substance use disorders: epidemiology, prevention and treatment,* National Drug and Alcohol Research Centre for the National Drug Strategy, Canberra: Department of Health and Ageing, ch 1.

Young people are likely to come in contact with the health care system at a variety of different access points that include (but are not limited to) the following:

- General Practitioners
- Child and Adolescent services
- Paediatricians
- Private practitioners (psychologists, psychiatrists, counsellors)
- School counsellors and/or health nurses
- Hospital wards and Emergency departments.

These services must consider the special needs of young people including language, resources and available materials in order to ensure services can adequately address the needs of this population. The NSW Department of Health, several non-government organisations and schools have initiated a number of focussed early identification, treatment and social programs designed to target young people with mental health needs and/or substance use disorders. These resources assist with detection and can link children to specialised services and resources. A list of key contacts and resources is available at Appendix 9.

Young people often attend health care services at the behest of parents and families; not because of their own motivation. Family members play an important role in the care of a young person with a comorbid mental health and substance use disorder particularly when conducting an assessment and in the planning and conduct of care and treatment.[50]

Practitioners have an opportunity to intervene early in a young person's life. Secondary prevention, psycho-education and engagement are extremely important in the treatment of young people.

14.2 Clients living with Hepatitis C and HIV

People living with HIV or Hepatitis C and a comorbid mental health and SUDs have specific care considerations which may impact their overall wellness. There is often a risk of interruption to the prescribed anti-retroviral treatment when

interventions to address mental health or a substance use disorder commence. It is essential that the practitioner caring for the client is alert to the importance of ongoing compliance with the client's prescribed anti-retroviral treatment.

In addition, clients who are taking anti-retrovirals may experience increased drug toxicity when using substances. The impact and effect of substance use therefore needs to be monitored carefully. A collaborative approach to care which involves the client's general practitioner, specialist physicians and relevant drug and alcohol and mental health practitioners is recommended to facilitate the delivery of comprehensive care. Collaboration may also assist practitioners to delineate between organic disease related illness and impairment due to mental illness and/or substance use. This may be difficult to distinguish and expert input may be required.

14.3 Clients residing in rural and remote communities

Evidence suggests that access to treatment remains a key concern for people living in rural and remote communities. In order to address this inequality, a number of online mental health and addiction resources/interventions as well as web/telephone based communication tools have been developed. These tools help to mitigate the negative impact of distance by making services and expertise increasingly accessible to clients in rural/regional NSW. A list of online, web-based resources is available at Appendix 8.

When providing care for a client who lives in a rural and remote community, it is important to consider involvement of broader health and community services. These programs and professionals become essential links to assist in the provision of care for clients with comorbidity in these settings and are valuable resources for clients.

Although the issue of confidentiality is of utmost importance to all clients, it is particularly important to clients of smaller communities where the likelihood of identifying a client is increased. Acknowledging that care is provided in accordance with the NSW Privacy laws and regulations and that the practitioner respects the client's confidential information may help to address this concern.

The ability to transport clients in a psychotic or violent state can be particularly problematic in the rural sector because of large distances and shortages of specialist services and personnel. Wherever possible, identify transport requirements as early as possible and follow local protocols regarding sedation. Finally, access to lethal means needs to be determined and factored into risk and suicide assessments when conducted.

14.4 Homeless Clients

Providing care for a homeless person with a comorbid mental health and substance use disorder presents a number of challenges for the practitioner and the client. These include poor access to primary health care, potential for poor medication compliance and significant challenges regarding follow up. Consideration of these challenges should be made during the early stages of care prior to the development of a management plan and should include questions such as: Will the client be able to afford medication? How will they seek help in the future? Do they have access to primary health care and if so, from whom?

Accessing the availability of outreach services and NGO programs that may be able to assist in overcoming some of the barriers to treatment may facilitate care delivery for this complex client population.

14.5 Aboriginal and Torres Strait Islander Clients

Evidence suggests that comorbid mental health and substance use disorders is a significant problem for Aboriginal and Torres Strait Islander (ATSI) communities. The complexity of needs prevalent in some ATSI communities present a challenge to the delivery of health services.

It is preferable that all drug and alcohol and mental health services identify and form partnerships with a local Aboriginal health service if they do not have an Aboriginal worker within their team. This helps to provide culturally appropriate care. Ideally, each client should be asked if they would prefer someone from within the cultural group to deliver their care however, if this is not possible, each client should be provided with the best standard of care.

When working with Aboriginal and Torres Strait Islander clients, it is essential to recognise that the client may be cared for in the context of a close-knit family and community. If this is the case then both the client and community are affected by and engaged in care delivery.

The issue of access is an essential element for consideration and should be guided by a principle of flexibility. Aboriginal

and Torres Strait Islander clients may access services outside the access pathways for mainstream service. This may include informal access pathways and environments for care, assessment and presentation. When providing care for an Aboriginal or Torres Strait Islander client, the practitioner should consider the different social constructs of illness and diagnosis and attempt to adapt approaches accordingly.

Key practice tips for conducting an assessment of Aboriginal and Torres Strait Islander clients

Access to services by Aboriginal people with comorbidity should be allowed in a variety of ways. Flexibility is the key.

Client assessment may be more successful in a place where the Aboriginal person feels most comfortable and should be considered.

Assessments should ideally take place with an Aboriginal worker present to assist in the communication and ability to trust. HOWEVER, if a service is not available, continue to provide care in line with the best practice principles.

14.6 Gay, Lesbian, Bisexual and Transgender Clients

Evidence suggests that there are high rates of and substance use and mental health problems amongst Gay and Lesbian people.[61 62] It is therefore assumed that the incidence of comorbid disorders is also high however there is a lack of formal literature to support this.

In order to reduce stigma and encourage open dialogue and disclosure, it is recommended that practitioners enquire about a client's sexual orientation and gender identification as part of a comprehensive assessment. Practitioners should remain cognisant of the potential sensitivity of disclosing this information. Although sexual orientation does not change the nature, type and standard of care delivered, it provides important information to the practitioner regarding potential risk factors including a potential increased risk of suicide that needs to be monitored closely.

14.7 Older adult clients

Older adults are at considerable risk for a comorbid mental health and substance use disorder. This client group will have an increasing prominence in care with an ageing population. An older adult may have been coping with substance use or mental health problems throughout their lives, or they may develop in later life. Older adults face multiple challenges including major life changes such as adapting to retirement and/or coping with the death of friends or loved ones[63].

The presence of a comorbid disorder in this population has serious implications and is associated with increased suicidality and greater service utilisation[64].

Older people are at particular risk for the development of anxiety and mood disorders with older adults tending to have more frequent mood episodes as they age, independent of their substance use[5.] Substance use in this population may be pre-existing or may be newly developed (for example dependence on benzodiazepines prescribed to assist the client cope following the death of a partner). The presence of a disorder may in fact be missed by the people caring for them with symptoms blamed on the 'normal ageing process'.

Particular attention to the physical needs of older adults should be addressed with consideration given to the possibility of other health conditions (which may be life-threatening) such as hypoglycemia, stroke or infections. These conditions and the risk of drug interactions and challenges regarding withdrawal need to be assessed and monitored carefully.

14.8 Clients with Chronic Pain

The role of chronic pain in clients with a comorbid disorder is complex. It is estimated that 20% of the Australian population suffer persistent pain[65]. Evidence suggests that the prevalence of chronic pain in people receiving methadone treatment is as high as 50%[66].

Mood disorders have been linked to chronic pain with the presence of depression associated with an array of poor pain outcomes and worse prognosis[67].

People who have had substance abuse problems in the past or a diagnosed psychiatric illness are 'at risk' for developing problems with prescription pain medication[68]. This history, and even active substance use, does not mean that treatment for chronic pain is contraindicated [3]. It does however highlight the need for collaborative care to provide the best care and treatment for the client.

Where available, it is advisable that a specialist pain service become involved in the provision of care for these clients,

ensuring that a comprehensive approach to the multitude of disorders is achieved.

Guidelines regarding the management of chronic pain are currently under development by the Royal Australian College of Physicians and will be available in the future.

14.9 Clients from Culturally and Linguistically Diverse Backgrounds

NSW is one of the most culturally and linguistically diverse communities in Australia. People have migrated from approximately 140 different countries and 16 per cent of the total NSW population was born overseas in a non-English speaking country[69]. This diversity has a significant impact on the need for and delivery of culturally appropriate care.

Evidence suggests that the reported level of substance use in CALD communities is less than that in the general population[70]. However, the prevalence of mental health or behaviour problems in people born overseas and/or who speak a language other than English within the home are similar to those born in Australia. Despite the prevalence of these problems, figures indicate that people from CALD communities are under-represented in both mental health and substance use disorder services[71]. This may suggest that the under-representation identifies under-utilisation rather than a reduced need[72].

Culturally specific understanding of approaches to both mental health and substance use disorders may result in barriers to clients accessing care and treatment services. Although these are different for different cultures they may include:

- cultural norms which resist openly acknowledging a personal problem may cause difficulties for people reaching out for assistance
- stigma associated with both mental health and substance use problems
- language barriers which inhibit service access
- lack of information available in community languages which contribute to a:
  - lack of awareness about the range of services and supports available
  - lack of knowledge regarding how to access appropriate services
  - misunderstanding of how services operate.
- service specific barriers such as a lack of understanding regarding CALD communities and their family ethos[55,56].

There are some specific tips and tools that can be used to improve communication with people from cultural groups other than your own. These include:

- asking the client what language they speak other than English
- asking the client if they would like access to a healthcare interpreter who speaks their language
- If yes, the following services may assist
  - local area NSW Health Care Interpreter Service
  - the Translating and Interpreting Service
  - remember to follow the guidelines regarding how to use the service employed.
- providing ongoing evaluation of assessment and care
- being clear, concrete and specific
- responding with respect, immediacy and timeliness
- respecting taboos
- being sensitive to embarrassment
- examining your own expectations[40,73].

SECTION 15

Care Coordination

15.1 What is care coordination?

Care coordination seeks to address the broad range of health and social needs of a person with a comorbid mental and substance use disorder.

The object of care coordination is to work towards continuity of care, timeliness of treatment and transitions between appropriate services based on the person's individual needs as well as the needs of a person's family and carer(s), where appropriate.

Care coordination acknowledges that people may require help with problems in various aspects including accommodation, finance, employment, education and physical health. Where a single service is unable to address these needs, care coordination seeks to use a collaborative approach to care.

15.2 Language in care coordination

The language used by mental health services and drug and alcohol services differs. This is particularly relevant when discussing care coordination where some terms have significantly different meanings across sectors and services.

15.3 Transitions in care coordination

A transition refers to the period of time following initial assessment and subsequent care and treatment of a person with a comorbid mental and substance use disorder. Transitions are sometimes also known as 'continuity of care', 'aftercare' or 'discharge planning'.

Transitions can be complicated due to the complex involvement of a number of stakeholders including the client, carer(s), practitioner and community services.

Good transitions require planning, good communication and negotiating skills in order to negotiate at the individual agency level. While clients and their family's and carer(s) do have a responsibility to participate actively in these discussions, the primary responsibility remains with practitioners, agencies and related staff to ensure any transition is workable and agreed to by all parties.

The importance of this communication during the period of transition has been highlighted as a key aspect in the prevention of suicide related deaths. There is evidence indicating that the risk of suicide is elevated during times of transition[74].

15.4 Types of transition

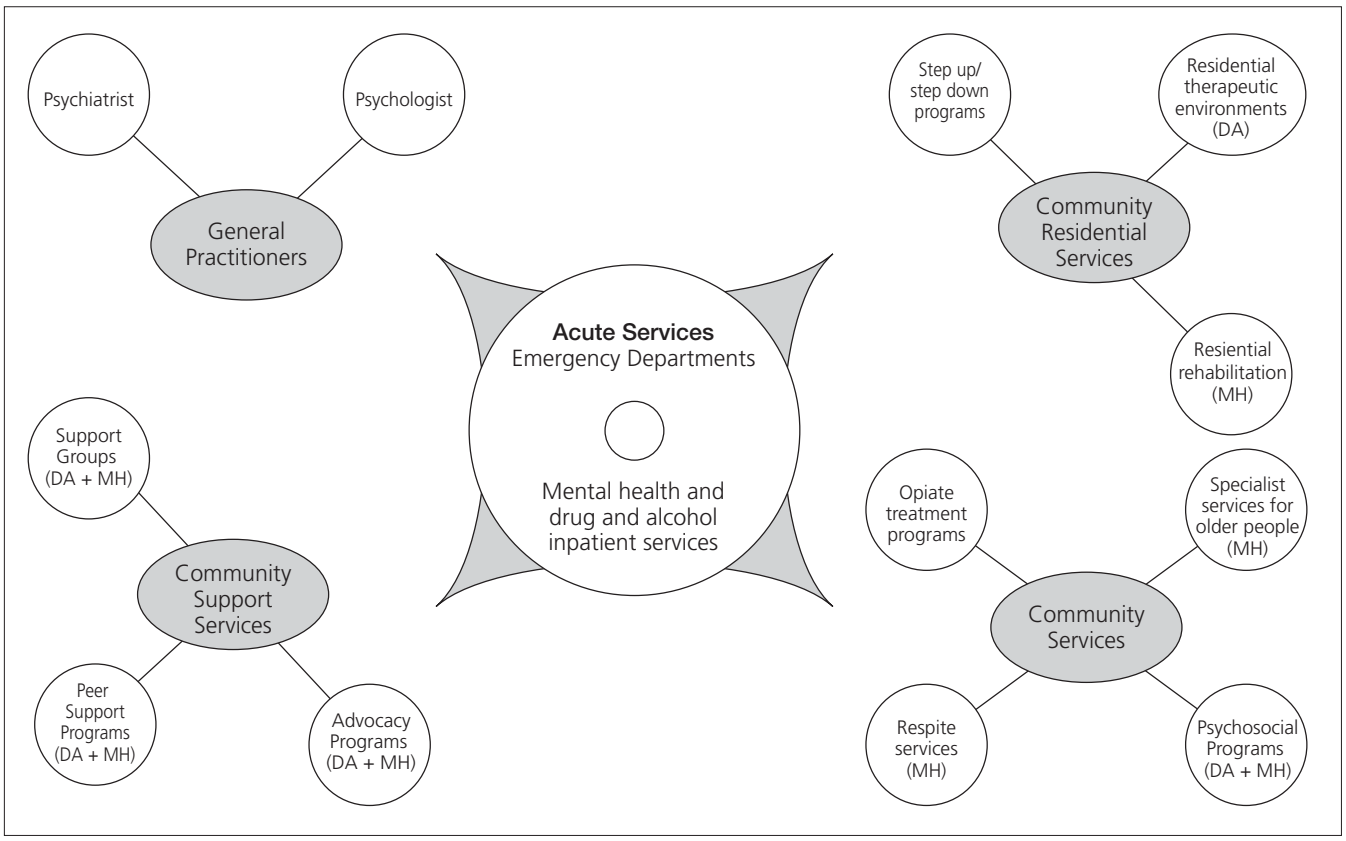
There are a myriad of clinical and community settings and environments that a client with a comorbid mental and substance use disorder may receive care and treatment. Likewise, there are a large variety of services which may be appropriate for a client to transition to and between during different stages of their 'journey', 'recovery' or 'rehabilitation'.

Examples of these include, but are not limited to the following (see diagram on next page):

The transition of clients to this range of services may be different depending upon whether the client:

- is subject to the Mental Health Act or not
- is having a transition to teams within Area Health Services who are subject to NSW Policy Directives and Area Polices and Procedures and/or
- is having a transition to NGO or private agencies whether under formal agreed procedures or not. Such NGO's will have specific policies and procedures, philosophy and Corporate Governance.

It is suggested that in order to facilitate the identification and subsequent transition to appropriate services that each service be aware of the range of services available within their area and the requirements for referral. Contact details for key contacts that can link you to local services are available at Appendix 8.



15.5 Principles of care coordination

- The no wrong door principle is at the centre of care coordination.
- The client remains the responsibility of the referring service until such time as a referral is accepted and a plan with supporting documentation agreed upon.
- Care coordination may include discharge, referral and co-case management between mental health and drug and alcohol services and within differing teams or practitioners within the respective sectors.
- Communication is key to decision making
- A client-centred approach is the focus

15.6 The importance of communication

Communication is key to the decision making surrounding transitions. All parties need to have adequate information provided which address both clinical information and the likely actions that follow the referral with a suggested timeline and contact details clarified.

The preferred options to make referrals are as follows:

1. Direct verbal agreement

This usually occurs when a practitioner telephones and talks to another practitioner resulting in an agreed outcome for how the referral is to proceed.

This is particularly relevant where:

– streamlined procedures are absent/unclear
– there are significant risk factors for clients or agencies
– there is information that needs to be conveyed which is not easily captured in documentation

2. **Streamlined written referral underpinned by written agreement between two or more agencies or services.**
   This occurs where established procedures for referrals exist between services.
   – Where these pathways exist:

Systematic and timely monitoring needs to occur to ensure referrals are actioned.

There need to be clear provisions for resolving disagreements or uncertainties in a timely manner usually by consultation with nominated senior clinicians or managers.

3. **Combination option 1 and 2 above: verbal referral that is underpinned by written agreement and associated procedures.**
   This option should be seen as the ideal type of referral particularly where significant risk factors are present or the treatment plan is complex.

15.7 Transitions checklist

- A primary coordinator has been identified to complete each stage of the transition.

- A comprehensive discharge care plan should be developed before discharge. This plan should include:

- The needs basis of referral – why is the client being referred/what are benefits for the client/expectations of the service:
  – outcomes of a thorough assessment of risk of harm to self and others.
  – the estimated date of discharge, the client's likely needs, and any risks at that time have been assessed and communicated early.
  – a plan for deterioration or crisis management.
  – involvement of the client, carer, external clinicians including General Practitioners and support agencies.
  – consideration of broader social and psychosocial needs (housing, employment, welfare benefits, disability support payments, access to education).

- Contact has been made with other service provider via telephone and/or accepted standardised referral pathway and the following has been communicated in a formal handover:
  – key demographic, diagnostic and treatment information
  – key psychosocial and historical issues of clinical relevance
  – identification and documentation of entry into a new service (if appropriate) and details of future re-entry pathway to the referring service including identifying the clinicians responsible for care.

- Client and carer information and education has been provided prior to discharge.

- A plan has been formulated with the client outlining how to cope with future crisis management. This may include the drafting of an Advanced Directive/Care Plan, where appropriate.

- The client and carer(s) have been 'engaged' in the transition process helping to plan and understand what the next steps in the journey.

SECTION 16

Specific Clinical Settings

The proposed location of the insertion has been indicated and will be formatted for the draft of the guidelines to be viewed by stakeholders throughout the review process.

16.1 Emergency Departments (ED)

At least 10% of all ED presentations are directly related to a comorbid substance use disorder and mental health disorder, with particularly high prevalence among presentations with behavioural disturbance, self-harm and trauma. The first priority of care in EDs is the recognition, assessment and management of acute clinical crises. Once these have been addressed, then routine screening for and consideration of substance use disorders and mental illness is recommended, especially in the high-prevalence presentation groups.

Clients may present to the ED during a state of acute distress, requiring chemical and/or physical restraint for effective management. Rapid chemical sedation with intravenous agents (eg. Midazolam, haloperidol, droperidol) is often the management of choice, but due to the possibility of airway and haemodynamic compromise, must only be performed in this manner by medical practitioners with adequate advanced airway management skills, and in an area with appropriate equipment and support staff.

Other methods of chemical sedation (eg utilising oral and/or intramuscular medication) can be safety utilised where such staff and facilities are not available – each ED should have locally applicable policies for this situation.

Further information and advice is available from:
Detailed information on the strategies regarding the management of clients with a comorbid disorder who are experiencing an acute crisis are included with the *NSW Health, Mental Health for Emergency Departments – A Reference Guide* (2008) (in press) This resource will be accessible via the NSW Health website when complete.

When clients with a comorbid mental health and substance use disorder present to an ED, they do so at a time of risk. This provides an opportunity for intervention including psycho-education and care. It is not however, a clinical setting which is conducive to the provision of extended care for a client.

The 'no wrong door policy' should be incorporated into care delivery and discharge, ensuring that appropriate care and referrals have been organised for each client. In order to facilitate this, all EDs should identify both mental health and drug and alcohol specialist services who are responsible for accepting care of clients with a comorbid disorder. This may be in the form of formal service agree-ments or may be expressed as defined service pathways[75].

16.2 Justice Health

Practitioners working within the Justice Setting must be cognisant of the different requirements and needs of clients being held in remand (unsentenced) versus sentenced prisoners. Appropriate referrals and consultation should take place between health and Corrective Services to ensure optimal management of the client, bearing in mind issues of confidentiality.

Of particular concern for practitioners working in the Justice Health environment is the transition period. When releasing a client from custody all clients should be reviewed to ensure that:

- they have access to medications post release
- they are aware of community services/care providers
- they have been referred to a service for care and that the service has accepted.

Where appropriate, a referral to the Connections program should also be considered for those in adult correctional centres to assist with post release care plan development and linkage with services in the community[76].

16.3 General Practice

General Practitioners play an essential role in the identification of clients with a comorbid mental health and substance use disorder through screening and assessment. It has been estimated that 12% of clients attending a general practitioner have a comorbid disorder. The following are specific considerations for the care of clients who present to a General Practitioner for care:

- consider the possibility of a substance use disorder especially for clients with chronic pain and users of benzodiazepines (The Royal Australian College of General Practitioners has specific guidelines available at http://www.racgp.org.au/guidelines)
- exclude disorders of an organic nature
- conduct a risk assessment where indicated
- use the time to provide secondary prevention where possible[77].

A number of resources have been developed to assist General Practitioners to manage clients with a comorbidity in the community. The following resources may be helpful:

- The 'Can Do' Initiative – The Australian General Practice Network – http://www.agpncando.com
- The Patient Journey Kit – NSW Department of Health – http://www.health.nsw.gov.au/resources/drugs/patientjourneykit1_pdf.asp
- The NSW Health Services Directory – NSW Department of Health – http://www.health.nsw.gov.au/services/index.asp

16.4 General Wards

Practitioners working in general wards are likely to care for a number of clients with comorbid conditions. Be aware of this possibility and integrate regular screening for comorbid disorders into practice. Identification can help to reduce the number of clients who 'fall through the cracks'. If detected, consider the special needs of the client early so that consultation with specialist services can be arranged and a coordinated management plan prepared.

Clients who are receiving medical care may have a number of pressing concerns and therefore consideration must be given as to the issues influencing a client's behaviour. For instance, when assessing for symptoms of an anxiety disorder, consider the impact of the treatment and or health problem/issue which may be influencing their behaviour.

In addition, it is likely that a substance using client may go through withdrawal if they do not have access to the substance which they use. If this is the case, refer to the Clinical guidelines for nursing and midwifery practice in NSW: Identifying and responding to drug and alcohol issues for further information and resources which are available at: http://www.health.nsw.gov.au/policies/gl/2008/pdf/GL2008_001.pdf [78]

Glossary of Terms

Abstinence: Refraining from drug use at all times.

Advanced Directive/care planning: refers to the process of preparing for scenarios and usually includes assessment of, and dialogue about, a person's under-standing of their medical history and condition, values, preferences, and personal and family resources. An Advance Directive is a document that describes a person's future preferences for medical treatment in anticipation of a time when they are unable to express those preferences because of illness or injury. Most commonly used in situations towards the end of life, there are some anecdotal reports of an increasing use in the mental health area as a means for consumers to have more input into their care at times when they have acute episodes and are considered unfit to make decisions on their own behalf.

Affect: Objective assessment of a person's emotional state. Described in terms of range and reactivity (from flat to blunted to restricted to normal to labile) and appropriateness (appropriate to inappropriate to the content of speech or ideation) and congruence to mood. Descriptors include euphoric, elevated, angry, irritable and sad.[36]

Amphetamine: The group of drugs commonly known as "speed". Sold as white or yellow powder, they can also be sold as tablets or as a liquid in capsules. Amphetamines can be swallowed, inhaled ("snorted") or injected. One form (ice) can be smoked. When bought illegally, they are often mixed with other substances. Amphetamine is a stimulant.[79]

Antidepressant: One of a group of psychoactive drugs prescribed for the treatment of depressive disorders. Also used for other conditions such as panic disorder.

Benzodiazepine: One of the sedative-hypnotic group of drugs. Introduced as a safer alternative to barbiturates, they have a general depressant effect on the central nervous system that increases with the dose, from sedation to hypnosis to stupor. Benzodiazepines have significant potential for dependence.[79]

Brief intervention: A treatment strategy in which short (between five minutes and two hours) structured therapy is offered on one occasion or spread over several visits. Aimed at helping a person to reduce or stop harmful drug and alcohol use.[36]

Cannabis: The generic name given to the psychoactive substance found in the marijuana plant Cannabis sativa, Delta 9-tetra-hydrocannabinol (THC).

Cocaine: A powerful central nervous system stimulant derived from the cocoa plant, used nonmedically to produce euphoria or wakefulness. Sold as white, translucent, crystalline flakes or powder.

Cognitive Behaviour Therapy: A time-limited, structured treatment that combines behavioural and cognitive strategies to address the client's perception and beliefs about their world.

Dialectical Behaviour Therapy: Refers to a therapy drawing from Cognitive Behaviour Therapy and Mindfulness Based Stress Reduction to provide treatment components such as group skills training, telephone counselling, behavioural and cognitive modification of problem behaviours, reflection, empathy and acceptance.

DSM IV TR: *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision*: Published by the American Psychiatric Association and contains a comprehensive classification system of psychiatric disorders, with clear diagnostic criteria.

Engagement: Refers to the client relationship with a counsellor and dedication/motivation to participate in treatment.

Harm minimisation / harm reduction: The concept of reducing harm associated with substance use without necessarily stopping use. Harm minimisation is the key philosophy for people working with alcohol and other drug issues in NSW. While abstinence is a part of harm minimisation, it is not the only goal.

Hazardous use: A pattern of substance use that increases the risk of harmful consequences for the user.

Illicit drug: An illegal substance.

Intoxication: The condition resulting from use of a psychoactive substance—that produces behavioural and/or physical changes.

Maintenance therapy: A form of treatment of substance dependence that involves prescribing a substitute drug, e.g. methadone for the treatment of heroin dependence and nicotine replacement therapy for the treatment of tobacco dependence.

Methadone: A synthetic opioid drug used in maintenance therapy for those dependent on opioids.

Mindfulness Based Stress Reduction: Is a meditative practice originating in Buddhism and involves intentionally bringing one's attention to a range of physical, emotional and cognitive experiences in the present moment.

Motivational Interviewing: Based upon the stages of change model, this model suggests that people will progress through a series of five stages in deciding and acing upon a plan to change a particular behaviour. Motivational interviewing draws heavily of basic counselling skills with the goal of helping to tip the balance of benefits and losses in favour of reducing/stopping problematic drug and alcohol use. Particularly effective in increasing treatment engagements and adherence.

Narcotic: A chemical agent that induces stupor, coma, or insensibility to pain. The term usually refers to opioids, which are called narcotic analgesics. In general use the term is often used incorrectly to refer generally to illicit drugs.

Opioids: The generic term applied to alkaloids from the opium poppy, their synthetic analogues, and compounds synthesised within the body.

Pharmacotherapy: When a suitable prescribed and supervised psychoactive medical drug is used either short term to ameliorate withdrawal (e.g. buprenorphine for opiate withdrawal), or longer-term maintenance and/or slow withdrawal (e.g. buprenorphine or methadone for opiate withdrawal) or Acamprosate of Naltrexone for the management of alcohol cravings after a withdrawal episode.

Polydrug use: Where a person uses more than one drug, often at the same time or following one another, and usually with the intention of enhancing, potentiating, or counteracting the effects of another substance.

Psychoactive substance: A substance that, when ingested, affects mental processes, emotions and behaviour.

Psychotropic: A term with the same meaning as "psychoactive" (ie, affecting the mind or mental processes).

Withdrawal: A series of symptoms that occur when a person who has developed tolerance to a drug (after long and/or high dose use) stops or reduces use of the drug.

Appendices

Appendix 1 – Legislation that governs care for mental health and drug and alcohol services

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 where those rights need to be curtailed, specifically for the person's own protection from serious physical harm and/or for the protection of others from serious physical harm. The Act sets out the circumstances in which a person's rights may 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 and have committed an offence and are mentally ill (i.e. forensic clients) (Mental Health (Criminal Procedure) Act 1990).

The Mental Health Act lists a number of ways in which an involuntary admission to hospital can be initiated. A person may be detained in a mental health facility in the following situations:

a) a mental health certificate (Schedule 1) has been provided by a medical practitioner or accredited person (see section 18),

b) an ambulance has transported a person (see section 20),

c) a police officer has apprehended a person (see section 22),

d) an order for examination and an examination or observation by a medical practitioner or accredited person has been completed (see section 23),

e) upon the order of a Magistrate or bail officer (see section 24),

f) following a transfer from another health facility (see section 25),

g) upon a written request to the authorised medical officer by a primary carer, relative or friend of the person (see section 26).

Community Treatment Orders (CTO) may also be used. These orders are made for people living in the community and do not require inpatient admission. The maximum duration of a CTO is 12 months.[80]

A copy of the Mental Health Act (2007) can be accessed on: http://www.legislation.nsw.gov.au/viewtop/inforce/act+8+2007+FIRST+0+N/

If information regarding the Mental Health (Criminal Procedures) Act is required, the Forensic Mental Health Service at Justice Health may be able to offer advice (Ph 02 9289 2977).

The Inebriates Act

The main purpose of the Inebriates Act is to provide for the care, control and treatment of an 'inebriate', that is a person who 'habitually uses intoxicating liquor or intoxicating or narcotic drugs to excess'.[81]

The Act makes provisions for the mandatory care of persons, without their consent, in specific clinical care environments. It is infrequently used today, but remains an active piece of legislation.[82]

In order of a person to be treated under the Act, an application must be made in court. It requires a signed affidavit that the person is an inebriate which is further supported by a medical certificate from a medical doctor. Both the applicant and the person for whom the application has been sought appear in open court where a magistrate decides whether the individual will be held under the Act.

A copy of the Inebriates Act (1912) can be accessed on: http://www.austlii.edu.au/au/legis/nsw/consol_act/ia1912113/

Appendix 2 – The Mental Health Clinical Documentation Suite (formerly MHOAT) Mental Health Assessment Pro-forma

NSW HEALTH

Site _____

Mental Health

ASSESSMENT

SMR025010

FAMILY NAME	MRN
GIVEN NAMES	☐ MALE ☐ FEMALE
D.O.B. ____/____/____	M.O.
ADDRESS	
LOCATION	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

CONSUMER CONTACT NUMBERS:

ALERTS/RISKS? ☐ No ☐ Yes Summary *(summarise after assessment completed)*

ASSESSMENT DETAILS

Date: Time: Location:

Referred by:

REASON FOR REFERRAL *(include mental health legal status at presentation)*

Sources of information *(indicate if corroborative history obtained, interpreter used, old notes accessed, details of people present at assessment)*

Communication issues *(e.g. language or cultural barriers, sensory impairment)*

HISTORY OF PRESENTING PROBLEM *(e.g. current symptoms, time course of current problems, any treatment already received for this problem/ episode, relevant negatives, current risk)*

Staff Name: Signature: Designation: Date:

BINDING MARGIN - NO WRITING

MENTAL HEALTH ASSESSMENT

SMR025.010

PH 608 - 11/2008

Page 1 of 8

NSW HEALTH

Site _____

Mental Health

ASSESSMENT

FAMILY NAME	MRN
GIVEN NAMES	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

PAST PSYCHIATRIC/MENTAL HEALTH HISTORY *(e.g. past episodes of current or other mental health problems, past treatments and hospitalisations, engagement with care)*

LEGAL ISSUES *(document current legal orders e.g. Guardianship, Protective Office; document past, current, pending court cases, conviction for violent offences)*

DRUG AND ALCOHOL HISTORY *(e.g. past and current substance use, amounts and frequency, features of dependence and abuse, prior treatments and their outcomes.)*

Indicate if ***Substance Use Assessment*** completed No ☐ Yes ☐ N/A ☐

FAMILY MEDICAL/MENTAL HEALTH HISTORY *(e.g. mental health, addiction or significant physical problems in parents or relatives; their treatments, experience of illness and care)*

Staff Name: Signature: Designation: Date:

BINDING MARGIN - NO WRITING

SMR025010

NSW HEALTH

Site _____

SMR025.010

Mental Health

ASSESSMENT

FAMILY NAME	MRN
GIVEN NAMES	☐ MALE ☐ FEMALE
D.O.B. ____/____/_____	M.O.
ADDRESS	
LOCATION	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

MEDICAL HISTORY *(e.g. medical conditions and treatments, relevant systems review, relevant investigations and results)*

Allergies/adverse drug reactions *(includes non-medication allergies, give details, document any alerts on page 1)*

CURRENT TREATMENTS

Current Medications *(use generic)*	Dose/frequency/route	Comments *(e.g. prescriber, side effects, adherence)*

Additional information *(e.g. medications recently ceased and reasons)*

Other treatments

Staff Name:	Signature:	Designation:	Date:

BINDING MARGIN - NO WRITING

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NSW HEALTH

Site _____

Mental Health

ASSESSMENT

FAMILY NAME	MRN
GIVEN NAMES	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

DEVELOPMENTAL AND PERSONAL HISTORY *(e.g. genogram; family, perinatal, childhood, and adolescent development; social, intellectual development; recreational, educational and employment history; premorbid personality; abuse and neglect)*

Male | Female | Pregnancy | Marriage Relationship | Separation | Divorce | Twins | Adoption | Significant Illness | Death | Non-marriage relationship | Miscarriage abortion | Unknown gender | Focal group of individuals

Staff Name: Signature: Designation: Date:

BINDING MARGIN - NO WRITING

SMR025010

SMR025.010 Page 4 of 8

NSW HEALTH

Site _____

SMR025010

Mental Health
ASSESSMENT

FAMILY NAME	MRN
GIVEN NAMES	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

BINDING MARGIN - NO WRITING

CURRENT FUNCTIONING AND SUPPORTS *(e.g. living situation, accommodation issues; family, relationships, other supports; social, educational, vocational functioning; ability to undertake responsibilities, daily tasks; financial issues, gambling; note strengths and weaknesses, any rehabilitation needs)*

Indicate if ***Functional Assessment (Older People)*** completed No ☐ Yes ☐ N/A ☐

PARENTAL STATUS AND/OR OTHER CARER RESPONSIBILITIES *(If pregnant, consider in Initial Management Plan as appropriate)*

Does the person have responsibility for children aged 18 years or less? ☐ No ☐ Yes

Does the person have any contact with children through access visits or shared residence? ☐ No ☐ Yes

Does the person have other carer responsibilities? *(e.g. aged or disabled adult)* ☐ No ☐ Yes

DETAILS OF CHILDREN AND/OR OTHER DEPENDENTS

Name *(First name & surname)*	Relationship	Age/Date of birth	Current whereabouts

Indicate if ***Family Focused Assessment (COPMI)*** completed ☐ No ☐ Yes

Are there concerns about the safety of the child, young person or other dependent? ☐ No ☐ Yes

If risk identified, where is the management plan documented? _____

Staff Name: Signature: Designation: Date:

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NSW HEALTH

Site _____

Mental Health

ASSESSMENT

FAMILY NAME	MRN
GIVEN NAMES	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

MENTAL STATE EXAMINATION

Appearance *(e.g. physical description; level of personal hygiene and grooming)*

Behaviour during interview *(e.g. rapport, engagement, psychomotor activity, interactions at assessment)*

Affect *(observed emotional responses e.g. appropriate, restricted, flattened)*

Mood *(reported feeling or emotion e.g. depressed, angry, euphoric or distressed)*

Speech *(e.g. quantity, rate, volume, tone, unusual characteristics)*

Thought Form *(e.g. logical, tangential, blocked, concrete)*

Thought Content *(e.g. obsessions, delusions, suicidal or homicidal ideation, view of future; for children consider play and fantasy)*

Perception *(e.g. auditory, visual or somatic hallucinations)*

Cognition & Intellectual Functioning *(e.g. orientation to time/place/person, memory, attention/concentration, planning)*

Indicate if ***Cognitive Assessment (RUDAS)*** *or* ***3MS/MMS*** completed No ☐ Yes ☐ N/A ☐

Insight and Judgement

Staff Name: Signature: Designation: Date:

BINDING MARGIN - NO WRITING

SMR025010

NSW HEALTH

Site _____

SMR025010

Mental Health
ASSESSMENT

FAMILY NAME	MRN
GIVEN NAMES	☐ MALE ☐ FEMALE
D.O.B. ____/____/_____	M.O.
ADDRESS	
LOCATION	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

PHYSICAL EXAMINATION SUMMARY *(e.g. key findings, information source, if referred to GP)*

Indicate if: ***Physical Examination*** completed No ☐ Yes ☐ N/A ☐ ***Physical Appearance*** completed No ☐ Yes ☐ N/A ☐

Major findings:

RISK ASSESSMENT

Y = Yes, No = No, UK = Unknown

	Suicide Y	Suicide N	Suicide UK	Violence Y	Violence N	Violence UK
Significant past history of risk	☐	☐	☐	☐	☐	☐
Recent thoughts, plans, symptoms indicating risk	☐	☐	☐	☐	☐	☐
Recent behaviour suggesting risk	☐	☐	☐	☐	☐	☐
Concern from others about risk *(assessment should include corroboration where possible)*	☐	☐	☐	☐	☐	☐

	Y	N	UK
Current problems with alcohol or substance misuse	☐	☐	☐
Major mental illness or disorder	☐	☐	☐
At risk mental state *(e.g. depression, hopelessness, despair, guilt, marked agitation, disorganisation, intoxication etc)*	☐	☐	☐
Person's level of risk appears to be highly changeable	☐	☐	☐
Significant uncertainty in the assessment of the level of risk	☐	☐	
Considering the above factors and information available from your assessment, is a more detailed assessment of suicide or violence risk required? *('Yes' to any of the above risk factors may indicate that a more detailed assessment is required.)*	☐	☐	
Indicate if ***Risk Assessment*** module has been completed	☐	☐	

Overall Level of Risk *(current/immediate)*

	High	Med	Low
Suicide	☐	☐	☐
Violence	☐	☐	☐
Other** *(specify)*	☐	☐	☐
Other** *(specify)*	☐	☐	☐

***Consider other risks e.g. child safety, absconding, exploitation, domestic violence, abuse, neglect, homelessness, falls, pet safety.*
For females aged 16 or over, please note that completion of the Screening for Domestic Violence module is mandatory.

MEASURES *(e.g. routine outcome measures such as the HoNOSCA, HoNOS, other scales or tools. Attach copies)*

Measure	Score/summary	Comment

FORMULATION/OVERALL CLINICAL IMPRESSION *(include current and longer term risk; document any 'Alert/Risks' on Page 1)*

Staff Name: Signature: Designation: Date:

BINDING MARGIN - NO WRITING

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NSW HEALTH

Site _____

Mental Health

ASSESSMENT

FAMILY NAME	MRN
GIVEN NAMES	☐ MALE ☐ FEMALE
D.O.B. _____ / _____ / _____	M.O.
ADDRESS	
LOCATION	
COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE	

PROVISIONAL DIAGNOSES

INITIAL MANAGEMENT PLAN

Has the Plan been discussed with a Consultant Psychiatrist/Senior Clinician? No ☐ Yes ☐ N/A ☐

Name: _____ Date: _____ Time: _____

CONTACTS

Has a primary carer been identified under the Mental Health Act 2007? No ☐ Yes ☐ N/A ☐

Communication undertaken with	Name	Contact details	Comment
Yes ☐ Primary carer / family			
Yes ☐ General Practitioner			
Yes ☐ NGO / Other *(specify)*			

Staff Name: Signature: Designation: Date:

BINDING MARGIN - NO WRITING

SMR025010

SMR025.010 Page 8 of 8

Appendix 3 – PsyCheck Screener

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

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

General Screen

Clinician to administer this section		
The following questions are about your emotional wellbeing. Your answers will help me get a clearer idea of what has been happening in your life and suggest possible ways that we might work together to relieve any distress you may be experiencing. We ask these questions of everybody, and they include questions about mental, physical and emotional health.		
1. Have you ever seen a doctor or psychiatrist for emotional problems or problems with your 'nerves'/anxieties/worries?	No	Yes
Details:		
2. Have you ever been given medication for emotional problems or problems with your 'nerves'/anxieties/ worries?		
No, never		
Yes, in the past but not currently	Medications:	
Yes, currently	Medications:	
Have you ever been hospitalised for emotional problems or problems with your 'nerves'/ anxieties/worries?	No	Yes
Details:		
4. Do you have a current mental health worker, psychiatrist, psychologist, general practitioner or other health provider? If 'No', go to Question 5.		
Psychiatrist	Psychologist	
Name:	Name:	
Contact details:	Contact details:	
Role:	Role:	
Mental health worker	General Practitioner	
Name:	Name:	
Contact details:	Contact details:	
Role:	Role:	
Other – specify:	Other – specify	
Name:	Name:	
Contact details:	Contact details:	
Role:	Role:	
5. Has the thought of ending your life ever been on your mind?	No	Yes	In 'No', go to Section 3
Has that happened recently?	No	Yes	In 'No', go to Section 2

Risk Assessment

Clinician to administer this section			
If the person says 'Yes' to recently thinking about ending their life (Question 5), complete the suicide/self-harm risk assessment below. Specific questions and prompts and further guidance can be found in the PsyCheck User's Guide.			
Risk factor:	Low risk	Moderate risk	High risk
1. Previous attempts: Consider lethality and recency of attempts. Very recent attempt(s) with moderate lethality and previous attempts at high lethality both represent high risk. Recent and lethal attempts of family or friends represent higher risk.			
History of harm to self	Previous low lethality	Moderate lethality	High lethality, frequent
History of harm in family members or close friends	Previous low lethality	Moderate lethality	High lethality, frequent
2. Suicidal ideation: Consider how the suicidal ideation has been communicated; non-disclosure may not indicate low risk. Communication of plans and intentions are indicative of high risk. Consider non-direct and non-verbal expressions of suicidal ideation here such as drawing up of wills, depressive body language, 'goodbyes', unexpected termination of therapy and relationships etc. Also consider homicidal ideation or murder/suicide ideation.			
Intent	No intent	No immediate intent	Immediate intent
Plan	Vague plan	Viable plan	Detailed plan
Means	No means	Means available	Means already obtained
Lethality	Minor self-harm Planned overdose, Firearms, hanging, jumping,	Behaviours, serious cutting, intervention unlikely	Intervention likely
3. Mental health factors: Assess for history and current mental health symptoms, including depression and psychosis.			
History of current depression:	Lower or unchanged mood	Enduring low mood	Depression diagnosis
Mental health disorder or symptoms	Few or no symptoms or well-managed significant illness	Pronounced clinical signs	Multiple symptoms with no management
4. Protective factors: These include social support, ability or decision to use support, family involvement, stable lifestyle, adaptability and flexibility in personality style etc.			
Coping skills and resources	Many	Some	Few
Family/friendships/networks	Many	Some	Few
Stable lifestyle	Many	Some	Few
Ability to use supports	Many	Some	Few

Self Reporting Questionnaire

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

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

Appendix 4 – The Mental Health Clinical Documentation Suite Substance Use Assessment Pro-forma

NSW HEALTH

Mental Health

Site

SUBSTANCE USE ASSESSMENT

SURNAME | MRN

OTHER NAMES | ☐ MALE ☐ FEMALE

D.O.B. _____/_____/_____ | M.O.

ADDRESS

LOCATION

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

This module can be used at any point of care; attach to relevant base module and summarise in relevant components. For example, if completed at assessment, please attach to Assessment module and summarise findings in Drug and Alcohol History on page 2.

Substance / drug type	Last used? *(date, time)*	Usual amount?	How often? *(e.g. 4 times a day, week(s))*	Duration of use	Route? *(e.g. oral, injection)*	Withdrawal risk *(low-high)**
Alcohol						
Tobacco						
Benzodiazepines						
Cannabis						
Amphetamines						
Cocaine						
MDMA (Ecstacy)						
Heroin						
Prescription analgesics						
Methadone						
Buprenorphine						
Solvents						
Hallucinogens						
Other *(Specify)*						

**Note below previous withdrawal experiences, types of symptoms and any complications*

COMMENTS / ADDITIONAL INFORMATION

E.g. related harms: physical, relationships, employment, finances, legal; gambling problems; readiness for change; factors influencing use; relapse factors

Staff Name: Signature: Designation: Date:

BINDING MARGIN - NO WRITING

SUBSTANCE USE ASSESSMENT

SMR025.040

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Page 1 of 2

NSW HEALTH

Mental Health

Site

SUBSTANCE USE ASSESSMENT

SURNAME	MRN
OTHER NAMES	☐ MALE ☐ FEMALE
D.O.B. ____/____/_____	M.O.
ADDRESS	
LOCATION	

COMPLETE ALL DETAILS OR AFFIX PATIENT LABEL HERE

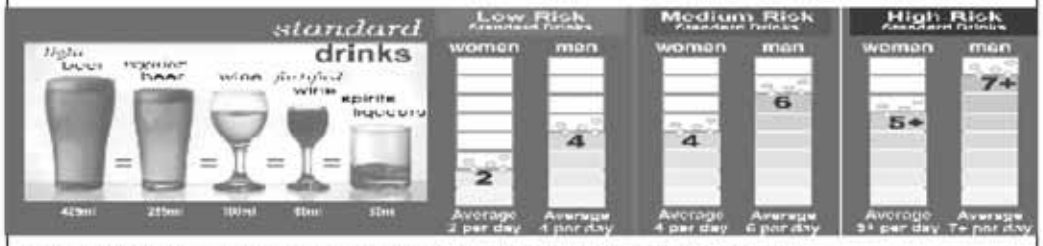
OVERVIEW *(tick or comment if dependence and/or abuse factors relevant in last 12 months)*

DEPENDENCE	**DRUG / SUBSTANCE** *(insert relevant substances/drugs from page 1)*		
	1	2	3
Tolerance			
Withdrawal			
Use more / longer than intended			
Inability or persistent desire to cut down			
Excess time obtaining/using/recovering			
Important activities given up			
Use despite physical/psychological problems			
ABUSE	1	2	3
Failure to fulfil obligations			
Use in hazardous situations			
Legal problems			
Use despite social and interpersonal problems			

SPECIFIC ISSUES TO BE ADDRESSED IN MANAGEMENT / CARE PLAN

Consider current/immediate and longer term issues; consider implications of any episodic or ongoing cognitive impairment

BINDING MARGIN - NO WRITING



Note that risky drinking limits may be lower for pregnant women, the elderly and other relevant groups who should drink less.

Mental health professionals seeking information and advice should (1) contact your local Alcohol and Other Drug specialist/service or (2) contact ADIS who provide advice to mental health professionals on illegal drug and alcohol use on:
Sydney Metro 9361 8000 Country 1800 422 599

Staff Name:	Signature:	Designation:	Date:

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Appendix 5 – The Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)

INTRODUCTION (Please read to client)

Thank you for agreeing to take part in this brief interview about alcohol, tobacco products and other drugs. I am going to ask you some questions about your experience of using these substances across your lifetime and in the past three months. These substances can be smoked, swallowed, snorted, inhaled, injected or taken in the form of pills (show drug card).

Some of the substances listed may be prescribed by a doctor (like amphetamines, sedatives, pain medications). For this interview, we will not record medications that are used as prescribed by your doctor. However, if you have taken such medications for reasons other than prescription, or taken them more frequently or at higher doses than prescribed, please let me know. While we are also interested in knowing about your use of various illicit drugs, please be assured that information on such use will be treated as strictly confidential.

NOTE: BEFORE ASKING QUESTIONS, GIVE ASSIST RESPONSE CARD TO PATIENT		
Q1. In your life, which of the following substances have you ever used? (NON-MEDICAL USE ONLY)	YES	NO
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)		
b. Alcoholic beverages (beer, wine, spirits, etc.)		
c. Cannabis (marijuana, pot, grass, hash, etc.)		
d. Cocaine (coke, crack, etc.)		
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)		
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)		
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)		
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)		
i. Opioids (heroin, morphine, methadone, codeine, etc.)		
j. Other – specify:		

(If completing follow-up please cross-check the patient's answers with the answers given for Q1 at baseline. Any differences on this question should be queried).

Probe if all answers are negative:	If 'NO to all items – end assessment
'Not even when you were in school?'	If YES to any item ask Q2 for each substance ever used

Q2. In the past three months, how often have you used the substances you mentioned (FIRST DRUG, SECOND DRUG, ETC)?	Never	Once or twice	Monthly	Weekly	Daily or almost daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
d. Cocaine (coke, crack, etc.)	0	2	3	4	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	2	3	4	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	2	3	4	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	2	3	4	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	2	3	4	6
j. Other – specify:	0	2	3	4	6

If 'Never' to all items in Question 2, skip to Question 6. If any substances in Question 2 were used in the previous three months, continue with Questions 3, 4 & 5 for each substance used.

Q3. During the past three months, how often have you had a strong desire or urge to use (FIRST DRUG, SECOND DRUG, ETC)?	Never	Once or twice	Monthly	Weekly	Daily or almost daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
d. Cocaine (coke, crack, etc.)	0	2	3	4	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	2	3	4	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	2	3	4	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	2	3	4	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	2	3	4	6
j. Other – specify:	0	2	3	4	6

Q4. During the past three months, how often has your use of (FIRST DRUG, SECOND DRUG, ETC) led to health, social, legal or financial problems?	Never	Once or twice	Monthly	Weekly	Daily or almost daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
d. Cocaine (coke, crack, etc.)	0	2	3	4	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	2	3	4	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	2	3	4	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	2	3	4	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	2	3	4	6
j. Other – specify:	0	2	3	4	6

Q5. During the past three months, how often have you failed to do what was normally expected of you because of your use of (FIRST DRUG, SECOND DRUG, ETC)?	Never	Once or twice	Monthly	Weekly	Daily or almost daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
d. Cocaine (coke, crack, etc.)	0	2	3	4	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	2	3	4	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	2	3	4	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	2	3	4	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	2	3	4	6
j. Other – specify:	0	2	3	4	6

Ask Questions 6 & 7 for all substances ever used (i.e. those endorsed in Question 1).

Q6. Has a friend or relative or anyone else ever expressed concern about your use of (FIRST DRUG, SECOND DRUG, ETC.)?	No, Never	Yes, in the last 3 months	Yes, but not in the last 3 months
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other – specify:	0	6	3

Q7. Have you ever tried and failed to control, cut down or stop using (FIRST DRUG, SECOND DRUG, ETC.)?	No, Never	Yes, in the last 3 months	Yes, but not in the last 3 months
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other – specify:	0	6	3

	No, Never	Yes, in the last 3 months	Yes, but not in the last 3 months
Q8. Have you ever used <u>any</u> drug by injection? (NON-MEDICAL USE ONLY)	0	6	3

IMPORTANT NOTE:

Patients who have injected drugs in the last 3 months should be asked about their pattern of injecting during this period, to determine their risk levels and the best course of intervention.

Pattern of injecting		Intervention
Once weekly or less or Fewer than 3 days in a row	→	Brief Intervention including "risks associated with injecting" card"
More than once per week or 3 or more days in a row	→	Further assessment and more intensive treatment*

HOW TO CALCULATE A SPECIFIC SUBSTANCE INVOLVEMENT SCORE

For each substance (labelled a. to j.) add up the scores received for questions 2 through 7 inclusive.
Do not include the results from either Q1 or Q8 in this score. For example, a score for cannabis would be calculated as:
Q2c + Q3c + Q4c + Q5c + Q6c + Q7c

Note that Q5 for tobacco is not coded, and is calculated as: Q2a + Q3a + Q4a + Q6a + Q7a

THE TYPE OF INTERVENTION IS DETERMINED BY THE PATIENT'S SPECIFIC SUBSTANCE INVOLVEMENT SCORE

	Record score	No intervention	Receive brief intervention	More intensive treatment
a. tobacco				
b. alcohol				
c. cannabis				
d. cocaine				
e. amphetamine				
f. inhalant				
g. sedatives				
h. hallucinogens				
i. opioids				
j. other drugs				

NOTE: *FURTHER ASSESSMENT AND MORE INTENSIVE TREATMENT may be provided by the health professional(s) within your primary care setting, or, by a specialist drug and alcohol treatment service when available.

Retrieved from World Health Organsation (WHO) [homepage on the Internet]. Geneva: The ASSIST Questionnaire v3.0 [cited 2009 Jan 29]. Available from: http://www.who.int/substance_abuse/activities/assist/en/index.html

WHO ASSIST v3.0 – Response Card for clients

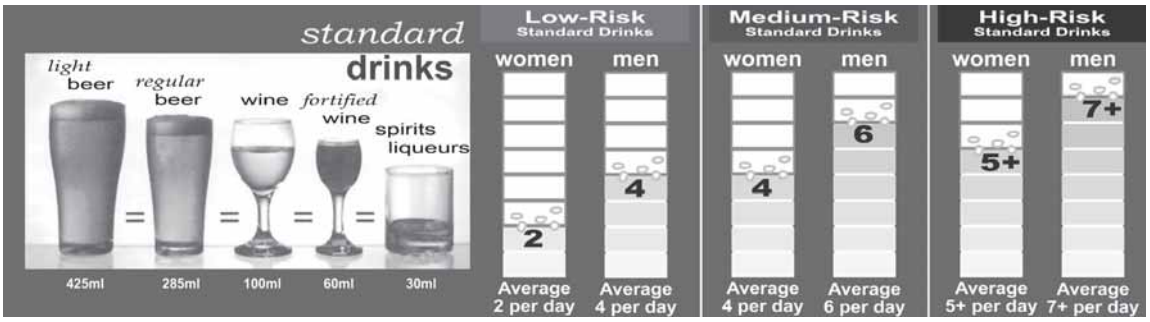
Response Card – Substances
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)
b. Alcoholic beverages (beer, wine, spirits, etc.)
c. Cannabis (marijuana, pot, grass, hash, etc.)
d. Cocaine (coke, crack, etc.)
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)
i. Opioids (heroin, morphine, methadone, codeine, etc.)
j. Other – specify:

Response Card (ASSIST Questions 2 – 5)	
Never: not used in the last 3 months	
Once or twice: 1 to 2 times in the last 3 months.	
Monthly: 1 to 3 times in one month.	
Weekly: 1 to 4 times per week.	
Daily or almost daily: 5 to 7 days per week.	

Response Card (ASSIST Questions 6 to 8)	
No, Never	
Yes, but not in the past 3 months	
Yes, in the past 3 months	

Appendix 6 – The Alcohol Use Disorders Identification Test (AUDIT)

Thank you for agreeing to take part in this survey about alcohol. Below are some questions about your experience of drinking alcohol during the past 12 months. Please be assured that the information on your drinking will be treated as strictly confidential. Please circle your answer to each question. Please see below for examples of 'standard drinks'.



1. HOW OFTEN DO YOU HAVE A DRINKING CONTAINING ALCOHOL?

Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
(0)	(1)	(2)	(3)	(4)

2. HOW MANY DRINKS CONTAINING ALCOHOL DO YOU HAVE ON A TYPICAL DAY WHEN YOU ARE DRINKING?

1 or 2	3 or 4	5 or 6	7 to 9	10 or more
(0)	(1)	(2)	(3)	(4)

3. HOW OFTEN DO YOU HAVE SIX OR MORE DRINKS ON ONE OCCASION

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
(0)	(1)	(2)	(3)	(4)

4. HOW OFTEN DURING THE LAST YEAR HAVE YOU FOUND THAT YOU WERE NOT ABLE TO STOP DRINKING ONCE YOU HAD STARTED?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
(0)	(1)	(2)	(3)	(4)

5. HOW OFTEN DURING THE LAST YEAR HAVE YOU FAILED TO DO WHAT WAS NORMALLY EXPECTED FROM YOU BECAUSE OF DRINKING?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
(0)	(1)	(2)	(3)	(4)

6. HOW OFTEN DURING THE LAST YEAR HAVE YOU NEEDED A FIRST DRINK IN THE MORNING TO GET YOURSELF GOING AFTER A HEAVY DRINKING SESSION?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
(0)	(1)	(2)	(3)	(4)

7. HOW OFTEN DURING THE LAST YEAR HAVE YOU HAD A FEELING OF GUILT OR REMORSE AFTER DRINKING?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
(0)	(1)	(2)	(3)	(4)

Appendix 7 – Possible drug interactions with methadone

Drug	Degree of interaction	Effect	Mechanism
Alcohol	Increased sedation	Additive CNS depression	
Barbiturates	Moderate	Reduced methadone levels, raised sedation	Raised hepatic metabolism, additive CNS depression
Benzodiazepines		Enhanced sedative effect	Additive CNS depression
Buprenorphine		Antagonist effect	Can only be used safely in low doses (20mg or less daily) methadone treatment
Carbamazepine	Moderate	Reduced methadone levels	Raised hepatic metabolism, methadone may need twice daily dosing regime
Chloral hydrate		Increased sedation	Additive CNS depression
Chlormethiazole		Increased sedation	Additive CNS depression
Cimetidine	Moderate	Possible increase in methadone levels	Inhibits hepatic enzymes involved in methadone metabolism
Cisapride Domperidone Metoclopramide		Morphine has an increased rate of onset of action and increased sedative effect when used with these drugs.	Unknown
Cyclizine	Severe	Injection with opiates causing hallucinations reported	Unknown
Codeine		Enhanced sedative effect	Additive CNS depression
Desipramine	Moderate	Raised desipramine levels (x2)	Unknown. Interaction not seen with other tricyclic anti-depressants
Dextropropoxyphene		Enhanced sedative effect	Additive CNS depression
Disulfiram	Avoid in combination with methadone formulations containing alcohol (check with manufacturers)	Very unpleasant reaction to alcohol which can be alarming	Inhibits alcohol metabolism allowing metabolites to build up
Erythromycin	In theory, should interact but combination has not been studied	Increase in methadone levels	Decreased methadone metabolism
Fluconazole	In theory, same as ketoconazole		
Fluoxetine Sertraline	Clinically important but not as significant as for fluvoxamine	Raised methadone levels	Decreased methadone metabolism
Fluvoxamine	Clinically important	Raised plasma methadone levels	Decerased methadone metabolism
Grapefruit juice	In theory, should interact and there have been several anecdotal reports	Raised methadone levels	Decreased methadone metabolism
Indinavir	Clinically important	Raised methadone levels	Decreased methadone metabolism
Ketoconazole	Clinically important	Raised methadone levels	Decreased methadone metabolism
Monoamine oxidase inhibitors anti-depressants including moclobamide and selegiline	Severe with pethidine although rare with methadone. Concurrent use should be avoided	CNS excitation; delirium, hyperpyrexia, convulsions or respiratory depression	Unknown

Drug	Degree of interaction	Effect	Mechanism
Naltrexone	Severe	Reverses the effects of methadone in overdose (long-acting)	Opiate antagonist works by competing for opioid receptor
Naloxone	Severe	Reverses the effects of methadone in overdose (long-acting)	Opiate antagonist works by competing for opioid receptor
Nevirapine	Clinically important	Decreased methadone levels	Increased methadone metabolism
Nifedipine	Has been demonstrated in vitro only	Increased methadone levels	Methadone increases the metabolism of nifedipine
Omeprazole	To date, demonstrated in animals only	Increased methadone levels	Possibly an effect upon methadone absorption from the gut
Other SSRIs	Theoretical	Raised plasma methadone levels	Decreased methadone metabolism
Other selective serotonin in re-uptake inhibitors	Theoretical		
Phenobarbitone	Moderate	Reduced methadone levels	Raised hepatic metabolism (see carbamazepine)
Phenytoin	Moderate	Reduced methadone levels, withdrawal symptoms	Raised hepatic metabolism (see carbamazepine)
Rifabutin	Occasionally clinically important	Decreased methadone levels	Increased methadone metabolism
Rifampicin	Severe	Reduced methadone levels, withdrawal symptom	Increased metabolism
Ritonavir	Clinically important	May reduce or increase plasma methadone levels	Increased or reduced methadone metabolism
Tricyclic anti-depressants, eg. Amitriptyline	Moderate	Increased sedation	Unknown
Urine acidifiers, eg. Ammonium chloride		Reduced methadone levels	Raised urinary excretion
Zidovudine		Possible raised levels of zidovudine	Unknown
Zopiclone		Increased sedation	Additive CNS depression

Adapted from the NSW Department of Health. *Clinical guidelines for nursing and midwifery practice in NSW: Identifying and responding to drug and alcohol issues.* North Sydney: NSW Health

Appendix 8 – Possible drug interactions with buprenorphine

Drug	Status of interaction	Effect	Mechanism
Alcohol	Clinically important	Increased sedation, increased respiratory depression. Combination may also have increased hepatotoxic potential	Additive central nervous system depression
Benzodiazepines	Clinically important	Enhanced sedative effect	Additive CNS depression
Methadone and other opioids	Clinically Important	Buprenorphine's antagonist effect may precipitate withdrawal in patients taking other opioids, or enhanced sedative and respiratory depression	Buprenorphine is a partial agonist of opiate receptors.
Naltrexone and naloxone	Clinically important	Greatly reduced antagonist effect of naltrexone and naloxone	Buprenorphine has higher affinity for opioid receptors than naltrexone and naloxone
Drugs that inhibit CYP 3A4			
Erythromycin and other macrolide antibiotics	Clinically important	Raised buprenorphine levels	Decreased buprenorphine metabolism
HIV protease inhibitors such as indinavir, ritonavir, saquinavir	Clinically important	Raised buprenorphine levels Decreased buprenorphine metabolism	
Ketoconazole and other azole antifungal agents	Clinically important	Raised buprenorphine levels	Decreased buprenorphine metabolism
Drugs that induce CYP 3A4			
Carbamazepine	Theoretical	Reduced buprenorphine levels	Increased buprenorphine metabolism
Barbiturates, eg phenobarbitone	Clinically important	Reduced buprenorphine levels, Increased sedation. Additive CNS depression	Increased buprenorphine metabolism
Phenytoin	Theoretical	Reduced buprenorphine levels	Increased buprenorphine metabolism
Rifampicin	Theoretical	Reduced buprenorphine levels	Increased buprenorphine metabolism

Sourced from the NSW Department of Health. *Clinical guidelines for methadone and buprenorphine treatment of opioid dependence*. North Sydney: NSW Health.

Appendix 9 – Contacts and resources

Youth Specific Resources	
DrugInfo Clearinghouse	http://www.druginfo.adf.org.au/
Headroom	http://www.headroom.net.au/
Kids Helpline	http://www.kidshelp.com.au/home_KHL.aspx?s=6
National Drug Campaign – Where's your head at?	http://www.drugs.health.gov.au/internet/drugs/publishing.nsf/Content/youth-home
Reach Out	www.reachout.com.au
Reality Check	http://www.realitycheck.net.au/text_site/home_text.html
The Source	http://www.thesource.gov.au/find/life/drugs_and_alcohol.asp
Ybblue	www.beyondblue.org.au/ybblue
Youth specific services in NSW – The New South Wales Association for Adolescent Health Website	http://www.naah.org.au/youth.cf

Adult web resources	
Australian Centre for Addiction and Mental Health Research	www.acar.net.au
Clinical Research Unit for Anxiety and Depression – Self Help Section	http://www.crufad.com/site2007/selfhelp/shindex.html
Moodgym	http://www.moodgym.anu.edu.au
Mental Health First Aid	http://www.mhfa.com.au/

Mental Health Crisis Services		
Sydney Central	9556 9100 (24 hours)	Mental Health Access Line
Sydney Northern	1300 302 980 (24 hours)	Northern Sydney Mental Health
Sydney South Eastern	1300 300 180 (24 hours)	Mental Health Service
Sydney South Western	1300 669 663 (24 hours)	Macarthur Mental Health Service
Sydney Western	9840 3047 (24 hours)	Cumberland Hospital
	9843 3237 (24 hours)	Parramatta Mental Health Team
	9881 8888 (24 hours)	Blacktown Mental Health Service
Central Coast	4320 3500 (24 hours)	Central Coast Mental Health Mental Intake Service
Far West	1800 665 066 (24 hours)	Mental Health Service
Greater Murray	1800 800 944 (24 hours)	Greater Murray Access Line
Illawarra	1300 552 289 (24 hours)	Mental Health Service
The Hunter	1800 655 085 (24 hours)	The Hunter Valley Mental Health Service
Macquarie	1800 011 511 (24 hours)	Mental Health Service
Mid North Coast	1300 303 900 (24 hours)	Mental Health Service
Mid Western	1800 011 511 (24 hours)	Mental Health Service
New England	6766 3400 (24 hours)	Community Mental Health
Northern Rivers	6620 2240 (after hours)	Richmond Clinic
Southern NSW	1800 677 114 (24 hours)	Mental Health Service
Wentworth	1800 650 749 (24 hours)	Mental Health Service

Comorbidity resources	
Clinical Treatment Guidelines for Alcohol and Drug Clinicians. No. 14: Co-occurring acquired brain injury / cognitive impairment and alcohol and other drug use disorders.	http://www.health.vic.gov.au/drugservices/downloads/abi_ctg.pdf
SAMSHA TIP 42: Substance Abuse Treatment for Persons With Co-Occurring Disorders (USA)	http://ncadistore.samhsa.gov/catalog/productDetails.aspx?ProductID=16979
Screening for and assessment of co-occurring substance use and mental health disorders by alcohol & other drug and mental health services.	http://www.dualdiagnosis.org.au/home/index.php?option=com_docman&task=doc_download&gid=23&Itemid=27&mode=view
The Patient Journey. KIT2: Supporting GPs to manage comorbidity in the community.	http://www.psyborg.com.au/kittest/kit2.pdf

NSW Health Care Interpreter Service			
Sydney South West (Western zone)	02 9828 6801	NSCC – Northern Sydney sector	02 9926 7690
Sydney South West (Eastern zone)	02 9515 9516	NSCC – Central Coast sector	02 4924 6286
SESIAHS – Northern Sector	02 9515 9516	Hunter New England	02 4924 6286
SESIAHS – Southern Sector	02 4274 4211	Sydney West	02 9840 3697
Greater Southern Area Health Service	02 4274 4211	To contact the Translating and Interpreting Service (TIS):	131 450

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	1300 662 263
Mid North Coast	02 6588 2882
Northern Rivers	02 6620 7612
Northern Sydney / Central Coast Area Health Service	
North Sydney	1300 889 788
Central Coast	4394 4880
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

Non-government Mental Health and Drug and Alcohol Services

Mental Health Coordinating Council (MHCC)

MHCC represents approximately 128 member organisations who provide 400 mental health programs including:

- Employment and supported education
- Peer support and consumer advocacy
- Day and rehabilitation program
- Supported accommodation and residential rehabilitation
- Respite and carer support
- Home based outreach support

Contact details for these services is available from: www.mhcc.org.au

The Network of Alcohol and other Drug Agencies

NADA represents approximately 104 member organisations who provide 168 drug and alcohol programs including:

- Non-residential rehabilitation programs
- Family support
- Residential rehabilitation
- Therapeutic communities

Further information about services in your area is available from: www.nada.org.au

Helplines		
Alcohol and Drug Information Service (ADIS)	9361 8000 or 1800 422 599	Offers a 24/7 confidential telephone information, advice and counselling service for people with problems related to drugs and alcohol.
Anxiety Disorders Support and Information Line	1300 794 992	Provides information regarding anxiety disorders and related available supports.
Mental Health Information Service	1300 794 991	Offers a service to assist people looking for information on any mental health issue and related service(s)

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