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NHMRC CENTRE OF RESEARCH EXCELLENCE in MENTAL HEALTH and SUBSTANCE USE
CREMS

# Identifying mental disorders and related conditions among patients with alcohol and other drug conditions

Dr Christina Marel

A/Prof Katherine Mills

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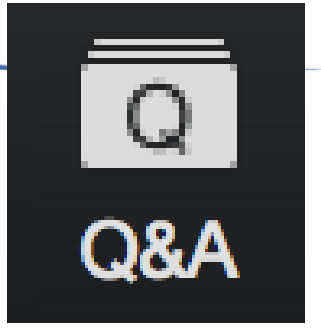
# Before we get started…

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# Identifying mental disorders and related conditions among patients with alcohol and other drug conditions

Dr Christina Marel

# National comorbidity guidelines

- *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*
- Download: https://comorbidity.edu.au/cre-resources/guidelines-management-co-occurring-alcohol-and-other-drug-and-mental-health-0


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# Learning outcomes


- Understanding of how, when and why to conduct assessments, with an improved awareness of structured and unstructured assessment techniques
- Improved understanding of the differences between substance-induced and independent mental health disorders
- Understanding of a coordinated approach to managing comorbidity, and how to involve multiple services to deliver coordinated care

# Overview

- Brief background: What do we know about comorbidity?
- How is comorbidity identified?
  - Screening
  - Assessment
  - Case formulation
    - Informal assessment
    - Standardised screening and assessment
- Coordinated care

# Case study: James

- 51 year-old male
- Employed full-time as an accountant
- Went to his GP asking for a prescription for oxycodone for back pain

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# What do we know about comorbidity?

# What is meant by ‘comorbidity’?

- Broad definition – the co-occurrence of two or more disorders in a person within a specified timeframe (e.g., lifetime, current)
- Our focus here: the co-occurrence of an AOD use disorder with one or more mental health disorder or condition

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# What is meant by ‘comorbidity’?

- Other types of comorbid conditions:
  - Other AOD use disorders (including tobacco)
  - Physical health conditions (e.g., cirrhosis, hepatitis, heart disease, diabetes)
  - Intellectual and learning disabilities
  - Cognitive impairment
  - Chronic pain
- Often referred to as ‘dual diagnosis’ - misnomer

# What do we know about comorbidity?

- Mental and substance use disorders are two of Australia's most common and burdensome health conditions, affecting 1 in 5 each year
- They frequently co-occur
- Estimated that up to ¾ of entrants to AOD treatment have a co-occurring mental health condition

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# How common is comorbidity?


*Source:* Kingston, Marel, Mills (2016), A systematic review of the prevalence of comorbid mental health disorders in people presenting for substance use treatment in Australia, *Drug Alc Rev,* DOI: 10.1111/dar.12448

# How common is comorbidity?

- There are a large number of people who present to AOD treatment who display *symptoms* of disorders while not meeting criteria for a *diagnosis* of a disorder
- Although may not meet full diagnostic criteria according to the classification systems their symptoms may nonetheless impact significantly on functioning and treatment outcomes

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# Mental health continuum

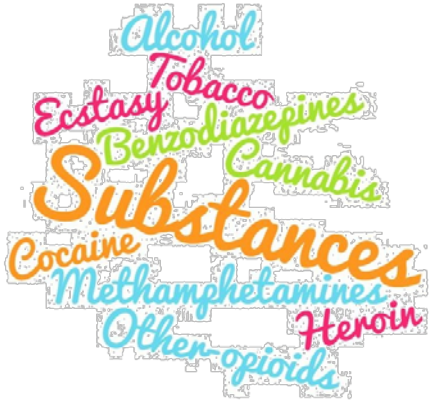

E.g., Mild depression responsive to medication

E.g., Severe depression needing hospital admission (suicidal delusional etc)

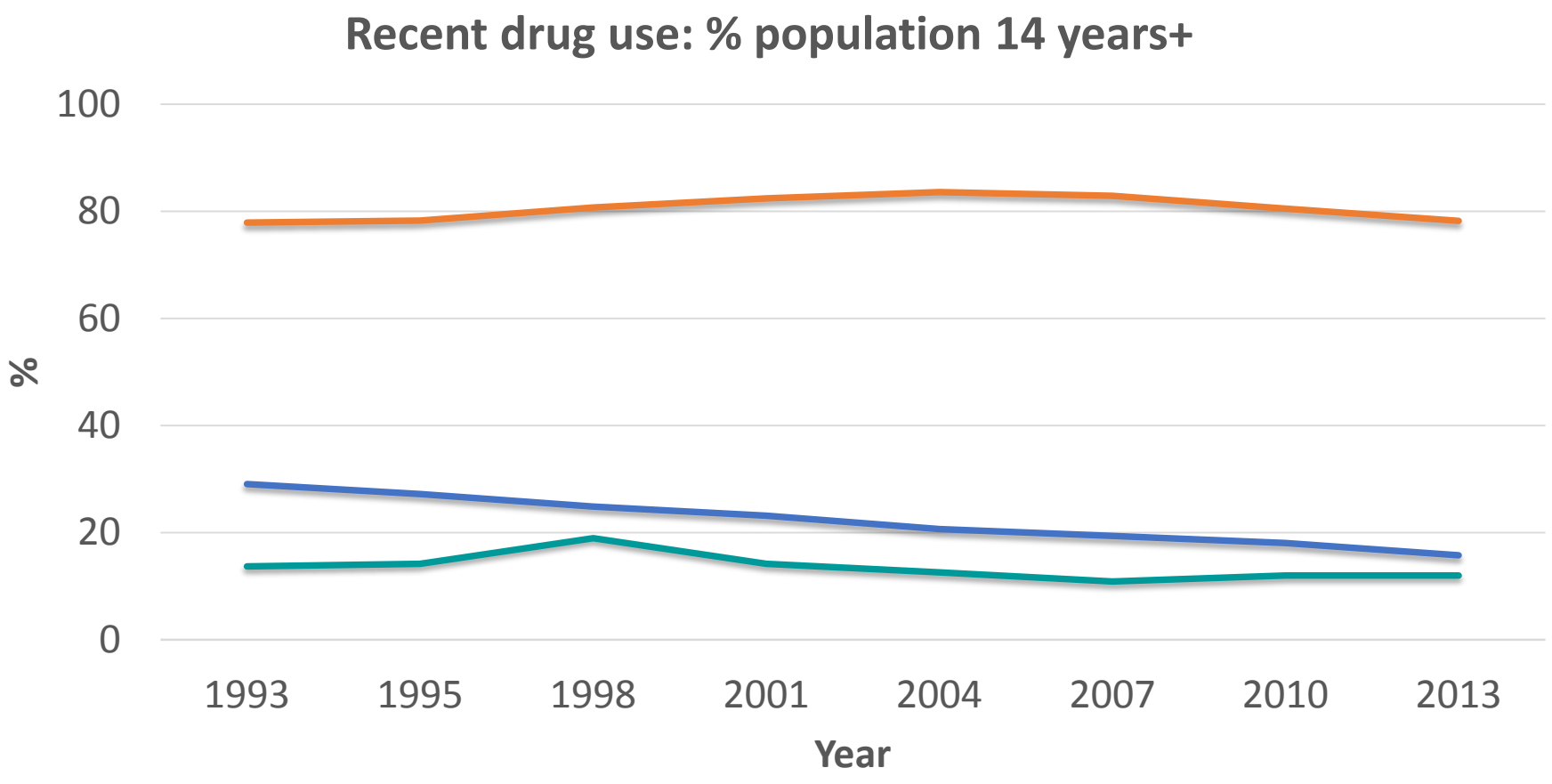
Move towards dimensional understanding of disorders in DSM-5

# Variation between substances

- Prevalence of mental health disorders may vary between substances
- Little research comparing the rates of mental health disorders across different types of AOD use disorders
- Substance use among those with mental health disorders mirrors general population trends in availability and fashion



# Prevalence of substance use: NDSHS




*Source:* https://www.aihw.gov.au/reports/illicit-use-of-drugs/ndshs-2013-detailed

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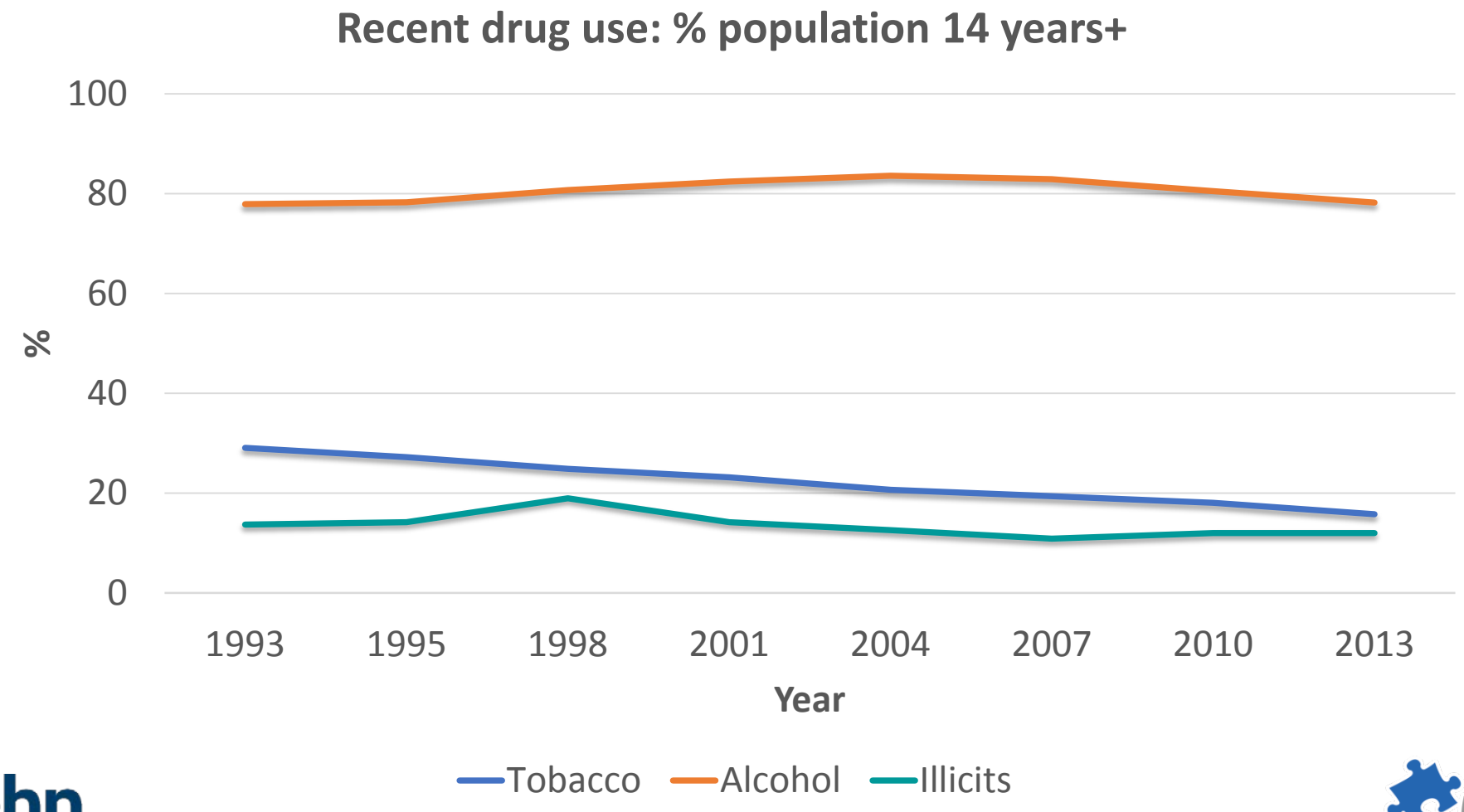


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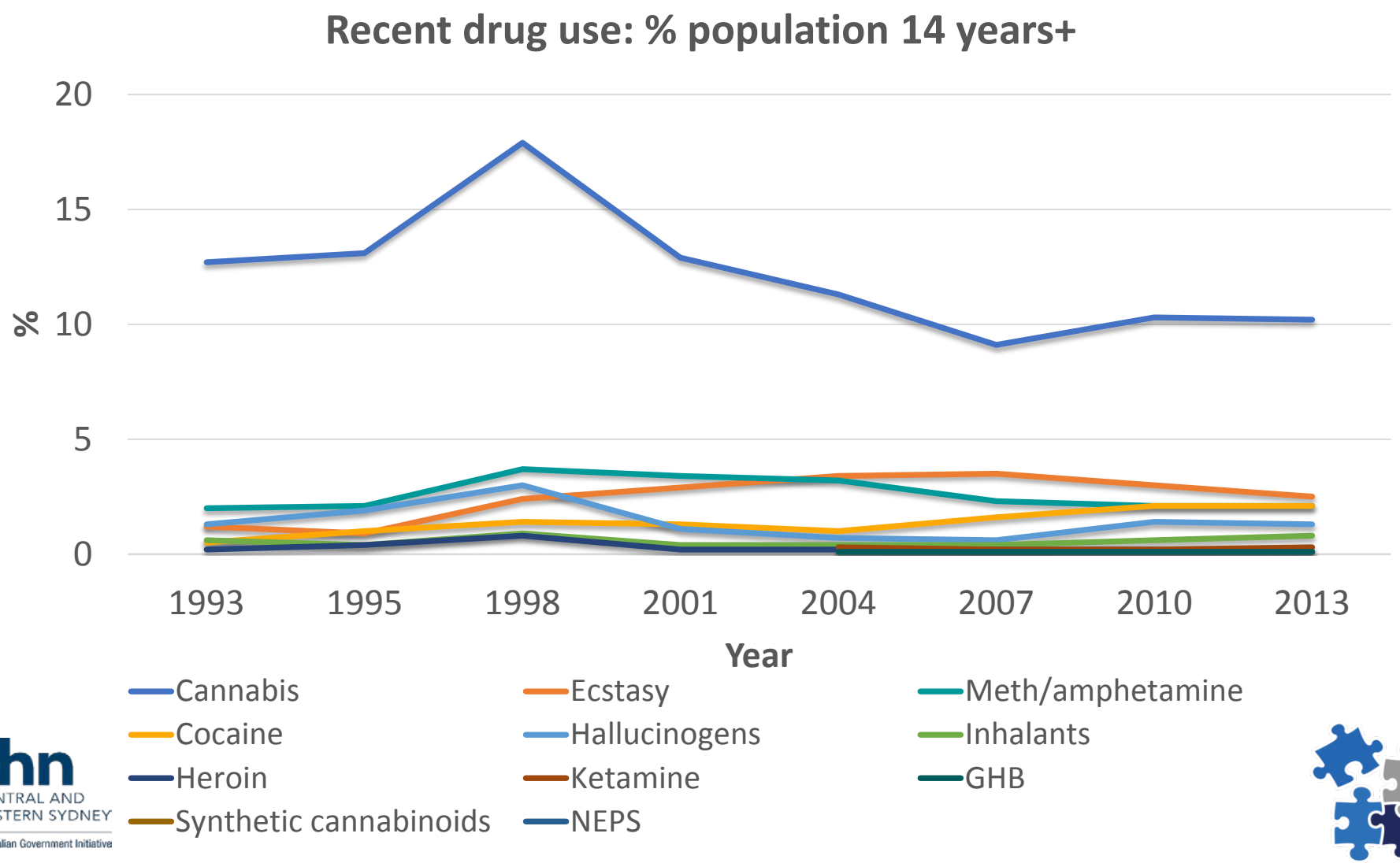


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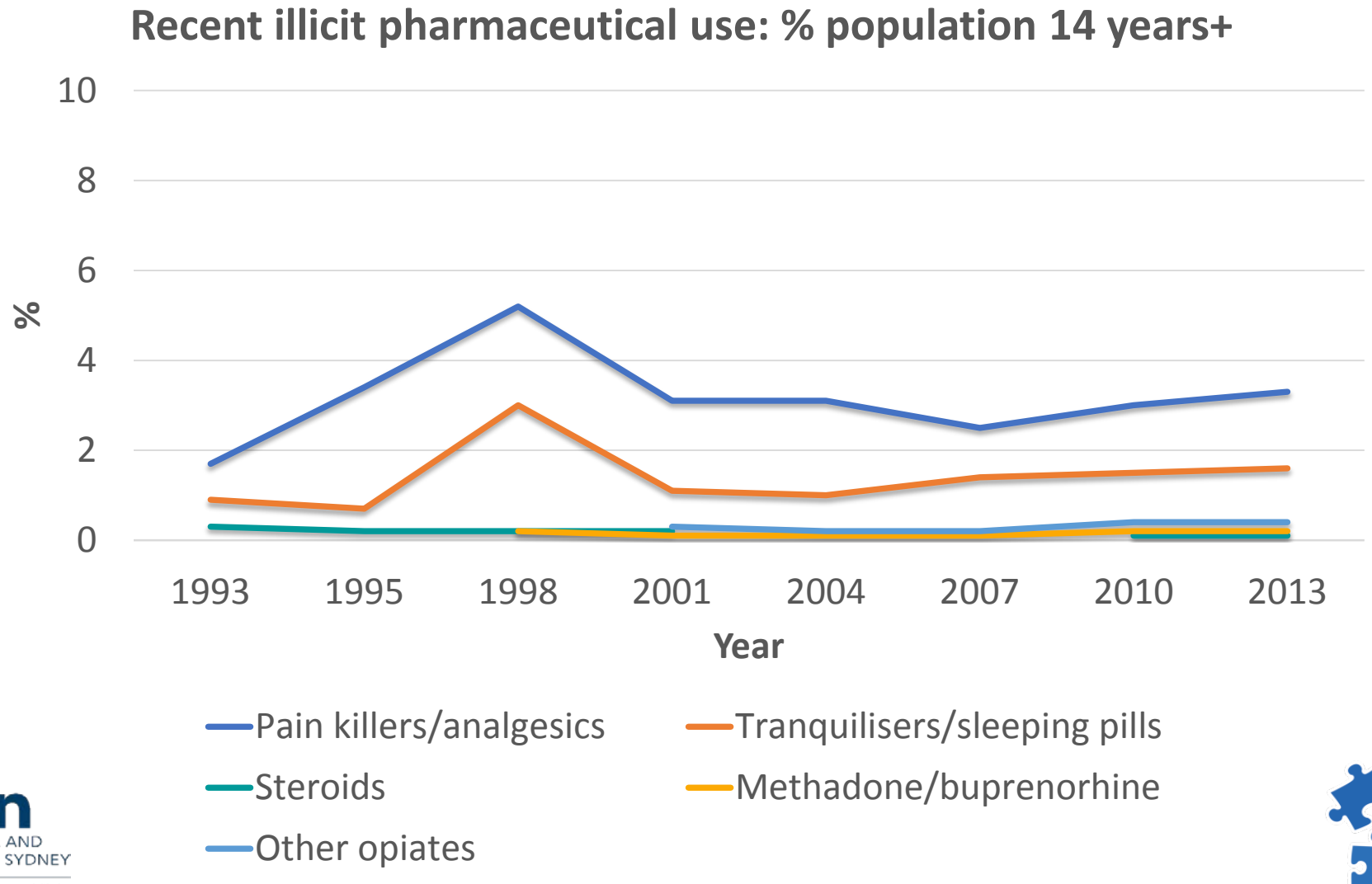
# Prevalence of substance use: NDSHS

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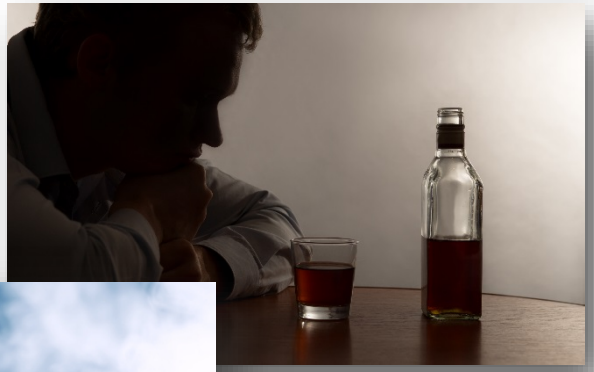
# Not everyone who uses becomes dependent

- When do we need to become concerned?
  - Use vs use disorder
- Tobacco (8.5%-67.5%)
- Cocaine (16.7%-24.2%)
- Heroin (21.1%-23.1%)
- Alcohol (4.8%-22.7%)
- Cannabis (3.9%-19.7%)

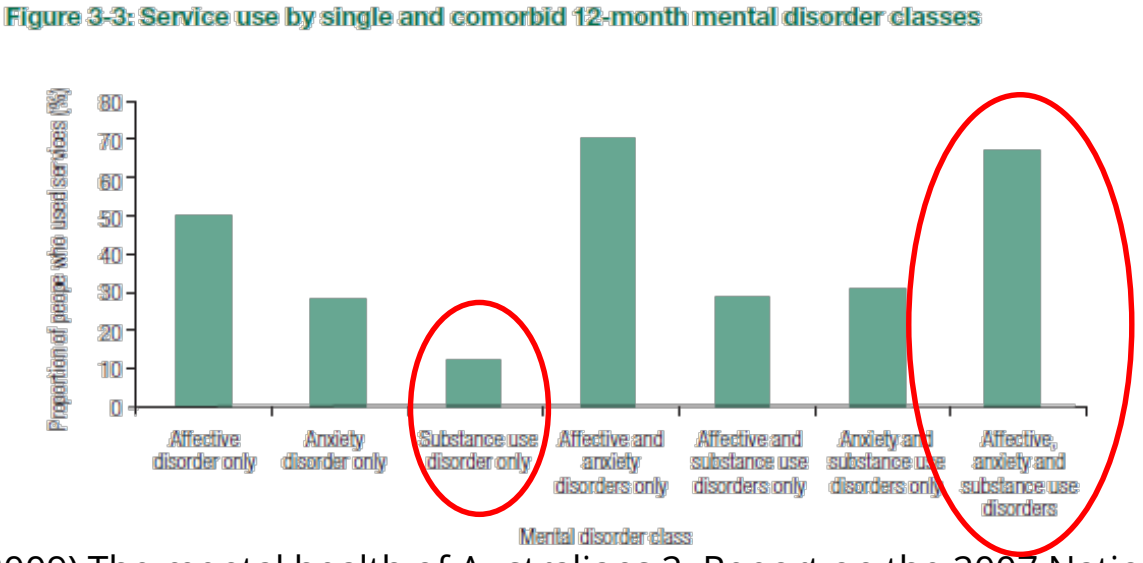


- Many people drink/use at high levels without meeting criteria for a disorder, they may be nonetheless be at risk of physical harm

*Source:* Marel et al, forthcoming

# Barriers to care

- Very few people with these conditions access treatment
- In part because they have difficulty accessing services and stigma




*Source:* Slade, et al (2009) The mental health of Australians 2. Report on the 2007 National Survey of Mental Health and Wellbeing. Department of Health and Ageing, Canberra.

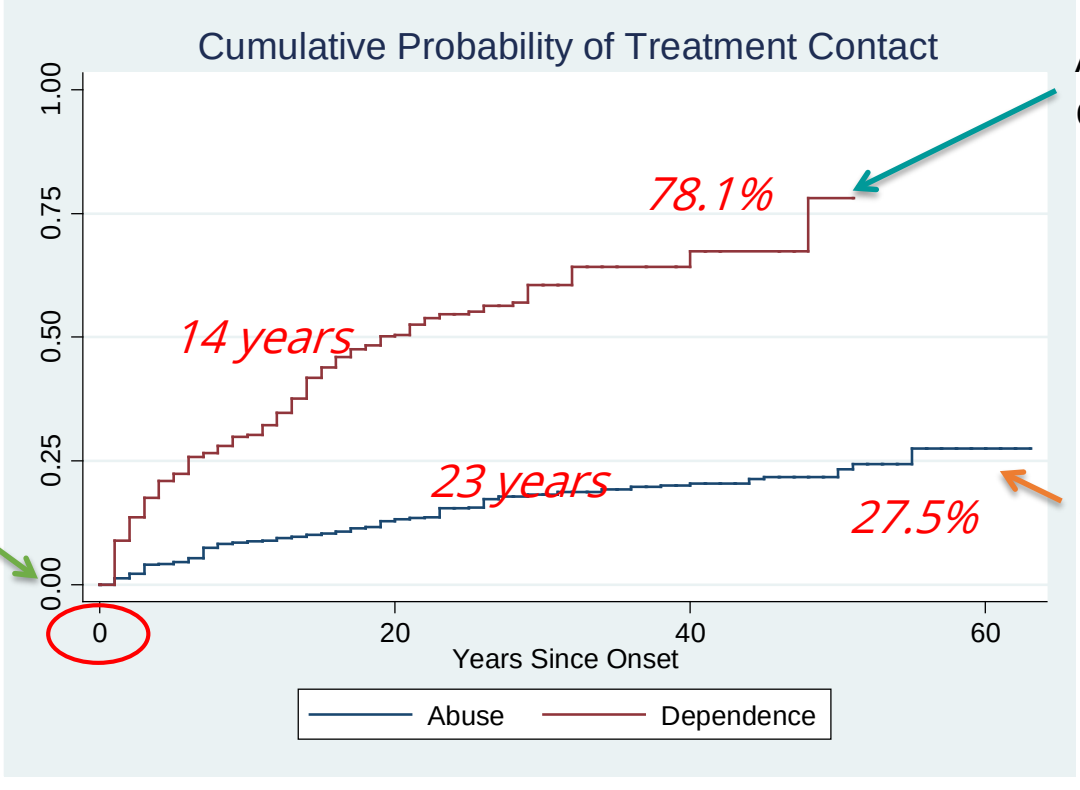
# The delay to seek treatment is long…

The median delay among those with alcohol use disorders who eventually make treatment contact in Australia is… **18 years**

**Onset:**

50% by age 20

75% by age 28




Lifetime treatment rate of AUDs is 34.6%

*Source:* Chapman C, Slade T, Hunt C, Teesson M (2015) Delay to first treatment contact for alcohol use disorder. Drug and Alcohol Dependence 147, 116-121

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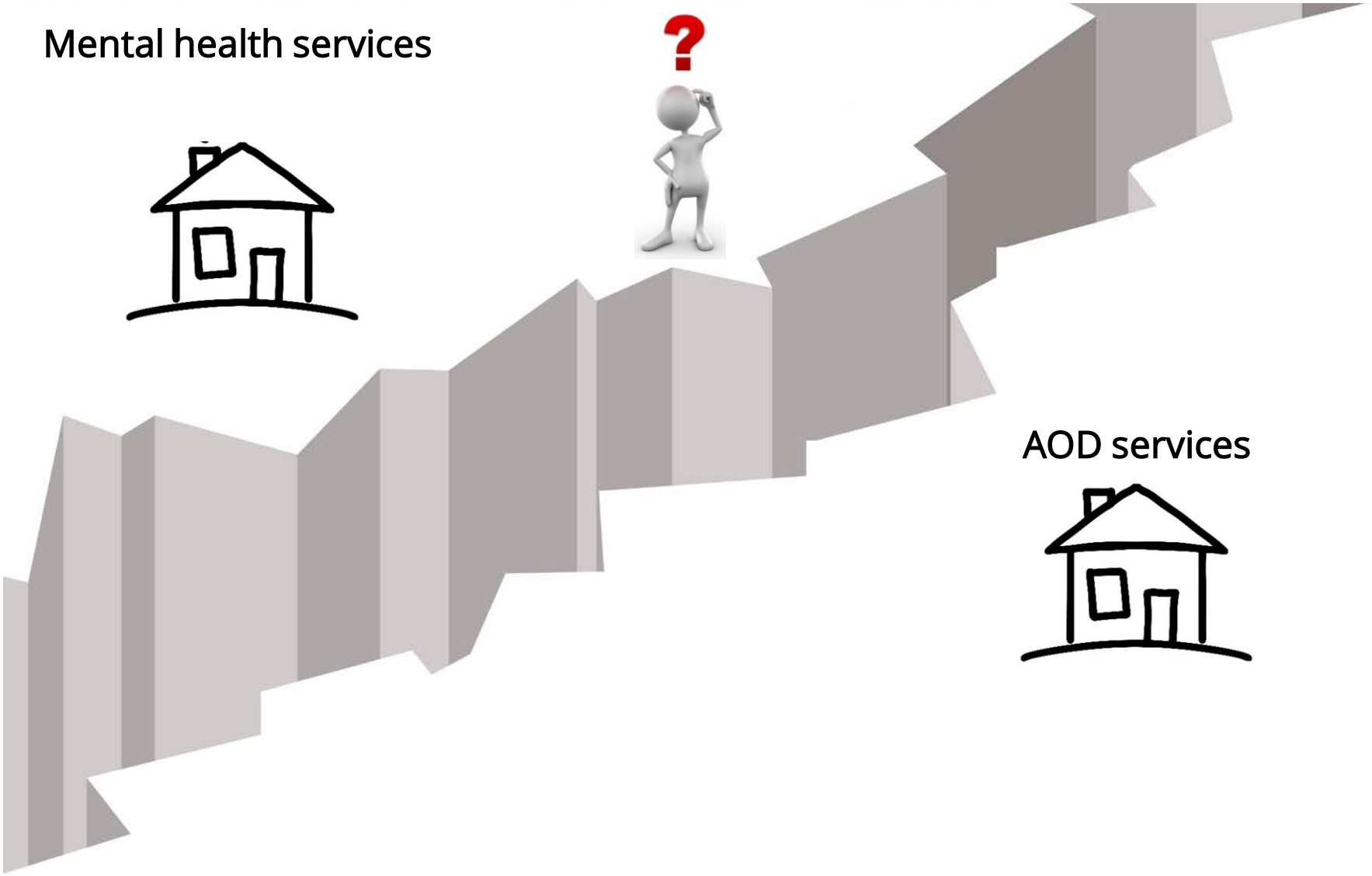
# Fragmented care

- “Siloed approach”
- “Fall through the gaps”

# Fragmented care



# The comorbidity roundabout

*Source:* Kay-Lambkin et al., (2004). 'The "comorbidity roundabout": A framework to guide assessment and intervention strategies and engineer change among people with co-morbid problems', Drug and Alcohol Review, 23, 407–24.

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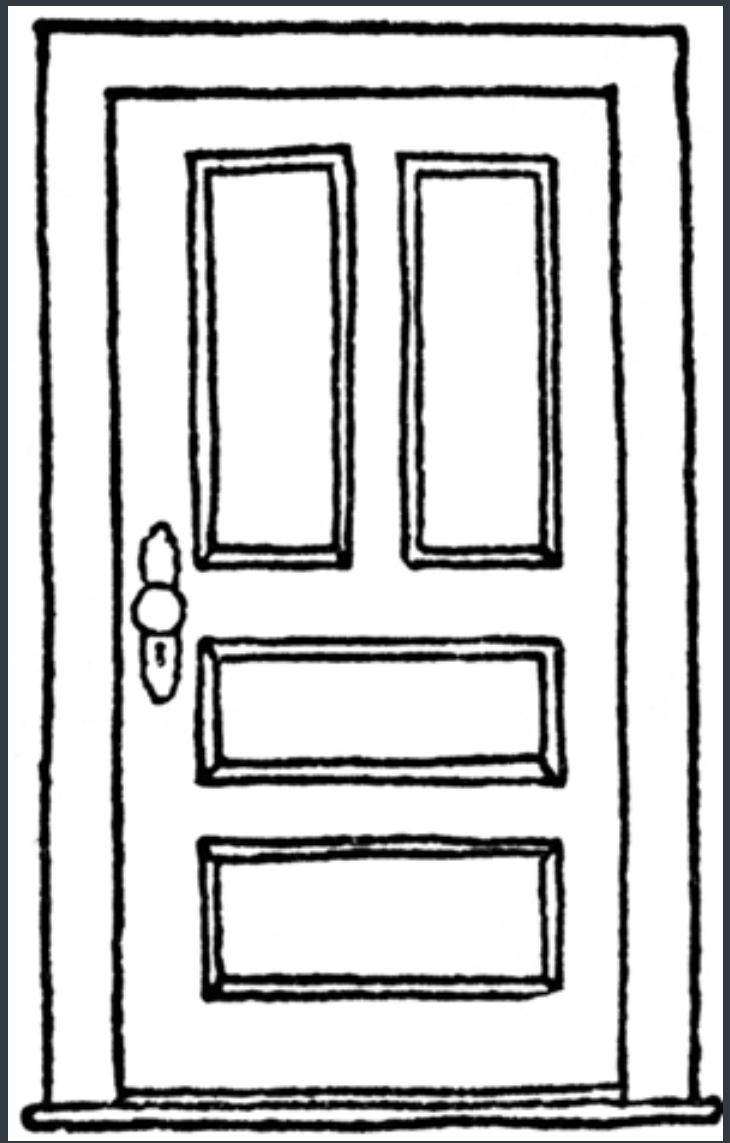

# Why is comorbidity a problem?

- Complex trauma histories
- Poorer physical and mental health
- Poorer social, occupational and interpersonal functioning
- More severe and extensive drug use histories
- Increased risk of self-harm and suicide
- Reduced life expectancy

*People with mental or substance use disorders die an astonishing 20 - 30yrs earlier than the general population, and spend the last 10yrs of life living with disabling chronic illnesses*

*Comorbid mental health and alcohol/other drug use disorders are one of health's most significant challenges**

*Mental Health Commission National Report Card, 2012

# Key points

- Comorbidity is common
- Complicates treatment and recovery
- Relationship of mutual influence
- A number of barriers make it difficult for people with comorbidity to receive effective treatment

# Overview

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# How is comorbidity identified?

# Identifying comorbidity

- Detection and treatment of comorbid conditions among AOD clients tends to be low
- Important for screening and assessment for comorbidity to be part of routine clinical care
- Identification of mental health problems can facilitate management during AOD treatment
- Does not mean that the healthcare worker has to personally treat these problems
  - BUT need to consider broader impact, manage and engage other services where necessary
- Diagnosis of mental health disorders requires assessment by mental health professionals (psychiatrists, clinical psychologists)
- Multiple assessments conducted throughout treatment, which can reflect symptom changes over time

# Become familiar with classifications

- Become familiar with the DSM-5
  - Limitations and recommendations regarding differential diagnosis
  - Signs and symptoms of disorders

Signs of disorders

Symptoms of disorders

# Step 1: Screening

- Process of identifying possible cases of co-occurring mental health conditions
- Not diagnostic – cannot establish whether a disorder exists
  - Identifies symptoms typical of a disorder
  - Highlights need for further assessment
- Ideally occur after 2-4 week stabilisation period
  - NB: “False positives” during intoxication and/or withdrawal
  - Screening best conducted after completion of acute AOD withdrawal
  - Not practicable, conduct multiple assessments over time

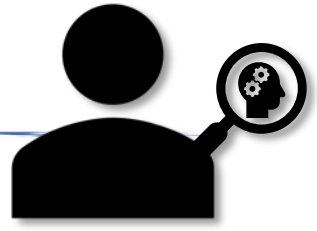
# Step 2: Assessment

- Detailed investigation of a person's mental health
- Ongoing process rather than a one-off event – involves the ongoing monitoring of clients' mental health symptoms and AOD use
- Ongoing assessment important because clients' mental health symptoms and AOD use may change throughout treatment

# Case formulation

- Involves:
  - Gathering information regarding factors that may be relevant to treatment planning
  - Formulating a hypothesis as to how these factors fit together to form the current presentation of the client's symptoms
- Should be aware of:
  - What problems exist? How did they develop? How are they maintained?
  - All aspects of the client's presentation, current situation, and the interaction between different factors/problems
- Person-centred, NOT service-centred

# Approach



- No standardised approach
- Crucial that a range of different dimensions be considered
- Combination of:
  - Informal
  - Standardised screening and assessments

# Informal assessment

# Informal assessment

- Semi-structured interview
- Provide a non-judgmental, empathetic, private and confidential environment
- Any limits to confidentiality should also be explained

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

# Mental state examination

- Should not consist of a series of direct questions
- Rather should be based on an overall evaluation of the client during the assessment(s)
- A record of the mental state examination should be completed after (rather than during) conversations with the patient

Page 229:
https://comorbidity.edu.au/sites/default/files/National%20Comorbidity%20Guidelines%202nd%20edition.pdf

# Mental state examination

- Consists of:
  - Appearance
  - Behaviour
  - Speech and language
  - Mood and affect
  - Thought content
  - Perception
  - Cognition
  - Insight and judgement

- May all be affected by intoxication or withdrawal

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# Mental state: Appearance

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

# Mental state: Behaviour

- **How is the client behaving?**
  - Motor activity – immobile, pacing, restless, hyperventilating
  - Abnormal movements – tremor, jerky or slow movements, abnormal walk
  - Bizarre/odd/unpredictable actions
- **How is the client reacting to the current situation and assessor?**
  - Angry/hostile towards interviewer/others
  - Unco-operative
  - Withdrawn
  - Over familiar/inappropriate/seductive
  - Fearful, guarded, hypervigilant

# Mental state: Speech and language

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

# Mental state: Speech and language

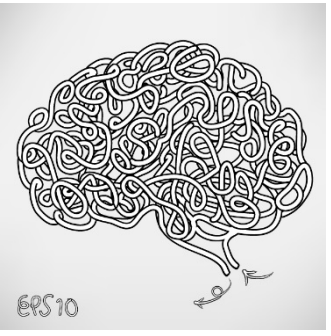
## How does the client express himself/herself?

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

# Mental state: Mood and affect

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

# Mental state: Thought content




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

# Mental state: Perception

- **Is the client experiencing any misinterpretations of sensory stimuli?**
  - Does the client report auditory, visual, olfactory or somatic hallucinations? Illusions?
  - Are they likely to act on these hallucinations?
  - Do you observe the client responding to unheard sounds/voices/unseen people/ objects?
  - Any other perceptual disturbances, such as derealisation (feeling one is separated from the outside world)-depersonalisation (feeling separated from one's own personal physicality), heightened/ dulled perception?

# Mental state: Cognition

## Level of consciousness

- Is the client alert and oriented to time, place, person?
- Is the client attentive during the interview (drowsy, stuporous, distracted)?
- Does the client's attention fluctuate during the interview?
- Does the client present as confused?
- Is the client's concentration impaired? (can he/she count from 100 or say the months of the year backwards?)

# Mental state: Cognition

- Orientation
  - Does the client know:
    - Who he/she is? Who you are?
    - Where he/she is? Why he/she is with you now?
    - The day of the week, the date, the month and the year?
- Memory
  - Can the client remember:
    - Why he/she is with you? (Immediate)
    - What he/she had for breakfast? (Recent)
    - What he/she was doing around this time last year? (Remote)
  - Are they able to recall recent events (memory and simple tasks e.g., calculation)?

# Mental state: Insight and judgement

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

# James' mental state examination

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

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# Source of referral and current healthcare providers

- Various sources of referral into treatment, most commonly self-referral
  - GP, family/friends, corrective services
- Identify all services currently involved in care
  - Counsellors, psychiatrists, prescribers, GP, probation/community offender service officers, case workers, social workers etc.
  - With clients' permission, liaise with these providers regarding treatment to ensure continuity of care

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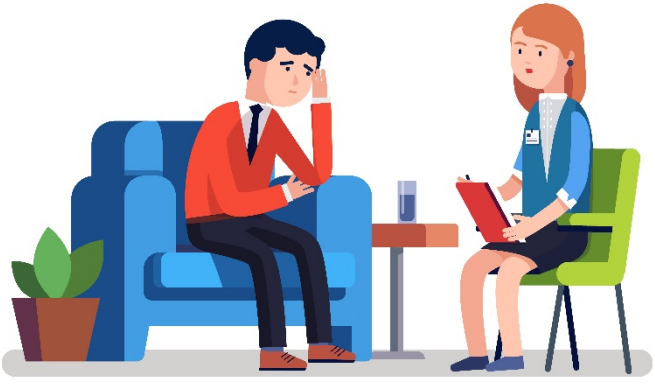
# Presenting issues

- What does the client perceive to be his/her biggest issues?
- Why are they in treatment?
  - Usually broad (e.g., psychological, social, health, legal, accommodation, financial)



# AOD use history

- Range of substances used
- Quantity, frequency, duration, circumstances of use
- Previous AOD-related problems
- Risk behaviours related to use (e.g., injection as mode of administration)
- Previous treatment attempts (why successful or unsuccessful)
- Understanding of development of AOD use over time, including periods of abstinence, and how these were supported
- Also ask about use of non-traditional or new and emerging psychoactive substances
  - E.g., legal highs, herbal highs, research chemicals, analogues, synthetics

Drug trends monitoring program: http://www.drugtrends.org.au/

# Addressing AOD use with clients/patients

- Some healthcare workers reluctant to address AOD use among clients/patients:
  - Concerned about damaging rapport
  - Belief that clients/patients won't be truthful
  - Unsure of what to do if AOD use is reported
  - Assumption that clients/patients do not use AOD
  - Lack of recognition of signs/symptoms of AOD use

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# Asking about AOD use

- Ways to ask:
  - Open-ended, non-judgmental

  *Can you tell me about your alcohol/drug use in the past month?*

  *Can you describe a typical/normal day?*

- Ways not to ask:
  - Judgmental

  *Don't you know the harm you're doing to yourself?*

  - Making assumptions

  *You don't use substances, do you?*

Health Pathways: https://sydney.healthpathways.org.au

Australian Drug Information Network (ADIN): https://www.adin.com.au/

Page 222: https://comorbidity.edu.au/sites/default/files/National%20Comorbidity%20Guidelines%202nd%20edition.pdf

# James's AOD use

- Until recently, 6-8 bottles of beer and ½ bottle of wine daily, several spirits weekly
- Never asked *directly* about AOD use
- When asked about drinking, has said he's a 'social' drinker, no follow-up questions
- Oxycodone use for back pain

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# Current situation

- Current accommodation
- Living arrangements
- Children
- Family and friends
- Social and other support networks
- Significant relationships
- Physical health
- Study
- Work commitments
- Legal and financial issues

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# Personal, medical and family history

- Can help understand the beginnings of the AOD use and mental health symptoms and impact on the client/patient's life
- Ask about:
  - Family context (including family history of comorbidity)
  - Child and adolescent experiences
  - School experiences (academic, social, bullying)
  - Traumatic experiences
  - Work history
  - Leisure pursuits and interests
  - Financial and housing information
  - Sexual/marital adjustment
  - Legal issues and illegal behaviour
  - Medical history (current, past and psychiatric medications)
  - Current and past pharmacological/psychological treatment

# Trauma history

- Traumatic events do not refer to any event that the person has found upsetting.
- Events where the individual perceived his/her own (or someone else's) life or physical integrity to be at risk, causing them to feel intense fear, helplessness or horror
- Trauma may be a one-off event or it may have occurred over a period of time

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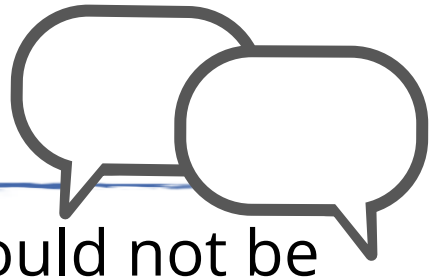
# Trauma history

- History of trauma exposure may be integrally linked with the person's current substance use
- Number of people with AOD use disorders who have experienced trauma describe their use as an attempt to self-medicate the thoughts and feelings they have had since the trauma
- Presence of a trauma history indicates that further investigation is required to determine whether the person may have symptoms of PTSD

# Asking about trauma



- Questioning needs to be sensitive and should not be pursued if the client does not wish to discuss it
- Before questioning the client:
  - Seek the client's permission to ask them about exposure to traumatic events
  - Advise the client that they do not have to talk about these experiences or provide any detail if they do not want to
  - Clearly communicate the reasons for asking about past trauma. It may not be readily apparent to the client that their current situation may be related to their past

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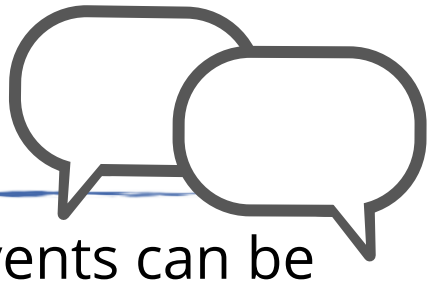
# Before asking about trauma



- Advise the client that talking about traumatic events can be distressing; even clients who want to talk about their trauma history may underestimate the level of emotion involved
- Studies have found that while some people may become upset when talking about these events, talking about the trauma does not overwhelm or re-traumatise the majority of people. On the contrary, most people describe the process as a positive experience
- Advise the client of any restrictions on confidentiality; for example, in relation to the mandatory reporting of children at risk or serious indictable offenses

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# Talking about trauma

- Ask the client if they've ever experienced any traumatic events such as witnessing or experiencing: car accidents or other types of accidents, natural disasters, war, adult/childhood physical or sexual assault, having been threatened
- Reliable reporting of events is best obtained by asking about specific event types.
  - Under-reporting of exposure tends to occur when people are asked only broad questions such as "have you ever experienced a traumatic event?"
- Standardised screening tools such as the Traumatic Life Events Questionnaire (TLEQ) and Trauma History Questionnaire (THQ) may be used to assess for a history of trauma exposure
  - Some clients find it easier to complete a self-report screener, however, should always be completed with a clinician present and should never be given to the client to complete at home

# Additional guidelines for discussing trauma


- Create a safe, welcoming environment
- Adopt a non-judgmental attitude
- Display a comfortable attitude if the client describes their trauma experience
- Commend the client for having the courage to talk about what happened
- Normalise the client's response to the trauma and validate their experiences
- Essential not to "dig" for information that is not forthcoming as this may result in destabilisation

# Psychiatric history

- Does the client have:
  - Any current mental health symptoms (e.g., depression, anxiety, psychosis)?
    - Experienced these in the past?
  - Ever been diagnosed with a mental health disorder?

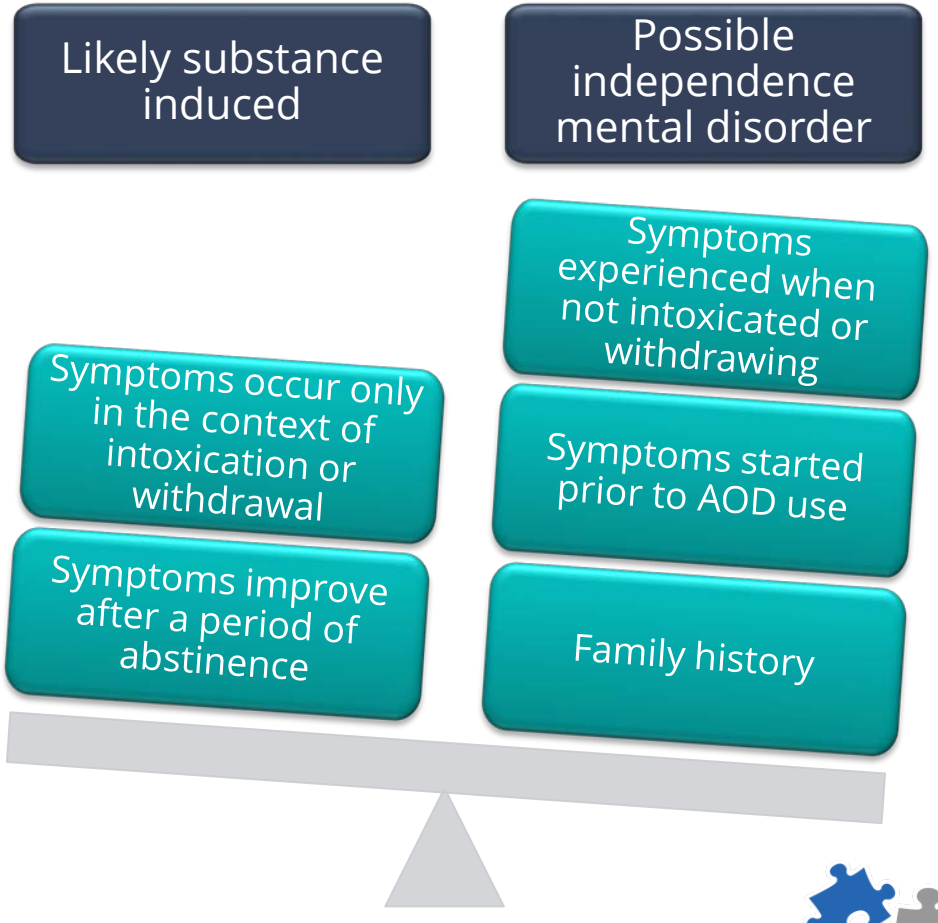
# Differentiating substance-induced disorders

- Symptoms of mood, anxiety and psychotic disorders may all be induced as a result of AOD use or withdrawal:
  - Alcohol use and withdrawal can induce symptoms of depression or anxiety
  - Manic symptoms can be induced by intoxication with stimulants, steroids, or hallucinogens
  - Psychotic symptoms can be induced by withdrawal from alcohol, or intoxication with amphetamines, cocaine, cannabis or LSD
- Other disorders that may result from AOD use include: substance-induced delirium, amnestic disorder, dementia, sexual dysfunction, and sleep disorder


If the client has mental health symptoms:
When did the symptoms start (did they start prior to AOD use)?
Do they only occur when the person is intoxicated or withdrawing?
Have the symptoms continued even after a period of abstinence (approx. 1 month)?
Do the symptoms change when the client stops using substances (i.e., do they get better or worse, or stay the same)?
Is there a family history of the particular mental health condition?

# Substance-induced disorders

- Occur as a direct consequence of AOD intoxication or withdrawal
- Symptoms only present during intoxication or withdrawal
- Symptoms displayed in the absence of intoxication or withdrawal suggestive of an independent mental health disorder



# Substance-induced psychosis

- Difficult to distinguish substance-induced psychosis from other psychotic disorders
- Factors that may help differentiate:
  - Substance-induced: Tend to appear quickly, last a shorter time (hours to days), until the effects of the drug wear off (can persist for days, weeks, months or longer)
  - Visual hallucinations more common in substance withdrawal and intoxication than in primary psychotic disorders
- Stimulant psychosis
  - More commonly associated with tactile hallucinations (“ice bugs”)
  - More agitated, energetic and physically strong, more challenging to contain in a safe environment, and
  - More difficult to calm with sedating or psychiatric medication than people with psychosis unrelated to the use of stimulants



# Risk assessment

- Risk to self and others
  - Suicidal thoughts
  - Self-harm
  - Domestic violence

    (perpetration or victimisation)
  - Homicidal thoughts/attempts
  - Child welfare
  - Also includes the evaluation of safety regarding sexual practices, injecting practices and other high-risk behaviours as appropriate

Where the risk is perceived as alarming, other services may need to be enlisted

(e.g., police, ambulance, crisis teams)

# Risk assessment: Suicide

- AOD clients at high-risk of suicide
- Presence of comorbid mental health disorders further increases this risk
- Important to conduct suicide risk assessments in the initial consultation phases and to monitor this risk throughout treatment
- Ascertain risk by directly enquiring about suicidal thoughts (frequency, intensity, plans, intent), history of suicidal behaviour and self-harm, current stressors, hopelessness, and protective factors (e.g., family, friends, other services)
- Page 79: https://comorbidity.edu.au/cre-resources/guidelines-management-co-occurring-alcohol-and-other-drug-and-mental-health-0

# Risk assessment: Suicide

- Discussing suicide with clients is vital and does **not** increase the risk of suicidal behaviour
- Rather, sensitive questioning can be a relief for clients who have been harbouring thoughts of self-harm, and an opportunity to receive the help and support that is needed
- Suicide Assessment Kit (SAK) resources, including videos: https://ndarc.med.unsw.edu.au/suicide-assessment-kit

Introducing the SAK

Role-plays demonstrating the use of the Suicide Risk Screener

Service providers about the process of intregrating the SAK in their service

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# Risk assessment: Suicide

- Questions used to complete this assessment might include:
  - Have you ever tried to kill yourself? Have you ever tried to harm yourself?
  - Have things been so bad lately that you have thought about killing yourself?
  - Do you have a current plan for how you would attempt suicide?
  - Because of the high rates of suicide, I ask all my clients about whether they have ever had any suicidal thoughts. I am wondering if you have ever been feeling so awful that you have begun thinking about suicide?
  - Have you had any thoughts of harming yourself? Are you thinking of suicide?
  - How often do you have these thoughts of killing yourself?
  - What has happened that makes life not worth living?
  - Do you have access to firearms or any other lethal means?
  - Is there anyone you rely upon for support?
  - Is there anything that is preventing you from acting on your thoughts?

| Worker rated risk level: | ☐ Low | ☐ Moderate | ☐ High |
|---|---|---|---|

| Level of risk | Suggested response |
|---|---|
| **Low**<br>• No plans or intent<br>• No prior attempt/s<br>• Few risk factors<br>• Identifiable 'protective' factors | • Monitor and review risk frequently<br>• Identify potential supports/contacts and provide contact details<br>• Consult with a colleague or supervisor for guidance and support<br>• Refer client to safety plan and keep safe strategies should they start to feel suicidal |
| **Moderate**<br>• Suicidal thoughts of limited frequency, intensity and duration<br>• No plans or intent<br>• Some risk factors present<br>• Some 'protective' factors | • Request permission to organise a specialist mental health service assessment as soon as possible<br>• Refer client to safety plan and keep safe strategies as above<br>• Consult with a colleague or supervisor for guidance and support<br>• Remove means where possible<br>• Review daily |
| **High***<br>• Frequent, intense, enduring suicidal thoughts<br>• Clear intent, specific/well thought out plans<br>• Prior attempt/s<br>• Many risk factors<br>• Few/no 'protective' factors<br>*or highly changeable | • If the client has an immediate intention to act, contact the mental health crisis team immediately and ensure that the client is not left alone<br>• Remove means where possible<br>• Call an ambulance/police if the client will not accept a specialist assessment, or the crisis team is not available<br>• Consult with a colleague or supervisor for guidance and support |

# Risk assessment: Domestic and family violence

- AOD use associated with domestic and family violence (perpetration and victimisation)
- Up to 80% of women attending treatment for their substance use have experienced AOD
- Commonly characterised as males using violence against females, other forms of violence:
  - Same sex
  - Non spousal
  - Carer
  - Children

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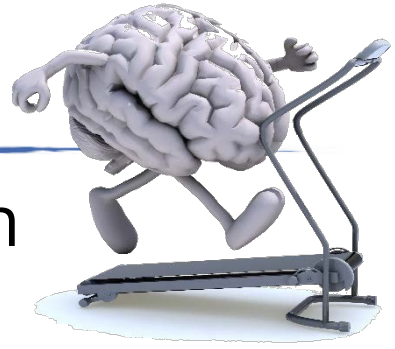
# Risk assessment: Domestic and family violence

- Understand the dynamics and complexities involved, and why many people remain in violent relationships
  - Fear of further violence, increased danger, loss of life, stalking or abduction
  - Isolation or rejection from family, friends and community
  - Loss of home, income, pets and possessions, or having a reduced standard of living
  - Negative impacts on children such as loss of school, friends, community, relationship with parent or family
  - Grief for loss of partnership
  - Feelings of guilt and self-blame
  - Fear of losing children or having children removed

# Criminal history

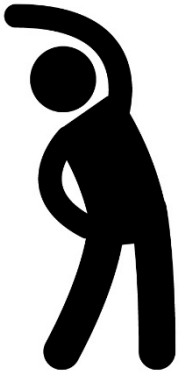
- Past and present criminal behaviour
- Arrest history
- Any impending court cases
- Outstanding warrants

# Strengths and weaknesses



- Usually deduced from other information collected throughout assessment
- Some examples of strengths include
  - Good social support, high self-esteem, insight
- Some examples of weaknesses include
  - Unemployment, risk taking, negative self-image

# Readiness for change



- Ascertain how motivated the client is to change his/her current AOD habits
- Involves exploration of the client's perception of the positive and negative aspects of continued drug use
- Relevant in assessing motivation to receive treatment for comorbid mental health conditions
  - Just because a person has presented for treatment for their AOD use, does not necessarily mean that they have the same readiness to receive mental health treatment

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

Adapted from Clancy and Terry 2007; page 73
https://comorbidity.edu.au/sites/default/files/National%20Comorbidity%20Guidelines%202nd%20edition.pdf

# Integrated Motivational Assessment Tool (IMAT)

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

Source: NSW Department of Health. (2007). *Mental health reference resource for drug and alcohol workers*. Sydney: NSW Department of Health; page 231
https://comorbidity.edu.au/sites/default/files/National%20Comorbidity%20Guidelines%202nd%20edition.pdf

# Standardised screening and assessment

# Standardised screening and assessment

- Should be completed upon entry into and exit from treatment, as well as at follow-up
- Provide useful clinical information (for both the client and AOD worker) on the client's case and an evaluation of how effective treatment has been

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# Standardised screening and assessment

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

# Standardised screening and assessment

- Standardised tools cover a range of areas which may be relevant to health services with AOD/mental health clients
- Some require specialist training, or else mislabelling, misinterpretation, or inappropriate use may occur
- Some are copyright protected and need to be purchased, and/or require specific qualifications
- Some are self-reporting (i.e., they may be self-completed by the client), others need to be administered
- Deady review of screening tools for use in AOD settings (2009):
  - Comprehensive review of all available screeners and assessment tools, including where to access, costs, validity and reliability
  - Report available for free download here: http://www.drugsandalcohol.ie/18266/1/NADA_A_Review_of_Screening,_Assessment_and_Outcome_Measures_for_Drug_and_Alcohol_Settings.pdf

# Some useful AOD screening instruments

- CAGE Questionnaire (problem drinking)
- Michigan Alcohol Screening Test (MAST; lifetime problems with alcohol use)
- Drug Abuse Screening Tool (DAST; past 12-month drug abuse)
- Alcohol Use Disorders Identification Test (AUDIT)
- Drug Use Disorders Identification Test (DUDIT)

# Camberwell assessment of need short appraisal schedule (CANSAS)

- Valid and reliable measure of need across 22 domains
- CANSAS-P the measure for client completion
- Rated on a three-point scale (no need, met need, unmet need)
- No staff training required to use or score measure

| Need score | Level of need |
|---|---|
| No need | This area is not a serious problem for me at all |
| Met need | This area is not a serious problem for me because of help I am given |
| Unmet need | This area remains a serious problem for me despite any help I am given |

Page 234:

https://comorbidity.edu.au/cre-resources/guidelines-management-co-occurring-alcohol-and-other-drug-and-mental-health-0

# Kessler psychological distress scale (K10)

- Widely used, self-report measure of psychological distress in past 4 weeks
- Used to identify those in need of further assessment for anxiety and depression
- 10 questions that are answered using a five-point scale (where 1 = none of the time, 5 = all of the time)
- Scores are summed: maximum score of 50 indicating severe distress, minimum score of 10 indicating no distress

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

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https://comorbidity.edu.au/cre-resources/guidelines-management-co-occurring-alcohol-and-other-drug-and-mental-health-0

# PsyCheck

- Three sections:
  - General Mental Health Screen, including history of treatment
  - Suicide/Self-Harm Risk Assessment
  - Self Reporting Questionnaire (SRQ) - assesses for current symptoms of depression and anxiety
- Manual includes training on how to administer, score and interpret the results of each section, and the subsequent steps to take according to the screening results.

www.psycheck.org.au

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PsyCheck

# Depression Anxiety Stress Scale (DASS)

- Valid and reliable measure of depression, anxiety and stress and general psychological distress
- Available in two forms: the DASS-21 and the DASS-42 (21 and 42 items respectively)
- Each rated on a four-point scale (0-3)
- Self-report instrument covering past week
- No special skills are required to administer or score it

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

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https://comorbidity.edu.au/cre-resources/guidelines-management-co-occurring-alcohol-and-other-drug-and-mental-health-0

# Primary Care PTSD Screen (PC-PTSD)

- Very brief (4 items)
- Designed for use in primary care and other medical settings to screen for PTSD
- Includes an introductory sentence to cue respondents to traumatic events; however, it does not include a list of potentially traumatic events.
- Score of three or above has been shown to indicate the presence of PTSD
- Page 324: https://comorbidity.edu.au/cre-resources/guidelines-management-co-occurring-alcohol-and-other-drug-and-mental-health-0

# Trauma Screening Questionnaire (TSQ)

- 10-item screening tool for PTSD
- Respondents endorsing at least six items should be assessed for the presence of PTSD
- Shown to be superior to a range of other PTSD screening measures
- Page 325: https://comorbidity.edu.au/cre-resources/guidelines-management-co-occurring-alcohol-and-other-drug-and-mental-health-0

# The Psychosis Screener

- Clinician administered interview-style questionnaire (7 items)
- Uses elements of the Composite International Diagnostic Interview (CIDI) to assess the presence of characteristic psychotic symptoms
- Moderate ability to discriminate between those who meet diagnostic criteria for psychotic disorders and those who do not in community and prison samples
- Page 326: https://comorbidity.edu.au/cre-resources/guidelines-management-co-occurring-alcohol-and-other-drug-and-mental-health-0

# Indigenous Risk Impact Screen (IRIS)

- Developed by an expert group of Indigenous and non-Indigenous researchers to assist with the early identification of AOD problems and mental health risks - reliable, simple and effective
- Consists of 13 items which are asked by the clinician (1-7 AOD risk; 8-13 MH risk)
- Items assessing mental health and emotional well-being focus on symptoms of anxiety and depression
- Score of 10 or greater on the AOD component indicates problematic use of AOD is likely
- Score of 11 or greater indicates the need for further assessment or brief intervention regarding mental health and emotional well-being
- Page 327: https://comorbidity.edu.au/cre-resources/guidelines-management-co-occurring-alcohol-and-other-drug-and-mental-health-0

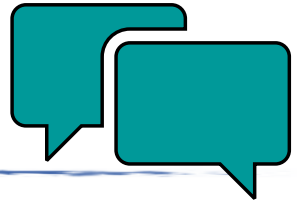
# Adult ADHD Self-Report Scale (ASRS)

- Developed by World Health Organisation to assess symptoms of ADHD in adults
- Full version = 18 items; short screener = 6 items
- Frequency of past 6-month ADHD symptoms on 5-item scale (never – very often)
- Page 328: https://comorbidity.edu.au/cre-resources/guidelines-management-co-occurring-alcohol-and-other-drug-and-mental-health-0

# Eating Disorder Examination (EDE) and Questionnaire (EDE-Q)

- Eating disorder examination (EDE) is a diagnostic interview, designed for clinician delivery
- Developers recommend clinician training to ensure all concepts being assessed are well understood
- EDE-Q is the questionnaire form of the EDE, self-report measure that can be completed by client
- Both EDE and EDE-Q 'gold standard' measures
- Free download from http://www.credo-oxford.com/7.2.html

# Feedback



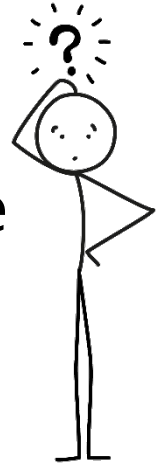
- Following completion of assessment procedures, it is important to interpret the results for the client in a way they can understand (i.e., not just giving them numerical test scores)
  - Focus first on the client's strengths
  - Gently and tactfully outline the client's difficulties
  - Focus on the pattern of results rather than just an overall score
  - Pull the assessment results together and offer hope for the future by discussing a treatment plan
- Note: Screening measures are not diagnostic
  - Do not to label a client as having a diagnosis of a disorder unless a comprehensive assessment has been made
  - Focus on the symptoms displayed by the client

# James

- 5 previous episodes of depression
  - DASS 21 – high depression, moderate anxiety
- Most recent episode very intense
  - History of suicidal ideation
  - Admission to local psychiatric unit
  - Prescribed antidepressants
  - Reliance on pharmacotherapy
  - Family history of depression
- Link between depression and AOD use?

# I've identified that the person has mental health symptoms... Now what

- Discuss with the client what they may expect to experience in relation to these symptoms should they reduce or stop using substances
  - May dissipate (especially if substance induced)
  - May increase when reduces or stops using (especially of using to self-medicate)
- It is important that the client knows that you will be monitoring these symptoms to determine whether further treatment may be required



# Key points

- Conduct routine screening and assessment for these comorbidity as part of case formulation
- Consider a range of factors, not only AOD and mental health issues, in case formulation
- Full assessment should ideally occur after a period of abstinence, or at least when client is not withdrawing or intoxicated
- Conduct multiple assessments throughout treatment, as symptoms may change over time
- Provide assessment feedback in a positive, easily understood way

# Overview

- Brief background: What do we know about comorbidity?
- How is comorbidity identified?
  - Screening
  - Assessment
  - Case formulation
    - Informal assessment
    - Standardised screening and assessment
- Coordinated care

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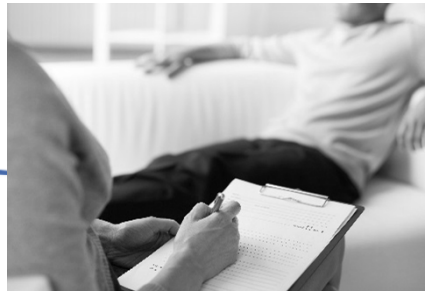
# Coordinated care

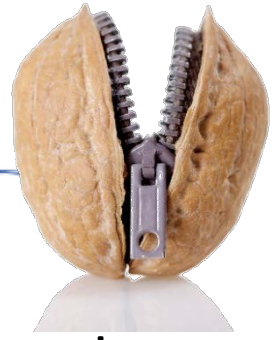
# Coordinated care

# James



- GP liaised with his psychologist and psychiatrist to devise some treatment options
  - Continue antidepressant medication
  - See psychologist weekly
  - Ongoing monitoring of physical health
  - Time off work
- Key points:
  - Not necessarily obvious. Higher prevalence of older people with AOD problems =>careful AOD history needed
  - Need to maintain treatment gains over long term (years vs days or weeks)

# In a nutshell



- AOD and MH disorders are common
- Important for all clients to be routinely screened and assessed as part of routine clinical care
- Clients with comorbid MH conditions often have variety of other medical, family and social problems
  - Consider a range of aspects in the process of case formulation, not just AOD and mental health
- In addition to mental health services, health workers may need to engage and develop strong links with range of other services

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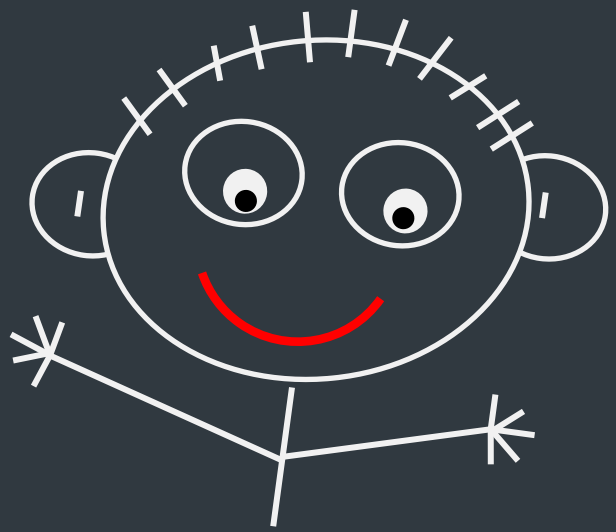
Treat the person, not the illness



# Thanks for being part of the CESPHN-CREMS Webinar Series

## Thank you!

c.marel@unsw.edu.au

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5 December 2017

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To complete CPD assessment **(available until 1 Feb 2018):**

https://unsw.au1.qualtrics.com/jfe/form/SV_a2D2VggGccxwFXn

Any questions?