Queensland Health

dual diagnosis clinician tool kit

co-occurring mental health and alcohol and other drug problems

Tomorrow's Queensland:
strong, green, smart, healthy and fair

Toward Q Tomorrow's Queensland

Queensland Government

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Queensland Health

dual diagnosis

clinician tool kit

Foreword

In September 2008, Queensland Health implemented the Queensland Health Dual Diagnosis Policy Service delivery for people with a dual diagnosis (co-occurring mental health and alcohol and other drug problems) which provides a mandate for collaborative and integrated service responses between Mental Health Services (MHS) and Alcohol, Tobacco and Other Drugs Services (ATODS) in the provision of services for people with a dual diagnosis.

The use of alcohol and other drugs by people with mental illness is associated with poor treatment outcomes, more severe illness and high service use, presenting a significant challenge for all service providers. The significant negative impacts of dual diagnosis on consumers, carers, family and services highlights the need for increased investment in improving the service system response for consumers with co-occurring problems.

Both national and state direction in policy and service delivery promotes a collaborative response to meeting the complex needs of these consumers. Queensland Health has made a commitment to the improvement of care for this client group through the establishment of a statewide partnership between the service sectors, and more recently, the amalgamation of the Mental Health Directorate and the ATOD Treatment Strategy Unit at the policy level. This partnership has led to the development of the *Queensland Health Dual Diagnosis Clinical Guidelines* and *Clinician Tool Kit*.

These resources have been developed to support Queensland Health clinicians (and services) in the provision of effective, safe, quality and holistic care to individuals presenting with dual diagnosis. Accompanying the Guidelines, the Dual Diagnosis Clinician Tool Kit provides a range of materials which will be updated and added to over time, to support clinicians in the management of individuals with dual diagnosis. I encourage all clinicians to review and utilise this resource in your daily management of consumers with dual diagnosis accessing Queensland Health services.

Dual diagnosis positions in both MHS and ATODS have been established to enhance capability of services to meet the needs of consumers with dual diagnosis through workforce development and cross-sector collaboration. District dual diagnosis coordinators will perform a key role in the promotion and implementation of these resources at the district level.

It is recommended that clinicians utilising this tool kit refer to the relevant chapter in the guidelines for further information to support your care of these consumers. Queensland Health clinicians are encouraged to seek advice and supervision to more effectively meet the needs of consumers with dual diagnosis.

Dr Aaron Groves
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Mental Health Alcohol and Other Drugs Directorate
Queensland Health

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1.1 National and Queensland Health guidelines and protocols

National and other states guidelines and protocols	
Alcohol, Tobacco and Other Drugs Guidelines for Nurses and Midwives	www.dassa.sa.gov.au/webdata/resources/files/ATOD_Clinical_Guidelines-book2.pdf
Alcohol Treatment Guidelines for Indigenous Australians	www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/426B5656C2395CC3CA2573360002A0EA/$File/alc-treat-guide-indig.pdf
Alcohol Treatment Guidelines for Indigenous Australians (videorecording)	www.rhef.com.au/programs/presenters/?program_id=63
Australian Indigenous HealthinfoNet; Protective and Health Risks	www.healthinfonet.ecu.edu.au/health-risks
Australian National Council on Drugs (ANCD)	www.ancd.org.au/
Comorbid Mental Disorders and Substance Use Disorders: epidemiology, prevention and treatment	www.health.gov.au/internet/main/publishing.nsf/Content/D588E61C48428185CA256F1900044A02/$File/mono_comorbid.pdf
Guidelines for Evaluating Alcohol and Other Drug Education and Training Programs	www.nceta.flinders.edu.au/pdf/evalu-guide.pdf
Guidelines for the provision of psychological services for, and the conduct of psychological research with, Aboriginal and Torres Strait Islander people of Australia	www.psychology.org.au/Assets/Files/aboriginal_ethical_guidelines.pdf
National Comorbidity Initiative	www.health.gov.au/internet/main/publishing.nsf/Content/BF7BA26E66DE9C03CA256F1900042149/$File/comorbidity.pdf
National Mental Health Policy 2008	www.health.gov.au/internet/main/publishing.nsf/Content/532CBE92A8323E03CA25756E001203BF/$File/finpol08.pdf
National Strategic Framework for Aboriginal and Torres Strait Islander Health: Context	www.health.gov.au/internet/main/publishing.nsf/Content/0EA5F561A75E8529CA257473001B8987/$File/nsfatsihcont.pdf
National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003–2013. Australian Government Implementation Plan 2007–2013	www.health.gov.au/internet/main/publishing.nsf/Content/59E57ED5E8E63C04CA2574040004878A/$File/nsfatsihimp2.pdf

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1.1 National and Queensland Health guidelines and protocols – *continued*

Queensland Health guidelines and protocols	
Clinical Protocols for Detoxification for General Practice and Community settings	www.health.qld.gov.au/atod/documents/24905.pdf
Clinical Protocols for Detoxification in Hospitals and Detoxification Facilities	www.health.qld.gov.au/atod/documents/24904.pdf
Clinical supervision guidelines for mental health services	http://qheps.health.qld.gov.au/mentalhealth/docs/superguide_2009.pdf
Framework for Implementation of the National Mental Health Plan 2003–2008 in Multicultural Australia	www.health.qld.gov.au/pahospital/qtmhc/docs/framework_nmhp.pdf
Guidelines for Acute Sedation in Adult Mental Health Inpatient Settings	http://qheps.health.qld.gov.au/mentalhealth/docs/acuteguidefeb09.pdf
Hepatitis C and Mental Health Protocols	www.qheps.health.qld.gov.au/mentalhealth/docs/23007.pdf
The Management of Psychostimulant Toxicity Guidelines for Emergency Departments	www.health.qld.gov.au/atod/documents/psychostimulant_toxic.pdf
Memorandum of understanding between the state of Queensland through Queensland Health and the state of Queensland through the Queensland Police Service: mental health collaboration	http://qheps.health.qld.gov.au/mentalhealth/docs/9393.pdf
Preventing and Responding to Mental Health Crisis Situations and Information Sharing Guidelines	www.qheps.health.qld.gov.au/mentalhealth/docs/police_32012.pdf
Protecting Queensland Children: Policy Statement and Guidelines on the Management of Abuse and Neglect in Children and Young People (0–18 years)	www.qheps.health.qld.gov.au/csu/policy.htm
Protocols for the delivery of social and emotional wellbeing and mental health services in Indigenous communities: Guidelines for health workers, clinicians, consumers and carers	www.uq.edu.au/nqhepu/index.html?page=110805&pid=0
Queensland Drug Strategy 2006–2010	www.health.qld.gov.au/atod/documents/31976.pdf
Queensland Health Aboriginal and Torres Strait Islander cultural capability framework	www.health.qld.gov.au/cpic/documents/renal_hand1.pdf
Queensland Health guidelines for suicide risk assessment and management	http://qheps.health.qld.gov.au/mentalhealth/docs/guide_suicide_risk.pdf
Queensland Drug Strategy: Midpoint Implementation Report October 2008	www.health.qld.gov.au/ph/documents/atodb/qds_midpoint.pdf
Queensland Health Policy: Service delivery for people with dual diagnosis (co-occurring mental health and alcohol and other drug problems)	http://qheps.health.qld.gov.au/mentalhealth/docs/ddpolicy080925.pdf
The Queensland Opioid Treatment Program Clinical Guidelines 2008	www.qheps.health.qld.gov.au/TPCH/adscl/ads_opioid_program.pdf
Queensland Plan for Mental Health 2007–2017	www.health.qld.gov.au/mentalhealth/abt_us/qpfmh/08132_qpfmh07.pdf
Queensland Needle and Syringe Program (QNSP)	www.health.qld.gov.au/qnsp/
Queensland Strategy for Chronic Disease: Framework for self-management 2008–2015	www.health.qld.gov.au/chronicdisease/documents/fw2008to15_full.pdf

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1.2 Websites

Queensland Government resources	
Alcohol and Drug Information Service (ADIS)	www.health.qld.gov.au/northside/documents/ads_insert1.pdf
Alcohol and Drug Training and Resource Unit (ADTRU)	http://qheps.health.qld.gov.au/tpch/adtru/adtru_home.htm
Queensland Centre for Mental Health Learning Training Resource Centre (QCMHL)	www.health.qld.gov.au/qcmhl/default.asp
Queensland Government Office for Aboriginal and Torres Strait Islander Partnerships	www.atsip.qld.gov.au/people/
Queensland Health Patient Safety Centre (PSC)	www.health.qld.gov.au/patientsafety/default.asp

Australian Government and other states resources	
Aboriginal and Torres Strait Islander Health and Welfare Unit, Australian Institute of Health and Welfare	www.aihw.gov.au/indigenous/health
Australian Government National Tobacco campaign	www.quitnow.info.au/
COAG National Action Plan on Mental Health (2006–2011): Progress Report 2006–07	www.coag.gov.au/reports/docs/AHMC_COAG_mental_health.pdf
Department of Health and Ageing	www.alcohol.gov.au/
Queensland MIND Essentials	www.health.qld.gov.au/mentalhealth/mindessentials.asp
Office for Aboriginal and Torres Strait Islander Health (OATSIH)	www.health.gov.au/oatsih
Veterans and Veterans Families Counselling Service (VVCS)	www.dva.gov.au/health_and_wellbeing/health_programs/vvcs/Pages/index.aspx
Fourth National Mental Health Plan	www.health.gov.au/internet/main/publishing.nsf/content/mental-pubs-f-plan09
Australia: the healthiest country by 2020 National Preventative Health Strategy – Overview: The conceptual framework for the Preventative Health Strategy	www.health.gov.au/internet/preventativehealth/publishing.nsf/Content/nphs-overview-toc~nphs-overview-5

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1.2 Websites – *continued*

Workforce development in Queensland	
Aboriginal and Torres Strait Islander Cultural Awareness Program	www.health.qld.gov.au/cunninghamcentre/html/primary_health.asp
Alcohol and Drug Information Service (ADIS)	www.health.qld.gov.au/northside/documents/ads_insert1.pdf
Alcohol and Drug Training and Resource Unit (ADTRU)	http://qheps.health.qld.gov.au/tpch/adtru/adtru_home.htm
Queensland Alcohol and Drug Research and Education Centre (QADREC)	www.uq.edu.au/qadrec/index.html
Australian Institute for Suicide Research and Prevention (Griffith University)	www.griffith.edu.au/health/australian-institute-suicide-research-prevention/programs-courses/Suicide-prevention-skills-training
Queensland Centre for Mental Health Learning	www.health.qld.gov.au/qcmhl/default.asp
Queensland Health Aboriginal and Torres Strait Islander cultural capability framework	www.health.qld.gov.au/cpic/documents/renal_hand1.pdf

Promotion prevention and early intervention resources	
Dovetail	www.dovetail.org.au/
Early Psychosis Prevention and Intervention Centre	www.eppic.org.au/
headspace	www.headspace.org.au/
National Cannabis Prevention and Intervention Centre	www.ncpic.org.au/
Orygen Youth Health	www.oyh.org.au/
Youth Gas	www.youthgas.com/
Centre for Youth Substance Abuse Research (CYSAR)	www.uq.edu.au/health/cysar

Dual Diagnosis websites	
Department of Health and Ageing – National Comorbidity Project	www.health.gov.au/internet/main/publishing.nsf/Content/BF7BA26E66DE9C03CA256F1900042149/$File/comorbidity.pdf
Dual Diagnosis Australia and New Zealand	www.dualdiagnosis.org.au/home/
Dual Diagnosis Support Victoria Vic Health	www.dualdiagnosis.ning.com

International Websites	
Motivational Interviewing Resources for Clinicians, Researchers and Trainers	www.motivationalinterview.org/
Substance Abuse and Mental Health Services Administration	www.samhsa.gov/
Dartmouth Psychiatric Research Centre	www.dms.dartmouth.edu/prc/dual/atsr/

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1.3 Non-Government Organisations and resources

Alcohol and other Drugs Council of Australia (ADCA)	www.adca.org.au/
Australian National Council on Drugs (ANCD)	www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/ancd-lp
Anex – Association for Prevention and Harm Reduction Programs Australia	www.anex.org.au/default.htm
Association of Relatives and Friends of the Emotionally and Mentally Ill (ARAFEMI)	www.arafemi.org.au/
Associations for the relatives and friends of the mentally ill (ARAFMI)	www.arafmiqld.org/
Australian Drug Foundation	www.adf.org.au/
Australian Drug Information Network	www.adin.com.au/content.asp?Document_ID=1
Beyond Blue National Depression Initiative	www.beyondblue.org.au
Black Dog Institute	www.blackdoginstitute.org.au/
'Can Do' Initiative – Managing Mental Health and Substance Use in General Practice	www.agpncando.com/
Counselling Online	www.counsellingonline.com.au
Drug Arm	www.drugarm.org.au
DrugInfo Clearinghouse	www.druginfo.adf.org.au/
Early Psychosis Prevention and Intervention Centre (EPPIC)	www.eppic.org.au/
Gambling Help – Relationships Australia (Queensland)	www.relationships.com.au/who-we-are/state-and-territory-organisations/qld
General Practice Queensland	www.gpqld.com.au
Inhalants	www.inhalants.org.au
Just Ask Us: Turning Point	www.justaskus.org.au/
Lifeline	www.lifeline.org.au
Mensline Australia	www.menslineaus.org.au
Mental Health Foundation of Australia	www.mhfa.org.au
Mental Illness Fellowship of Queensland (Schizophrenia Fellowship of Queensland)	www.sfq.org.au
Meth Org Au	www.meth.org.au/index.php?id=2
Mindframe National Media Initiative	www.livingisforeveryone.com.au/
Moodgym	www.moodgym.anu.edu.au/welcome

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1.3 Non-Government Organisations and resources – *continued*

Multicultural Mental Health Australia (MMHA)	www.mmha.org.au/About
Partners in Mind	www.partnersinmind.com.au
The National Cannabis Prevention and Information Centre (NCPIC)	www.ncpic.org.au/
The National Centre for Education and Training on Addiction (NCETA)	www.nceta.flinders.edu.au/
National Drug and Alcohol Research Centre	www.ndarc.med.unsw.edu.au/NDARCWeb.nsf/page/home
National Drug Research Institute (NDRI)	www.ndri.curtin.edu.au/
On Track	www.ontrack.org.au/web/ontrack
PsyCheck	www.psycheck.org.au
Queensland Alcohol and Drug Research and Education Centre (QADREC)	www.uq.edu.au/qadrec/
Queensland Alliance	www.qldalliance.org.au
Queensland Network of Alcohol and Drug Agencies (QNADA)	www.qnada.org.au/
Quitline	www.quitnow.info.au/internet/quitnow/publishing.nsf/Content/getting-help
Register of Australian Drug and Alcohol Research (RADAR)	www.radar.org.au/
Sane Australia	www.sane.org/
Salvation Army	www.salvos.org.au/need-help/drugs-and-alcohol/
Turning Point	www.turningpoint.org.au/

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1.4 Treatment Resources

Alcohol and Drug Information Service (ADIS)	www.health.qld.gov.au/northside/documents/ads_insert1.pdf
Alcohol and Drug Training and Resource Unit (ADTRU)	www.qheps.health.qld.gov.au/tpch/adtru/adtru_home.htm
Alcohol and Other Drugs Handbook for Health Professionals	www.health.gov.au/internet/main/publishing.nsf/Content/phd-aodgp
AUDIT – The Alcohol Use Disorders Identification Test – Guidelines for Use in Primary Care	http://whqlibdoc.who.int/hq/2001/who_msd_msb_01.6a.pdf
The Clinical Treatment Guidelines for Alcohol and Drug Clinicians series, Turning Point Alcohol and Drug Centre	www.turningpoint.org.au/library/lib_ctgs.html
Clinical Treatment Guidelines for Alcohol and Drug Clinicians: Methamphetamine Dependence and Treatment, Turning Point	www.turningpoint.org.au/library/cg_14.pdf
Life Promotion Clinic – Griffith University	www.griffith.edu.au/health/australian-institute-suicide-research-prevention/research/life-promotion-clinic
Queensland – MIND Essentials	www.health.qld.gov.au/mentalhealth/mindessentials.asp
Hunter New England Mental Health Service – Psychiatry and Substance Use DVD	www.hnehealth.nsw.gov.au/__data/assets/pdf_file/0011/56747/dvd.pdf
A Manual of Mental Health Care In General Practice	www.health.gov.au/internet/main/publishing.nsf/Content/2A24B141E32953BECA256F1900133822/$File/mangp.pdf
National Guidelines for Treatment of Alcohol Problems	www.health.gov.au/internet/alcohol/publishing.nsf/Content/treat-guide
On Track	www.ontrack.org.au/web/ontrack
Psychostimulants Information for Health Care Workers	www.health.qld.gov.au/atod/documents/31977.pdf
The Queensland Health Mental Health Services Statewide Standardised Suite of Clinical Documentation	www.health.qld.gov.au/patientsafety/mh/mhform.htm
Suicide Risk Assessment and Management	www.health.qld.gov.au/qcmhl/infoday/suicide_risk.pdf
World Health Organization. The International Classification of Diseases – 10 Classification of Mental and Behavioural Disorders	www.who.int/classifications/icd/en/
Ups and Downs Self Help Manual An introductory self-help booklet for people living with substance use and mental health problems	www.health.qld.gov.au/mentalhealth/docs/self_help_manual.pdf

Journals	
Advances in Dual Diagnosis	www.metapress.com/content/121394
Drug and Alcohol Review	www.informaworld.com/smpp/title~content=t713412284~db=all
Journal of Dual Diagnosis	www.tandf.co.uk/journals/titles/15504263.asp
Mental Health and Substance Use: dual diagnosis	www.tandf.co.uk/journals/rmhs
Of Substance National Magazine on Alcohol, Tobacco and Other Drugs	www.ofsubstance.org.au

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1.5 Resources for Families

Alcohol and Drug Information Service (ADIS)	www.health.qld.gov.au/northside/documents/ads_insert1.pdf
Alcohol and Drug Service Community Teams	www.health.qld.gov.au/northside/documents/ads_insert4.pdf
Association for Relatives and Friends of the Mentally Ill (ARAFMI)	www.arafmiqld.org
Australian Parenting	www.raisingchildren.net.au
Child and Youth Mental Health Service, Child and Family Therapy Unit	www.health.qld.gov.au/rch/families/cymhs_cftu.asp
Children's Health Services	www.health.qld.gov.au/rch/
The Coloured Kit	www.youthcoalition.net/projects/colouredkit.html
Department of Child Safety	www.childsafety.qld.gov.au
Kids Help Line	www.kidshelp.com.au
Koping Library	www.health.qld.gov.au/rch/professionals/cymhs_early_interv.asp#akp
Lifeline	www.lifeline.org.au
Mater Child and Youth Mental Health Service	www.kidsinmind.org.au/
Mensline Australia	www.menslineaus.org.au
Mental Health Carers	www.health.qld.gov.au/mhcarer
Mindframe National Media Initiative	www.livingisforeveryone.com.au/
Mood Gym	www.moodgym.anu.edu.au/welcome
NSW Dual Diagnosis Support Kit	www.community.nsw.gov.au/about_us/news_and_publications/dual_diagnosis_resources.html
On Track	www.ontrack.org.au/web/ontrack
Parentline	www.parentline.org.au/
Relationships Australia (Problem Gambling)	www.relationships.com.au/what-we-do/services/problem-gambling
SANE Australia	www.sane.org/youth/youth/helping_young_people_understand_mental_illness.html
SANE Australia (Youth Specific)	www.itsallright.org/
Significant Others Support Program	www.quihn.org/sos_txt.html
Veterans and Veterans Families Counselling Service (VVCS)	www.dva.gov.au/health_and_wellbeing/health_programs/vvcs/Pages/index.aspx
Well Ways: Building a Future	www.mifa.org.au/well-ways-carers
Young Carer's Program	www.carersqld.asn.au

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1.6 Resources for Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander Health and Welfare Unit, Australian Institute of Health and Welfare	www.aihw.gov.au/indigenous/health
Aboriginal and Islander Community Health Service Brisbane Ltd	www.aichs.org.au/
Alcohol and Drug Information Service (ADIS)	www.health.qld.gov.au/northside/documents/ads_insert1.pdf
Association for Relatives and Friends of the Mentally Ill (ARAFMI)	www.arafmiqld.org
Australian Indigenous Healthinfo Net	www.healthinfonet.ecu.edu.au/
Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS)	www.aiatsis.gov.au/
Carers Australia (information for working with Indigenous and Torres Strait Islander Carers and their Communities)	www.carersaustralia.com.au/?/qld/section/24:indigenous-carers
Cooperative Research Centre for Aboriginal Health	www.crcah.org.au
Children of Parents with a Mental Illness (COPMI)	www.copmi.net.au/
Dare to Lead	www.daretolead.edu.au/
Department of Child Safety	www.childsafety.qld.gov.au
Guidelines for the provision of psychological services for, and the conduct of psychological research with, Aboriginal and Torres Strait Islander people of Australia	www.psychology.org.au/Assets/Files/aboriginal_ethical_guidelines.pdf
Indigenous Australian Alcohol and Other Drugs Bibliographic Database	www.db.ndri.curtin.edu.au/
The Indigenous Outreach Community Team	www.health.qld.gov.au/northside/documents/ads_insert6.pdf
Indigenous Psychological Services	www.indigenouspsychservices.com.au/
The Indigenous Risk Impact Screen and Brief Intervention (IRIS)	www.health.qld.gov.au/atod/prevention/iris.asp
Lifeline – emotional wellbeing	www.justask.org.au/
Mental Health Association (QLD) Inc	www.mentalhealth.org.au
Mental Health Carers (ARAFMI)	www.arafmiqld.org/
National Aboriginal Community Controlled Health Organisation	www.naccho.org.au/
National Indigenous Drug and Alcohol Committee	www.nidac.org.au/
Office for Aboriginal and Torres Strait Islander Health (OATSIH)	www.health.gov.au/oatsih

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1.6 Resources for Aboriginal and Torres Strait Islander people – *continued*

Queensland Government Office for Aboriginal and Torres Strait Islander Partnerships	www.atsip.qld.gov.au/people/
SmokeCheck Indigenous Tobacco Brief Intervention Project	www.health.qld.gov.au/atod/prevention/smokecheck.asp
Social and Emotional Wellbeing Regional Centres	www.healthinfonet.ecu.edu.au/health-resources/programs-projects?pid=93
Suicide Call Back Service	www.livingisforeveryone.com.au/IgnitionSuite/uploads/docs/LIFE-Fact%20sheet%2016.pdf
Suicide prevention in Indigenous communities	www.livingisforeveryone.com.au/IgnitionSuite/uploads/docs/LIFE-Fact%20sheet%2016.pdf
Indigenous Wellbeing Centre	www.iwc.org.au/index.html
Westerman Indigenous Psychservices	www.indigenouspsychservices.com.au/

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1.7 Resources for young people

Just ask us – 24/7 online network	www.justaskus.org.au/
Alcohol and Drug Information Service (ADIS)	www.health.qld.gov.au/northside/documents/ads_insert1.pdf
Association for Relatives and Friends of the Mentally Ill (ARAFMI)	www.arafmiqld.org
Child and Youth Mental Health Service, Child and Family Therapy Unit (over 14)	www.qheps.health.qld.gov.au/rch/Cymhs/pdfs/Policy1-3-1_7a.pdf
Child and Youth Mental Health Service, Child and Family Therapy Unit (under 14)	www.health.qld.gov.au/rch/families/cymhs.asp
Children's Health Services	www.health.qld.gov.au/rch/families/cymhs.asp#program
Create Foundation	www.create.org.au
Department of Child Safety	www.childsafety.qld.gov.au/
Family Drug Support	www.fds.org.au
headspace	www.headspace.org.au
Highsnlows	www.highsnlows.com.au/index.php?option=com_video_comments&task=viewall&Itemid=20
Interactive forum	www.reachout.com.au
Its Allright	www.itsallright.org
Kids helpline	www.kidshelp.com.au
Lifeline	www.lccq.org.au
MAISE program	www.quihn.org
Mater Child and Youth Mental Health Service	www.kidsinmind.org.au/
Mood Gym	www.moodgym.anu.edu.au/welcome
Open Doors	www.opendoors.net.au
Orygen Youth Health	www.oyh.org.au/
Parentline	www.parentline.com.au
Queensland Health – Young Carers	www.health.qld.gov.au/mhcarer/young_carers.asp
Queensland Health Sexual Health, HIV and Hepatitis C Teen Site	www.health.qld.gov.au/istaysafe/default.asp
Reach Out	www.reachout.com.au
SANE Australia	www.sane.org/youth/youth/helping_young_people_understand_mental_illness.html
Sexual Assault Service	www.livingwell.org.au/Counsellingandsupport/Queenslandsexualassaultservices.aspx
Significant Others Support Program	www.quihn.org/sos_txt.html
Somazone – Information for young people	www.somazone.com.au/
Suicide Call Back Service	www.crisissupport.org.au/SuicideCallback.aspx
Young Carer's Program	www.carersaustralia.com.au/?qld/section/27:young-carers
Youth Beyond Blue	www.ybblue.com.au
Youth Community Team (Hot House Finney Road)	www.health.qld.gov.au/northside/documents/ads_insert7.pdf
Zig Zag Young Women's Resource Centre	www.zigzag.org.au/index.html

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1.8 Resources for Parents with Dual Diagnosis

Association for Relatives and Friends of the Mentally Ill: (ARAFMI)	www.arafmiqld.org
Carers Australia supporting Young Carers	http://national.carersaustralia.com.au/?/section/27:young-carers
Children of Parents with a Mental Illness (COPMI)	www.copmi.net.au/
The Coloured Kit	www.youthcoalition.net/projects/colouredkit.html
Koping Library	www.health.qld.gov.au/rch/professionals/cymhs_early_interv.asp#akp
NSW Dual Diagnosis Support Kit	www.community.nsw.gov.au/docswr/_assets/main/documents/dualdiagnosis_zcard.pdf
Queensland Health Carers Information	www.health.qld.gov.au/mhcarer
Queensland Health – Young Carers	www.health.qld.gov.au/mhcarer/young_carers.asp
SANE Australia	www.itsallright.org
Young Carer's Program	www.carersqld.asn.au

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1.9 Dual Diagnosis Clinician Capability Framework

Dual Diagnosis Clinician Capabilities			
Unit A: Context (Queensland Health Dual Diagnosis Clinical Guidelines – Chapters 1 and 4)		**Essential**	**Advanced**
Capability 1: Dual Diagnosis principles/models of care	People with dual diagnosis are the expectation not the exception **Attitudes and values:** ▪ will assess consumers as persons with mental health and substance use issues ▪ promote an approach to services that are welcoming and respectful ▪ promote a holistic and comprehensive approach	▪ engage people with dual diagnosis in an empathetic and accepting manner ▪ follow district protocols regarding provision of care to consumers according to the Queensland Health Dual Diagnosis Policy (2008) ▪ seek assistance or supervision regarding implementation of treatment models e.g. stage wise treatment	▪ provide integrated care based on stage wise treatment ▪ demonstrate a high level understanding of evidence based treatment models ▪ contribute to a constructive review of treatment guidelines and models of care ▪ promote concepts and implementation of service models within the context of service area
Capability 2: Queensland Health Dual Diagnosis Policy (2008) and Legislation	Service delivery for people with dual diagnosis is consistent with the clinician's role description including responsibilities and accountabilities **Attitudes and values:** ▪ understand that identifying dual diagnosis provides for safe and effective treatment ▪ respect the legal processes and policies governing practice	▪ knowledge of the Queensland Health Dual Diagnosis Policy (2008) ▪ implement Queensland Health Dual Diagnosis Policy (2008) according to district protocols and or procedures under guidance and supervision ▪ working knowledge of relevant legislation for safe and effective practice in dual diagnosis	▪ demonstrate a high level knowledge of the Queensland Health Dual Diagnosis Policy (2008) ▪ demonstrate advanced skills in implementing Queensland Health Dual Diagnosis Policy (2008) according to district protocols and procedures ▪ consult with others regarding interpretation and implementation of the Queensland Health Dual Diagnosis Policy (2008) and relevant judicial acts ▪ demonstrate a high level knowledge and the ability to implement legislation relevant to position e.g. *Mental Health Act 2000; Health Service Act 2000, Health (Drugs and Poisons) Regulation 1996; Child Protection Act 1999*

Chapter 1 – Introduction

1.9 Dual Diagnosis Clinician Capability Framework – *continued*

Dual Diagnosis Clinician Capabilities			
	Unit A: Context (Queensland Health Dual Diagnosis Clinical Guidelines – Chapters 1 and 4)	**Essential**	**Advanced**
Capability 3: Prevalence/reasons/impacts	Acknowledge dual diagnosis prevalence, reasons for and impacts upon the individual, carers, significant others and community **Attitudes and values:** ▪ acknowledge that people may have more than one problem ▪ acknowledge the level of impact dual diagnosis has for the individual, carers and significant others	▪ aware of prevalence within treatment populations ▪ seek assistance/consultation regarding reasons individuals develop dual diagnosis ▪ aware of the impact of dual diagnosis on individuals, carers and significant others	▪ high level knowledge of the prevalence within treatment populations and the broader community ▪ high level understanding of reasons why individuals develop dual diagnosis incorporating bio-psychosocial domains ▪ aware of associated impacts for individuals, carers, significant others and the broader community including government and non-government services
Capability 4: Psychoactive drugs misuse	The nature and effects of psychoactive drugs are varied and complex **Attitudes and values:** ▪ open to learning about psychoactive drug trends and associated effects ▪ non-judgemental when gathering personal client information pertaining to psychoactive drug use	▪ develops and maintains knowledge of psychoactive drug trends and methods of use ▪ shares new knowledge with treatment team ▪ seeks assistance and or supervision as required	▪ demonstrate high level knowledge of current psychoactive drug trends ▪ provide high level knowledge of interactions between psychoactive drugs and mental state ▪ provide high level knowledge of interactions between psychoactive drugs and prescribed medications ▪ provide consultation regarding psychoactive drugs

Chapter 1 – Introduction

1.9 Dual Diagnosis Clinician Capability Framework – *continued*

Dual Diagnosis Clinician Capabilities			
Unit B: Disorders (Queensland Health Dual Diagnosis Clinical Guidelines – Chapters 3 and 4)		**Essential**	**Advanced**
Capability 5: Diagnostic criteria	Recommended classification systems are used to diagnose dual diagnosis **Attitudes and values:** ■ acknowledge that people may have more than one problem ■ ensure that people with dual diagnosis receive appropriate treatment despite the degree of dual diagnosis	■ knowledge of recommended classification systems e.g. ICD-10 and or DSM-IV-TR ■ knowledge of diagnostic criteria for major mental health disorders and substance related disorders	■ demonstrate high level knowledge of diagnostic criteria according to recommended classification systems for: – Mental disorders – Substance related disorders – Common co-morbidities
Unit C: Clinical Practice (Queensland Health Dual Diagnosis Clinical Guidelines – Chapters 5, 6, 7, 8 and 9)		**Essential**	**Advanced**
Capability 6: Engagement	Clinical practice will be adapted to maximise engagement with people presenting with dual diagnosis **Attitudes and values:** ■ people with dual diagnosis will be valued as individuals with strengths and capacity for pride, self-respect and a sense of self worth	■ understand the barriers to engagement for people with dual diagnosis ■ demonstrate interpersonal communication skills ■ demonstrate knowledge and skills to engage people with dual diagnosis ■ seek assistance and or supervision regarding engagement processes	■ identify and understand barriers to engagement for people with dual diagnosis ■ demonstrate high level knowledge and skills to engage people with dual diagnosis ■ provide consultation regarding engagement process

Chapter 1 – Introduction

1.9 Dual Diagnosis Clinician Capability Framework – *continued*

Dual Diagnosis Clinician Capabilities			
Unit C: Clinical Practice (Queensland Health Dual Diagnosis Clinical Guidelines – Chapters 5, 6, 7, 8 and 9)		**Essential**	**Advanced**
Capability 7: Identification and screening	Identification and screening for dual diagnosis are key elements of the recommended assessment packages for both ATODS and MHS **Attitudes and values:** ▪ acknowledge that identification and screening are key elements of safe and effective treatment delivery	▪ demonstrate knowledge of identification and screening tools attached to assessment packages for ATODS and MHS ▪ utilise information from identification and screening tools to assess the presence of dual diagnosis ▪ routinely undertake an assessment of risk ▪ seek assistance/supervision regarding the identification and screening for dual diagnosis	▪ demonstrate high level knowledge and skill regarding the use of identification and screening tools attached to assessment packages for ATODS and MHS ▪ provide knowledge of other evidence based screening tools for advanced screening ▪ offer consultation regarding the identification and screening for dual diagnosis
Capability 8: Comprehensive assessment	Bio-psychosocial assessments for dual diagnosis are key elements of the recommended assessment packages for both ATODS and MHS **Attitudes and values:** ▪ acknowledge that a comprehensive assessment is a key element of safe and effective treatment delivery	▪ demonstrate knowledge and skill regarding the use of standardised assessment packages for ATODS and MHS ▪ seek collateral information to enhance assessment processes when appropriate ▪ routinely integrate assessment of risk as part of a comprehensive assessment ▪ identify adult clients who are parents and facilitate conversation regarding the care of their children ▪ seek assistance and or supervision regarding a comprehensive integrated assessment	▪ demonstrate high level knowledge and skill in conducting a bio-psychosocial assessment ▪ confidently and routinely provide an advanced standardised and formal integrated assessment including seeking collateral information when appropriate ▪ demonstrate high level knowledge and skills regarding assessment of adult clients who are parents and their capacity to provide care for their children ▪ provide consultation regarding a comprehensive integrated assessment

Chapter 1 – Introduction

1.9 Dual Diagnosis Clinician Capability Framework – *continued*

Dual Diagnosis Clinician Capabilities			
Unit C: Clinical Practice (Queensland Health Dual Diagnosis Clinical Guidelines – Chapters 5, 6, 7, 8 and 9)		**Essential**	**Advanced**
Capability 9: Care plan development	Care plans are based on thorough screening and assessment of bio-psychosocial domains **Attitudes and values:** ■ respect clients intentions regarding treatment goals in accordance with harm minimisation philosophy ■ reinforce strengths and instil hope in achieving goals in accordance with a recovery based approach	■ identify strengths and problem areas and link strategies to these ■ demonstrate an ability to establish and prioritise treatment goals based on urgent needs (in collaboration with the client and the treating team) ■ seek assistance to incorporate stage wise treatment matching in the design of the care plan ■ develop and implement a risk management plan with periodic review and seek assistance when required ■ include family and or significant others in care plan development	■ demonstrate high level knowledge and skill in comprehensive and integrated care planning ■ demonstrate a high level ability to develop and implement a comprehensive risk management plan with periodic review ■ provide consultation particularly in relation to stage wise treatment matching with appropriate bio-psychosocial intervention
Capability 10: Evidence based interventions	Service delivery will be provided in accordance with the best available evidence **Attitudes and values:** ■ understand that clinical practice is based on the best available evidence	■ demonstrate basic knowledge and implementation of evidence based interventions ■ seek supervision regarding refining knowledge and skills around evidence based interventions	■ demonstrate high level knowledge and implementation of advanced evidence based interventions ■ provide consultation regarding the implementation of evidence based interventions ■ update knowledge and skills in accordance with evidence based practice

Chapter 1 – Introduction

1.9 Dual Diagnosis Clinician Capability Framework – *continued*

Dual Diagnosis Clinician Capabilities			
Unit D: Collaboration (Queensland Health Dual Diagnosis Clinical Guidelines – Chapter 2)		**Essential**	**Advanced**
Capability 11: Collaborative care	Service delivery will be provided to clients with mental illness and substance dependence according to collaborative care and co-case management protocols **Attitudes and values:** ▪ acknowledge and respect skills and experience of other professionals to provide holistic and co-ordinated care ▪ acknowledge a no wrong door approach to service delivery	▪ identify and seek assistance regarding the need for collaborative case management ▪ gain client consent regarding collaborative care ▪ engage with respective services according to protocols ▪ maintain collaborative working relationships with respective service with ongoing supervision ▪ include clients in all aspects of establishing, maintaining and monitoring collaborative case management arrangements ▪ routinely share information pertaining to client care ▪ document arrangements in progress notes and care plan per protocols ▪ involve collaborating case manager in case review process as per protocols	▪ develop District specific collaborative care and co-case management protocols according to Queensland Health Dual Diagnosis Policy (2008) and relevant evidence based practice ▪ accurately identify clinical and operational circumstances that indicate collaboration is required ▪ independently establish and maintain arrangements with collaborating service according to co-case management protocols ▪ provide consultation regarding collaborative case management ▪ lead case review process involving collaborative service according to protocols
Capability 12: Community linkages	Collaborative partnerships involving the government and non-government sector is paramount to meet the complex needs of people with dual diagnosis and to sustain recovery **Attitudes and values:** ▪ view active engagement with community agencies as an essential part of client care and recovery	▪ identify key agencies in the community relevant to promoting client recovery ▪ engage agencies in partnership with client to discuss meeting the clients needs ▪ include agencies in care planning and review processes ▪ seek assistance with establishing linkages with agencies and or community groups	▪ actively develop and support formalised partnership agreements with agencies/community groups to promote client recovery ▪ establish working relationships with key agencies or community groups which are maintained and nurtured

Chapter 1 – Introduction

1.9 Dual Diagnosis Clinician Capability Framework – *continued*

Dual Diagnosis Clinician Capabilities			
	Unit E: Tailoring the response (Queensland Health Dual Diagnosis Clinical Guidelines – Chapter 10)	**Essential**	**Advanced**
Capability 13: Aboriginal and Torres Strait Islander peoples	Dual diagnosis continues to be a major concern for Aboriginal and Torres Strait Islander communities in Queensland **Attitudes and values:** ■ respect Aboriginal and Torres Strait Islander people in a culturally appropriate and supportive manner ■ non-discriminatory and inclusive of community support networks	■ implement the Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010–2033 ■ demonstrate the skills, knowledge and behaviours that are required to plan, support, improve and deliver services in a culturally respectful and appropriate manner ■ utilise resources as developed in the Queensland Health Aboriginal and Torres Strait Islander Cultural Capability Framework 2010–2033 including the use and engagement of interpreter services for Aboriginal and Torres Strait Islander peoples ■ participate in cultural awareness training ■ provide culturally appropriate service delivery as per service protocol ■ invite family or supports as suggested by the client to be involved in health interventions ■ seek advice from Aboriginal and Torres Strait Islander health workers regarding engagement, consultation and interventions	■ provide a high level of culturally appropriate intervention as per service protocol ■ establish links and working relationships with Aboriginal and Torres Strait Islander support agencies/ networks ■ tailor service provision to suit individual needs ■ provide consultation regarding engagement and intervention for Aboriginal and Torres Strait Islander peoples

Chapter 1 – Introduction

1.9 Dual Diagnosis Clinician Capability Framework – *continued*

Dual Diagnosis Clinician Capabilities			
Unit E: Tailoring the response (Queensland Health Dual Diagnosis Clinical Guidelines – Chapter 10)		**Essential**	**Advanced**
Capability 14: Forensic and criminal justice	Awareness of the relationship between offending behaviour, substance use and mental health problems and strategies essential to assess and treat people involved in the criminal justice system **Attitudes and values:** ■ maintain a non-judgmental approach to clients who have engaged in offending behaviour	■ aware of treatment options for this population ■ aware of relevant legislation ■ seek supervision regarding refining knowledge and skills	■ provide a high level of assessment and treatment to clients involved in the criminal justice system ■ understand factors that contribute to offending and how to assess these ■ engage with other agencies in providing integrated care to clients who are offending ■ provide consultation regarding forensic and criminal justice issues
Capability 15: Youth	Assessment, screening and care for young people with dual diagnosis are performed in accordance with the young person's developmental stage and level of function **Attitudes and values:** ■ recognise the unique needs of youth with dual diagnosis ■ recognise the importance of and give consideration to a young person's support system	■ understand that dual diagnosis symptoms and treatment for youth differs from adult populations ■ knowledge of the *Child Protection Act 1999* ■ knowledge of consent issues – i.e. Gillick Competence ■ understand importance of engaging significant others in the treatment process ■ seek supervision regarding refining knowledge and skills	■ offer high level knowledge of adolescent development and the impact of substance use and mental health problems ■ demonstrate high level knowledge and skills to complete screening, assessment and care planning within the context of the young person's developmental stage and include significant others ■ demonstrate high level knowledge and ability to critically reflect on child protection, consent and confidentiality issues enabling decisive and appropriate outcomes ■ demonstrate high level ability to undertake care planning and implementation using a resilience model

Chapter 1 – Introduction

1.9 Dual Diagnosis Clinician Capability Framework – *continued*

Dual Diagnosis Clinician Capabilities			
Unit E: Tailoring the response (Queensland Health Dual Diagnosis Clinical Guidelines – Chapter 10)		**Essential**	**Advanced**
Capability 16: Culturally and linguistically diverse (CALD) populations	Assessment and treatment recognises the cultural diversity of clients and possible impact on the ability to engage the client in treatment **Attitudes and values:** ■ respect cultural diversity ■ engage with culturally appropriate service providers to ensure appropriate service provision	■ access mental health and alcohol and drug information in languages other than English ■ awareness of the procedures for engaging an interpreter ■ utilise visual aids and health promotion resources when spoken language is a barrier ■ undertake the Queensland Health recommended cultural awareness program ■ seek supervision regarding refining knowledge and skills	■ offer knowledge of dual diagnosis issues impacting on CALD populations ■ demonstrate high level ability to tailor treatment to meet the needs of this population ■ offer high level knowledge of potential support services for clients from a CALD background ■ actively engage with community agencies providing support to individuals from a CALD background
Capability 17: Older people	Assessment and care for older people is often complex due to multiple diagnoses resulting in decreased functioning and quality of life **Attitudes and values:** ■ challenge ageist attitudes to avoid direct and indirect discrimination ■ recognise and respect the unique needs of older people with dual diagnosis	■ understand that older people have further bio-psychosocial complexities and require comprehensive assessment and screening ■ demonstrate an ability to obtain collateral information from family/significant others ■ seek supervision regarding refining knowledge and skills	■ offer high level knowledge of the complexity of assessment and intervention for older people with dual diagnosis ■ demonstrate high level ability to tailor treatment to meet the needs of this population ■ provide consultation regarding comprehensive assessment and intervention for older people

chapter 4
alcohol and other drug use

Chapter 4 – Alcohol and drug use

4.1 Information on substances

CNS Depressants	Stimulants	Hallucinogens
Alcohol	Nicotine	LSD (lysergic acid diethylamide)
Opioids: heroin, codeine, oxycodone, methadone, morphine pethidine, buprenorphine (Subutex, Suboxone)	Caffeine	MDMA (ecstasy) *
	Amphetamines: methamphetamine and dexamphetamine	Magic mushrooms
		Ketamine
		GHB (gamma-hydroxy-butyrate)
Cannabis*	Cocaine	Cannabis*
Benzodiazepines	Appetite suppressants	Mephadrone*
Volatile substances: aerosols, glues, paint and petrol	Mephadrone*	

**Some substances fit more than one category*

Alcohol

Alcohol is a central nervous system (CNS) depressant. Its properties contribute to changes in mood, cognition and behaviour. The main psychoactive ingredient in beverage alcohol is ethyl alcohol. Alcohol may adversely affect brain development and lead to alcohol-related problems in later life, including a range of chronic diseases and trauma. Drugs such as cannabis, methamphetamines, ecstasy, cocaine and heroin are increasingly used with alcohol, placing users at greater risk of harm, particularly from the effects of multiple depressant drugs.

Opioids (heroin, methadone, morphine, buprenorphine, physeptone, oxycodone)

These are a group of alkaloids. Heroin (diacetylmorphine) is the most commonly used opioid in metropolitan areas, while elsewhere in Queensland diverted prescription opioids are more likely. However, prescriptions opioids are becoming increasingly popular. Opioids are usually injected intravenously. They may also be swallowed or inhaled (smoked) although this is less common. Buprenorphine tablets are given sublingually.

As a class, opioids produce a sense of euphoria, detachment and well being in addition to their analgesic properties. Fatal overdose may result from respiratory depression which leads to circulatory collapse. Prolonged, regular use of opioids may lead to the development of tolerance and dependence. Cessation of use results in an unpleasant, though not usually life threatening withdrawal state (cold turkey), which is characterised by: restlessness, insomnia, piloerection (goosebumps), pupillary dilatation, lachrymation, nasal discharge, sweating, vomiting, diarrhoea, abdominal pain, hyperaesthesia, paraesthesia and abdominal, back and leg cramps, together with strong cravings to use again. Withdrawal related fatalities have been described in users with co-existing medical conditions such as cardiovascular disease.

Sedatives (benzodiazepines i.e. diazepam, temazepam, alprazolam)

Benzodiazepines are central nervous system depressants used in clinical practice for sedation and the relief of anxiety. They are also widely misused for illicit or non-prescribed purposes. They have anti-anxiety, anti-convulsant, hypnotic and muscle relaxant properties. Their use results in performance deficits including memory impairment, motor incoordination, decreased reaction time and ataxia. Although benzodiazepines may be safely used in the short term to reduce anxiety, their propensity to produce tolerance, dependency and withdrawal states is now widely recognised and can occur at therapeutic levels. They should be only prescribed for short periods (1–2 weeks) and other approaches should be used to treat anxiety (psychological therapies, anti-depressants) in the long-term.

Cannabis (THC)

The major active element in cannabis is $\Delta 9$ Tetrahydrocannabinol. Cannabis is usually smoked but can also be ingested, producing a sense of relaxation and euphoria often described as a ‘high’. It may produce mild paranoid ideation. There is evidence that cannabis can trigger psychosis in vulnerable individuals, or produce an acute confusional state with delusions and hallucinations. However, this generally only occurs at consistent high levels of use.

Chapter 4 – Alcohol and drug use

4.1 Information on substances

Tobacco

Tobacco contains about 4,000 chemicals including nicotine, a number of known carcinogens, carbon monoxide, hydrogen cyanide, various nitrogen oxides and tar. Nicotine is the agent responsible for physical dependence. It is a toxic alkaloid, with a half life of 1–2 hours. Nicotine rapidly crosses the blood brain barrier to stimulate both the dopaminergic and noradrenergic pathways in the brain. Nicotine effects on the cardiovascular system are mediated by sympathetic neural stimulation together with an increase in levels of circulating catecholamines. It has the apparent paradoxical effect of being both a stimulant (at low doses) and a relaxant (at high doses).

Stimulants (amphetamines, methylene-dioxy-meth-amphetamine – MDA, MDEA, MDMA, ecstasy)

Stimulants cause an elevation of mood, increased alertness and physical activity. They may be taken orally, nasally or injected intravenously. Amphetamine causes a dose dependent toxicity, and can cause an amphetamine psychosis commonly called 'speed psychosis'. This condition usually subsides over a week although amphetamine use can precipitate a more prolonged, psychotic illness.

Methamphetamine (ice)

Ice is a purified crystalline form of methamphetamine. It is a synthetically produced stimulant which causes excitement, alertness and euphoria. Ice is approximately 80 per cent pure in comparison to other forms of amphetamines which in Australia are around 10-30 per cent pure. The risk of developing methamphetamine dependence from ice is much higher due to the purity of the drug. Injecting users are five times more likely to develop dependence than those who use the drug by other routes.

Cocaine (crack, coke, nose candy)

This stimulant is derived from the leaves of the coca plant. It is usually smoked or snorted although it can also be injected intravenously. Cocaine rapidly produces central nervous system stimulation and a sense of euphoria. Users often develop a craving for cocaine, tolerance and psychological dependency. Chronic usage can lead to paranoid psychosis. Cocaine users sometimes experience 'formication' (Cocaine bugs), a feeling as if insects are crawling under the skin.

Mephadrone (miaow miaow, m-cat, meph, 'drone, kitty cat)

This is a relatively 'new' substance on the scene which has gained notoriety, particularly in the UK, where it was recently banned. It is sold as 'plant food' often through the internet. It has euphoric and stimulant properties and like ecstasy is regarded as an entactogen. Multiple side effects include paranoia, seizures and impaired peripheral circulation. As synthetic chemists try to keep ahead of regulatory processes, many more 'new' substances are likely to emerge.

Hallucinogens (LSD, phencyclidine, magic mushrooms)

These substances have been known and used for many years. They are usually taken orally, giving rise to heightened perceptions, vivid imagery, illusions and hallucinations and often a state of euphoria. Sometimes a 'bad trip' occurs with terrifying hallucinations and delusional thinking. Those who use the drug regularly, may experience 'flash backs' to a 'bad trip'. Neurological damage can occur.

Inhalants (benzene, toluene, butane, propane, acetone, trichlorofluoromethane, dichloromethane)

Inhalants or 'volatile substances' are central nervous system depressants. Inhalants rapidly change from a liquid or semisolid state to a vapour when exposed to air. Common inhalants include: petrol; lacquers and varnishes containing benzene and adhesives; spray paints; glues and paint thinners containing toluene; amyl nitrate and nitrous oxide. These solvents are generally inhaled via sniffing. However, they can also be consumed by huffing (holding a saturated piece of material over the nose and/or mouth) or bagging (inhaling vapours from a plastic bag). The rapid onset, euphoric effects of inhalants, and their relative low cost and accessibility influence the appeal and uptake of these substances particularly to disaffected adolescent users. Adverse effects range from nausea, headaches, diarrhoea and abdominal pain, to more severe effects including seizures, coma, cardiopulmonary arrest and death.

Anabolic steroids

Unlike the substances above, anabolic steroids are not primarily used for their psychoactive effects. They are synthetic modifications of the male hormone testosterone. Steroids have traditionally been used to enhance sporting performance. It is now common for steroids to be used by both males and females for cosmetic purposes, due to their real or imagined effects on body image. The drug can be ingested orally or injected, often directly into the muscle where the effect is sought. Anabolic steroids are commonly used in 'stacks' i.e. in combination with other drugs at the same time. Steroids are associated with a variety of side effects from relatively minor cosmetic changes to life threatening complications including cholestatic jaundice and carcinoma of the prostate. The use of other drugs to counter the side effects of steroids often results in higher risk due to drug interactions.

References:

National Centre for Education and Training on Addiction (NCETA) Consortium 2004, *Alcohol and other drugs: A handbook for health professionals*. Australian Government Department of Health and Ageing.

Chapter 4 – Alcohol and drug use

4.2 Street names for drugs

Drug	Street Names
Alcohol	Grog, piss, cans, six pack, long necks, slabs, casks
Benzodiazepines	Benzos, pills, jack & jills, downers, seras, rowies
Buprenorphine (Subutex / Suboxone)	Bupe, subbie
Heroin	Smack, hammer
Methadone syrup and tablets	'done
Morphine, oxycodone	Morph, oxy, grey nurse
GHB (gamma-hydroxybutyrate)	Fantasy, grievous bodily harm, liquid ecstasy, liquid e
Cannabis/marijuana	Grass, pot, ganja, reefer, joint, yarndi, weed, bush (medium strength), hydro (high strength); 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	Gold top mushrooms, magic mushies
Ketamine	Special K, k, vitamin k
PCP (phencyclidine)	Angel dust, super weed, killer weed
Mephadrone	Miaow Miaow, m-cat, plant food, drone, bubbles, kitty cat

Adapted with permission from: NSW Department of Health 2009, *N.S.W. Clinical Guidelines for care of persons with comorbid mental illness and substance use disorders in acute care settings,* NSW Department of Health, Sydney.

Chapter 4 – Alcohol and drug use

4.3 Street drug measurements

Slang names	Units
Point or cap	0.1 gm
Quarter	0.25 gm
Weight, gram	1 gm
Eight-ball	1/8 oz i.e. ~3.5 gm
Ounce	28 gms (i.e. bulk purchase THC)

(Courtesy Dr J Hayllar 2010)

Chapter 4 – Alcohol and drug use

4.4 Price, purity, use and availability of substances in Queensland 2009

Substance	Price/Unit	Purity	Daily use (approx)	Availability
Alcohol (Fourex Lager XXXX)	$2.50/10gms	‹ 45%	33% › 50gms	Very easy
Tobacco	$10/20 cigs	1%	40 – 80mg	Very easy
Cannabis	$25 or $20/gm hydro/bush	0.3 – 4% (‹ 20%)	0.25 – 1gm	Easy
Heroin	$50/cap (point) (i.e. 100mg)	30%	¼ – 1 gm	Difficult
Morphine	50c/mg	80%	100 – 600mg	Easy
Methadone	50c – $1/ml/mg	Varies	60 – 150mg	Difficult
Buprenorphine	$1 – $5/mg	80%	10 – 40mg	Difficult
Methamphetamine	$50/point	20/40%	0.5 – 3gm	Easy
Cocaine		15%		Very difficult
Ecstasy	$20/tab		1 – 3 tabs	Easy
Benzodiazepines	$1/mg	80 + %	30 – 150mg	Easy

Chapter 4 – Alcohol and drug use

4.5 Flowchart for collaborative management of opioid dependence in consumers of mental health services

Routine screening of AOD use in consumers of the mental health service

- initial presentation
- ongoing review

Identification of opioid use

- Needle marks
- Urine drug screen
- Severity of dependence scale
- Opioid withdrawal scale

Opioid dependence diagnosed

Discuss with ATODS the management of opioid dependence

Management

If consumer is *agreeable* to ATODS reviews:

- ATODS to perform specialist assessment
- Identify treatment needs
- Develop integrated care plan with MHS addressing opioid dependence
- Assessment of interactions of opioid use with MH medications
- Manage opioid dependence within harm reduction framework
  - maintenance treatment (Suboxone/Methadone)
  - detoxification
  - residential rehabilitation services
- Ongoing management of mental health problem
- Identify if MHS are to remain involved

Option 1: Transfer management to ATODS as primary provider if all parties agreeable (consumer/carer/ATODS/MHS)

Option 2: OR collaborative management
Consultation with ATODS to identify primary service provider for coordination of treatment

Management

If consumer is *not agreeable* to ATODS review:

- Document consumer's wishes on clinical chart
- Consider consistency with MH treatment plan

If involuntary treatment:
- refer to Dual Diagnosis Co-ordinator or Consultation Liason Officer with clear documentation of decision process and/or consult with ATODS regarding need for specialist assessment and level of risk

If voluntary treatment:
- Medical assessment
- Medical Officer to liaise with ATODS to inform treatment
- Assess interactions of opioid use with MH medications
- Consultation to be recorded in the clinical chart
- Assertively engage consumer in treatment
- Provide consumer with psychoeducation, brief interventions and harm minimisation interventions
- Ongoing assessment and review
- Ongoing consultation with ATODS for advice/input into treatment plan

Collaborative Care

Either co-case management with ATODS (where primary service provider negotiated and agreed) or collaborative management, where MHS is primary service provider.

Primary service provider to:

- Record dual diagnosis in clinical chart and Information System
- Engage General Practitioner in care
- Manage exchange of information at regular intervals and at times of significant clinical change
  - provide relevant documentation (case notes, care plans, discharge summaries, medication sheets) to other service provider
  - organise joint case conferencing
  - advise all parties of changes to treatment plan/status of care
  - maintain and update relevant information systems

chapter 5
dual diagnosis assessment

Chapter 5 – Dual Diagnosis Assessment

	Description/Scoring	
5.1 Mental State Examination (MSE)	The MSE interview schedule has been a main stay of psychiatric assessment and continues to be used by MHS for this purpose. Whereas the client's history remains stable, the client's mental state can change from day to day or hour to hour. The mental state examination is the description of the client's appearance, speech, actions, and thoughts during the interview. It is recommended that clinicians use the mental state interview schedule attached to the relevant assessment package. **Key references:** Sadock BJ 2007, *Kaplan & Sadock's Synopsis of Psychiatry. Behavioral Sciences/Clinical Psychiatry*, 10th Edition, Wolter Kluwer/ Lippincott Williams & Wilkins, Philadelphia.	http://ndarc.med.unsw.edu.au/NDARCWeb.nsf/resources/Guidelines6/$file/AppendicesF.pdf
5.2 Mini-Mental State Examination (MMSE)	The MMSE is a set of questions that provides a score about a person's general level of cognitive impairment. It takes five minutes to administer and covers such areas as the ability to recall facts, to write and calculate numbers. The test provides a quick way to determine if more in-depth neurological testing is needed. Score one point each for correct answer. A MMSE score of less than 23 is indicative of cognitive impairment. Scores should be used as a guide only; they may not necessarily correlate to functional performance. Therefore collateral information from family and carers, and functional observation by the multidisciplinary team is very important in interpreting results. **Key references:** Folstein, MF, Folstein, SE & McHugh PR 1975, 'Mini-Mental State: A Practical method for grading the cognitive state of patients for the clinician', *Journal of Psychiatric Research*, vol.12, issue 10, pp. 189–198.	www.health.gov.au/internet/main/publishing.nsf/Content/mental-pubs-m-mangp-toc~mental-pubs-m-mangp-app~mental-pubs-m-mangp-app-2
5.3 Psychosis Screener	The Psychosis Screener consists of seven items; the first six items cover the following features of psychotic disorders: delusions of control, thought interference and passivity, delusions of reference or persecution and grandiose delusions. The final item records whether a respondent reports ever receiving a diagnosis of Schizophrenia. Scores on the screener range from zero to six. Analysis indicated that scores of three or more discriminate adequately between cases and non-cases of Schizophrenia or Schizoaffective disorder (Degenhardt et al, 2005). **Key references:** Degenhardt, L, Hall, W, Korten, A & Jablensky, A 2005, *Use of a brief screening instrument for psychosis: Results of an ROC analysis,* NDARC Technical Report No. 210, National Drug and Alcohol Research Centre, NSW. Deady, M 2009, *A Review of Screening, Assessment and Outcome Measures for Drug and Alcohol Settings*, Network of Alcohol and Other Drugs Agencies, NSW.	http://ndarc.med.unsw.edu.au/NDARCWeb.nsf/resources/Guidelines8/$file/AppendicesO.pdf
5.4 PsyCheck	The PsyCheck manual includes training on how to administer, score, interpret the results of each section, and the subsequent steps to take according to the screening results. If the results of the screening tool indicate a high presence of symptomatology, further assessment may be warranted. **Key references:** 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*, Turning Point Alcohol and Drug Centre Inc, Fitzroy, Vic. Deady, M 2009, *A Review of Screening, Assessment and Outcome Measures for Drug and Alcohol Settings*, Network of Alcohol and Other Drugs Agencies, NSW.	www.psycheck.org.au

Chapter 5 – Dual Diagnosis Assessment – *continued*

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<tr><th></th><th>Description/Scoring</th><th></th></tr>
<tr><td>5.5
Kessler (K-10)</td><td>The Kessler 10 consists of ten questions that are answered using a five-point scale (where 5 = all of the time, and 1 = none of the time). For all questions, the client circles the answer best describing them in the past four weeks. Scores are then summed with the maximum score of 50 indicating severe distress, and the minimum score of ten indicating no distress. Clients can self complete or it can be interviewer-administered for those with poor literacy.

<table>
<tr><th>K10 score</th><th>Level of psychological distress</th></tr>
<tr><td>10–15</td><td>Low</td></tr>
<tr><td>16–21</td><td>Moderate</td></tr>
<tr><td>22–29</td><td>High</td></tr>
<tr><td>30–50</td><td>Very High</td></tr>
</table>

Key references: Kessler, RC, Andrews, G, Colpe, LJ, Hiripi, E, Mroczek, DK, Normand, SLT, Walters, EE & Zaslavsky, A. 2002, Short screening scales to monitor population prevalence and trends in nonspecific psychological distress, Psychological Medicine, vol. 32, no. 6, pp. 959–976.

Deady, M 2009, A Review of Screening, Assessment and Outcome Measures for Drug and Alcohol Settings, Network of Alcohol and Other Drugs Agencies, NSW.</td><td>www.beyondblue.org.au/index.aspx?link_id=89.678

www.sswahs.nsw.gov.au/MHealth/mhoat/kessler10_lm/Module_SR1_v2.pdf

www.sswahs.nsw.gov.au/MHealth/mhoat/kessler10_l3d/Module_SR2_v2.pdf

Available in the ATODS IS</td></tr>
<tr><td>5.6
Depression, Anxiety and Stress Scale 21 (DASS 21)</td><td>The DASS 21 has been shown to be a valid and reliable screening tool to measure depression, anxiety and stress and can be used to measure such states over time (outcomes). Further assessment, clinical interventions and or referrals would be appropriate for clients falling into the moderate – extreme ranges of each domain.

Key references: Lovibond, SH & Lovibond, PF 1995, Manual for the depression anxiety stress scales, 2nd edn, Psychology Foundation of Australia, Sydney, NSW.

Deady, M 2009, A Review of Screening, Assessment and Outcome Measures for Drug and Alcohol Settings, Network of Alcohol and Other Drugs Agencies, NSW.

<table>
<tr><th>DASS21 Interpretation</th><th>Normal</th><th>Mild</th><th>Moderate</th><th>Severe</th><th>Extreme</th></tr>
<tr><td>Depression</td><td>0–9</td><td>10–13</td><td>14–20</td><td>21–27</td><td>28+</td></tr>
<tr><td>Anxiety</td><td>0–7</td><td>8–9</td><td>10–14</td><td>15–19</td><td>20+</td></tr>
<tr><td>Stress</td><td>0–14</td><td>15–18</td><td>19–25</td><td>26–33</td><td>34+</td></tr>
</table>
</td><td>www2.psy.unsw.edu.au/groups/dass/Down_W6/dass21.doc

www2.psy.unsw.edu.au/groups/dass/

Available in the ATODS IS</td></tr>
</table>

Chapter 5 – Dual Diagnosis Assessment – *continued*

	Description/Scoring	
5.7 Primary Care PTSD Screen (PC-PTSD)	The PC-PTSD is a brief screen which has been validated for post traumatic stress disorder in people with alcohol and other drug problems. It is very brief (four items – one concerning each PTSD symptom cluster) and includes an introductory sentence to cue respondents to traumatic events. However, it does not include a list of potentially traumatic events. It can be used by any worker in need of a general screen for PTSD. Current research suggests that the results of the PC-PTSD should be considered 'positive' if a client answers 'yes' to any three items. **Key references:** Prins, A, Kimerling, R, Cameron, R, Oumiette, PC, Shaw, J, Thrailkill, A, Sheikh, J & Gusman, F 1999, The Primary Care PTSD Screen (PC-PTSD). *Paper presented at the 15th annual meeting of the International Society for Traumatic Stress Studies,* Miami, FL. Deady, M 2009, *A Review of Screening, Assessment and Outcome Measures for Drug and Alcohol Settings*, Network of Alcohol and Other Drugs Agencies, NSW.	www.ptsd.va.gov/professional/pages/assessments/pc-ptsd.asp
5.8 Aboriginal and Torres Strait Islander Risk Impact Screen (IRIS)	The IRIS is a statistically validated tool effective in the early identification of alcohol misuse and mental health risks for Aboriginal and Torres Strait Islander peoples. The IRIS is made up of two sets of questions, with items one through seven forming the 'drug and alcohol risk' component and items eight through 13 forming the 'mental health and emotional well-being risk' component. The items assessing mental health and emotional well-being focus on symptoms of anxiety and depression. The client chooses the answer from a list of response options which best describes his/her current situation. The use of this tool requires training in administration and scoring. **Key references:** Schlesinger, CM, Ober, C, Mccarthy, MM, Watson, JD & Seinen, A 2007, 'The development and validation of the Aboriginal and Torres Strait Islander risk impact screen (IRIS): a 13-item screening instrument for alcohol and drug and mental health risk', *Drug and Alcohol Review*, vol. 26, no. 2, pp. 109–117. Deady, M 2009, *A Review of Screening, Assessment and Outcome Measures for Drug and Alcohol Settings*, Network of Alcohol and Other Drugs Agencies, NSW.	www.health.qld.gov.au/atod/prevention/iris.asp
5.9 WHO Quality of Life Scale (WHOQoL-BREF)	The WHOQoL-BREF produces domain scores, but not individual facet scores, unlike the longer, original version. It is a self-report measure consisting of 26 items scored on a five point scale, which add to four separate domain scores. There are also two items that are examined separately: Question one asks about an individual's overall perception of quality of life and question two asks about an individual's overall perception of his or her health. Domain scores are scaled in a positive direction (i.e. higher scores denote higher quality of life). The mean score of items within each domain is used to calculate the domain score. Mean scores are then multiplied by four in order to make domain scores comparable with the scores used in the WHOQOL-100, and subsequently transformed to a 0–100 scale, using the formula above. **Key references:** The World Health Organization 2004, *Quality of Life (WHOQoL)-BREF* World Health Organization, Geneva, Switzerland. Deady, M 2009, *A Review of Screening, Assessment and Outcome Measures for Drug and Alcohol Settings*, Network of Alcohol and Other Drugs Agencies, NSW.	www.who.int/substance_abuse/research_tools/en/english_whoqol.pdf Available in the ATODS IS

Chapter 5 – Dual Diagnosis Assessment – *continued*

	Description/Scoring	
5.10 Alcohol Use Disorders Identification Test (AUDIT)	The AUDIT can be self or clinician administered and scored without specific training. It is scored by adding the scores on each of the ten items (items one to eight are scored on a zero – four scale and items nine and ten are scored zero, two, four). A score of eight or above (for men and perhaps four and above for adolescents and women) is thought to be indicative of alcohol problems. Since the effects of alcohol vary with average body weight and differences in metabolism, establishing the cut off point for all women and men over age 65 one point lower at a score of seven will increase sensitivity for these population groups. It takes between two to five minutes to complete and one minute to score. It has been shown to require a minimum reading level of seventh grade (Hays, Merz, & Nicholas, 1995), which suggests it is suitable for people with low levels of literacy (e.g. those for whom English was a second language). AUDIT Interpretation – Cut Offs: Abstinence – 0 Low Risk – 1–7 Risky Use – 8–12 Dependent – 13+ **Key references:** Dawe, S, Loxton, NJ, Hides, L, Kavanagh, D & Mattick, RP 2002, *Review of diagnostic screening instruments for alcohol and other drug use and other psychiatric disorders*, 2nd edn, Commonwealth Department of Health and Ageing, Canberra. Deady M 2009, *A Review of Screening, Assessment and Outcome Measures for Drug and Alcohol Settings*, Network of Alcohol and Other Drugs Agencies, NSW.	www.nceta.flinders.edu.au/pdf/GP-Project/GP-Resource-Kit_files/B31-Ho5.pdf www.therightmix.gov.au/resources/documents/D718_-_Alcohol_Screen_AUDIT_-_Health_Professionals1.pdf Available in the ATODS IS and Mental Health Services CIMHA (as part of **Consumer Assessment** for Adult and Older Persons and **Drug Assessment Problem List** for **CYMHS**)
5.11 Severity of Dependence Scale (SDS)	The SDS contains five items, takes less than one minute to complete and one minute to score. Each item is scored on a four-point scale, and no specific training is required for use of the scale. A total SDS score can be obtained by adding the scores for all items with higher total scores indicating higher levels of psychological dependence. For amphetamines, a score of four or more indicates dependence; for cannabis, a score of three or more indicates dependence; for benzodiazepines, a score of six or more indicates dependence. **Key references:** Gossop, M, Darke, S, Griffiths, P, Hando, J, Powis, B, Hall, W & Strang, J 1995, 'The severity of dependence Scale (SDS): Psychometric properties of the SDS in English and Australian samples of heroin, cocaine and amphetamine users', *Addiction*, vol. 90, pp. 607–614. Dawe, S, Loxton, NJ, Hides, L, Kavanagh, D, & Mattick, RP 2002, *Review of diagnostic screening instruments for alcohol and other drug use and other psychiatric disorders,* 2nd edn, Commonwealth Department of Health and Ageing, Canberra. Deady M 2009, *A Review of Screening, Assessment and Outcome Measures for Drug and Alcohol Settings*, Network of Alcohol and Other Drugs Agencies, NSW.	www.emcdda.europa.eu/attachements.cfm/att_7364_EN_english_sds.pdf Available on Mental Health Services CIMHA (as part of **Consumer Assessment** for Adult and Older Persons and **Drug Assessment Problem List** for **CYMHS**)

Chapter 5 – Dual Diagnosis Assessment – *continued*

	Description/Scoring	
5.12 DrugCheck Problem List	The DrugCheck Problem List can be used as a screening instrument, or as part of a motivational interview. In people with Schizophrenia or other psychoses, a **score of two or more** indicates high risk of a substance use disorder (detects 97 per cent of people with DSM-IV Abuse or Dependence on the substance, with specificity of 84 per cent; Positive Predictive Value: 91 per cent, Negative Predictive Value: 94 per cent). The first eight items can be used as a short form, with the same cutoff. Sensitivity of detecting cases is slightly reduced (91 per cent), but specificity remains the same.	*Problem list located electronically on the Clinician Tool Kit CD.* Available on Mental Health Services CIMHA (as **Drug Assessment Problem List** for CYMHS, Adult and Older Persons)
5.13 Fagerstrom Test for Nicotine Dependence	The Fagerstrom Test for Nicotine Dependence comprises six items that measure smoking related behaviours. Smoking within 30 minutes of waking, smoking more than 15 cigarettes per day and a prior history of withdrawal symptoms in previous quit attempts indicate nicotine dependence. Smokers that score above the median of five points are considered highly dependent.	Available in the ATODS IS

Normative data on inpatients with psychosis

% scoring this or less	Men (N = 374)	Women (N = 142)
50%	3	1
60%	5	3
70%	7	4
80%	10	6
90%	14	9
Range	0–24	0–15
Average (Standard deviation)	50 (5.7)	2.9 (3.7)

Key references: Kavanagh, DJ, Trembath, M, Shockley, N, Connolly, J, White, A, Alex Isailovic, A, Young, RMcD, Saunders, JB & Byrne, G (in submission 2010). The predictive validity of the DrugCheck Problem List as a screen for substance use disorders: Examination of the measure in people with psychosis. A copy is available from the author, at david.kavanagh@qut.edu.au

Score	Result
0–2	Very low dependence
3–4	Low dependence
5	Medium dependence
6–7	High dependence
8+	Very High dependence

Key references: Heatherton TF, Kozlowski LT, Frecker RC & Fagerstrom KO 1991, 'The Fagerstrom Test for Nicotine Dependence: A revision of the Fagerstrom Tolerance Questionnaire', *British Journal of Addictions*, vol. 86, no. 9, pp. 1119–27.

Chapter 5 – Dual Diagnosis Assessment – *continued*

	Description/Scoring	
5.14 Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES-D)	The SOCRATES-D (Personal drug use questionnaire) is available in pencil-and-paper self-administered format and can be administered in approximately three minutes. No special training is required for the administration of this instrument. The three scales are scored separately. Each scale has items that are summed to derive the scale score: Problem Recognition (seven items), Ambivalence (four items), Taking Steps (eight items).	Available in the ATODS IS
5.15 Recovery Attitudes Questionnaire (RAQ-7)	The RAQ was designed to measure respondent's attitudes about the supposition that people can recover from mental illness. Scoring is done by designating the degree to which items represent opinions on a five point Lickert scale, higher scores indicating a more positive attitude to the idea of recovery.	www.tecathsri.org/pub_pickup/pn/pn-43.pdf

Total Scores	Recognition	Ambivalence	Taking Steps
90 Very High		19–20	39–40
80		18	37–38
70 High	35	17	36
60	34	16	34–35
50 Medium	32–33	15	33
40	31	14	31–32
30 Low	29–30	12–13	30
20	27–28	9–11	26–29
10 Very Low	7–26	4–8	8–25

Key references: Miller, WR & Tonigan, JS 1996, 'Assessing drinkers' motivation for change: The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES)', *Psychology of Addictive Behaviors*, vol. 10, pp. 81–89.

Gossop, M, Stewart, D & Marsden, J 2007, 'Readiness for change and drug use outcomes after treatment', *Addiction*, Vol. 102, no. 2 Feb 2007, pp. 301–308.

Key references: Ruth, OR, Kathryn, K, Dawna P 2000, *'Can we measure recovery? A Compendium of recovery and recovery-related instruments'*, Human Services Research Institute, Cambridge, MA.

Borkin, JR, Steffen, JJ, Ensfield, LB, Krzton, K, et al 2000, 'Recovery Attitudes Questionnaire: Development and Evaluation', *Psychiatric Rehabilitation Journal*, vol. 24, no. 2, pp. 95–102.

chapter 6
risk assessment

dual diagnosis
clinician tool kit

Chapter 6 – Risk Assessment

6.1 Suicide Risk Assessment Guide

To be used as a guide only and not to replace clinical decision-making and practice.

Issue	High Risk	Medium Risk	Low Risk
'At risk' Mental State ▪ Depression ▪ Psychotic ▪ Hopelessness, despair ▪ Guilt, shame, anger, agitation ▪ Impulsivity.	**E.g.** ▪ Severe depression; ▪ Command hallucinations or delusions about dying; ▪ Preoccupied with hopelessness, despair, feelings of worthlessness; ▪ Severe anger, hostility.	**E.g.** ▪ Moderate depression; ▪ Some sadness; ▪ Some symptoms of psychosis; ▪ Some feelings of hopelessness; ▪ Moderate anger, hostility.	**E.g.** ▪ Nil or mild depression, sadness; ▪ No psychotic symptoms; ▪ Feels hopeful about the future; ▪ None/mild anger, hostility.
Suicide attempt or suicidal thoughts ▪ Intentionality ▪ Lethality ▪ Access to means ▪ Previous suicide attempt/s.	**E.g.** ▪ Continual / specific thoughts; ▪ Evidence of clear intention; ▪ An attempt with high lethality (ever).	**E.g.** ▪ Frequent thoughts; ▪ Multiple attempts of low lethality; ▪ Repeated threats.	**E.g.** ▪ Nil or vague thoughts; ▪ No recent attempt or one recent attempt of low lethality and low intentionality.
Substance disorder ▪ Current misuse of alcohol and other drugs.	**E.g.** ▪ Current substance intoxication, abuse or dependence.	**E.g.** ▪ Risk of substance intoxication, abuse or dependence.	▪ Nil or infrequent use of substances.
Corroborative History ▪ Family, carers ▪ Medical records ▪ Other service providers/ sources.	**E.g.** ▪ Unable to access information, unable to verify information, or there is a conflicting account of events to that of those of the person at risk.	**E.g.** ▪ Access to some information: some doubts to plausibility of person's account of events.	**E.g.** ▪ Able to access information / verify information and account of events of person at risk (logic, plausibility).
Strengths and Supports (coping and connectedness) ▪ Expressed communication ▪ Availability of supports ▪ Willingness / capacity of support person/s ▪ Safety of person and others.	**E.g.** ▪ Patient is refusing help; ▪ Lack of supportive relationships / hostile relationships; ▪ Not available or unwilling / unable to help.	**E.g.** ▪ Patient is ambivalent; ▪ Moderate connectedness; ▪ Few relationships; ▪ Available but unwilling / unable to help consistently.	**E.g.** ▪ Patient is accepting of help; ▪ Therapeutic alliance forming; ▪ Highly connected / good relationships and supports; ▪ Willing and able to help consistently.
Reflective Practice ▪ Level and quality of engagement ▪ Changeability of risk level ▪ Assessment confidence in risk level.	▪ Low assessment confidence or high changeability or no rapport, poor engagement.		▪ High assessment confidence / low changeability; ▪ Good rapport, engagement.

No (foreseeable) risk:
Following comprehensive suicide risk assessment there is no evidence of current risk to the person; no thought of suicide or history of attempts; and has a good social support network.

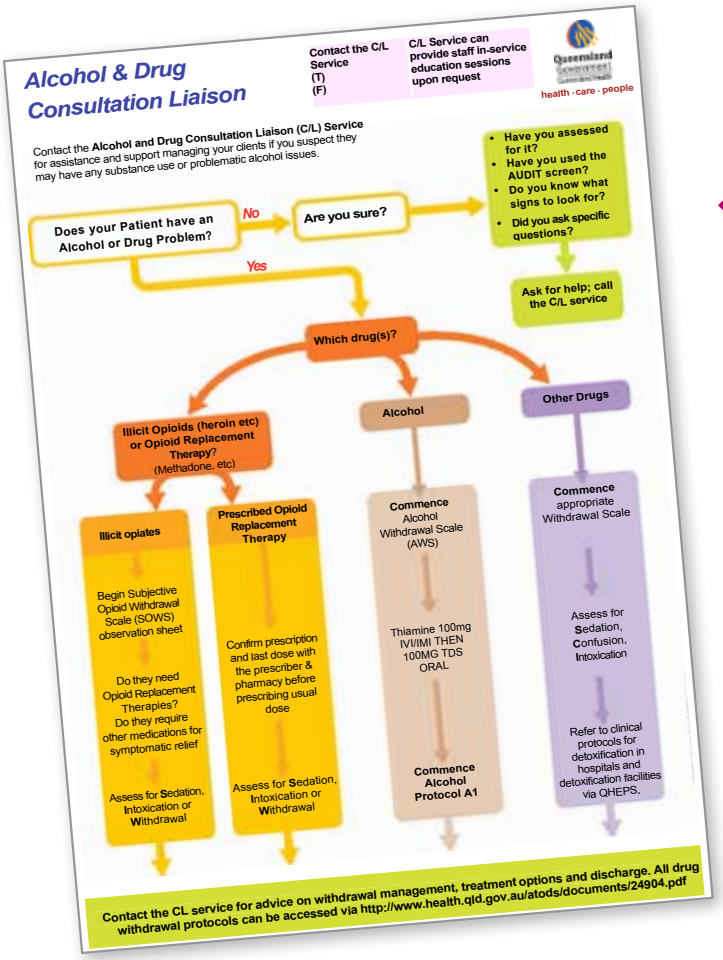
Is this person's risk level changeable? **Highly Changeable** **Yes** ☐ **No** ☐

Are there factors that indicate a level of uncertainty in this risk assessment?
E.g. poor engagement, gaps in/on conflicting information. Low Assessment Confidence **Yes** ☐ **No** ☐

chapter 7
medical interventions

Chapter 7 – Medical Interventions

7.1 Hospital Alcohol and Drug Service flowchart (HADS)



Click here to view the resource

chapter 8
motivational enhancement approaches

Chapter 8 – Motivational enhancement approaches

8.1 Personal history of substance use instructions and template

Approach this assessment using a motivation enhancement style (listening with empathy, without confrontation or judgement).

This assessment has multiple uses:

- Resulting information can be used in assessment reports.
- In a later motivational interview, see if the previous upsides and downsides of beginning or increasing substance use still apply. Similarly, see if the pros and cons of stopping or cutting down may be relevant now.
- Previous attempts to control substance use can be used to build self-efficacy—e.g. drawing attention to successful aspects, and eliciting strategies that can be reapplied in a new attempt.
- Previous triggers may provide hints of risky situations for return to substance use in the future—apply problem solving to address any that are may be problematic.

ID: _____

1. **When did you first start using *(drug name)*?** .....

   What triggered that? .....

   Did ***(drug name)*** change anything in your life back then?

   Upside: .....

   Downside: .....

2. **Have there been times you used *(drug name)* more than usual? When were they?**

   From .....to .....

   From .....to .....

   What triggered you doing that? .....

   When you used it more, did that change anything in your life?

   Upside: .....

   Downside: .....

3. **Have there been times you stopped using *(drug name)*, or used it less? When were they?**

   From .....to .....

   From .....to .....

   What triggered you doing that? .....

   When you stopped or cut down, did that change anything in your life?

   Upside: .....

   Downside: .....

   What triggered you going back to ***(drug name)***? .....

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Chapter 8 – Motivational enhancement approaches

8.2 Good and not so good things of substance use

WHAT I AM DOING NOW...

This sheet will help you work out whether you want to make a change to what you are doing—or if you are happy with the way things are.

What I am doing now: _____ *(e.g. smoking, drinking/ using drugs)*

Good things about that

- _____
- _____
- _____
- _____
- _____

Not so good things about that

- _____
- _____
- _____
- _____
- _____

Do any of these things worry or concern you. Why?

Circle the one that worries you most.

IF I MADE A CHANGE...

What I could decide to do: _____ *(e.g. stop using, cut down, use it more safely)*

Downsides to changing

- _____
- _____
- _____
- _____
- _____

Check your list of good things. Are there other things you'd miss?

Read your list. *Do those things always happen?*
Are there other ways to get them?
Put brackets around things you can get in other ways.

Upsides to changing

- _____
- _____
- _____
- _____
- _____

What is the best about making the change? Circle that one.

READ OVER THIS PAGE. HOW DO YOU FEEL ABOUT THIS?

Click here to view the resource

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Chapter 8 – Motivational enhancement approaches

8.3 Timeline FollowBack 2

Date:	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
What happened							
What and how much							
Date:	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
What happened							
What and how much							
Date:	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**	**Sunday**
What happened							
What and how much							

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Chapter 8 – Motivational enhancement approaches

8.4 Integrated Motivational Assessment Tool

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

Key References:

Katherine, LM, Mark, D, Heather, P, Claudia, S, Maree, T, Richard, M & Lucy, B 2009, *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*, National Drug and Alcohol Research Centre, University of New South Wales, Sydney.

Clancy, R & Terry, M, 2007, *Psychiatry & Substance Use*. NSW Health, Sydney.

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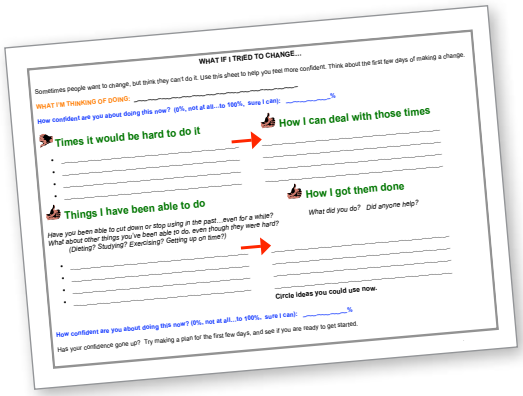
chapter 9
psychosocial treatments

Chapter 9 – Psychosocial treatments

9.1 Start Over and Survive (SOS) worksheets

Key reference: Kavanagh, DJ, Young, RM, White, A, Jenner, L & Clair, A 2000, 'Start over and survive (SOS): A brief intervention for substance abuse in psychosis', *13th International Symposium for the Psychological Treatment of Schizophrenia and other psychoses*, vol. 102, pp. 71, Munksgaard.

Click on the links below to view the resources within section 9.1:



9.1.1 Building confidence to say no to drugs

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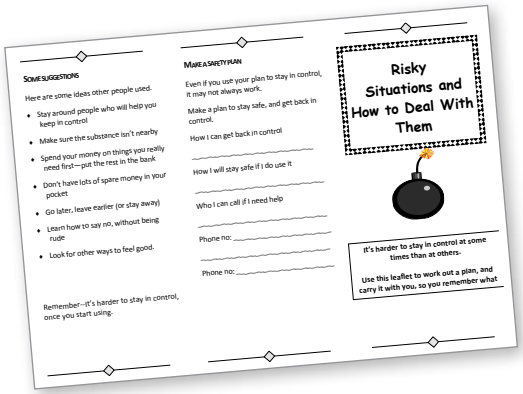

9.1.2 Risky situations brochure

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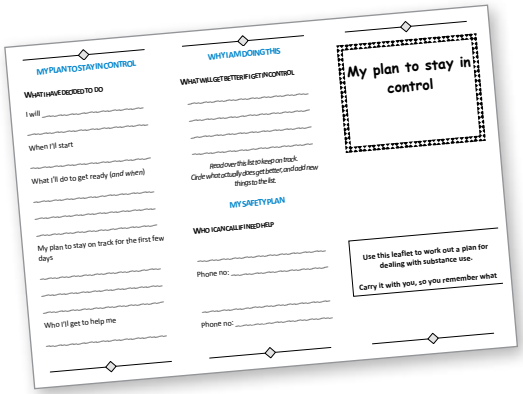

9.1.3 My plan to stay in control

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Chapter 9 – Psychosocial treatments

9.2 Self-monitoring card

This card will help you see how much you're using.

Carry it in your wallet or purse.

Put a cross in the box, when you have one.

In case you lose the card, don't write what you are tracking.

Date starting:.....

15+ *write no:*							
14							
13							
12							
11							
10							
9							
8							
7							
6							
5							
4							
3							
2							
1							
DAY:							

Date starting:.....

15+ *write no:*	**14**	**13**	**12**	**11**	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**	**DAY:**

Date starting:.....

15+ *write no:*	**14**	**13**	**12**	**11**	**10**	**9**	**8**	**7**	**6**	**5**	**4**	**3**	**2**	**1**	**DAY:**

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Chapter 9 – Psychosocial treatments

9.3 Pleasant events schedule

Being in the country	Going to lectures or talks	Listening to the sounds of nature
Washing your hair	Talking about sports	Having friends come to visit
Dating or courting	Meeting someone new	Going out to visit friends
Woodwork or carpentry	Giving presents	Playing football or cricket
Going to a barber or beautician	Having coffee or tea with friends	Using cologne or perfume
Gardening or landscaping	Creating or arranging songs	Listening to music
Talking about philosophy or religion	Going to the beach	Having lunch with friends or associates
Running or jogging	Playing tennis	Walking barefoot
Bushwalking	Preparing a new or special dish	Playing cards or board games
Swimming	Just sitting and thinking	Playing frisbee or catch
Taking a long, hot bath	Watching people	Being in the city
Fishing	Writing letters, cards or notes	Singing
Tai Chi or yoga or meditation	Going to the library or art gallery	Sitting or lying in the sun
Beachcombing	Cooking meals	Being with someone you love
Reading novels, magazines and newspapers	Exploring (e.g. hiking away from known routes)	Doing housework or laundry or cleaning things
Looking at the stars or the moon	Acting	Wearing informal clothes (dressing down)
Dancing	Bicycling	Going to a party

Adapted with permission from Mental Health Advice Book (Appendix G), Department of Veterans Affairs (Adapted from MacPhillamy and Lewinsohn 1971). (http://at-ease.dva.gov.au/www/html/383-appendix-g-pleasant-events-schedule.asp?intSiteID=1).

chapter 10
tailoring the response

QUEENSLAND HEALTH

REFERRAL GUIDE FOR CULTURALLY APPROPRIATE ASSESSMENT AND TREATMENT

The following resource is a guide for referral processes for consumers from culturally and linguistically diverse (CALD) backgrounds to ensure access to culturally appropriate assessment and treatment as recommended by the *Achieving Balance: Report of the Queensland Review of Fatal Mental Health Sentinel Events (2005). T*his Referral Guide expands on the information on pp 8, 15 and 16 of the *User Guide for the State-wide Standardised Suite of Clinical Documentation for Queensland Health Mental Health Adult Services* and is in line with the *Non English Speaking Background Mental Health Policy Statement* (1996) and the *Framework for the Implementation of the National Mental Health Plan in Multicultural Australia 2003–2008.*

Clinician Check list for working with CALD Consumers	Options	Resources and Contacts
When working with a CALD consumer with a diagnosis of **schizophrenia** check the following: ⓘ If language barrier present, has interpreter been used? ⓘ Have cultural issues been identified as a barrier to assessment and/or treatment? ⓘ Will a socio-cultural assessment enhance the current assessment and/or treatment plan? ⓘ Are there other cultural issues? E.g. Is psycho-education required for the consumer or family/carers? If any of the above issues are identified follow the options outlined in the next column	☑ Organise interpreter through ISIS or district interpreter coordinator ☑ Utilise clinical review to determine what cultural issues have been identified as a barrier in the assessment and/or treatment and decide whether a socio-cultural assessment is required ☑ Consult Multicultural Mental Health Coordinator (MMHC), if present in service, for information and assistance about resources and support available locally. If no MMHC in district, seek assistance from the Transcultural Clinical Consultation Service	District Interpreter Coordinator *Insert local contact* District Multicultural Mental Health Coordinator *Insert local contact*
When working with a CALD consumer with **complex** needs <u>check all of the above</u> plus the following: ⓘ Is the consumer from a refugee background? ⓘ Are there complex family issues? ⓘ Are multiple service agencies involved? ⓘ Is the consumer being assessed and/or treated under the Mental Health Act? ⓘ Are there forensic and/or dual diagnosis issues? If any of the above issues are identified follow the options outlined in the next column	☑ Refer to Transcultural Clinical Consultation Service for socio-cultural assessment	Transcultural Clinical Consultation Service: Ph 3167 8333 or 1800 188 189 (outside Brisbane metropolitan) and speak with intake officer or via email tccs@health.qld.gov.au

What if a CALD consumer refuses referral to the Transcultural Clinical Consultation Service?

- ☑ Document consumer's refusal to be referred for socio-cultural assessment.
- ☑ You can request cultural input and advice from a clinical specialist and/or bilingual mental health consultant via the Transcultural Clinical Consultation Service to consult directly regarding any cultural issues of concern.

QUEENLSAND HEALTH

REFERRAL GUIDE FOR CULTURALLY APPROPRIATE ASSESSMENT AND TREATMENT

The following resource is a guide for referral processes for consumers from culturally and linguistically diverse (CALD) backgrounds to ensure access to culturally appropriate assessment and treatment as recommended by the *Achieving Balance: Report of the Queensland Review of Fatal Mental Health Sentinel Events (2005).*This Referral Guide expands on the information on pp 8, 17 and 18 of the *User Guide for the State-wide Standardised Suite of Clinical Documentation for Queensland Health Child and Youth Mental Health Services* and is in line with the *Non English Speaking Background Mental Health Policy Statement* (1996) and the *Framework for the Implementation of the National Mental Health Plan in Multicultural Australia 2003–2008.*

Clinician Check list for working with CALD Consumers	Options	Resources and Contacts
When working with a CALD consumer with a diagnosis of **schizophrenia** check the following: ⓘ If language barrier present, has interpreter been used? ⓘ Have cultural issues been identified as a barrier to assessment and/or treatment? ⓘ Will a socio-cultural assessment enhance the current assessment and/or treatment plan? ⓘ Are there other cultural issues? E.g. Is psycho-education required for the consumer or family/carers? If any of the above issues are identified follow the options outlined in the next column	☑ Organise interpreter through ISIS or district interpreter coordinator ☑ Utilise clinical review to determine what cultural issues have been identified as a barrier in the assessment and/or treatment and decide whether a socio-cultural assessment is required ☑ Consult Multicultural Mental Health Coordinator (MMHC), if present in service, for information and assistance about resources and support available locally. If no MMHC in district, seek assistance from the Transcultural Clinical Consultation Service	District Interpreter Coordinator *Insert local contact* District Multicultural Mental Health Coordinator *Insert local contact*
When working with a CALD consumer with **complex** needs <u>check all of the above</u> plus the following: ⓘ Is the consumer from a refugee background? ⓘ Are there complex family issues? ⓘ Are multiple service agencies involved? ⓘ Is the consumer being assessed and/or treated under the Mental Health Act? ⓘ Are there forensic and/or dual diagnosis issues? If any of the above issues are identified follow the options outlined in the next column	☑ Refer to Transcultural Clinical Consultation Service for socio-cultural assessment	Transcultural Clinical Consultation Service: Ph 3167 8333 or 1800 188 189 (outside Brisbane metropolitan) and speak with intake officer or via email tccs@health.qld.gov.au

What if a CALD consumer refuses referral to the Transcultural Clinical Consultation Service?

- ☑ Document consumer's refusal to be referred for socio-cultural assessment.
- ☑ You can request cultural input and advice from a clinical specialist and/or bilingual mental health consultant via the Transcultural Clinical Consultation Service to consult directly regarding any cultural issues of concern.