THIRD EDITION

GUIDELINES ON THE MANAGEMENT OF

co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings

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Australian Government
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Abbreviations

ACT	Acceptance and Commitment Therapy
ADHD	Attention-Deficit/Hyperactivity Disorder
AOD	Alcohol and Other Drugs
ASPD	Antisocial Personality Disorder
ASRS	Adult ADHD Self-Report Scale
ASSIST	Alcohol, Smoking and Substance Involvement Screening Test
AUDIT	Alcohol Use Disorders Identification Test
BDI	Beck Depression Inventory
BMI	Body Mass Index
BPD	Borderline Personality Disorder
CAN	Camberwell Assessment of Need
CANSAS	Camberwell Assessment of Need Short Appraisal Schedule
CBT	Cognitive Behaviour Therapy
CBT-E	CBT-Enhanced
CIDI	Composite International Diagnostic Interview
CPT	Cognitive Processing Therapy
CPTSD	Complex PTSD
CVD	Cardiovascular Disease
DASS	Depression Anxiety Stress Scale
DAST-10	Drug Abuse Screening Test-10
DBT	Dialectical Behavioural Therapy
DBT-S	Modified DBT
DDP	Dynamic Deconstructive Psychotherapy
DFST	Dual Focus Schema Therapy
DSM	Diagnostic and Statistical Manual of Mental Disorders
DUDIT	Drug Use Disorders Identification Test
ECT	Electroconvulsive Therapy
ED	Eating Disorders
EDE	Eating Disorder Examination
EDE-Q	Eating Disorder Examination-Questionnaire
EMDR	Eye Movement Desensitisation and Reprocessing
ERP	Exposure Response Therapy
FBT	Family-Based Treatment
GAD	Generalised Anxiety Disorder
GHQ	General Health Questionnaire
GP	General Practitioner
ICAT	Integrative Cognitive-Affective Therapy
ICBT	Integrated CBT
ICD	International Classification of Diseases
IGT	Integrated Group Therapy
IPDS	Iowa Personality Disorder Screen
IPT	Interpersonal Psychotherapy
IRIS	Indigenous Risk Impact Screen
ITQ	International Trauma Questionnaire
K10	Kessler Psychological Distress Scale
LAI	Long Acting Injectable

LEC-5	Life Events Checklist for DSM-5
MANTRA	Maudsley Model of Anorexia Nervosa Treatment for Adults
MAOI	Monoamine Oxidase Inhibitors
MAST	Michigan Alcohol Screening Test
MBT	Mentalisation Based Treatment
MHCC	Mental Health Coordinating Council
MI	Motivational Interviewing
MoCA	Montreal Cognitive Assessment
NaSSA	Noradrenaline and Specific Serotonergic Agent
NDIS	National Disability Insurance Scheme
NHMRC	National Health and Medical Research Council
NICE	National Institute for Health and Care Excellence
NMDA	N-methyl-D-aspartate
NRI	Noradrenaline Reuptake Inhibitor
NRT	Nicotine Replacement Therapy
NSMHWB	National Survey of Mental Health and Wellbeing
OCD	Obsessive-Compulsive Disorder
PCL-5	PTSD Check List for DSM-5
PC-PTSD-5	Primary Care PTSD for DSM-5
PE	Prolonged Exposure
PHQ	Patient Health Questionnaire
PS	Psychosis Screener
PTSD	Post Traumatic Stress Disorder
RANZCP	Royal Australian and New Zealand College of Psychiatrists
RCT	Randomised Controlled Trial
RIMA	Reversible Inhibitor of Monoamine oxidase A
RRFT	Risk Reduction through Family Therapy
rTMS	Repetitive Transcranial Magnetic Stimulation
SAD	Social Anxiety Disorder
SAK	Suicide Assessment Kit
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPAS-SR	Standardised Assessment of Personality – Abbreviated Scale
SCL-90-R	Symptom Checklist-90-Revised
SNRI	Serotonin and Noradrenaline Reuptake Inhibitor
SRQ	Self-Reporting Questionnaire
SSCM	Specialist Supportive Clinical Management
SSRI	Selective Serotonin Reuptake Inhibitors
TCA	Tricyclic Antidepressants
TGA	Therapeutic Goods Administration
TLFB	Timeline Follow Back

Glossary

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

Alcohol and/or other drug (AOD) use disorders	The presence of an AOD use disorder as defined by the DSM-5. This term is used interchangeably with 'substance use disorders' and includes the use of alcohol; benzodiazepines; cannabis; methamphetamines, cocaine, and other stimulants; hallucinogens; heroin and other opioids; inhalants; and tobacco.
AOD workers	All those who work in AOD treatment settings in a clinical capacity. This includes, but is not limited to, nurses, medical practitioners, psychiatrists, psychologists, counsellors, social workers, and other AOD workers.
AOD treatment settings	Specialised services that are specifically designed for the treatment of AOD problems and include, but are not limited to, facilities providing inpatient or outpatient detoxification, residential rehabilitation, substitution therapies (e.g., methadone or buprenorphine for opiate dependence), and outpatient counselling services. These services may be in the government or non-government sector.
Co-occurring conditions	Use of the term 'co-occurring conditions' in these Guidelines refers to the co-occurrence of one or more AOD use conditions with one or more mental health conditions.
Mental disorders	Refers to the presence of a mental disorder (other than AOD use disorders) as defined by the DSM-5.
Mental health conditions	Refers to those with a diagnosable mental disorder as well as those who display symptoms of disorders while not meeting criteria for a diagnosis of a disorder.

In a nutshell...

These Guidelines aim to provide alcohol and other drug (AOD) workers with evidence-based information to assist with the management of co-occurring AOD and mental health conditions. They represent an update and revision of the second edition of these Guidelines, published in 2016.

Population estimates indicate that more than one-third of people with an AOD use disorder have at least one co-occurring mental disorder; however, the rate is even higher among those in AOD treatment programs. Additionally, there are a large number of people who present to AOD treatment who display *symptoms* of disorders while not meeting criteria for a *diagnosis* of a disorder.

The high prevalence of co-occurring AOD and mental health conditions means that AOD workers are frequently faced with the need to manage complex psychiatric symptoms whilst treating clients' AOD use. Furthermore, clients with co-occurring mental health conditions often have extensive trauma histories, and a variety of other medical, family, and social problems (e.g., housing, employment, welfare and legal problems). As such, it is important that AOD workers adopt a holistic and trauma-informed approach to the management and treatment of co-occurring conditions that is based on treating the person, not the illness (see **Chapter B1** and **Chapter B2**).

The first step in responding to co-occurring AOD and mental health conditions is being able to identify the person's needs (see **Chapter B3** and **Chapter B4**). Despite high rates of co-occurring mental disorders among clients of AOD services, it is not unusual for these co-occurring conditions to go unnoticed, mostly because AOD workers are not routinely looking for them. It is a recommendation of these Guidelines that all clients of AOD treatment services be screened and assessed for co-occurring mental disorders as part of routine clinical care.

Once identified, symptoms of mental health conditions may be effectively managed while the person is undergoing AOD treatment (see **Chapter B6** and **Chapter B7**). The goal of management is to allow AOD treatment to continue without mental health symptoms disrupting the treatment process, and to retain clients in treatment who might otherwise discontinue such treatment. *Co-occurring conditions are not an insurmountable barrier to treating people with AOD use disorders.* Indeed, research has shown that clients with co-occurring mental health conditions can benefit just as much as those without co-occurring conditions from usual AOD treatment.

Some clients with co-occurring conditions may require additional treatment for their mental health problems (see **Chapter B7**). The evidence base regarding interventions designed for the treatment of specific co-occurring conditions is growing, but still in its infancy. Where there is an absence of specific research on co-occurring AOD and mental disorders, it is recommended that best practice is to use the most effective treatments for single disorders. Both psychosocial and pharmacological interventions have been found to have some benefit in the treatment of many co-occurring disorders. Consideration should also be given to the use of e-health interventions, physical activity, and complementary and alternative therapies, as an adjunct to traditional treatments.

In addition to mental health services, AOD workers may need to engage with a range of other services to meet clients' needs, including housing, employment, education, training, community, justice, and other support services. A broad, multifaceted, and coordinated approach is needed in order to address all of these issues effectively, and it is important that AOD services and workers develop links with a range of local services (see **Chapter B5**). Worker self-care and the provision of training and support for AOD workers are also essential to the provision of effective care for co-occurring conditions (**Chapter B8**).

About these guidelines

Key points

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

Rationale

In 2007, the Australian Government Department of Health and Ageing funded the development of the first edition of the 'Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings' (the Guidelines) [1]. The development of these Guidelines was funded as part of the National Comorbidity Initiative in order to improve the capacity of AOD workers to respond to co-occurring mental health conditions. Building on the success of the first edition [2], the Australian Government Department of Health funded the update and revision of these Guidelines to bring them up to date with the most current evidence, and these were published in 2016 [3]. Funding for the development of an accompanying online training program was also provided and was launched in 2017. Since their publication in 2016, more than 23,500 hard and electronic copies of the second edition have been distributed across Australia, and the Guidelines are also being used as a recommended text in vocational and educational training courses across Australia. At the time of writing, more than 7,400 people were registered users of the online training program and more than 1,700 people had completed the full program.

The impact of the Guidelines is demonstrated not only by their popularity, but by their perceived utility. Evaluations of both the first and second edition of the Guidelines and its accompanying online training program found them to be relevant and useful to clinical practice, enabling AOD workers to respond to co-occurring AOD and mental health conditions with greater confidence [2, 4]. More specifically, in an evaluation of the online training program, the vast majority of participants (>94%) reported that

the program had increased their knowledge, confidence, and capacity to address comorbidity in their practice. Moreover, 89% reported using what they had learnt in their clinical practice, and 58% reported improved client outcomes [4].

While the Guidelines have proved to be an extremely successful clinical resource, the scientific evidence regarding the management and treatment of co-occurring disorders has grown considerably since the second edition was published. As such, the Australian Government Department of Health and Aged Care funded researchers at the Matilda Centre for Research in Mental Health and Substance Use at the University of Sydney, to update and revise the Guidelines to bring them up to date with the most current evidence. The purpose of this chapter is to describe the aims, scope, and development of the revised Guidelines.

Guideline aims

These Guidelines aim to provide AOD workers with up-to-date, evidence-based information on the management of co-occurring mental health conditions in AOD treatment settings. They are based on the best available evidence and draw upon the experience and knowledge of clinicians, researchers, consumers, and carers. The intended outcome of the Guidelines is increased knowledge and awareness of co-occurring mental health conditions in AOD treatment settings, improved confidence and skills of AOD workers, and increased uptake of evidence-based care. By increasing the capacity of AOD workers to respond to co-occurring mental health conditions, it is anticipated that the outcomes for people with co-occurring mental health conditions will be improved.

These Guidelines are not a policy directive and are not intended to replace or take precedence over local policies and procedures. The Guidelines are not formal recommendations, but instead provide guidance for AOD workers when working with clients who have co-occurring mental health conditions. The Guidelines are not a substitute for training; rather, they should be used in conjunction with appropriate co-occurring AOD and mental health training and supervision. Workers should use their experience and expertise in applying recommendations into routine clinical practice.

Intended audience

The Guidelines have been designed primarily for AOD workers. When referring to AOD workers, we are referring to all those who work in AOD treatment settings in a clinical capacity. This includes nurses, medical practitioners, psychiatrists, psychologists, counsellors, social workers, and other AOD workers.

AOD treatment settings are those specialised services that are specifically designed for the treatment of AOD problems and include, but are not limited to, facilities providing inpatient or outpatient detoxification, residential rehabilitation, substitution therapies (e.g., methadone or buprenorphine for opiate dependence), and outpatient counselling services. These services may be in the government or non-government sector.

Although these Guidelines focus on AOD workers, a range of other health professionals may find them useful. However, it should be noted that different patterns of co-occurring conditions are seen across different health services [5]. For example, AOD treatment services are most likely to see co-occurring

depressive, anxiety, and personality disorders; mental health services, on the other hand, are more likely to see people experiencing schizophrenia and bipolar disorder co-occurring with AOD use disorders [6].

These Guidelines have been developed with the assumption that the management and treatment of co-occurring AOD and mental health conditions will be provided by trained practitioners. AOD workers differ in their job descriptions, education, training, and experience. This may range from people who are highly qualified with little experience to those with fewer qualifications but much experience [7]. The amount of time that AOD workers spend with clients also varies widely depending on the type of service provided, and the presentation of the client. For example, AOD workers may have very brief contact with clients who present in medical or psychiatric crisis (who may then be referred to other services); they may work with them for one week if they are entering detoxification, or they may work with them for several months or years if they present for substitution therapy, residential rehabilitation, or outpatient counselling.

Given the differences in AOD workers' roles, education, training, and experience, it is not expected that all AOD workers will be able to address co-occurring conditions to the same extent. Each AOD worker should use these Guidelines within the context of their role and scope of practice. At a minimum, however, it is suggested that all AOD workers should be 'comorbidity informed'. That is, all AOD workers should be knowledgeable about the symptoms of the common mental health conditions that clients present with (see **Chapter A4**) and how to manage these symptoms (see **Chapter B7**). The provision of opportunities for continuing professional development for AOD staff in the area of co-occurring mental health conditions should be a high priority for AOD services.

Relationship with existing guidelines

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

All AOD workers should refer to the standards and competencies relevant to their own professions; for example, those specified by the Australian Psychological Society, the Royal Australian and New Zealand College of Psychiatrists, the Australian Medical Association, the Nursing Board, the Australian Association of Social Workers, the Australian Counselling Association, and Volunteering Australia. In addition, the National Practice Standards for the Mental Health Workforce [8] provide practice standards for services and professionals who work with people who have mental health conditions.

Development

The current Guidelines represent an update, revision, and expansion to the second edition of the Guidelines [3]. Like the first and second editions, these Guidelines are based on the best available research evidence, developed in consultation with an expert panel of academic researchers, clinicians, people with lived experience, family members and carers (see p.ii and iii). In addition to reviewing,

synthesising, and updating the evidence to date with guidance from our expert panel, feedback on the second edition of the Guidelines was obtained from key-stakeholders (including people with lived experience of AOD and mental health conditions, clinicians, academics, family and carers) via two national discussion forums open to interested key stakeholders (conducted online due to COVID-19 restrictions which allowed for a larger number of participants to attend from across Australia), an online survey seeking feedback on the second edition, and written submissions from any person wishing to provide feedback.

Both clinical and scientific knowledge about what treatment modalities may help people experiencing co-occurring AOD and mental health conditions has been included, and as such, a variety of psychotherapies and pharmacotherapies are discussed. We have also included discussion of physical activity, some complementary and alternative therapies, as well as e-health and telehealth interventions. The clinical evidence for the efficacy of these interventions varies greatly, and it is critical to note that although there may be limited scientific evidence to recommend a treatment as best practice, that does not necessarily mean that the treatment is ineffective. That is, the quality of some studies evaluating some interventions is not as rigorous as others and does not provide adequate support or evidence for clinical guidance.

Holistic health care

Given the multitude of problems with which clients present to treatment, the goal of any service should be to improve clients' quality of life across all domains, including health, social welfare and housing, employment, criminal justice and, of course, AOD and mental health. As such, these Guidelines adopt a holistic health care approach to the management and treatment of co-occurring AOD and mental health conditions, which is based on the adage 'Treat the person, not the illness' [9]. It is essential to consider the whole person, taking into account psychological, physical, and sociodemographic perspectives when consulting with clients with co-occurring mental health conditions (Figure 1).

Figure 1: Holistic health care framework: Physical and mental health

Comparison with 2016 Guidelines

Structure

The structure of the third edition of the Guidelines is similar to the second edition, and is formatted in four parts:

- **Part A** addresses the nature and extent of co-occurring AOD and mental health conditions and discusses why it is important for AOD services to respond. Information regarding the prevalence, guiding principles, and classification of disorders is contained in Part A.
- **Part B** contains information on how to respond to co-occurring conditions, including the provision of holistic and trauma-informed care, identifying co-occurring conditions, assessing risk, coordinating care, approaches to managing and treating specific co-occurring conditions, and worker self-care.
- **Part C** addresses specific population groups.
- **Appendices** contain a range of useful resources, techniques, and worksheets.

Changes in diagnostic criteria

The diagnostic criteria for mental health disorders are defined in internationally accepted diagnostic manuals. Research settings most commonly use the Diagnostic and Statistical Manual of Mental Disorders (DSM), published by the American Psychiatric Association [10]. Although the fifth version of this manual (DSM-5) has been in use since 2013, some studies included in the literature reviews have still relied on DSM-IV-TR criteria for mental disorders. As such, we refer to both DSM-IV-TR and DSM-5 criteria where appropriate. The other major classification system is the International Classification of Diseases (ICD [11]). ICD-11 is due to come into effect from 1 January 2022. Although widely used in clinical practice in many parts of the world, ICD is a general medical classification system and is rarely used in the type of research studies included for review. Nevertheless, ICD is also referred to in these Guidelines and key differences between the DSM-5 and ICD-11 classification systems are noted.

Language

Both AOD and mental health conditions are stigmatised conditions, and it is vital that any communication regarding clients experiencing possible mental disorders – whether that communication involves the client, loved ones or other healthcare providers – remains respectful, non-judgemental, compassionate and client-centred. The language used throughout this document reflects that used in the diagnostic classification systems to provide workers with the functional knowledge to identify conditions and facilitate communication with other areas of health (e.g., mental health services). We acknowledge that, while some people experience formal acknowledgement of their mental health symptoms through diagnostic labelling as a way of legitimising and explaining their ongoing distress, this is not the case for everyone; others may perceive diagnostic labelling as stigmatising, and feel a sense of powerlessness [12]. The language AOD workers use to describe symptoms and disorders should

be based on the needs of the client, but as detailed in **Chapter B3**, formal diagnoses can only be given by a health professional who is qualified and trained to do so (e.g., a registered psychologist or psychiatrist).

We also acknowledge that over time, preferences regarding the terms used to refer to the co-occurrence of AOD and mental health conditions have evolved. While these Guidelines continue to be referred to as the 'Comorbidity Guidelines', the term 'comorbidity' as a reference to co-occurring AOD and mental health conditions, has not been used in the third edition. Rather, based on consultations with experts and key stakeholders, the terms 'co-occurring conditions' or 'co-occurring AOD and mental health conditions' have been used throughout this document. There has been a similar evolution in terms of language used to describe different population groups. While we have used particular language throughout this document, we acknowledge there is no all-inclusive term and not everyone will identify with the language used in these Guidelines. Our intention in utilising particular terminology is to describe the evidence regarding co-occurring conditions.

Case studies

A series of case studies have been included to highlight some of the presenting issues that are experienced by AOD clients with co-occurring mental health conditions and demonstrate some examples of pathways through treatment.

Limitations of the Guidelines

As noted above, these Guidelines are not intended to be used prescriptively; rather AOD workers should use their experience and expertise in applying the Guidelines within the context of their role.

These Guidelines are based on the evidence currently available. As new and emerging treatments will likely contribute to a strong evidence base which should be included in future revisions, it is recommended that the Guidelines be updated every five years.

Part A: About co-occurring conditions

Part A: About co-occurring conditions

Part A of the Guidelines aims to provide workers with background information about co-occurring AOD and mental health conditions. In this document, we use the term 'mental disorder' when referring to people with a diagnosable mental disorder as defined by the DSM, as well as 'mental health condition', when referring to both those who have a diagnosable disorder *as well* as those who display *symptoms* of disorders while not meeting criteria for a *diagnosis* of a disorder. Although there may be several reasons why two or more disorders may co-occur, it is most likely that the relationship between co-occurring conditions is one of mutual influence (see **Chapter A1**).

Mental disorders are common among clients of AOD services, in particular, anxiety, depression, PTSD, and personality disorders (see **Chapter A2**). In addition, there are many people who present to AOD treatment who display *symptoms* of disorders while not meeting criteria for a *diagnosis* of a disorder. While people who experience co-occurring conditions may have more complex profiles, they have been found to benefit as much from traditional AOD treatment methods as those without co-occurring mental health conditions.

When working with clients with co-occurring mental health conditions, it is recommended that AOD services and AOD workers consider the guiding principles described in **Chapter A3**. Although not all AOD workers are able to formally diagnose the presence or absence of mental disorders, it is important for all AOD workers to be aware of the characteristics of disorders so that they are able to describe and elicit information about mental health symptoms when undertaking screening and assessment, and to inform treatment planning (see **Chapter A4**).

A1: What are co-occurring conditions?

A1: What are co-occurring conditions?

Key points

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

In these Guidelines, 'co-occurring conditions' refers to the co-occurrence of one or more AOD use disorders with one or more mental health conditions. This phenomenon is often referred to as 'dual diagnosis'; however, this term is often misleading, as many clients present with a range of co-occurring conditions of varying severity [13]. It should be noted that there are other types of co-occurring conditions. For example, a person may have co-occurring AOD use disorders (i.e., more than one AOD use disorder). Indeed, one of the most common and often overlooked co-occurring conditions in AOD clients is tobacco use (discussed in **Chapter B1**; [14–17]). Other conditions that are often found to co-occur with AOD use disorders are physical health conditions (e.g., cirrhosis, hepatitis, heart disease, diabetes), intellectual and learning disabilities, cognitive impairment, and chronic pain [18–24]. This combination of substance use, mental and physical health conditions is often referred to as 'multimorbidity' [25]. While there are a number of different types and possible combinations of co-occurring conditions, these Guidelines focus on the co-occurrence of AOD use disorders and mental health conditions.

To be classified as having a mental disorder, a person must meet a number of diagnostic criteria (see **Chapter A4** for a discussion of the classification of mental disorders). There are, however, a large number of people who present to AOD treatment who display *symptoms* of disorders while not meeting criteria for a *diagnosis* of a disorder. For example, a person may exhibit depressed mood or anxiety without having a diagnosable depressive or anxiety disorder. Although these people may not meet full diagnostic criteria according to the classification systems, their symptoms may nonetheless impact significantly on their functioning and treatment outcomes [26, 27]. For example, people who report symptoms of depression but do not meet diagnostic criteria may have reduced productivity, increased help-seeking, and an increased risk of attempted suicide [28]. Therefore, rather than viewing mental health as merely the

presence or absence of disorder, mental health conditions can be viewed as a continuum ranging from mild symptoms (e.g., mild depression) to severe disorders (e.g., schizophrenia or psychotic/suicidal depression).

In this document we use the term co-occurring 'mental disorder' when referring to people with a diagnosable mental disorder, as defined by the DSM [10, 29]. When using the term 'mental health condition', we are referring to both people who have a diagnosable disorder as well as people who display *symptoms* of disorders while not meeting criteria for a *diagnosis* of a disorder.

Why do co-occurring conditions occur?

There are a number of possible explanations as to why co-occurring conditions may occur (see Figure 2):

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

Direct causal hypothesis

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

In some cases where co-occurring conditions exist, the AOD use disorder occurs as a consequence of repeated AOD use to relieve or cope with mental health symptoms. This relationship is often described as the 'self-medication hypothesis', in that substances are used in an attempt to medicate mental health symptoms [30–32]. In these circumstances, mental health conditions may become more apparent after the AOD use has ceased. Certain mental health conditions may also impair a person's ability to make sound judgements regarding their AOD use. For example, people with some personality characteristics or cognitive impairment may have difficulty identifying social cues about appropriate use. This may lead the person to use in greater quantities or with greater frequency, increasing the likelihood of developing an AOD use disorder.

The mental health condition may be a consequence of AOD use

Alternatively, AOD intoxication and withdrawal can induce a variety of mental health symptoms and disorders, such as depression, bipolar, anxiety, obsessive-compulsive, and psychotic disorders (see Chapter A4 for a discussion of substance-induced disorders). For example, alcohol use and withdrawal can induce symptoms of depression or anxiety [33–35]; symptoms of mania can be induced by intoxication with stimulants, steroids, or hallucinogens; and psychotic symptoms can be induced by withdrawal from alcohol, or intoxication with alcohol, stimulants, cannabis, or hallucinogens [36–38]. Other disorders that can come about from AOD use include substance-induced neurocognitive disorder, sexual dysfunction, and sleep disorder [10]. In the majority of cases, these effects subside and eventually

disappear with abstinence [39, 40]. For some, however, symptoms may continue even after they have stopped drinking or using substances. Regardless of whether the co-occurring disorders are classified as independent or substance-induced, they may be associated with poorer treatment outcomes [34].

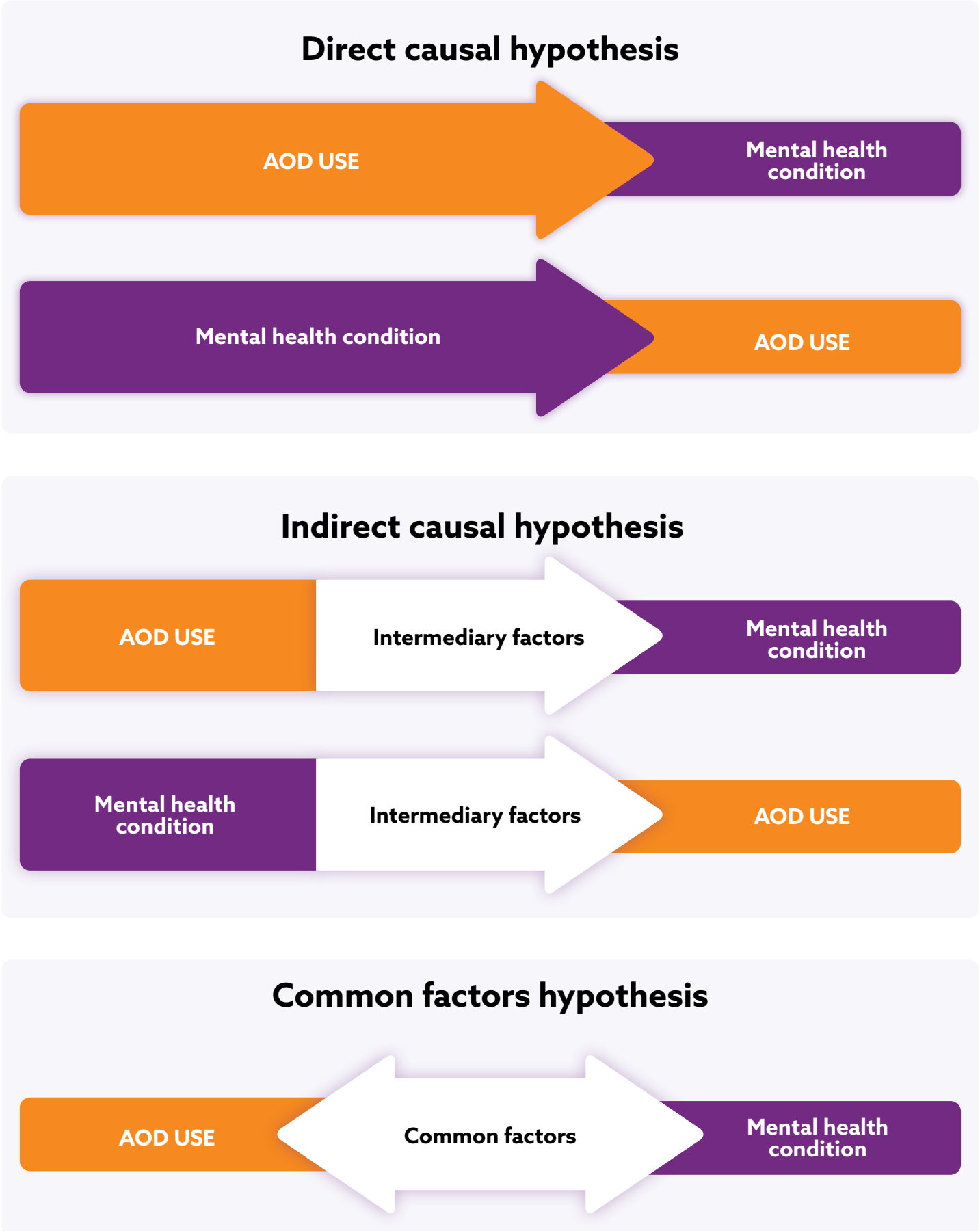
Indirect causal relationship

An indirect causal relationship is said to exist if one condition has an effect upon an intermediary factor that, in turn, increases the likelihood of developing the second condition [41]. For example, research has shown that the presence of early onset AOD use reduces the likelihood of completing high school, entering tertiary education, and completing tertiary education [42, 43]. This poor level of education may lead to later life difficulties (e.g., unemployment) that may lead to other problems, such as depression [44, 45]. Similarly, the reverse is possible, whereby a depressive disorder may lead to difficulties completing study and work commitments, which may in turn lead to difficulties finding employment, increasing the risk of problematic levels of AOD use [46–48].

Common factors

The co-occurrence of two conditions may also come about due to the presence of shared biological, psychological, social, or environmental risk factors. That is, the factors that increase the risk of one condition may also increase the risk for another [49–57]. For example, both AOD and mental health conditions have been associated with lower socioeconomic status, cognitive impairment, the presence of conduct disorder or behavioural disinhibition in childhood and antisocial personality disorder (ASPD). It is also possible that a genetic vulnerability to one disorder may increase the risk of developing another disorder [49, 58–60]. An increasing body of research has focused on epigenetics; that is, the way in which a person's environment and experiences can influence gene expression. For example, childhood trauma and adversity has consistently been associated with alterations in the expression of genes that have been associated with the development of mental health and AOD use disorders [61]. Importantly, research has also shown that psychotherapy can also impact positively on genetic expression [62]. However, just as with other risk factors, underlying genetic vulnerability may increase the risk of developing a disorder – it does not mean a person is predestined to develop an AOD use disorder or depression, for example.

Figure 2: Explaining co-occurring conditions

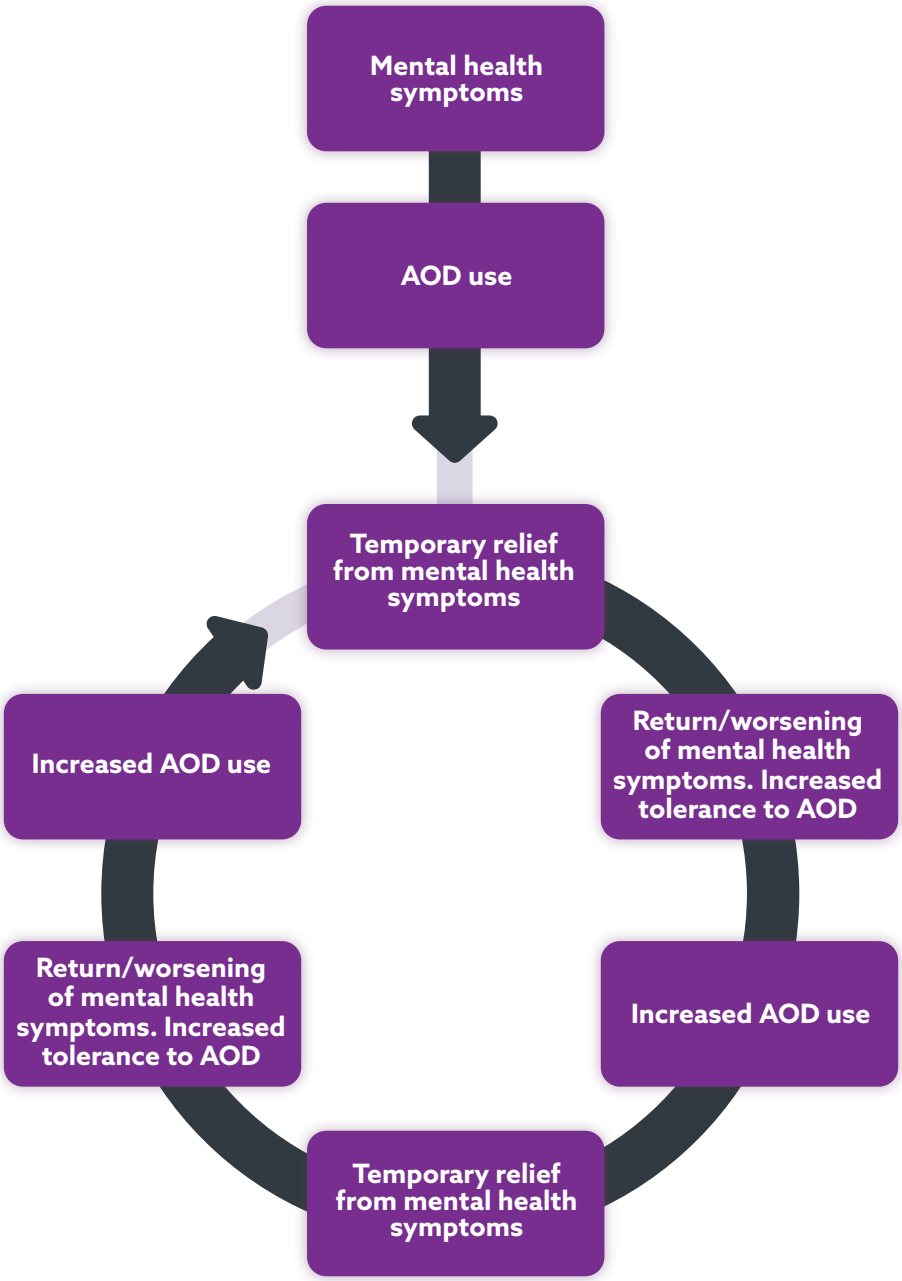


Does causality matter?

In the past, there has been a focus on establishing the order of onset of conditions to identify which is the primary disorder. Conditions may occur in any order, or they may develop at the same time. The evidence regarding the typical order of onset of disorders is not consistent, and differences have been observed between males and females [63, 64]. It appears, however, that social anxiety disorder (SAD), specific phobia, and post traumatic stress disorder (PTSD) tend to predate the AOD use disorder in most – but not all – cases, whereas generalised anxiety disorder (GAD), panic disorder, depression, and dysthymia, tend to have their onset after the onset of an AOD use disorder [63, 65].

Establishing the order of onset of conditions can be useful in understanding the relationship between conditions, and in developing a case formulation (see **Chapter B3**). It is important to note, however, that once co-occurring conditions have been established it is most likely that the relationship between them is one of mutual influence rather than there being a clear causal pathway [65, 66] (see Figure 3). Regardless of how the co-occurrence came about, both conditions may serve to maintain or exacerbate each other. For example, a person may engage in AOD use to reduce symptoms of depression; however, research suggests that repeated use may lead to increased depression [33]. It is also possible that the relationship between disorders may change over time [66, 67]. For example, depression may trigger alcohol use on some occasions, while it may be the result of alcohol use on others [68]. Irrespective of what order co-occurring conditions have developed, the strategies used to manage these conditions are the same.

Figure 3: Example of a relationship of mutual influence between AOD use and mental health conditions



A2: How common are co-occurring conditions and why are they of concern?

A2: How common are co-occurring conditions and why are they of concern?

Key points

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

How common are mental disorders?

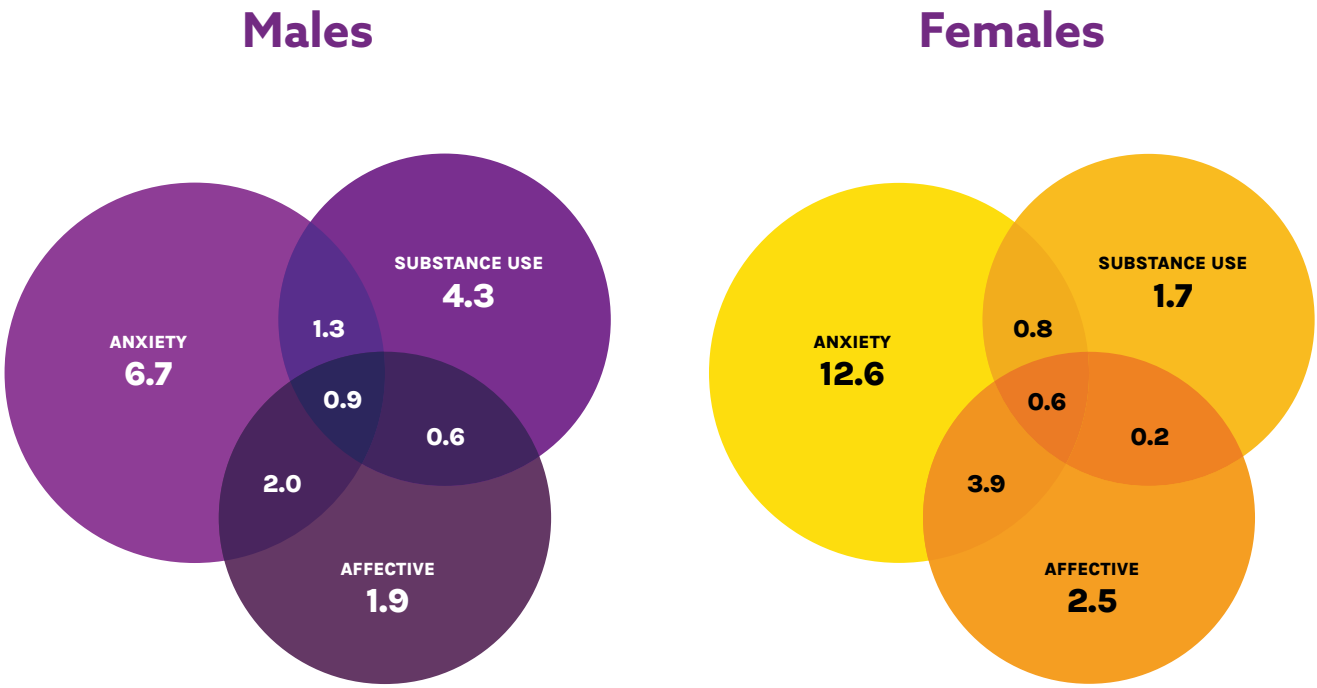
In Australia, mental and AOD use disorders are the fourth leading cause of burden of disease (12% of total burden) following cancer (18%), cardiovascular disease (CVD; 14%), and musculoskeletal conditions (13%) [69]. Research conducted on the general population indicates that approximately one in two people will develop a mental disorder at some point in their life [63, 70]. The Australian National Survey of Mental Health and Wellbeing (NSMHWB) conducted in 2007 found that more than 41% of Australian adults (45% of men and 38% of women) had experienced a substance use, anxiety, or mood disorder in their lifetime [63]. The projected lifetime prevalence of these disorders is 28%, 25%, and 23% respectively [71]. Just over 10% of Australian adults had experienced two classes of mental disorders, and just over 4% had experienced three [63].

The 2007 NSMHWB also found that one in five Australian adults (18% of men and 22% of women) had a substance use, anxiety, or mood disorder in the past year, representing close to 3.2 million Australian adults [72]. Approximately 25% of people with mental disorders were found to have two or more classes of mental disorder [73]. The prevalence of single and co-occurring substance use, anxiety, and affective (i.e., mood) disorders among Australian men and women from the NSMHWB is depicted in Figure 4. The overlapping portions of the circles indicate the proportion of the population who have co-occurring disorders. For example, 1.3% of men and 0.8% of women have a substance use and anxiety disorder only.

Recently released preliminary findings from the 2020-21 NSMHWB report comparable estimates of lifetime (44%) and past year (21%) mental disorder. Findings from the 2017-2018 Australian National

Health Survey [74] have shown that mental and behavioural conditions continue to affect around one in five Australians (20.1%), making these conditions the most commonly experienced chronic conditions in Australia. Furthermore, comparisons with the previous 2014-2015 survey suggest that both anxiety-related conditions and depression are becoming more prevalent in the Australian community, affecting 13.1% (an increase from 11.2% in 2014-15) and 10.4% (an increase from 8.9% in 2014-2015) of Australians respectively [74]. Despite significant government investment in mental health services, the potential for a shadow pandemic of mental ill health as a consequence of the COVID-19 pandemic remains a concern, particularly among young Australians [75].

Figure 4: Prevalence (%) of single and co-occurring DSM-IV affective, anxiety and substance use disorders amongst Australian males (left) and females (right) in the past year



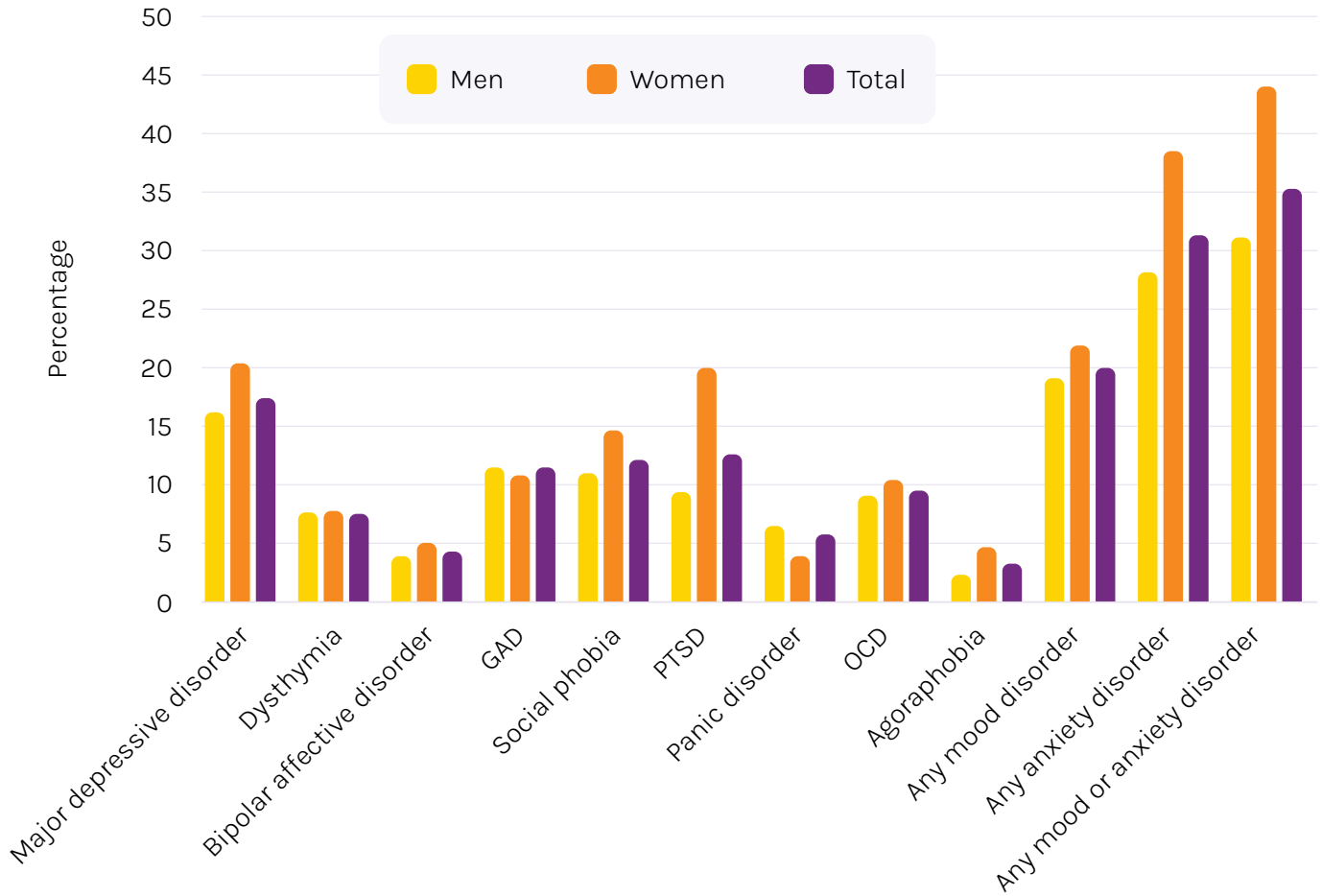
Source: Teesson et al. [73].

How common are co-occurring mental disorders among clients of AOD treatment services?

General population estimates indicate that 35% of Australians with a substance use disorder (31% of men and 44% of women) have at least one co-occurring mood/affective or anxiety disorder (see Figure 5), but this rate is even higher among people entering AOD treatment programs. Although reported rates vary across studies, it is estimated that at least 47% of people seeking AOD treatment have a current mental disorder [76], and at least one in three have multiple co-occurring conditions [77–81]. Thus, in many service settings, co-occurring mental disorders are the norm rather than the exception.

The most frequently seen mental disorders among people seeking AOD treatment mirror those observed in the general population. Although estimates vary substantially between studies depending on the methods and timeframes used to assess for conditions, the most common are anxiety disorders (12 – 91%), most commonly GAD (1 – 75%); depression (27 – 85%); PTSD (5 – 66%); and personality disorders, in particular ASPD (2 – 72%) and borderline personality disorder (BPD; 16 – 48%); bipolar disorders (4 – 53%); obsessive-compulsive disorder (OCD; 1 – 52%); and psychotic disorders (2 – 41%) [76, 81–83]. Although less common, studies have also found elevated rates of eating disorders (ED; 2 - 34%), and attention-deficit/hyperactivity disorder (ADHD; 2 - 6%) [76, 83]. Despite these high rates, these conditions often go unrecognised. It should also be borne in mind that the prevalence of mental disorders may vary between substances, however, little research has been conducted comparing the rates of mental disorders across different types of AOD use disorders [76].

Figure 5: Prevalence (%) of mental disorders in the past year among adults with substance use disorders in the 2007 National Survey of Mental Health and Wellbeing



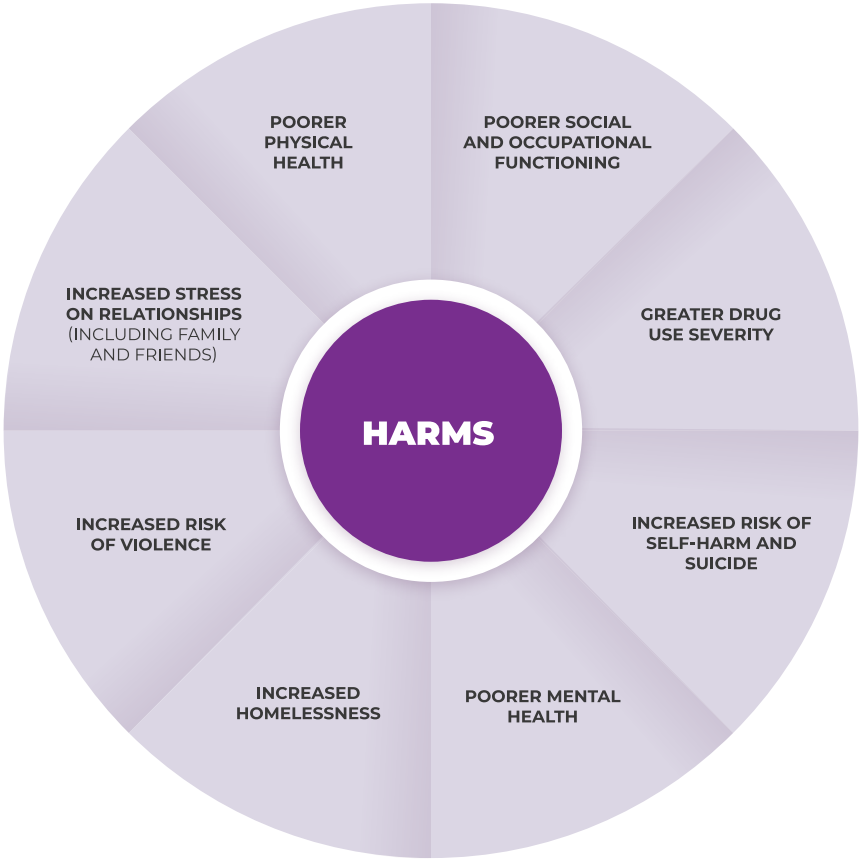
GAD = generalised anxiety disorder; PTSD = post traumatic stress disorder; panic disorder (with or without agoraphobia); OCD = obsessive compulsive disorder; agoraphobia (without panic disorder).

The number of potential combinations of disorders and symptoms is also infinite. Furthermore, as mentioned in **Chapter A1**, there are a large number of people who present to AOD treatment who display symptoms of disorders while not meeting criteria for a diagnosis of a disorder [84, 85]. People who display a number of symptoms of a disorder but do not meet criteria for a diagnosis are sometimes referred to as having a 'subsyndromal' or 'partial' disorder. Although these people may not meet full diagnostic criteria according to the classification systems (described in **Chapter A4**), their symptoms may nonetheless impact significantly on their functioning and treatment outcomes [84, 86–89].

What are the harms associated with co-occurring disorders?

The high prevalence of co-occurring mental disorders means that AOD workers are frequently faced with the need to manage complex psychiatric symptoms, which has been cited as a major challenge and ongoing training gap for almost two-thirds (62%) of Australian AOD workers [7]. Clients with co-occurring mental and AOD use disorders present to treatment with a more complex and severe clinical profile, including poorer general physical and mental health, greater drug use severity, and poorer functioning (see Figure 6) [90–93]. The presence of co-occurring mental health conditions may also place an enormous strain on clients' families and others close to them, both emotionally and financially.

Figure 6: Harms associated with co-occurring mental health and AOD use conditions



What is the impact of co-occurring mental disorders on treatment outcomes?

The influence of mental disorders on treatment outcomes in clients with AOD use disorders is not straightforward and may be influenced by a number of factors [87, 94]. Although some studies have shown that clients with co-occurring mental disorders have poorer treatment outcomes [79, 87, 91, 95, 96], others have clearly demonstrated that clients with co-occurring conditions benefit from treatment just as much as those without co-occurring conditions in terms of their AOD use, general physical and mental health, and functioning – even those with severe mental disorders [78, 87, 92, 97–102]. However, while both those with and without co-occurring conditions follow a similar course in terms of their treatment outcomes (i.e., both groups improve), those with co-occurring conditions continue to drink or use more, be in poorer physical and mental health, and display poorer functioning following treatment. That is, they present to treatment with a more severe clinical profile, and despite similar levels of improvement, continue to demonstrate a poorer clinical profile at follow-up. These findings indicate that AOD services and AOD workers do exceptionally well at treating AOD use (despite the poorer clinical profile described in the previous section) and its associated disability, but that the disability associated with the co-occurring condition remains.

A3: Guiding principles

A3: Guiding principles

Key points

When working with clients with co-occurring mental health conditions, it is recommended that AOD services and AOD workers take the following principles into consideration:

- First, do no harm.
- Work within your capacity.
- Engage in ongoing professional development.
- Recognise that the management of co-occurring conditions is part of AOD workers' core business.
- Provide equity of access to care.
- Adopt a 'no wrong door' policy.
- Recognise that co-occurring conditions are common and that all clients should be routinely screened for co-occurring conditions.
- Conduct ongoing monitoring of symptoms and assessment of client outcome.
- Focus on engaging the client in treatment.
- Adopt a holistic approach based on treating the person, not the illness.
- Adopt a client-centred approach.
- Adopt a trauma-informed care approach.
- Emphasise the collaborative nature of treatment.
- Have realistic expectations.
- Express confidence in the effectiveness of the treatment program.
- Adopt a non-judgemental attitude.
- Adopt a non-confrontational approach to treatment.
- Involve families and carers in treatment.
- Involve peers in treatment.
- Consult and collaborate with other health care providers.
- Ensure continuity of care.

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

First, do no harm

The principle 'first, do no harm' underscores the provision of all health care. AOD workers must consider the risks and benefits of potential actions and avoid those that may result in harm to the client or to the community more broadly. In the example of pharmacological treatment, harms to consider may include interactions between substances, overuse, and potential for dependence or misuse [103].

Work within your capacity

In line with the principle above, each AOD worker should work within their capacity to address co-occurring conditions. As mentioned in Part A, AOD workers differ with regard to their roles, education, training, and experience. It is not expected that all AOD workers will be able to address co-occurring conditions to the same extent. It is essential that appropriate supervision be provided to AOD workers working with clients with co-occurring conditions, particularly those with less experience working with mental health conditions [104].

Engage in ongoing professional development

All AOD workers should be knowledgeable about the symptoms of the common mental health conditions that clients present with and how to manage these symptoms. In addition to being able to identify and manage co-occurring conditions, staff should also be trained in appropriate referral processes (see **Chapter B5**; [105]). Where AOD workers do not have these skills, professional development should be provided to bring them to a level of confident and competent performance. The provision of opportunities for continuing professional development for AOD staff should be a high priority for AOD services. Indeed, mental health training for AOD workers is also valued by clients and may strengthen workers' credibility, insofar as trained staff are seen to have the knowledge to help with clients' medication and emotional needs [106]. AOD workers should seek out, and actively engage in, training that addresses co-occurring conditions. It is important that professional development in this area be ongoing, as it is an ever-evolving area of research. AOD workers are encouraged to update their knowledge by accessing new research and training opportunities, and new clinical guidelines as they emerge (**Appendix B** and **Appendix C** provide some useful resources and research organisations).

Recognise that the management of co-occurring conditions is part of AOD workers' core business

AOD treatment services and AOD workers need to recognise that working with co-occurring mental health conditions is part of their core business. Indeed, managing co-occurring mental disorders is the core business of all health care providers.

Provide equity of access to care

Cases have been documented where clients of AOD services have received prejudicial treatment or been refused entry to treatment due to the presence of co-occurring disorders. All clients, regardless of their mental health status, are morally and legally entitled to equal access to the highest quality of care [107].

Adopt a 'no wrong door' policy

In line with the above principles, AOD services (and all other health services) should adopt a 'no wrong door' policy. No client should be turned away from treatment; rather, it is necessary to establish where the client will receive the most appropriate care. Care should be coordinated, connected, and streamlined so that clients are assessed and treated appropriately regardless of the 'type' of treatment service and to reduce unnecessary referral [108]. When a person presents at a facility that is not equipped to provide a particular type of service, they should be guided to appropriate facilities (using active referral methods discussed in **Chapter B5**), with follow-up by staff to ensure that they receive appropriate care [102, 109–111]. In this way, every door in the health care system should provide access to the services needed. Guidance about which sector of the health care system should have primary responsibility for co-occurring presentations is provided in Figure 7. It should be noted, however, that it can be difficult to discern which areas should take primary responsibility for individual cases as the severity of conditions may be interpreted differently by various service providers.

Figure 7: Clinical governance

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

Source: NSW Health [112].

Recognise that co-occurring conditions are common and that all clients should be routinely screened for co-occurring conditions

Despite the fact that co-occurring mental health conditions are common among people with AOD use disorders, they are often overlooked in AOD treatment settings [113, 114], mostly because AOD workers are not routinely looking for them. As part of routine clinical care, all clients should be screened for co-occurring conditions. Chapter B3 discusses how to screen and assess for co-occurring conditions.

Conduct ongoing monitoring of symptoms and assessment of client outcomes

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

It is often difficult for clients to detect subtle changes over time. Integrated screening and assessment at different timepoints, and provision of feedback to clients, are important steps for client engagement [115]. Ongoing monitoring is rated by health professionals as one of the top non-pharmacological strategies for promoting treatment adherence among clients with co-occurring conditions [116]. Evidence of a reduction in psychiatric symptoms may help to maintain client motivation. On the other hand, evidence that there has been no change or that their psychiatric symptoms have worsened may help clients understand why they have been using substances and alert them to the need to address these issues.

Focus on engaging the client in treatment

The development of a trusting therapeutic alliance with the client is essential to engaging the client in the treatment process and has been linked to both improved client outcomes related to AOD use (e.g., decrease in alcohol use) and mental health (e.g., improvement in depressive symptoms) [117–120]. Engaging clients in treatment can be difficult, particularly at the start of treatment where therapy may be challenging and attachment needs are activated [121]. For example, in clients with personality or psychotic disorders, difficulties engaging may be due to a history of poor relationships with AOD and other health professionals; a bias towards suspiciousness or paranoid interpretation of relationships; or a chaotic lifestyle, making appointment scheduling and engaging in structured work more difficult [122]. Conversely, a positive therapeutic relationship allows clients to modify their maladaptive relational patterns and learn how to form healthy relationships [123]. The following strategies may assist in engaging the client in treatment [115, 121, 123–127].

- Express empathetic, optimistic, non-judgemental, and compassionate attitudes.
- Provide individualised care that includes identified strengths as well as problems.
- Adopt a holistic approach including both recovery-oriented and trauma-informed principles.
- Be flexible yet consistent with appointments.
- Protect confidentiality and privacy.
- Promote client motivation and self-efficacy.
- Work with the client's current stage of readiness to change (as discussed in **Chapter B3**).

Adopt a holistic approach that focuses on treating the person, not the illness

The primary goal of AOD treatment services is to address clients' AOD use. In order to do so effectively, AOD workers must take into account the broad range of issues that clients present with, including their mental health. When considering co-occurring conditions, one cannot look at the person's AOD use and mental health alone. Clients with co-occurring conditions often have a variety of other medical, family, and social problems (e.g., housing, employment, welfare, and legal problems). These problems may be contributing to the client's AOD and mental health conditions, or they may be the product of their AOD and mental health conditions. Indeed, clients appreciate when services have recognised and addressed connections between co-occurring issues and other aspects of their life [125], and express greater satisfaction with care when it focuses on their AOD use while supporting their other needs [128]. Clients also need to be viewed in light of their age, gender, sexual orientation, culture, ethnicity, spirituality, socioeconomic status, and cognitive abilities.

Adopt a client-centred approach

AOD workers are specialists in their field. It is important to acknowledge, however, that it is the client who is the expert on themselves. It is important that AOD workers listen to what clients want to achieve from treatment and use this as the basis of creating shared treatment goals. Listening to what clients want will assist in identifying other services that may need to be engaged. Listening will also assist with collaboratively developing a treatment plan that is tailored to the client and considers their social and treatment context and readiness for change [129]. Tailoring treatment to clients' individual needs is associated with greater client-reported care satisfaction and perceived benefit from treatment [127, 130].

In terms of clients' AOD use, the goal of abstinence is usually favoured, particularly for those whose mental health conditions are exacerbated by AOD use, or for those whose AOD use is more severe [131]. Abstinence is also preferred for those with more severe mental disorders (or cognitive impairment) because even low-level substance use may be problematic for these people [132]. Those taking medications for mental health conditions (e.g., antipsychotics, antidepressants, mood stabilisers) may also find that they become intoxicated even with low levels of AOD use due to the interaction between the drugs.

Although abstinence is favoured, it is recognised that many people with co-occurring conditions prefer a goal of moderation. In order to successfully engage with the client, AOD workers should discuss treatment considerations with their client, accommodate a range of treatment goals and adopt a harm reduction approach [129, 133, 134].

Adopt a trauma-informed care approach

As described in **Chapter B2**, the provision of trauma-informed care is essential given the high rates of trauma among clients of AOD services and the fundamental role that trauma symptoms may play in a person's recovery [135, 136]. Exposure to traumatic life events is almost universal among clients of AOD services [83, 137, 138], and has been found to play a key role in both the development and maintenance of AOD use disorders [139, 140]. A trauma-informed care approach involves recognition of the high rates of trauma exposure and the provision of a safe environment that is healing and not retraumatising [141]. Further discussion of the elements of trauma-informed care is provided in **Chapter B2**.

Emphasise the collaborative nature of treatment

Clients with co-occurring conditions often feel that they have very little control over their lives. It is important they understand that you will be working together throughout treatment, to help them re-establish a sense of autonomy and control. Collaborative approaches to decision-making about treatment, such as shared decision-making, have been shown to support clients with co-occurring conditions take a more active and informed role in their decision-making about treatment, in line with most clients' preferences for involvement in treatment decision-making [142]. Shared decision-making may also facilitate agreement between clinicians and clients in terms of treatment decisions and treatment goals, as well as shared perceptions of the working alliance [142].

Have realistic expectations

It is important that AOD workers have realistic expectations regarding the course of treatment and outcomes to be expected of clients with co-occurring conditions. It is commonly believed that clients with co-occurring conditions are more difficult to treat, require more intensive treatments, and have poorer treatment outcomes. However, co-occurring conditions are not an insurmountable barrier to treating people with AOD use disorders. It is important that treatment plans are developed collaboratively to build patient trust and treatment engagement [133], and tailored to the client's readiness for change [129]. As discussed in **Chapter A2**, research has shown that clients with co-occurring conditions can benefit just as much as those without co-occurring conditions from usual AOD treatment [78, 99, 102, 143].

Express confidence in the effectiveness of the treatment program

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

Adopt a non-judgemental attitude

Clients with co-occurring conditions have often been subjected to stigmatisation and discrimination in relation to their AOD use (particularly those who use illicit drugs) and their mental health condition [144]. People with mental disorders have traditionally been viewed by society as violent, brain damaged, intellectually disabled, unimportant, untrustworthy, or worthless. As a result, clients with co-occurring conditions will often feel too ashamed or embarrassed to tell people about them, even health professionals [107].

A non-judgemental approach can help reduce client's feelings of shame [130]. AOD and other health professionals should treat people with co-occurring conditions with the same respectful care that would be extended to someone with any other health condition. Just as people with an AOD use disorder should not be thought of or referred to as an 'addict', a person with schizophrenia should not be referred to or thought of as 'schizophrenic'. The mental health condition does not define the person; rather, it is one aspect of the person.

Adopt a non-confrontational approach to treatment

Sustained emotional distress can worsen a number of mental health conditions and a highly demanding or confrontational treatment approach may be harmful to those with mental health conditions [132]. Emotional distress may be triggered by criticism, rejection, or an inability to deal with task demands [145]. It is recommended instead that a non-confrontational motivational enhancement approach be used [133]. Motivational interviewing (MI) techniques are described in **Appendix E**.

Involve families and carers in treatment

With the client's consent, AOD workers should involve the client's family and carers where possible and appropriate. Families and carers should be involved as much as possible in decisions regarding treatment and discharge planning, as they will often need to facilitate the client's access to other services. With the client's consent, family members/carers should be provided with regular feedback so that they know their views and feelings are valued. It is important to clarify with clients specifically what information they consent to being shared with their families or carers. Families and carers should also be informed of services available to them in the form of advocacy and support groups.

Two useful resources are available, and may have relevant information for families, carers, and friends:

- Tools for change: A new way of working with families and carers, developed by the Network of Alcohol and other Drugs Agencies, available as part of the Families and Carers Toolkit [146].
- Guidelines to consumer participation in NSW drug and alcohol services, developed by the NSW Ministry of Health [147]. www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2015_006.pdf

Involve peers in treatment

Peer workers play an important role in the delivery of treatment for people with co-occurring conditions. Peers provide important connections for clients, which may complement the therapeutic alliance formed with an AOD worker [148]. Clients also view peers as useful for helping to de-stigmatise their AOD use and mental health conditions [130]. There is some preliminary evidence to suggest that more formal peer recovery support services are helpful across a number of AOD treatment settings in terms of reducing AOD use and relapse rates, improving relationships with AOD workers and social supports, as well as increasing retention in and satisfaction with treatment [149].

Consult and collaborate with other health care providers

AOD clients present with diverse issues that cannot possibly be addressed by one health professional or service alone. A broad, multifaceted, and multidisciplinary approach is needed in order to address all of these issues effectively [107, 150]. It is important that AOD services and AOD workers develop links with a range of local support services to provide specialised, coordinated and continuous care for clients. Such services include mental and community health practitioners, housing, employment, and welfare services [105]. General practitioners (GPs) in particular play an important role in delivering care to people with co-occurring conditions, as they are often their first and most consistent point of contact [151]. Ideally, case management and treatment should be shared by health care providers/services, and there should be good communication and sharing of information between these professionals.

Ensure continuity of care

People with co-occurring conditions often have difficulty navigating their way through the services required to address all of their needs. It is crucial that systems be established that ease clients' transitions between services to prevent them from 'falling through the gaps' between services [109]. Continuity of care greatly influences whether clients feel their needs have been met and whether they are satisfied with treatment [128]. In addition to improved satisfaction, increased continuity of care is also linked to increased client commitment to treatment, better quality of life, improved community functioning, and reduced violent behaviour [128]. Chapter B5 discusses methods that may be used to refer clients to other services.

A4: Classification of disorders

A4: Classification of disorders

Key points

- There are many different mental disorders, with different presentations. They are generally characterised by a combination of abnormal thoughts, perceptions, emotions, behaviour and relationships with others.
- Not all AOD workers are able to formally diagnose the presence or absence of mental disorders. Diagnoses of mental disorders should only be made by suitably qualified and trained health professionals.
- It is nonetheless useful for all AOD workers to be aware of the characteristics of disorders so that they are able to describe and elicit information about mental health symptoms when undertaking screening and assessment, and to inform treatment planning.
- It is important that clients suspected of having a co-occurring mental health condition undergo a medical assessment as many symptoms of mental disorders mimic those of physical disorders.

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

It is nonetheless useful for all AOD workers to be aware of the characteristics of disorders so that they are able to describe and elicit information about mental health symptoms when undertaking screening and assessment (discussed in **Chapter B2**), and to inform treatment planning. Many more people will present with symptoms than will meet criteria for a diagnosis of a disorder; however, these symptoms are distressing and need to be managed nonetheless. It is hoped that the descriptions provided here will increase AOD workers' knowledge and awareness of different signs (i.e., what is objectively visible about the client, such as sweating) and symptoms (i.e., what the client describes, such as sadness) of disorders. The case studies provided throughout these Guidelines also provide examples of how symptoms may present in clients with co-occurring mental disorders.

There are many kinds of mental disorders, with each disorder comprising a group of signs and symptoms. A certain number of criteria for a particular disorder need to be met within a certain timeframe for a person to be diagnosed as having that disorder. However, as described in **Chapter A1**, there are many people who present to AOD treatment who display *symptoms* of disorders, while not meeting criteria for a *diagnosis* of a disorder. For example, a person may present with depressed mood or anxiety symptoms, without having a diagnosable depressive or anxiety disorder. Although these people

may not meet full diagnostic criteria according to the classification systems, their symptoms may nonetheless impact significantly on their functioning and treatment outcomes [26, 27, 152]. As such, rather than viewing mental health as merely the presence or absence of disorder, it may be more useful to consider mental health conditions as a continuum, ranging from mild symptoms to severe disorders (Figure 8).

Figure 8: Continuum of mental health conditions

The diagnostic classification systems

There are two main classification systems used to diagnose mental disorders:

- The Diagnostic and Statistical Manual of Mental Disorders, currently in its fifth edition (DSM-5-TR) [10].
- The International Classification of Diseases, currently in its 11th revisions (ICD-11 [11]), which only recently came into effect on 1 January 2022 [11].

Although these systems are similar, there are a number of important differences. The disorder descriptions outlined in this chapter are based on the most recent edition of the DSM, released in March 2022 (DSM-5-TR [10]), but some references are made to the ICD-11 [11]. In particular, we have highlighted several key changes between the DSM-5-TR and ICD-11 that AOD workers should be aware of. It should be noted, however, that these are not the only differences between the two classification systems. It is also important to note that the disorder descriptions provided in the current versions of both the DSM and ICD vary to those provided in earlier versions, as each edition is updated to reflect evolutions in our understanding of disorders based on research. As such, AOD workers are encouraged to familiarise themselves with both the DSM-5-TR and ICD-11, in particular their uses, limitations, and recommendations regarding differential diagnosis (i.e., determining which symptoms are attributable to which disorder). The DSM-5-TR disorders described here have also been cross-referenced with the corresponding ICD-11 codes in Appendix D. Irrespective of any differences between classification systems, AOD workers should be mindful that the move towards a more dimensional approach of diagnosing mental health conditions emphasises the need for not only clinical judgement and expertise, but of central importance, the need to consider the whole person rather than a person presenting to treatment with a checklist of symptoms.

In these Guidelines we focus on 10 categories of disorder that are most commonly seen among people with AOD use disorders, grouped by DSM-5-TR and ICD-11 classification (Table 1).

Table 1: DSM-5-TR and ICD-11 classifications of most commonly co-occurring mental disorders among people with AOD use disorders

DSM-5-TR classification	ICD-11 classification
Attention-deficit/hyperactivity disorder	Attention deficit hyperactivity disorder
Schizophrenia spectrum and other psychotic disorders	Schizophrenia or other primary psychotic disorders
Bipolar disorders	Bipolar or related disorders
Depressive disorders	Depressive disorders
Anxiety disorders	Anxiety or fear-related disorders
Obsessive-compulsive disorder	Obsessive-compulsive disorder
Trauma-related disorders	Disorders specifically associated with stress
Feeding and eating disorders	Feeding or eating disorders
Personality disorders	Personality disorders and related traits or patterns
Substance-induced disorders	Substance-induced psychotic disorders Substance-induced mood disorders Substance-induced anxiety disorders Substance-induced obsessive-compulsive disorder

There are, however, a number of other disorder types that people with AOD use disorders may experience. These include somatoform disorders, sleep disorders, and adjustment disorders. For further information on these disorders readers are referred to the DSM-5-TR and ICD-11.

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

What is attention-deficit/hyperactivity disorder (ADHD)?

The core feature of ADHD is an ongoing pattern of inattention and/or impulsivity-hyperactivity, which interferes with functioning (see Table 2).

- **Inattention** refers to difficulties sustaining attention to tasks that are not frequently rewarding or highly stimulating, distractibility, and difficulties with organisation.
- **Impulsivity** refers to acting in response to immediate stimuli, without consideration of the outcome.
- **Hyperactivity** refers to excessive motor activity and difficulties remaining still, typically evident in situations that require behavioural self-control.

Many people experience periods of distraction and have difficulty concentrating. Similarly, many people experience periods of excitability or zealousness, which can sometimes be described as 'hyperactive'. ADHD is distinct from relatively short periods of over-excitability or distraction in that it involves severe and persistent symptoms that are present in more than one setting (e.g., home and work). The extent of inattention and hyperactivity-impulsivity is also outside what would be expected given a person's age and level of intellectual functioning.

A case study example of how a person experiencing co-occurring ADHD and AOD use disorder may present is illustrated in Box 1.

Table 2: Attention-deficit/hyperactivity disorder (ADHD)

Attention-deficit/hyperactivity disorder (ADHD)
ADHD is characterised by a persistent and debilitating pattern of persistent inattention and/or hyperactivity-impulsivity where at least five inattention or hyperactivity-impulsivity symptoms are present. Symptoms need to have been experienced for at least six months, and several need to have been present prior to age 12: **Inattention:** • Lacking attention to detail. • Difficulty maintaining focus during work, study, or conversation. • Appearing not to listen when spoken to. • Difficulty following instructions and completing housework, work, or study. • Difficulty organising time and materials. • Avoiding tasks that involve constant mental energy. • Losing material possessions. • Easily distracted. • Forgetting to return calls, pay bills, keep appointments.

Table 2: Attention-deficit/hyperactivity disorder (ADHD) (continued)

Attention-deficit/hyperactivity disorder (ADHD)
Hyperactivity and impulsivity: • Fidgeting, tapping hands or feet, wriggling in seat. • Leaving seat in inappropriate situations. • Inappropriately restless. • Unable to relax or engage in activities quietly. • Unable to keep still for extended periods. • Talking excessively. • Interrupting conversations. • Difficulty waiting in line or for their turn. • Intruding on or taking over from others.

Box 1: Case study A: What does co-occurring ADHD and AOD use look like? Sam's story

Case study A: Sam's story

Sam, a 25-year-old who identified as female, was referred to her local AOD service by her GP. Her presentation followed a routine visit to her GP, during which she mentioned that her alcohol use had increased during the COVID-19 lockdowns. She also occasionally used methamphetamines. Sam has been living with her partner for the past two years, but there has been recent strain in their relationship, exacerbated by the ongoing pandemic lockdowns, that has contributed to her increase in drinking, putting further strain on their relationship. Although Sam's partner accompanied her to her appointment with the AOD service, they remained in the waiting room for the duration of the session. Sam had been working in the hospitality industry but has been out of work for the past 12-months or so, due in part to the impact of COVID-19 on the hospitality industry, but also due to Sam's unreliability as an employee leading to her dismissal from numerous jobs.

Sam first began drinking alcohol while at high school, though she never considered herself to have a 'drinking problem'. During the assessment, Sam also mentioned that she had experimented with other substances while in high school, including taking one of her friend's Ritalin on a few occasions, but did not experience a 'high' like her other friends seemed to. When asked about her use of methamphetamines, Sam described feelings of relaxation following their use. Sam also mentioned that she sometimes used cannabis to help her get to sleep but found that sometimes her use of cannabis led to outbursts of anger.

Sam had difficulties at school and left at the end of year 10. Her teachers described her as intelligent, but her concentration and attention were poor, and she therefore frequently failed to complete her homework and her teachers noted that she 'underperformed' in her exams. Sam later reported that she had great

Box 1: Case study A: What does co-occurring ADHD and AOD use look like? Sam's story (continued)

difficulty revising and her attention to revision was often impaired because her 'thoughts strayed all over the place.' Sam was often irritable with her siblings and lost many friends because she was notoriously unreliable at meeting them as arranged. Sam also spoke of difficulties she had getting to sleep during her childhood, and of sometimes feeling incredibly tired. Sam enrolled in a design course at TAFE after leaving school but was not able to complete the course.

Key points:

- What are the primary concerns for Sam?
- Where to from here?

Case study A continues in Chapter B7.

What are schizophrenia spectrum and other psychotic disorders?

Schizophrenia spectrum and other psychotic disorders are among the most stigmatised disorders, even within healthcare. Historically, these disorders have not been well understood and people experiencing them have been marginalised, ostracised, incarcerated, and institutionalised. Although the term 'schizophrenia' literally means 'split mind', these disorders are not associated with any 'multiple personality' or dissociative disorders. Rather, schizophrenia refers to what is sometimes called a 'split' from reality.

The current classification systems consider schizophrenia to be on a spectrum of disorders that vary in terms of symptom severity and duration, all with similar symptoms. A person experiencing schizophrenia spectrum or other psychotic disorders can lose touch with reality. Their ability to make sense of both the world around them and their internal world of feelings, thoughts, and perceptions is severely altered. The most prominent symptoms are delusions, hallucinations, disorganised thinking, grossly disorganised or abnormal behaviour, and negative symptoms (see Table 3), which are not attributable to the effects of AOD use or withdrawal, medication use, or another physical condition (e.g., brain tumour). In general, these symptoms are clustered into three main categories: positive, negative and disorganised symptoms.

Table 3: Predominant symptoms associated with schizophrenia spectrum and other psychotic disorders

Positive symptoms: Behaviours or symptoms that are abnormally present

Delusions are fixed beliefs that usually involve a misinterpretation of perceptions or experiences and are resistant to change in light of conflicting evidence. For example, people who experience delusions may feel that someone is out to get them, that they have special powers, or that passages from the newspaper have special meaning for them. Delusions can be either bizarre or non-bizarre.

- Bizarre delusions are those that are clearly implausible, not understandable to same-culture peers, and not derived from ordinary life experiences (e.g., the belief that one's brain has been removed and replaced with someone else's without leaving any wounds or scars).
- Non-bizarre delusions are those which involve situations that could conceivably occur in real life (e.g., being followed, poisoned, or deceived by one's partner).

Hallucinations are false perceptions such as seeing, hearing, smelling, sensing, or tasting things that others cannot. These are vivid and clear, with the impact of regular perceptions, and are not under voluntary control. Hallucinations can occur in any sensory modality but auditory hallucinations, experienced as voices distinct from a person's own thoughts, are the most common in schizophrenia and related disorders. It is important to note that the classification of an experience as either a delusion or a hallucination is dependent upon culture. That is, the experience must be one that most members of that culture would consider a misrepresentation of reality.

Negative symptoms: Behaviours or symptoms that are abnormally absent

Negative symptoms account for much of the morbidity associated with schizophrenia but are less prominent in other psychotic disorders. These include:

- Diminished emotional expressiveness (i.e., reductions in intensity of emotional expressiveness).
- Avolition (i.e., lack of interest in initiating or continuing with activities).
- Alogia (i.e., restricted speech fluency and productivity of thought and speech).
- Anhedonia (i.e., restricted ability to experience pleasure from positive stimuli).
- Asociality (i.e., a lack of interest in social interactions).

Table 3: Predominant symptoms associated with schizophrenia spectrum and other psychotic disorders (continued)

Disorganised symptoms: Jumbled thoughts, behaviours, or speech
Disorganised speech usually reflects disorganised thinking, and involves difficulty with communication, through difficulty keeping track of conversations, switching between unrelated topics, with incoherent words or sentences. A person's speech might be rambling with tangential ideas, with speech that can be difficult to understand, or even incoherent. These unconnected ideas and sentences are sometimes called a 'word salad'.
Grossly disorganised or abnormal behaviour may be evident in several ways, ranging from inappropriate behaviour or silliness to unpredictable agitation. There may be problems with goal-directed behaviour interfering with usual daily activities, or difficulty with activities of daily living. Catatonic behaviour, which is a decreased reactivity to the environment (sometimes to the extreme of complete unawareness, maintaining a rigid or inappropriate posture, or complete lack of verbal or motor response) may be present, which can include purposeless and excessive motor activity.

People with AOD use disorders may display symptoms of psychosis that are due to either intoxication or withdrawal from substances. However, if the person experiences psychotic episodes even when they are not intoxicated or withdrawing, it is possible that they may have one of the disorders described in Table 4. Schizophrenia spectrum and other psychotic disorders are severely disabling mental disorders. Psychotic symptoms may also present in people with major depressive disorder or bipolar I disorder, or from a medical condition.

A case study example of how a person experiencing co-occurring psychosis and AOD use disorder may present is illustrated in Box 2.

What are the different types of schizophrenia spectrum and other psychotic disorders?

The particular combination of symptoms a person displays, and their duration, determines what diagnostic category they may fall into. There are five types of psychotic disorders described in the DSM-5-TR (see Table 4):

- Schizophrenia.
- Schizophreniform disorder.
- Schizoaffective disorder.
- Brief psychotic disorder.
- Delusional disorder.

Table 4: Types of psychotic disorders

Disorder	Symptoms
Schizophrenia	Schizophrenia is one of the most common and disabling of the psychotic disorders. It affects a person's ability to think, feel, and act. To be diagnosed with schizophrenia, two or more of the following symptoms must have been continuing for a period of at least six months: • Delusions. • Hallucinations. • Disorganised speech. • Grossly disorganised or catatonic behaviour. • Negative symptoms (diminished emotional expression or avolition). These symptoms cause significant impairment in a person's functioning at work, social relationships, or self-care. People are considered to have particular 'types' of schizophrenia depending upon the predominance of symptoms displayed (paranoid, disorganised, catatonic, undifferentiated, or residual type).
Schizophreniform disorder	Schizophreniform disorder is characterised by a symptomatic presentation that is equivalent to schizophrenia except its duration is limited to more than one month and less than six months, and it is not necessary to have a decline in social or occupational functioning.
Schizoaffective disorder	Schizoaffective disorder is characterised by the symptoms of schizophrenia alongside a major depressive or manic episode (described later in this chapter). This disorder may be divided into two types: • Bipolar type (if the mood episode is manic). • Depressive type (if the mood episode is major depressive).
Brief psychotic disorder	Brief psychotic disorder is a disturbance when delusions, hallucinations, or disorganised speech are present, with or without grossly disorganised or catatonic behaviour, for at least one day but less than one month.
Delusional disorder	Delusional disorder is characterised by at least one month of delusions. Hallucinations and other positive symptoms of schizophrenia are relatively absent, and functioning is not significantly impaired.

It should be noted that there are differences between the DSM-5-TR and ICD-11 classification systems regarding the types of psychotic disorders and their definitions. For example, ICD-11 does not distinguish between schizophrenia and schizophreniform disorder. Further, experiences of influence, passivity or control are recognised as separate from delusional symptoms of schizophrenia in ICD-11.

Box 2: Case study B: What does co-occurring psychosis and AOD use look like? Amal's story

Case study B: Amal's story

Amal, a 21-year-old who identified as male, presented to his local AOD service at the insistence of his parents. Both his mother and father accompanied him to his appointment and joined in the consultation. When the AOD worker asked Amal what had brought him in, his father answered that they had brought Amal in because of his ongoing methamphetamine use. He said that Amal lived with them, and they had been aware of some methamphetamine use in the past. The last time they had become aware of Amal's methamphetamine use was approximately a year ago, and at that time Amal had promised not to use again. Amal's father appeared to be quite angry and explained to the AOD worker that Amal had agreed at that time that if he were 'caught' using again, he would be brought straight to the AOD service.

During the assessment, Amal's father continued speaking and answering the AOD worker's questions on Amal's behalf. The AOD worker thanked Amal's parents for the support they showed in coming with Amal to his appointment and for being willing to be involved in his treatment planning – she spoke of the importance of active family involvement in helping people to achieve their goals. She asked Amal's parents to please go back to the waiting room for the remainder of Amal's assessment, until she was ready to discuss the next steps with the whole family. Once his parents left the room, Amal appeared to visibly relax. He said they were annoying, but he was happy for them to be involved in his treatment planning.

In talking about his methamphetamine use, Amal described periods of hallucinations and delusions that he has experienced in the past during the context of use but had not experienced these recently. He said that his neighbours were trying to obtain his family's house and had poisoned all of the plants in their front yard. After a discussion regarding various treatment options, Amal chose to try inpatient detoxification and Amal's family were happy with this plan.

A few days into Amal's detoxification, he began exhibiting suspicious and paranoid behaviours. His roommate complained to the nurse unit manager that Amal had been sitting up in his bed all night watching him sleep and believed he had gone through his belongings. Amal was also observed mumbling to himself. Upon questioning, Amal appeared to be highly paranoid, suspicious, watchful and guarded, was mumbling to himself and appeared to be responding to internal stimuli.

Box 2: Case study B: What does co-occurring psychosis and AOD use look like? Amal's story (continued)

Key points:

- What are the primary concerns for Amal?
- Where to from here?

Case study B continues in Chapter B7.

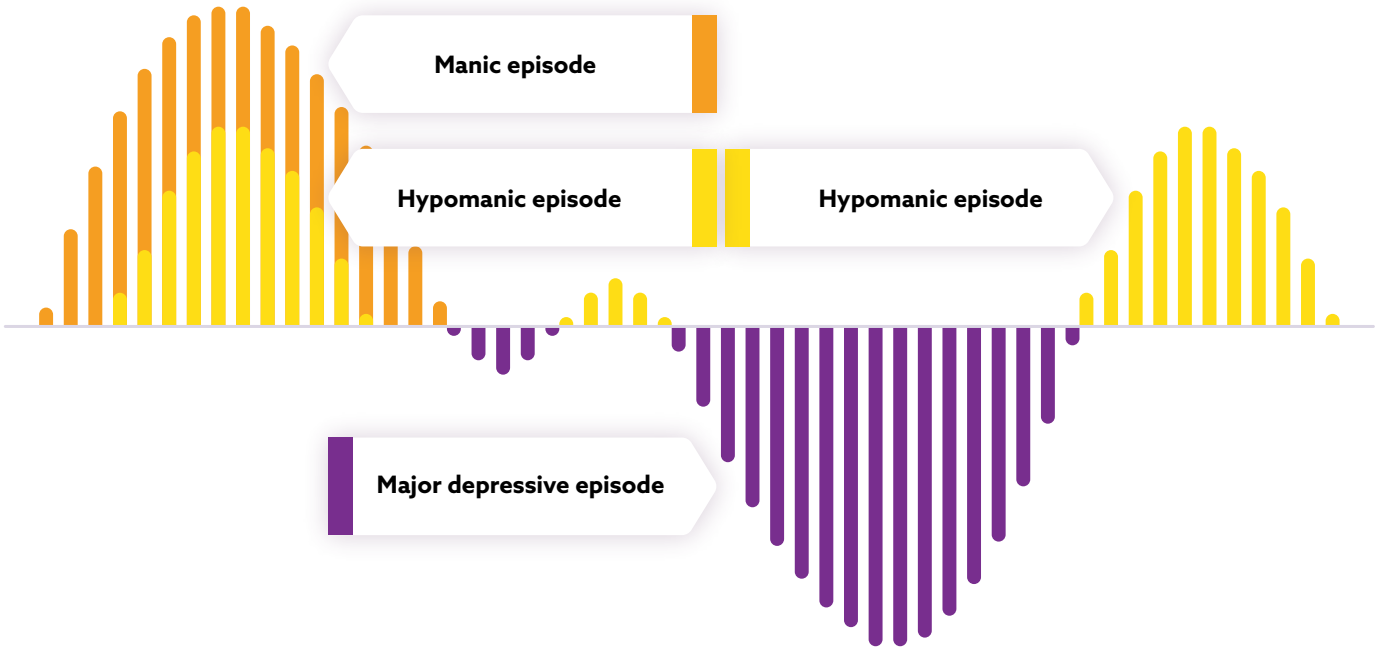
What are bipolar disorders?

Previously classified as mood disorders, bipolar disorders are a distinct category of disorder in the DSM-5-TR, characterised by recurrent episodes of mood disturbances.

There are three types of mood disturbance episodes (see Figure 9, Table 5):

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

Figure 9: The spectrum of bipolar episodes



Adapted from Black Dog Institute [153].

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

Table 5: Types of bipolar episodes

Major depressive episode
In a major depressive episode, five or more of the following symptoms are experienced nearly every day for at least two weeks: • Depressed mood most of the day, nearly every day (e.g., feels sad, empty, hopeless; appears tearful). • Loss of interest or enjoyment in activities. • Reduced interest or pleasure in almost all activities. • Change in weight or appetite. • Difficulty concentrating or sleeping (e.g., sleeping too much or too little). • Restlessness and agitation. • Slowing down of activity. • Fatigue or reduced energy levels. • Feelings of worthlessness or excessive/inappropriate guilt. • Recurrent thoughts of death, suicidal thoughts, attempts, or plans.
Manic episode
During a manic episode, the person experiences an abnormally or persistently elevated, expansive, or irritable mood and increased goal-directed activity or energy for at least one week. The episode is characterised by the person experiencing some of the following symptoms: • Inflated self-esteem or grandiosity. • Decreased need for sleep. • Increased talkativeness or pressured speech. • Flight of ideas or racing thoughts. • Distractibility. • An increase in goal directed activity (e.g., at work, school, or socially). • Excessive involvement in pleasurable activities that have a high potential for painful consequences (e.g., buying sprees, sexual indiscretions, dangerous driving).

Table 5: Types of bipolar episodes (continued)

Hypomanic episode
A hypomanic episode is the same as a manic episode but is less severe. A hypomanic episode need only last four days and does not require the episode to be severe enough to cause impairment in social or occupational functioning.

What is the difference between depression and mania?

Having fluctuations in feelings, mood swings, and a wide range of emotions is very common; almost everyone can relate to emotional upheavals and changes in mood. However, when these emotions or moods are severe to the point of impairing a person's ability to function, there may be a disorder present. It can be difficult to understand how depression and mania co-exist. Table 6 compares some of the key features of both.

Table 6: Comparison of mania and depression in bipolar disorder

	Mania	Depression
Energy levels	Increased energy, increase in activity and/or goal directed activities. May spend more money.	Loss of energy, decrease in activity and interest in activities. Withdrawal from social contact and activities. Change in eating patterns – loss of appetite or overeating.
Changes in sleep pattern	Decreased need for sleep without feeling tired.	Disrupted sleep patterns, with trouble falling or staying asleep, waking too early, sleeping too much. Fatigue.
Thoughts and feelings	Feeling good, high or exhilarated. May think they are chosen, special, gifted, entitled. Increased libido. Increased thinking, disorganised, flood of ideas. May feel agitated, irritable, intense emotions, argumentative.	Feeling down, low, empty, hopeless, worthless, irritable or anxious. Think they are useless, a burden, and the cause of their own problems. Decreased libido. Impaired thinking, concentration, decision making, motivation. May have thoughts of death or suicide.
Speech and sensations	Pressured speech, maybe without enough time to convey all of the ideas, inappropriate. Heightened perception and sensation.	Speech can be slowed, with few ideas. Dulled perception and sensation, but in some cases some senses can be heightened (e.g., taste and smell).

Table 6: Comparison of mania and depression in bipolar disorder (continued)

	Mania	Depression
Delusions, hallucinations	In severe cases of mania, there may be grandiose delusions (e.g., may think they are God, or they are a superhero sent to save the world).	In severe cases of depression, there can be nihilistic delusions (e.g., may think their body is decaying).

Adapted from Black Dog Institute [154].

What are the different types of bipolar disorders?

There are three main types of bipolar disorders (see Table 7):

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

It is also possible for a person to have mixed episodes, whereby a person experiences several manic and several depressive symptoms simultaneously, or rapidly alternates between them, either day-to-day, or even within the same day.

A case study example of how a person experiencing co-occurring bipolar and AOD use disorder may present is illustrated in Box 3.

Table 7: Types of bipolar disorders

Disorder	Symptoms
Bipolar I disorder	Bipolar I is characterised by one or more manic episodes, which can be preceded or followed by hypomanic or major depressive episodes.
Bipolar II disorder	Bipolar II is characterised by recurring mood episodes, consisting of at least one or more major depressive episodes and at least one hypomanic episode.
Cyclothymic disorder	Cyclothymic disorder is characterised by chronic (at least two years), fluctuating disturbances in mood involving numerous periods of hypomanic and depressive symptoms. The symptoms do not meet the criteria for a manic or major depressive episode.

Box 3: Case study C: What does co-occurring bipolar disorder and AOD use look like? Scott's story

Case study C: Scott's story

Scott, a 25-year-old who identified as male, presented to an AOD service on the recommendation of his manager. Scott worked on a remote mining site in a 'fly-in-fly-out' capacity, where he worked in cycles consisting of 14 consecutive days of 12-hour shifts, followed by 14 days of leave. In a random drug test, Scott screened positive for amphetamine-type stimulants, and he was advised by his supervisor, who was very supportive, to take leave to address this in his home city. Scott's girlfriend accompanied him to his assessment at his local AOD service.

On assessment, Scott told the AOD worker that he loved his job but found the cycles of long shifts and long periods of leave incredibly difficult. He had recently been using stimulants more often to help him get through the long shifts, but knew it was a risk with the random drug testing that sometimes takes place. Scott told the AOD worker that he started smoking pot when he was about 13 years old and remembers drinking a lot of alcohol at high school parties, though he didn't remember drinking much apart from at social gatherings. At university, Scott used cocaine and MDMA recreationally.

Scott had not told his GP about his AOD use but had seen him in the past about several periods of depression that he first experienced in his teens. He said that during these times, he had experienced very low mood, had no energy or interest in anything, and spent all of his time in his bedroom watching TV or sleeping. Scott said that although he had at times thought that life wasn't worth living when he was feeling extremely low, he had never seriously considered killing himself. He said he had previously been prescribed two different types of antidepressants but couldn't remember what they were – he stopped taking them because he thought they helped for a little while, but then stopped working. He had never seen a psychologist.

When not feeling low, Scott said he considered himself as a 'party guy', and the type of guy that people enjoyed being around – he loved to have fun at work. Because of the nature of his work, Scott earned a lot of money but had been spending beyond his means on extravagant purchases and getting into debt. He told the AOD worker that recently, he was called into his manager's office because a couple of his co-workers had complained about him, saying they didn't want to work on the same shift as him, because they thought he was behaving recklessly and dangerously, compromising their safety. Scott said he was shocked by this and thought they were over-reacting – he didn't think there was a problem and thought they should all 'lighten up'.

Key points:

- What are the primary concerns for Scott?
- Where to from here?

Case study C continues in Chapter B7.

What are depressive disorders?

The predominant feature of depressive disorders is the presence of sad, empty, or irritable mood, accompanied by physical and cognitive changes that significantly impair a person's ability to function. Differences between the depressive disorders depend largely on duration, timing, or origin.

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

What are the different types of depressive disorders?

There are two main types of depressive disorders (see Table 8):

- Major depressive disorder.
- Persistent depressive disorder.

A case study example of how a person experiencing co-occurring depression and AOD use disorder may present is illustrated in Box 4.

Table 8: Types of depressive disorders

Disorder	Symptoms
Major depressive disorder	Major depressive disorder is characterised by one or more major depressive episodes in which five or more of the following symptoms are experienced nearly every day for at least two weeks: • Depressed mood most of the day, nearly every day (e.g., feels sad, empty, hopeless; appears tearful). • Loss of interest or enjoyment in activities. • Reduced interest or pleasure in almost all activities. • Change in weight or appetite. • Difficulty concentrating or sleeping (e.g., sleeping too much or too little). • Restlessness and agitation. • Slowing down of activity. • Fatigue or reduced energy levels. • Feelings of worthlessness or excessive/inappropriate guilt. • Recurrent thoughts of death, suicidal thoughts, attempts, or plans.

Table 8: Types of depressive disorders (continued)

Disorder	Symptoms
Major depressive disorder	A person may have a single episode, or they may have recurrent episodes over their lifetime. The duration of depressive episodes may range from weeks to years.
Persistent depressive disorder	Persistent depressive disorder is a consolidation of the previous diagnoses of dysthymia and chronic major depressive disorder, and is characterised by at least two years of depressed mood more days than not, as well as other depressive symptoms such as appetite changes, sleeping problems, fatigue, feelings of worthlessness and hopelessness.

Box 4: Case study D: What does co-occurring depression and AOD use look like? Sheryl's story

Case study D: Sheryl's story

Sheryl, a 49-year-old who identified as female, was brought in to see her GP at the insistence of one of her adult daughters. On a routine visit home, her daughter became very concerned about her, insisted on making an appointment for Sheryl, and also accompanied Sheryl to her GP appointment.

Sheryl told her GP that since her twin daughters had moved out of home, which occurred several months earlier, she and her husband had separated. They had been together for 29 years. Since they all left, she has felt depressed and does not feel like she has any purpose. She was not able to leave her home much during the pandemic, but she was not bothered by this as she had no desire to leave the house and lost interest in things that she used to enjoy, such as gardening. She also hadn't kept in touch with her friends and hadn't even told them that her husband left. Sheryl also told the GP that she suspected that she's peri-menopausal and thought these feelings were 'normal' for this stage of life.

The GP conducted a routine medical assessment, which included Sheryl's weight, blood pressure, and ordered blood tests. The GP remarked that Sheryl had gained a significant amount of weight in the past two months which surprised Sheryl, as she hadn't been eating and had almost no appetite. Sheryl's daughter asked her mother why she hadn't noticed that her clothes were tighter, and Sheryl said that she hadn't been getting dressed – she had been wearing pyjamas or her nightgown around the house most of the time.

The GP asked Sheryl a little more about her sense of purposelessness, and Sheryl assured her that she had no plans to end her life. Sheryl said that she 'just wants to sleep'. She told the GP that she had always had trouble sleeping and was very 'high strung' and anxious when she was younger, working in a high-

Box 4: Case study D: What does co-occurring depression and AOD use look like? Sheryl's story (continued)

pressure job. Sheryl and her husband's family were very conservative, so when Sheryl became pregnant, she gave up her career to become a full-time mum, as was expected of her, but expressed that she was also happy to do so. Sheryl told the GP that over the past few months, she'd had more trouble sleeping and had been taking more of the sleeping tablets prescribed to her to help her get to sleep and stay asleep throughout the night. Sheryl also said that sometimes she had been taking sleeping pills during the day, as she had just wanted to sleep.

Key points:

- What are the primary concerns for Sheryl?
- Where to from here?

Case study D continues in Chapter B7.

What are anxiety disorders?

Feeling anxious is not necessarily problematic. Many people feel anxious because they have reason to; for example, they may be in prolonged lockdown due to an ongoing global pandemic, be facing economic hardship, be experiencing difficulties with housing or relationships, or may be preparing for a presentation at work. Many people undergoing AOD treatment will experience anxiety which can be a consequence of intoxication, withdrawal, or learning to live without using substances. This anxiety usually reduces over time with a period of abstinence. A person's anxiety is problematic, however, when it is persistent, or so frequent and intense that it prevents the person from living their life in the way that they would like.

People with anxiety disorders often experience intense feelings of fear and anxiety. Fear is an emotional response that refers to real or perceived imminent threat, and anxiety is the anticipation of future threat. Although fear and anxiety overlap, they are associated with differing autonomic responses. Fear is associated with a flight or fight response, thoughts of immediate danger, and escape. Anxiety is more commonly associated with muscle tension, hypervigilance in preparation for danger, and avoidance. Feelings of panic are also common among people with anxiety disorders.

Panic attacks in themselves are not a specific disorder, but when they are severe and bring about a sustained change in behaviour, they may amount to panic disorder (Table 10). Panic attacks are a symptom common to many of the anxiety disorders. The symptoms of a panic attack are outlined in Table 9, although not all panic attacks include all symptoms. Panic attacks can be terrifying. As many panic attack symptoms mirror those of a heart attack, many people who experience them (particularly

for the first time) have a genuine fear that they are going to die. Given the overlap in symptoms (e.g., shortness of breath, chest pain and tightness, numbness and tingling sensations), it is important that a person displaying these symptoms be referred to a medical practitioner.

Table 9: Symptoms of a panic attack

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

What are the different types of anxiety disorders?

Anxiety disorders differ from one another in the types of objects or situations that induce fear, anxiety or avoidance, and duration. There are a number of different types of anxiety disorders (see Table 10):

- Generalised anxiety disorder (GAD).
- Panic disorder.
- Agoraphobia.
- Social anxiety disorder (SAD).
- Specific phobia.

There are some differences in the way that DSM-5-TR and ICD-11 classify anxiety disorders. In relation to GAD, for example, while both systems base the diagnosis on the presence of anxiety and worry in relation to different life situations, events or activities, the ICD-11 also allows for 'free-floating anxiety', or general apprehension that is not focused on any particular circumstance. Another difference is in the length of time symptoms are required to be present to receive a diagnosis (i.e., at least 6-months for DSM-5-TR relative to 'at least several months' in ICD-11 [155]).

A case study example of how a person experiencing co-occurring anxiety and AOD use disorder may present is illustrated in Box 5. It should be noted that OCD, PTSD, and acute stress disorder were previously categorised as anxiety disorders but have been moved from this broader disorder category in the DSM-5-TR. These disorders are described later in this chapter.

Table 10: Types of anxiety disorders

Disorder	Symptoms
Generalised anxiety disorder (GAD)	GAD is marked by excessive anxiety or worry, occurring more days than not, for at least six months, about a number of events or activities (e.g., performance at work or school). The worry or anxiety is difficult to control and is associated with at least three of the following: • Restlessness or edginess. • Being easily fatigued. • Difficulty concentrating. • Irritability. • Muscle tension. • Sleep disturbance (difficulty falling or staying asleep, restless, unsatisfying sleep). These symptoms cause significant distress or interfere with a person's occupational or social functioning.
Panic disorder	Panic disorder involves the experiencing of unexpected panic attacks followed by at least one month of persistent concern or worry about having another attack, and the implications of having another attack. As a result, the person changes their behaviour in relation to the attacks. Panic disorder is sometimes accompanied by agoraphobia.
Agoraphobia	Agoraphobia involves marked fear or anxiety about two or more of the following, for at least six months: • Using public transportation (e.g., buses, trains, taxis, planes, ships). • Being in open spaces (e.g., parking lots, bridges). • Being in enclosed spaces (e.g., shops, movie theatres). • Standing in line or being in a crowd. • Being outside the home alone. The person avoids these situations because of anxiety about being in places or situations from which escape might be difficult or embarrassing, or in which help may not be available, in the event of a panic attack. The person avoids these places or situations, or if such situations are endured there is considerable distress or anxiety, or the need for a companion.

Table 10: Types of anxiety disorders (continued)

Disorder	Symptoms
Social anxiety disorder (SAD)	SAD (formerly known as social phobia) is characterised by excessive anxiety or worry about one or more social situations for at least six months, where their actions may be analysed by others. Examples of these kinds of situations include meeting new people, or eating, drinking, performing, or speaking in public. A person with SAD fears they will be negatively evaluated, humiliated, embarrassed, or rejected. The social situations almost always provoke the same feelings of distress or anxiety and are avoided or endured with intense fear or anxiety, which is disproportionate to the actual threat posed by the situation. Fearing embarrassment, humiliation, or rejection is not necessarily unusual, but a person with SAD will fear the situation to the point where their avoidance or anxiety causes significant distress and interferes with their ability to function.
Specific phobia	Specific phobia is characterised by excessive or unreasonable fear of a specific object or situation that causes immediate anxiety and/or panic attacks, for at least six months. Phobic cues may include animals; blood, injury or injections; situations involving the natural environment (such as heights or storms); or other specific situations such as airplanes, lifts, or enclosed spaces. The person avoids the feared places or situations, or if such situations are endured there is considerable distress or anxiety. Having a fear is not so unusual, but when it interferes with performing the responsibilities in a person's life it can become a problem. For example, having a fear of flying is not a problem until a person finds themselves planning a holiday overseas or that they need to travel for work.

Box 5: Case study E: What does co-occurring anxiety and AOD use look like? Declan's story

Case study E: Declan's story

Declan, a 37-year-old account executive for a high-profile advertising agency, was referred to his local AOD service after a recent hospital admission. Declan's job is extremely stressful, with numerous social activities and events, that he has been finding increasingly difficult. He is very fit and attends the gym most days before work.

Box 5: Case study E: What does co-occurring anxiety and AOD use look like? Declan's story (continued)

On assessment, Declan told the AOD worker that he didn't know if he should be there at all, he didn't think he had much of a problem, but his recent hospital trip had scared him, and he thought it wouldn't hurt to see if he needed help. Declan said that his job required him to meet with important clients and also present in client meetings, which he hated. In particular, he hated the attention and having people looking at him when he spoke. After presenting at a meeting with important clients about 18 months ago, Declan was asked a very difficult question and felt his mind go blank. He felt everyone looking at him and started sweating and shaking, had difficulty breathing, with tightness in his chest accompanied by chest pain. He thought he was having a heart attack and collapsed mid-meeting. Declan was taken by ambulance to hospital, where he was told he had experienced a panic attack.

While his colleagues are also his mates, they have also taken to making fun of the incident, often asking before big client meetings whether Declan will make it through, or should they have the ambulance on stand-by. Declan has since been terrified of having another panic attack, and has been feeling increased anxiety at client lunches, meetings, and seminars. One evening, Declan told his boss about his anxiety, but his boss did not seem to understand the severity of Declan's fear, and replied, 'yes, I used to feel nervous before presenting as well. Don't worry, it'll get easier the more you do it, I'll put you down to do a few more'. In talking to another close colleague about his anxiety about a year ago, his colleague mentioned that he also sometimes felt nervous before big meetings but felt much better after doing a couple of lines. Since that time, Declan has been using cocaine before client lunches and meetings and found that it increased his confidence and reduced his anxiety.

Declan's most recent hospital admission followed another incident where he was taken to emergency after collapsing in a client meeting mid-presentation. He expected to be told that he had experienced another panic attack but was shocked when he was told by the doctors that he had experienced a heart attack. His blood tests showed recent amphetamine type substance use.

Key points:

- What are the primary concerns for Declan?
- Where to from here?

Case study E continues in Chapter B7.

What is obsessive-compulsive disorder (OCD)?

Previously categorised as an anxiety disorder, OCD now sits within the 'obsessive-compulsive and related disorders' category in DSM-5-TR, which also includes body dysmorphic disorder, hoarding disorder, trichotillomania (hair-pulling disorder), and excoriation (skin picking disorder).

OCD is characterised by the presence of obsessions, compulsions, or both (see Table 11 and Table 12). It is distinct from feeling a need for neatness, cleanliness, or order (which is sometimes referred to as 'obsessive-compulsive' or 'OCD'). OCD is often long-lasting and debilitating with people feeling compelled to prevent disasters befalling loved ones or alleviate anxiety by performing rituals which cause significant distress.

Table 11: Predominant symptoms associated with OCD

Obsessions and compulsions
Obsessions (often referred to as ruminations) are recurring, persisting thoughts, urges, or images that are intrusive and unwanted, and cause anxiety or distress in most people. The person attempts to ignore or suppress their obsessive thoughts, urges or images, or counteract them with another thought or action (i.e., by performing a compulsion). Examples of obsessions include persistent fears of contamination, thinking they are to blame for something, or an overwhelming need to do things perfectly.
Compulsions (often referred to as rituals) are repetitive mental acts or behaviours that a person feels driven to perform, in response to an obsession or according to rules that must be strictly followed. The mental acts or behaviours are aimed at preventing or reducing anxiety or distress, or preventing a dreaded event; however, the behaviours or mental acts are not connected to what they are designed to counteract in any realistic way, or they are clearly excessive. Examples of compulsive behaviours include the need to repeatedly wash one's hands due to the fear of contamination, check that things have been done (e.g., whether doors or windows have been locked, appliances switched off), or avoid certain objects and situations (e.g., holes in the road, cracks or lines in the pavement). Examples of mental acts include counting or repeating words silently.

A case study example of how a person experiencing co-occurring OCD and AOD use disorder may present is illustrated in Box 6.

Table 12: Obsessive-compulsive disorder (OCD)

Obsessive-compulsive disorder (OCD)
OCD is characterised by the presence of obsessions, compulsions, or both. The obsessions or compulsions are time-consuming, taking at least one hour per day, or cause significant distress. As the performance of these rituals is time-consuming, they can significantly interfere with the person's social and occupational functioning.

Box 6: Case study F: What does co-occurring OCD and AOD use look like? Ayla's story

Case study F: Ayla's story

Ayla is a 19-year-old who is currently living with her parents. She presented to her local AOD service at the insistence of her parents who came across her stash of cannabis when her mother was straightening her room. Although her mother has brought Ayla to her appointment, she has remained in the waiting room while Ayla speaks to the AOD worker.

On assessment, Ayla was at first quiet and appeared to be withdrawn. She told the AOD worker that she had been using cannabis daily to slow down or dampen her thoughts. Ayla eventually broke down in tears and told the AOD worker that she had been having obsessive thoughts and behaviours that she had to perform, for a long time. Ayla said that when she was in school, she was always the last one to leave the classroom because she had to make sure that every letter on the whiteboard had been copied down in her notebook exactly right. She was usually late to the next class because of this repetitive checking, and she often had difficulty sleeping because she was reliving the day's classes in her mind, trying to remember if she had copied down all the notes correctly. On one occasion, she was called in to see the school counsellor because of her continual lateness. The counsellor told Ayla that she thought Ayla might have generalised anxiety disorder and should try to 'forget' about her obsessive thoughts and stop worrying so much. The counsellor told her to focus on what she wanted to do after she left school.

Ayla told the AOD worker that as she got a bit older, she started having intrusive negative thoughts about harm befalling her family. Ayla said that if she didn't tap her bedroom door handle seven times every time she entered or left the room, her family would die. Seven was a meaningful number for Ayla, because she had two parents plus two sisters plus two dogs (and herself). If Ayla didn't feel 'right' about the tapping, or if she thought she tapped eight times instead of seven, she had to start again. Ayla told the AOD worker that her tapping then extended to a need to check and recheck all the lights in her room before leaving her room and when going to bed. Ayla tried to explain that even when the lights were off, she would have to carefully check the bulb and the light switch, not believing or trusting her eyes that they were off, so needing to turn them on and back off again. When she left home, she would take pictures of the switches and the globes and keep looking at them and also replay the ritual of turning them off over and over in her mind.

Ayla told the AOD worker that tapping or turning the switches would provide her with a few seconds of relief, but this was always short-lived, and she would need to repeat it to alleviate her obsessive thoughts. Ayla said it was like 'an itch that I just have to scratch'. She told the AOD worker that she understood that there was no logic or rationality to her thoughts and behaviours, but she couldn't stop herself from performing her rituals. Ayla said she was lonely but had trouble forming and maintaining friendships because she was always distracted by her thoughts and couldn't engage with another person.

Since leaving school she had tried several different part-time jobs, but because she took several hours to leave the house, she was unable to keep any of them. Her sisters and a couple of old school friends had told her to relax, and Ayla had tried yoga, meditation, and mindfulness – all of which she found frustrating

Box 6: Case study F: What does co-occurring OCD and AOD use look like? Ayla's story (continued)

and of little benefit. Ayla told the AOD worker that smoking weed was the only thing she has found useful, as it dulled and slowed her thoughts. She said that smoking a 'ton' of weed was the only way she could now get to sleep.

Ayla told the AOD worker that she was completely exhausted and just wanted the obsessions and compulsions to stop. She said the only way she could realistically see that happening was if she ended her life.

Key points:

- What are the primary concerns for Ayla?
- Where to from here?

Case study F continues in Chapter B7.

What are trauma-related disorders?

Trauma is a term that is widely used and may mean different things to different people. In these Guidelines, we use the word trauma to refer to an extremely threatening or horrific event, or a series of events, in which a person is exposed to, witnesses, or is confronted with a situation in which they perceive that their own, or someone else's, life or safety is at risk [10, 11]. Examples of potentially traumatic events include, but are by no means limited to, being involved in a road traffic accident; experiencing or being threatened with physical or sexual assault; being in a life-threatening car or other form of accident; combat exposure or being in a place of war or conflict; or witnessing any of these events. The most important factor in understanding a person's experience of an event is whether or not they perceived it to be a traumatic event; events that may be traumatic to some people may be perceived as relatively minor, and vice versa.

Most people will experience some emotional or behavioural reactions following exposure to a traumatic event such as anxiety or fear, aggression or anger, depressive or dissociative symptoms. These emotional and behavioural responses are to be expected and are a completely normal response to an adverse event. For the majority of people, these reactions will subside and/or reduce in intensity over time without the need for any intervention; for some people, however, these reactions may be prolonged, leading to significant distress, as well as impairment in social, occupational and other areas of functioning [102, 156, 157].

What are the different types of trauma-related disorders?

There are two main trauma-related disorders according to DSM-5-TR:

- Post traumatic stress disorder (PTSD).
- Acute stress disorder.

Previously classified as anxiety disorders, these disorders have been grouped with other trauma- and stressor-related disorders in the DSM-5-TR. It should be noted that the DSM-5-TR does not require a person to have experienced a sense of fear, helplessness, or horror at the time of the traumatic event, in order to meet criteria for either of these disorders, as was the case in DSM-IV-TR.

The structure of the criteria has also changed (there are now four symptom clusters instead of three) and three new symptoms have been added. A summary of the DSM-5-TR criteria is provided in Table 13; however, readers are encouraged to refer to DSM-5-TR for a more detailed explanation of the changes made between editions. A case study example of how a person experiencing co-occurring PTSD and AOD use disorder may present is illustrated in Box 7.

Table 13: Types of trauma-related disorders

Disorder	Symptoms
Post traumatic stress disorder (PTSD)	PTSD is a disorder that may develop after a person has experienced or been exposed to a traumatic event during which the person perceived their own (or someone else's) life or physical integrity to be at risk. Following the event, for at least one month, the person experiences some of the following symptoms: • Re-experiencing: Spontaneously re-experiencing the event in the form of unwanted and intrusive memories, recurrent dreams or nightmares, or 'flashbacks'. • Avoidance: Avoiding memories, thoughts, feelings, or external reminders of the event (e.g., people, places or activities). • Negative cognitions and mood: Feeling a distorted sense of blame of self or others, feeling detached from others or less interest in activities, or inability to remember key aspects of the event. • Arousal: Aggressive, reckless, self-destructive behaviour, sleep disturbances, hypervigilance, or increased startle response. Symptoms may begin immediately after the traumatic event, or they may appear days, weeks, months or even years after the trauma occurred.
Acute stress disorder	Acute stress disorder is similar to PTSD but lasts for less than one month following exposure to a traumatic event. Acute stress disorder may remit within one month following exposure to the traumatic event, or it may progress to PTSD.

It should be noted that unlike the DSM-5-TR, the ICD-11 has not expanded the number of symptom clusters that are required to meet a diagnosis of PTSD. According to ICD-11, a diagnosis of PTSD continues to be based on the presence of re-experiencing, avoidance, and arousal symptoms. However, the ICD-11 has introduced a new diagnosis of complex PTSD that is characterised by an additional cluster of symptoms referred to as disturbances in self-organisation (see Table 14). These disturbances in self-organisation include difficulties in regulating emotion (e.g., problems calming down, feeling numb or emotionally shutdown), negative self-perception (beliefs about oneself as being not good enough, worthless, or a failure), and difficulties sustaining relationships and feeling close to others [155]. Although complex PTSD may arise in relation to any trauma, it is typically associated with prolonged or repeated interpersonal traumas or neglect that occur during childhood [158].

A person can either be diagnosed as having PTSD or complex PTSD, but not both. That is, according to ICD-11, a person who is experiencing re-experiencing, avoidance, and arousal symptoms, but not disturbances in self-organisation, may be diagnosed as having PTSD; whereas a person who is experiencing re-experiencing, avoidance, and arousal symptoms, and disturbances in self-organisation, may be diagnosed as having complex PTSD. Although DSM-5-TR does not recognise complex PTSD as a separate diagnosis, two of the three symptoms of disturbances in self-organisation (negative self-perception and difficulties sustaining relationships) are included within the DSM-5-TR's newly added PTSD symptom cluster of negative cognitions and mood [155]. To bring these two different but overlapping concepts together, in these Guidelines, we refer to the broad diagnosis of PTSD but highlight that many people will experience it in its more complex form.

Another notable difference between the DSM-5-TR and ICD-11 is that the ICD-11 no longer classifies acute stress reaction as a mental disorder, but as one of the 'Factors Influencing Health Status or Contact with Health Services'. In doing so, the ICD-11 recognised that these acute responses to trauma are considered to be normal given the severity of the stressor, and usually subside within a few days following the event or removal from the threatening situation.

Table 14: Symptoms of PTSD and complex PTSD according to ICD-11

	Symptoms	PTSD	Complex PTSD
Core PTSD symptoms	**Re-experiencing:** Re-experiencing the traumatic event(s) in the present in the form of vivid intrusive memories, flashbacks, or nightmares; may occur via one or multiple sensory modalities and is typically accompanied by strong or overwhelming emotions, particularly fear or horror, and strong physical sensations.	✓	✓
	Avoidance: Avoidance of thoughts and memories of the event or events, or avoidance of activities, situations, or people reminiscent of the event(s).	✓	✓
	Arousal: Persistent perceptions of heightened current threat (e.g., hypervigilance, enhanced startle response).	✓	✓

Table 14: Symptoms of PTSD and complex PTSD according to ICD-11 (continued)

	Symptoms	PTSD	Complex PTSD
Disturbances in self-organisation	**Problems in affect regulation:** E.g., problems calming down, feeling numb or emotionally shutdown.	✗	✓
	Negative self-perception: Beliefs about oneself as diminished, defeated or worthless, accompanied by feelings of shame, guilt or failure related to the traumatic event.	✗	✓
	Relationship difficulties: Difficulties in sustaining relationships and in feeling close to others.	✗	✓

Box 7: Case study G: What does co-occurring PTSD and AOD use look like? Julie's story

Case study G: Julie's story

Julie, a 35-year-old who identified as female, had presented for AOD treatment on a number of occasions for polydrug use, although she was primarily concerned with her use of heroin and prescription opioids. She had been using on and off for the past 20 years and struggled to control her alcohol and cannabis use. Her longest period of abstinence from heroin was six months. At the time of her presentation, she was receiving the Disability Support Pension and lived in accommodation provided by the Department of Housing with her partner, though they hadn't been together for very long. Her most recent relapse occurred following a sexual assault by her former partner.

In Julie's treatment file, one of Julie's prior treating clinicians had noted a history of 'childhood trauma', but no specific details. Subsequent admissions referred to this having been 'noted on previous admission' with no further information provided. After Julie's disclosure of the impact of the most recent assault, the AOD worker asked whether she had experienced any other traumatic events during her life, in childhood or as an adult, and provided some examples of the types of events she was referring to.

Julie was quiet for a moment and became teary, before stating that she had. The AOD worker gently assured Julie that she did not have to talk about anything that she did not want to but asked if it would be ok for them to ask her a few more questions so she could get an understanding of how those events may be contributing towards where she is now. Julie consented, aware that she could stop at any time, or take a break if needed. Julie went on to describe a history of multiple traumas including sexual abuse by a family member that took place over several years, and a number of physical and sexual assaults. Her most recent sexual assault occurred within the context of ongoing domestic violence by her previous partner.

Box 7: Case study G: What does co-occurring PTSD and AOD use look like? Julie's story (continued)

Key points:

- What are the primary concerns for Julie?
- Where to from here?

Case study G continues in Chapter B7.

What are feeding and eating disorders (ED)?

The predominant feature of ED is a persistent disturbance in eating or eating-related behaviours that impacts on food intake and impairs physical health or psychosocial functioning. Some people with ED describe symptoms similar to those associated with AOD use, such as craving and patterns of compulsive use. It is thought this may in part be due to the shared neural pathways, including those involved in self-control and reward; however, in general, the shared features are not well understood [10].

What are the different types of ED?

Although there are several types of ED, we have focused on three main types:

- Anorexia nervosa.
- Bulimia nervosa.
- Binge eating disorder.

Anorexia nervosa, bulimia nervosa and binge eating disorder are characterised by a dysfunctional system of self-evaluation, which, rather than being based on personal qualities and achievements across several domains – such as academic or athletic accomplishments, work achievements, or relationship qualities – is disproportionately focused on weight, size, shape and appearance [159–161]. Binge eating episodes (described in Table 15) are present in bulimia nervosa and binge eating disorder. However, the compensatory behaviours to prevent weight gain, such as strenuous exercise, self-induced vomiting, or misuse of laxatives, that follow episodes of binge eating in bulimia nervosa, are not a feature of binge eating disorder. The types of eating disorders included in these Guidelines are described in Table 16.

Table 15: Binge eating episode

Binge eating episode
An episode of binge eating is characterised by both of the following: • Eating, within a two-hour period, an amount of food that is definitely more than what most people would eat in a similar period of time, under similar circumstances. • A sense of lack of control regarding eating behaviours during the episode (i.e., a person feeling that they are unable to stop eating or control what or how much they are eating).

A case study example of how a person experiencing co-occurring ED and AOD use disorder may present is illustrated in Box 8.

Table 16: Types of feeding and eating disorders (ED)

Disorder	Symptoms
Anorexia nervosa	There are three primary features of anorexia nervosa: • Persistent restriction of energy intake. • Intense fear of gaining weight or becoming fat, or persistent behaviour that interferes with weight gain. • Disturbance in self-perceived weight or shape, disproportionate influence of body weight or shape on self-evaluation, or persistent lack of recognition of the seriousness of the current low body weight. Maintained body weight is below minimally normal for age, sex, development, and physical health.
Bulimia nervosa	Bulimia nervosa is characterised by three essential features, which must occur on average at least once a week for three months: • Recurrent episodes of binge eating. • Recurrent inappropriate compensatory behaviours to prevent weight gain (e.g., vomiting, use of laxatives or other medication, fasting, excessive exercise). • Distorted self-image that is disproportionately influenced by body shape or weight. People with bulimia nervosa are typically ashamed of their eating problems, may attempt to hide their symptoms, and may be within a normal weight range.
Binge eating disorder	The predominant feature of binge eating disorder is recurrent episodes of binge eating that occur at least once a week for three months. The episodes of binge eating cause significant distress to the person.

Box 8: Case study H: What does co-occurring ED and AOD use look like? Kai's story

Case study H: Kai's story

Kai is a 26-year-old who identified as non-binary, and was referred to their local AOD service after being discharged from hospital. Kai had attempted to overdose at home by taking some of their mother's sleeping pills, some non-prescribed opioids along with a bottle of vodka. Kai's mother found Kai unconscious and called an ambulance. Kai managed to convince the very busy staff at emergency that their overdose had been an accident. Though hesitant to believe them, the doctor reluctantly agreed to discharge Kai, provided they would contact their local AOD service the next day. Kai agreed and Kai's mother promised to take them.

On assessment, the AOD worker noted Kai's loose clothing. Kai told the AOD worker that they wore baggy clothing to not draw attention to themselves and said they came from a traditional and conservative family. Kai said their family loved them a lot but they have struggled to understand their non-binary identity. They have had difficulties with pronouns and have been awkward when speaking about Kai to family or friends, which has led to increased discomfort and distance in their relationship. Kai has struggled with feelings of shame and guilt, which have been compounded by their family's discomfort around them. They told the AOD worker they had been drinking a bottle of wine every day, been taking non-prescribed opioids for at least the past few years, and smoking cigarettes.

The AOD worker also noted that Kai seemed to be lacking in energy, appeared to be slight and fragile, and looked very cold. Kai told the AOD worker that they had previously been diagnosed with anorexia nervosa and had been hospitalised several times in the past for refeeding and monitoring. Kai said that their mother had always been extremely weight conscious as far back as they could remember, constantly dieting and monitoring her own food intake as well as the intake of the rest of the family. Kai said they had struggled with feelings of perfectionism their whole life, and felt they could control being thin. Kai said that they were aware things 'weren't great' at the moment and alcohol had been the primary caloric intake for the past few months. They told the AOD worker that they were extremely tired, felt isolated and alone and wanted it to stop.

Key points:

- What are the primary concerns for Kai?
- Where to next?

Case study H continues in **Chapter B7**.

What are personality disorders?

The term 'personality trait' refers to a person's individual patterns of thinking, feeling, and behaving. These patterns of thinking and behaving usually begin in childhood and continue through to adulthood. Our personality traits make us who we are – they are what make each of us unique. However, personality traits can become problematic when they cause difficulties with relationships, education or employment, and sometimes with the law. If patterns of thinking, feeling, or behaving are creating lots of problems in many areas of a person's life, they may have a personality disorder [10, 162].

Personality disorders are highly stigmatised conditions, even within mental health and healthcare more broadly. As such, it is vital that any communication regarding clients with possible personality disorders – whether the communication involves the client, loved ones or other healthcare providers – remains respectful, non-judgemental, compassionate and client-centred. As mentioned in the introduction of these Guidelines, the language used in this section and throughout this document is intended to provide workers with the functional knowledge to identify conditions and communicate with other areas of health (e.g., mental health services). As such, we have used diagnostic and classification terminology as included in the DSM-5-TR and ICD-11. However, we also make reference to resources that workers may find useful when communicating with their clients, or with broader audiences.

A wide range of personality disorders are currently recognised by the DSM-5-TR (see Table 17). All involve pervasive patterns of thinking and behaving, which means that the patterns exist in every area of a person's life (i.e., work, study, home, leisure, and so on). The most significant feature of personality disorders is their negative effect on personal relationships. A person with an untreated personality disorder often has difficulty forming long-term, meaningful, and rewarding relationships with others. A person with a personality disorder may not necessarily become upset by their own thoughts and behaviours but may become distressed by the consequences of their behaviours [163].

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

It is important to note that there is a great deal of contention as to the utility of the DSM-5-TR's current approach to diagnosing personality disorders, and DSM-5-TR itself has proposed an alternative model for personality disorders (see Section III of DSM-5-TR; [10]) which is more aligned with the ICD-11 classification [164]. The ICD-11 approach first assesses whether a person meets general criteria for a personality disorder, establishes severity (mild, moderate, or severe), and then describes the main features that contribute to the personality disturbance based on trait domain qualifiers. These include negative affectivity, detachment, dissociality, disinhibition, and anankastia. A borderline pattern is also available, which corresponds to DSM-5-TR BPD.

What are the different types of personality disorders?

Based on their similarities, personality disorders are grouped into three clusters (see Table 17). Among those with AOD use disorders, two Cluster B personality disorders, ASPD and BPD, are most prevalent and tend to impact most upon treatment [162, 165–167].

Table 17: Types of personality disorders

Personality disorders

CLUSTER A: 'odd' or 'eccentric' characteristics

People with Cluster A-type personality disorders often appear to be odd or eccentric. They have significant impairment but infrequently seek help:

Paranoid personality disorder is characterised by a pattern of distrust and suspiciousness such that others' motives are interpreted as malevolent.

Schizoid personality disorder is characterised by a pattern of detachment from social relationships and a restricted range of emotional expression.

Schizotypal personality disorder is characterised by a pattern of acute discomfort in close relationships, cognitive or perceptual distortions, and eccentricities of behaviour.

CLUSTER B: 'dramatic', 'emotional', or 'impulsive' characteristics

People with Cluster B-type personality disorders appear to be dramatic, emotional, and erratic. Generally, they experience significant impairment and are of considerable concern to health care providers. Of all the personality disorders, people with Cluster B disorders most commonly present to services:

Antisocial personality disorder (ASPD) is characterised by a pattern of disregard for and violation of the rights of others. Individuals with this personality disorder are typically aggressive, unlawful, and impulsive.

Borderline personality disorder (BPD) is characterised by a pattern of instability in interpersonal relationships, self-image, and feeling states, with marked impulsivity and chaos.

Histrionic personality disorder is characterised by a pattern of excessive emotionality including being dramatic, attention-seeking, and seductive.

Narcissistic personality disorder is characterised by a pattern of grandiosity and self-centredness and thus lacking empathy for others.

CLUSTER C: 'anxious', 'fearful', or 'avoidant' characteristics

People with Cluster C-type personality disorders appear to be anxious and fearful and are generally less impaired than those with Cluster B personality disorders:

Avoidant personality disorder is characterised by a pattern of social inhibition with feelings of inadequacy and hypersensitivity to negative evaluation. Individuals tend to be needy but scared of relationships. There is some debate that this is a form of long-term social phobia.

Dependent personality disorder is characterised by a pattern of submissive and clinging behaviour related to an excessive need to be taken care of. These individuals tend to be indecisive and fear abandonment.

Obsessive-compulsive personality disorder is characterised by a pattern of preoccupation with orderliness, perfectionism, and control; thus, these individuals tend to be rigid and inefficient.

Antisocial personality disorder (ASPD)

The main feature of ASPD (previously known as 'psychopathy' or 'sociopathy') is a pattern of personality traits that involves the disregard of other people's feelings or rights. People with ASPD may behave in ways that are considered deceitful or manipulative to get their own way (e.g., behaving in a very charming way in order to obtain something, and then indifferently once they have it [168]). The main characteristics of ASPD are described in Table 18.

ASPD begins in childhood or early adulthood and continues into adulthood. For a diagnosis of ASPD to be made, the person must be at least 18 years old, and have experienced some symptoms of conduct disorder before the age of 15. The behaviours characteristic of conduct disorder fall into the following characteristics: aggression to people and animals, destruction of property, deceitfulness or theft, and serious violation of rules. For people with ASPD, this pattern of antisocial behaviour continues into adulthood.

Table 18: Characteristics of ASPD

Main characteristics of ASPD
Difficulty following rules or conforming to social norms with respect to lawful behaviour. People with ASPD may repeatedly be involved in behaviours that are grounds for arrest (e.g., destroying property, harassing others, stealing, or pursuing illegal occupations).
Behaving deceptively or manipulatively. People with ASPD may be deceptive or manipulative in order to get their own way (e.g., to obtain money, sex, or power).
A tendency for impulsive behaviour due to a failure to plan ahead. Decisions may be made on the spur of the moment, without forethought, and without consideration of the consequences for themselves or others. This may lead to sudden changes of jobs, residences, or relationships.
Irritability and aggression. A person with ASPD may be repeatedly involved in physical fights or assaults and may be aggressive towards other people.
Disregard for their own or other's safety. For example, recurrent speeding, driving while intoxicated, multiple accidents, or high-risk sex.
Consistent and extreme irresponsibility. For example, irresponsible work behaviour, such as long periods of unemployment despite several job opportunities, abandonment of jobs without a plan for getting another, or repeated unexplained absences from work. Financial irresponsibility may include acts such as defaulting on debts and failing to provide child support.
The absence of remorse for the consequences of their actions. People with ASPD tend to provide superficial excuses for having hurt, mistreated, or stolen from someone. They may blame the victims of their actions for being foolish, helpless, or deserving their fate. People with ASPD may have difficulty showing empathy towards other people or remorse for their behaviour and may instead focus on self-interests.

Borderline personality disorder (BPD)

BPD comprises a pattern of personality traits that involves strong emotions, issues with self-image [169], impulsive behaviours and unstable relationships with other people. BPD is also characterised by impulsivity, particularly in relation to behaviours that may be self-damaging. People with BPD experience difficulties regulating their emotions and expressing their feelings to other people. They are often described as having very intense, uncontrollable emotions, that can change suddenly. The distress associated with such overwhelming feelings can result in some people with BPD hurting themselves or others as a way of coping with their intense emotions [169].

As with ASPD, behaviours typically begin in early adolescence or early adulthood, and are pervasive across several areas of a person's life (e.g., work, study, relationships). The main characteristics of BPD are described in Table 19.

A case study example of how a person experiencing co-occurring BPD and AOD use disorder may present is illustrated in Box 9.

Table 19: Main characteristics of BPD

Main characteristics of BPD
Extreme efforts to avoid rejection or abandonment. Such threats of rejection may be real or imagined. A person with BPD may be extremely sensitive to perceived signs of criticism or rejection, because they fear the person may leave or abandon them.
A pattern of unstable and intense interpersonal relationships, characterised by the person alternating between idealising a person and devaluing them.
Identity disturbance. Markedly and persistent unstable self-image or sense of self. This may result in sudden changes in a person's goals or life values, jobs or career aspirations, sexual identity, or friends.
Impulsivity, particularly in relation to behaviours that are self-damaging (e.g., spending money irresponsibly, binge eating, substance use, unsafe sex, reckless driving).
Recurrent suicidal behaviour, gestures, threats, or self-mutilating behaviour (e.g., cutting or burning) are also common.
Unstable mood (e.g., intense dysphoria, irritability, anxiety or anger usually lasting only a few hours and rarely longer than a few days).
Chronic feelings of emptiness.
Inappropriate, intense anger or difficulty controlling anger (e.g., frequent displays of temper, constant anger, recurrent physical fights).
Transient, stress-related paranoid thoughts or severe dissociative symptoms (i.e., where the person temporarily loses touch with where they are in time and/or space).

Box 9: Case study I: What does co-occurring BPD and AOD use look like? Mira's story

Case Study I: Mira's story

Mira, a 23-year-old who identified as female, was transferred into her local AOD service's opioid treatment program following her recent release from prison. She had been imprisoned for six months for assault and had been receiving methadone while in prison. Upon her release, Mira was living with her older sister. Prior to her incarceration, Mira had been using a range of substances, including heroin, amphetamines, benzodiazepines, cannabis, alcohol and tobacco. Her physical health was visibly poor.

During the assessment, Mira told her AOD worker that she had been raised by her mother and grandmother; her mother had experienced several episodes of depression that had led to hospital admissions. It also became clear that Mira's mother had experienced domestic violence by her partner. Mira eventually told her AOD worker that this man had also sexually abused her, with some of the abusive episodes occurring before puberty. Over the course of her teenage years, Mira displayed episodes of anger and, although she made some close friends, she very quickly alienated them with either outbursts of anger or becoming 'too close and clingy.'

Although Mira had several short-term relationships with men, she quickly realised that some of these relationships were the same as those formed by her mother and involved domestic violence. Despite this realisation, Mira experienced intense feelings of rejection at the end of her relationships, which led to her self-harming by cutting. She had multiple episodes of hospitalisation from self-harming and suicide attempts, the most recent of which was shortly before she went to prison. Mira told the AOD worker that while she was in prison, she had been diagnosed by a forensic psychologist as having BPD.

Key points:

- What are the primary concerns for Mira?
- Where to from here?

Case study I continues in Chapter B7.

What are substance-induced disorders?

Substance-induced disorders are disorders that occur as a direct physiological consequence of AOD intoxication or withdrawal. For a diagnosis of a substance-induced disorder to be made, symptoms of the disorder must only be present following intoxication or withdrawal. If the person displays symptoms of the disorder in the absence of intoxication or withdrawal, it is possible they may have an independent mental disorder. It is crucial to note that not everyone with mental health symptoms who uses substances is experiencing a substance-induced disorder, and co-occurring AOD and mental disorders are not necessarily substance-induced. Symptoms of substance-induced disorders tend to reduce over time with a period of abstinence [35].

As described in **Chapter A1**, symptoms of mood, anxiety, and psychotic disorders may all be induced as a result of AOD use or withdrawal. For example, alcohol use and withdrawal can induce symptoms of depression or anxiety [33–35]; symptoms of mania can be induced by intoxication with stimulants, steroids, or hallucinogens; and psychotic symptoms can be induced by withdrawal from alcohol, or intoxication with alcohol, stimulants, cannabis, or hallucinogens [36–38]. Other disorders that may result from AOD use include substance-induced delirium, amnestic disorder, dementia, sexual dysfunction, and sleep disorder.

Substance-induced psychotic disorder

It is often extremely difficult to distinguish substance-induced psychosis from other psychotic disorders. With substance-induced psychosis, symptoms (usually delusions and/or hallucinations) tend to appear quickly and last a relatively short time, from hours to days, until the effects of the drug wear off. For some, however, psychosis can persist for days, weeks, months, or longer [170, 171]. It is possible that these people were already at risk for developing a psychotic disorder which has been triggered by substance use [172].

Visual hallucinations are generally more common in substance withdrawal and intoxication than in primary psychotic disorders [173]. Stimulant intoxication, in particular, is more commonly associated with tactile hallucinations, where the patient experiences a physical sensation that they interpret as having bugs under the skin [174, 175]. These are often referred to as ‘ice bugs’ or ‘cocaine bugs’. Visual, tactile and auditory hallucinations may also be present during alcohol withdrawal [176].

People with stimulant psychosis may appear more agitated, hostile, energetic and physically strong, more challenging to contain in a safe environment, and more difficult to calm with sedating or psychiatric medication, than people with psychosis not related to the use of stimulants [177, 178]. Other features that differentiate substance-induced psychosis from schizophrenia include higher likelihood of polysubstance dependence, a forensic history, ASPD, trauma history, parental substance misuse, lower likelihood of family history of psychosis; and a lack of negative and cognitive symptoms with a return to normal inter-episode functioning during periods of abstinence [177]. A case study example of how a person experiencing co-occurring substance-induced psychosis may present is illustrated in Box 10.

It is important to differentiate between symptoms of psychosis and delirium. Delirium presents as a disturbance of consciousness and cognition that represents a significant change from the person’s previous level of functioning. The person has a reduced awareness of their surroundings, their attention wanders, questions often have to be repeated, they have difficulty concentrating, and it may be difficult to engage them in conversation. Changes in cognition may include short-term memory impairment, disorientation (regarding time or place), and language disturbance (e.g., difficulty finding words, naming objects, writing). Perceptual disturbances (e.g., hallucinations) may also occur. Delirium develops over a short period of time (usually hours to days) and tends to fluctuate during the course of the day. For example, a person may be coherent and co-operative in the morning but in the afternoon may be disruptive and wanting to go home to a partner who died years ago. The identification of substance-induced delirium is particularly important for clients undergoing alcohol withdrawal as delirium may progress to delirium tremens, a serious complication that may result in death [176].

Box 10: Case study J: What does substance-induced psychosis look like? Michael's story

Case Study J: Michael's story

Michael, an 18-year-old who identified as male, was brought to emergency by the police. Michael started screaming at his parents one evening and threatened them with a knife. His parents called 000, and police took Michael to the nearest hospital emergency for an evaluation. Prior to this, Michael's parents had noticed that he was uncharacteristically irritable and paranoid, spending long periods of time alone in his bedroom. He did not appear to be sleeping well and was observed to be mumbling to himself. For the past month, he had not gone to any of his university classes.

When he arrived at emergency, Michael was extremely agitated and attempted to strike the nurses and security team. He was given intramuscular lorazepam and haloperidol, but following their administration, tried to flee the hospital because he said the staff were trying to kill him. He appeared to be responding to internal stimuli and would not cooperate with anyone who attempted to conduct a psychiatric evaluation. His parents told hospital staff that he had been diagnosed with ADHD about four weeks earlier and had been prescribed lisdexamfetamine by his treating psychiatrist.

Two weeks later, his psychiatrist had increased his lisdexamfetamine, which Michael took in the morning, and also prescribed dexamphetamine for Michael to take every afternoon to help improve his concentration and ability to study. After having a short sleep, Michael appeared calmer and said that he had some exams coming up which he was very worried about, and had taken double doses of his dexamphetamine tablets over the past three days because he didn't want to sleep, and needed the additional time to prepare for his exams.

Prior to his ADHD diagnosis, Michael had no psychiatric or AOD use history. His urine toxicology was positive only for amphetamines. Michael had no history of any medical condition, no history of seizures or head trauma. There was no family history of any psychiatric disorders. Michael's stimulant medications were discontinued when he was admitted to emergency, and he was treated with risperidone. Michael also started psychotherapy. After five days, Michael was no longer experiencing any hallucinations or delusions, and he was released from hospital with a follow-up appointment to see his psychiatrist.

Key points:

- Symptoms of psychosis emerged within hours of Michael's increased ADHD medication. Following withdrawal from his medication, the psychotic symptoms dissipated within a few days, and Michael regained insight into the situation.
- This pattern of symptoms corresponds with DSM-5-TR substance-induced psychotic disorder, which requires delusions or hallucinations that develop during or soon after medication intoxication or withdrawal. The fact that Michael's symptoms resolved within several days further supports a medication-induced psychotic disorder – this would not be the case for an independent psychotic disorder.

Adapted from Henning, Kurtom, and Espiridion [179].

What do discrepancies between classification systems mean for AOD workers?

In considering the key differences between classification systems, AOD workers should be mindful that the move towards a more dimensional approach of diagnosing mental health conditions emphasises the need to not only use clinical judgement and expertise, but to consider the whole person, with complex presenting issues. While there may be differences between the classification systems, these are often of a technical nature and do not represent huge departures from the diagnoses themselves. For example, there may be differences in which symptoms appear within a particular criterion for a disorder as opposed to another criterion within the disorder (i.e., whether symptom A belongs in criterion B or criterion C of a particular disorder; how many symptoms are required and over what period of time), but the core features of disorders nonetheless remain the same. Irrespective of diagnosis, clinical focus should stay on the person and their presenting symptoms, including their psychological, physical and sociodemographic needs (described in **Chapter B3** and **Chapter B5**).

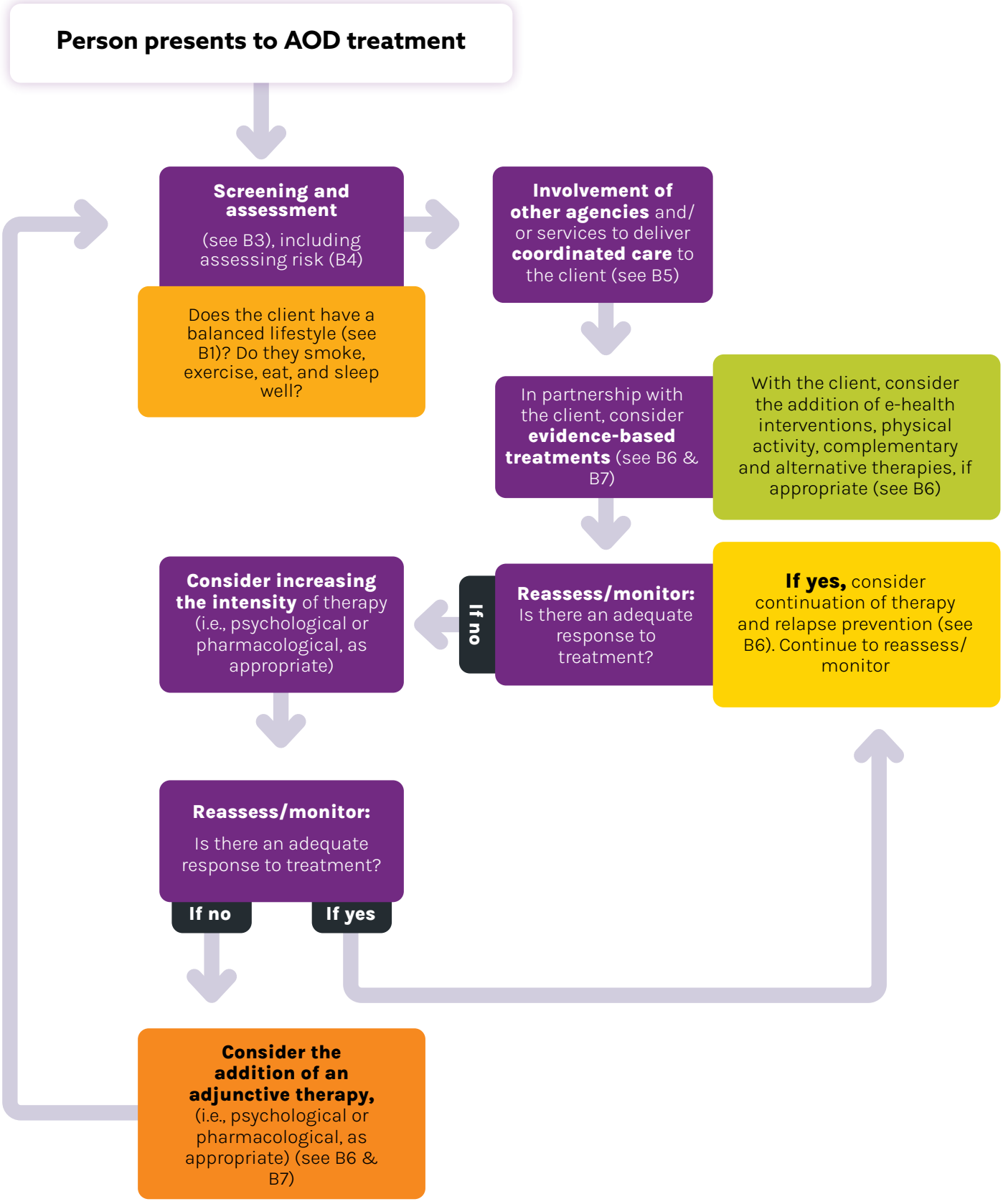
Part B: Responding to co-occurring conditions

Part B: Responding to co-occurring conditions

Part B of the Guidelines aims to provide workers with a range of options for managing and treating mental health symptoms within a holistic health care approach that involves multiple services and integrated care coordination. Mental health symptoms can be identified through screening and assessment processes (see **Chapter B3**), or they may arise spontaneously during the client's treatment. There is a distinction between the management of co-occurring mental health conditions and their treatment. The goal of management is to allow AOD treatment to continue without mental health symptoms disrupting the treatment process, and to retain clients in treatment who might otherwise discontinue such treatment. Without further treatment, these techniques on their own may not provide long-term relief from symptoms; however, they may allow the client's AOD use to be treated in the interim. Both the management and treatment of specific co-occurring disorders are discussed in **Chapter B7**.

It is essential to consider the whole person and accept that one approach is not necessarily going to work for all clients. Different clients present with unique psychological and sociodemographic backgrounds, and it is important to take these factors into consideration when responding to co-occurring conditions. It is also critical to remember that the process of assessments, screenings, monitoring, cooperation, collaboration, and partnerships are indeed processes, which should be ongoing throughout all stages of management and treatment. Figure 10 illustrates a pathway through care model, highlighting the continuing stages of reassessment, monitoring, and client involvement.

Figure 10: Pathway through care model



B1: Holistic health care

B1: Holistic health care

Key points

- People with co-occurring AOD and mental health conditions are at increased risk of physical health problems, with higher mortality rates than the general population.
- People with co-occurring conditions are at particular risk of developing CVD, due to high rates of smoking, overweight and obesity, diabetes, poor diet, physical inactivity, high alcohol consumption, and the use of some antipsychotic medications.
- Recent research has highlighted the need for interventions that focus on overall wellbeing, including reducing smoking, improving dietary habits, increasing physical activity, and sleep patterns.
- Crucial to this approach is the inclusion of multiple service providers who reflect the complex needs of clients, and can deliver the right care, to the right person, at the right time.

The co-occurrence of poor physical and mental health has been well documented; in particular, the role that mental health conditions play in increasing vulnerability to physical disability and poorer outcomes [180–182]. Consumers of mental health services have more than double the mortality rate than the general population [183], largely attributable to CVD [184].

Risk factors for CVD are prominent among people with AOD and mental health conditions [184, 185], and include high rates of smoking [186–188], overweight and obesity [189–191], diabetes [192, 193], poor diet [194, 195], physical inactivity [196–198], excessive alcohol consumption [199, 200], and the use of some antipsychotic medication [201].

Furthermore, these risk factors also place people at risk of metabolic syndrome [202]. Metabolic syndrome is the presence of three or more of the following risk factors [203]:

- Elevated waist circumference (or central obesity).
- Raised triglycerides.
- Increased blood pressure.
- Increased glucose.
- Lowered high-density lipoprotein cholesterol.

Approximately one third of Australians have metabolic syndrome [204], which is directly affected by sleep, physical activity, and dietary behaviours [205, 206]. People with mental disorders (e.g., schizophrenia, bipolar disorder, depression, PTSD, BPD) are at high-risk of metabolic syndrome and associated morbidity and mortality, particularly those prescribed antipsychotics [202, 205, 207, 208].

What is a holistic health care framework?

The multitude of risk factors for premature mortality and poor physical health among those with AOD and mental health conditions provides the impetus for interventions that focus on overall wellbeing. However, there has been hesitation on the part of some service providers to address multiple health behaviours simultaneously due to the belief that making too many lifestyle changes will undermine a person's recovery from AOD use. While this view has been particularly prominent in relation to addressing smoking cessation [209], it has not been confirmed by the evidence, which supports multiple health behaviour change [209–212]. For example, two reviews of smoking cessation interventions found that addressing smoking during AOD treatment actually enhanced long-term AOD treatment outcomes [213, 214]. AOD service providers have a significant opportunity to address multiple risk behaviours of clients with co-occurring conditions and help reduce the risk factors and incidence of chronic disease. There are four primary behavioural risk factors with which AOD workers should be familiar:

- Smoking.
- Diet.
- Physical activity.
- Sleep.

Smoking

Smoking rates among those attending AOD treatment are high, ranging between 48-94% [215–217]. People with AOD and mental health conditions also smoke substantially more cigarettes per day, and are more likely to be nicotine dependent, than the general population [218]. Despite tobacco accounting for the highest rate of mortality among people with AOD and mental health conditions, the focus of AOD treatment has primarily centred on substances other than tobacco [219, 220]. There can be a reluctance to address smoking by AOD workers due to the belief that doing so might exacerbate other AOD use [221], and increase psychiatric symptoms and aggression [209, 222]. However, this view is not supported by the evidence [223]. On the contrary, smoking cessation is associated with improvements in depression [224, 225] and anxiety [226] when integrated into a treatment plan for mental disorders. Three Cochrane reviews have examined the evidence relating to the treatment of nicotine dependence in schizophrenia [227], depression [228] and AOD use disorders [229]. The findings indicate that rates of smoking abstinence were increased by the use of bupropion among people with schizophrenia without threat to their mental health [227]; the inclusion of a psychosocial mood management component to standard smoking cessation treatment among people with current and past depression [228]; and the inclusion of pharmacotherapy (nicotine replacement therapy [NRT], bupropion, varenicline, naltrexone, or topiramate), with no effects on other AOD use (alcohol, opioids, stimulants, cannabis [229]).

Compounds found in tobacco smoke have been shown to increase the rate at which some psychiatric medications are metabolised, by activating particular enzymes involved in the metabolism of those medications [230, 231]. For people who smoke cigarettes while being treated with some psychiatric medications, including olanzapine and clozapine, the increase in metabolism means blood concentrations of these medications are decreased. Differences in the metabolism rates of some

psychiatric medications between those who smoke and those who do not smoke, have implications for the required therapeutic dosages of these medications. A meta-analysis examining the effect of smoking on the concentration to dose ratio of olanzapine and clozapine found daily doses for each should be reduced by 30% and 50% respectively, for people who do not smoke compared to people who smoke [230].

Smoking cessation in the context of an AOD or mental disorder may mean that a person can reduce their psychiatric medication. Crucially, the changes in metabolism associated with reducing or stopping smoking can result in toxic or even fatal levels of clozapine or olanzapine [230–232]. As differences in olanzapine and clozapine blood levels between people who smoke and people who do not smoke are triggered by tobacco smoke, NRT – while useful in managing symptoms of nicotine withdrawal – cannot counteract the effect [231]. Given the potential for toxicity, it has been recommended that doses of olanzapine or clozapine be reduced by 30-40% three to five days after stopping smoking, with close ongoing monitoring of blood concentration [231, 232].

Other substances that may be impacted by changes in metabolism from reducing or stopping smoking and warrant dose reductions following smoking cessation include [233]:

- Benzodiazepines.
- Beta blockers.
- Caffeine and alcohol.
- Chlorpromazine.
- Clopidogrel (consider use of alternative among people who do not smoke, e.g., prasugrel or ticagrelor).
- Flecainide.
- Fluvoxamine.
- Haloperidol.
- Heparin.
- Imipramine.
- Insulin.
- Methadone.
- Theophylline.
- Warfarin.

NRT can be used to minimise the physiological symptoms of nicotine withdrawal, and is available in patches, gum, inhalers, lozenges, and microtabs [234]. NRT is not recommended without a clinical assessment, or as a first-line treatment for AOD clients who [235, 236]:

- Are pregnant or likely to become pregnant.
- Are currently breastfeeding.
- Have significant cardiac or active vascular disease.
- Have nicotine sensitivities or allergies.

Clinicians managing clients on NRT should regularly monitor clients' withdrawal to tailor the NRT dose, and address triggers, cravings, and stress through accompanying psychosocial interventions. For example, Baker and colleagues [237] provided up to 24-weeks supply of NRT to Australians who both smoked tobacco and were diagnosed with a psychotic disorder. NRT was accompanied by feedback provided to each participant on their smoking and levels of dependence, and a case formulation developed with participants, focusing on individual risk factors for CVD, utilising a MI approach and CBT strategies. The study found that both NRT plus a telephone-based intervention for smoking cessation (focused on monitoring smoking and discussing CVD risk factors) and NRT plus an intensive face-to-face healthy lifestyles intervention were effective in reducing smoking among people with severe mental health disorders. A follow-up study similarly found that both interventions were effective in maintaining rates of reduced smoking 36-months post-intervention [238]. There is also evidence that combination NRT (i.e., the use of more than one type of NRT together, such as patches and gum) and NRT containing higher doses of nicotine, are more effective at improving abstinence from smoking than single-form and lower doses, respectively [239].

Promising findings have arisen from a recent Australian RCT investigating the effects of an integrated smoking cessation program, consisting of routine screening, assessment, treatment for smoking (involving psychoeducation, quit kits/plans, NRT, regular feedback about progress, post-discharge management), and smoking-cessation training for staff into existing AOD services. Compared to those attending AOD services without the smoking cessation program, clients who received the 12-week program reported a reduction in the average number of cigarettes smoked per day at eight-week follow-up [240].

Despite evidence to suggest that smoking can be effectively addressed in clients of AOD and mental health services, there have been inconsistencies with the implementation of smoking interventions in practice. For example, a greater number of AOD staff smoke in comparison to the general population, and sometimes smoke with clients in order to promote a therapeutic relationship [221, 241, 242]. Higher rates of staff smoking with clients in AOD services are associated with lower intentions to quit among clients [241]. Negative attitudes among treatment staff towards smoking cessation have been acknowledged as potential barriers to effectively targeting nicotine dependence [243], with AOD staff rating treatment for smoking as less important than treatment for other AOD use [220], and with staff who smoke themselves less likely to initiate smoking cessation among clients, and be less successful when they do [244, 245].

Diet

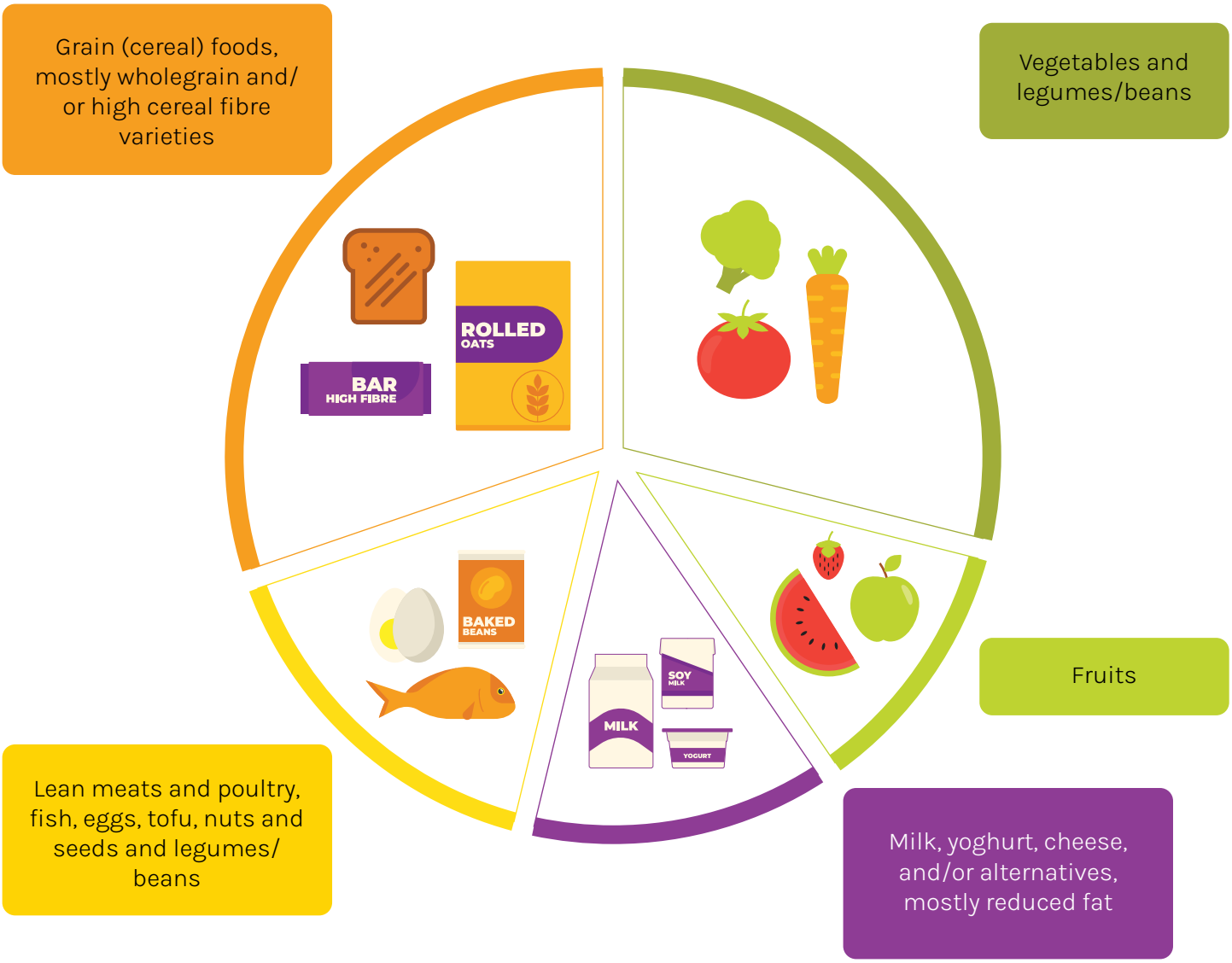
Clients of AOD treatment services tend to have poor dietary habits, eating nutrient-poor, energy-dense food, often to excess [246, 247]. It is common for people accessing AOD treatment to report unhealthy eating patterns, weight gain and obesity, which suggests that energy-dense diets are sometimes used to substitute AOD during recovery [248, 249]. AOD use also impacts nutrition directly by reducing available energy and nutrient absorption, and disrupting hormones which monitor the feeling of fullness after eating and other food cues [246, 250]. People accessing mental health treatment also frequently demonstrate poor dietary habits such as skipping breakfast, consuming more calories in the evening, avoiding foods that require chewing, and a lack of structure for mealtimes [194]. Programs targeting

the preparation of nutritional food can produce lasting weight loss and improvements in mental health symptoms among people with mental health conditions [194], and AOD workers can assist by encouraging clients to follow Australian dietary guidelines (see Figure 11). Specifically, clients should be encouraged to [237]:

- Eat a variety of foods that are high in fibre and low in fat.
- Eat seven or more fruits and vegetables per day.
- Drink plenty of water.
- Make healthy food choices and eat regularly.
- Manage healthy eating patterns (e.g., ensuring that breakfast is eaten every day, and eating patterns are maintained on weekends and weekdays).

Figure 11: Australian dietary guidelines

Enjoy a wide variety of nutritious foods from these five food groups every day. Drink plenty of water.



Adapted from the NHMRC [251].

AOD workers may also find the spending structure displayed in Table 20 useful. Developed under the *FOODcents* program to promote healthy eating on a limited budget, the spending structure was designed to be utilised alongside the Australian Government Department of Health's healthy eating guidelines [252]. It is recommended that 60% of food budget is allocated to food from the 'eat most' group, and 10% to the 'eat least' group.

While the *FOODcents* program is no longer available, *Food Sensations* is a similar education program for families, funded by the Western Australian Department of Health, which also provides information on healthy diet, food budgeting, meal planning, reading food labels, and food safety. At the time of writing, free online programs are provided for organisers and participants, delivered over four weeks. Further information and additional resources are available via the *Food Sensations* website: **https://www.foodbank.org.au**

Table 20: *FOODcents* spending guide

Category	Examples	Recommended spending
Eat most	Bread, cereals, rice, pasta, flour, fruit, vegetables, baked beans, lentils	60% of budget
Eat moderately	Lean meat, chicken, fish, eggs, nuts, milk, cheese, yoghurt	30% of budget
Eat least	Butter, margarine, oil, sugar, biscuits, cake, chocolate, chips, soft drink, coffee, salad dressing, sauce	10% of budget

Source: Western Australian Network of Alcohol and other Drug Agencies [253], and FOODcents [252].

There has been increasing attention paid to the connection between the mind and gut in recent years, including how diet quality impacts mood. Growing evidence has highlighted the relationship between microbiota in the gut and anxiety and depressive behaviours, which suggests that modifying the gut microbiome can impact symptoms of stress, anxiety, and depression [254, 255]. Although the communication pathways between the gut microbiome and brain are not fully understood, the immune and hormonal systems, as well as the vagus nerve, are thought to be involved [256]. While more rigorous research is needed to establish how microbiota can be utilised in treatment approaches, one promising microbiota-focused treatment involves the use of probiotics, which have been shown to improve depressive symptoms among people with depression and schizophrenia [257–259].

Evidence has also supported the relationship between diet quality and mood, with foods believed to be beneficial for mental health. Omega-3 fatty acids, niacin, folate, vitamin B6, and vitamin B12 have been associated with improved mental health and mood, while saturated fats and simple sugars have been

associated with poorer mental health and mood [260, 261]. 'Western' dietary patterns involving a high intake of red meat, confectionary, and refined or processed foods are similarly associated with poorer nutrition [262], whereas the Mediterranean diet [263] and diets that include more fish, reduced red meat, and/or more fruits and vegetables [264] have been associated with high nutritional quality and improved mood. However, it is also important to tailor diets to individual clients depending on differences in preferences, activity levels and metabolism. Although the effects of dietary interventions on overall mood are yet to be robustly evaluated, evidence from several systematic reviews suggest interventions involving dietary changes (e.g., adhering to a specific diet), nutrient supplementation, and/or nutritional counselling may be an effective adjunct to psychotherapy and/or pharmacotherapy for improving depressive symptoms [264–268].

Physical activity

Although the physical and psychological benefits of exercise have been well established, it is estimated that over half of Australian adults are inactive, with few achieving the recommended 30 minutes of moderate intensity exercise most days [269]. Insufficient physical activity accounts for approximately 9% of premature mortality worldwide [270]; an estimated 46% of which could be prevented by meeting minimum physical activity requirements [271]. As such, an increasing amount of research has focused on the potential benefits of exercise in AOD and mental health treatment [272]. Physical activity is highlighted as a safe alternative behaviour to AOD use, that is naturally rewarding and engaging, with various health benefits [272, 273]. Physical activity and exercise have been associated with improved health [274], improved depression and mood [275, 276], reduced levels of anxiety [277, 278], reduced effects of AOD withdrawal [279–281], and are considered to be safe when exercises have been individually tailored [282–284]. A study examining the effects of an 8-week structured exercise program (treadmill and weight training) on depression and anxiety symptoms among people in treatment who were newly abstinent from methamphetamine, found those in the exercise group had significantly greater reductions in depression and anxiety symptoms compared to those in the control group (health education sessions) [285]. Further, a dose effect was found, whereby those who had attended more exercise sessions during the eight-week program illustrated greater reductions in depression and anxiety compared to those who had attended fewer sessions [285].

Regular exercise is also associated with other positive behaviours, such as healthy diet and sleep patterns [286, 287], and overall feelings of wellbeing, vitality, high energy, and motivation to maintain healthy lifestyle practices [288–291]. Physical activity is inversely related to smoking status (i.e., people who do not smoke are more physically active than people who smoke [292, 293]), number of cigarettes smoked, and nicotine dependence, and recent evidence suggests that exercise may be an effective complementary intervention to smoking cessation strategies [294–296]. Physical activity improves cardiovascular, pulmonary, and immune functioning, which can in turn assist with the prevention of chronic disease [297]. Smoking cessation is more successful for those who exercise during their attempts to quit smoking [294, 298], and exercise can assist with the prevention of relapse [299]. Physical activity can also alleviate symptoms of smoking withdrawal, such as irritability, depression, restlessness, and stress [279, 300–302].

Research suggests that although people with AOD use disorders may be interested in increasing their levels of physical activity [303], it is unclear how frequently those in AOD treatment regularly engage in moderate to vigorous levels of exercise [272]. Few treatment programs incorporate dedicated time for exercise [272, 304], despite it being a rewarding, accessible, sustainable, and safe behaviour that can be used to manage cravings and urges to use AOD [272]. Three reviews – one systematic and two meta-analyses – examining the effects of exercise-based interventions for AOD use on recovery, physical fitness, and psychological health found that exercise is a potentially promising accompanying treatment for AOD use [305–307]. Physical activity was associated with reductions in AOD use, cravings, withdrawal symptoms, and improved abstinence, alongside improvements in depression, anxiety, stress, and quality of life, as well as significant fitness improvements in the exercise groups [305–307]. Exercising in calmer environments, such as outdoors, has also been associated with greater reductions in stress [308]. Taken in combination, these factors make physical activity an appealing, adjunctive intervention to assist with relapse prevention among those in treatment for AOD use.

There are several physical activity and sedentary behaviour guidelines for adults, outlined in Table 21. Although associated with a range of benefits, the ideal dose (i.e., type of exercise, duration, and intensity) of exercise to maximise the effects of potential health and psychological benefits, is not clear and continues to be the subject of research. Evidence to date suggests that the ideal dose varies considerably between people, and depends on individual preferences, as well as baseline physical fitness levels [309]. However, given that many people with AOD use are fairly inactive, an initial program of light to moderate intensity exercise is likely to be more beneficial than vigorous exercise, may assist with program adherence and retention [310], and align with client preferences [284]. Supervised physical activity may be useful to ensure information about safe exercise (e.g., importance of warm-up, cool-down, and stretching) and exercise intensity are provided (e.g., using heart-rate monitors) [272]. Encouraging the pursuit of home-based exercise is likely to be important for clients to establish and maintain exercise levels after the conclusion of the activity program, and integrating exercise into psychotherapy may enhance treatment outcomes [272].

Evidence examining the exercise attitudes and behaviours of people in AOD treatment identified that, although the majority of those in treatment were interested in participating in physical activities as part of their AOD recovery, many were reluctant due to perceived barriers which included financial costs and lack of motivation [303]. As such, techniques such as self-monitoring, goal setting, contingency management, and relapse prevention planning may be useful [272, 310]. Wearable devices that track physical activity (e.g., pedometers, heart-rate monitors, fitness trackers; sometimes called activity trackers or wearable activity trackers) can increase motivation and reduce AOD use when exercise is used as a coping strategy to manage AOD cravings [311–313]. Data from interviews conducted among people with AOD use disorders suggests that activity trackers can help people stay accountable to an exercise plan, strengthen motivation to remain abstinent from AOD by tracking progress in physical activity goals, and reinforce positive changes that are being made [314]. Cardiovascular (e.g., running), resistance (e.g., weight training), yoga, and isometric exercise have all been successfully piloted as aids to assist smoking cessation, but need further testing in larger RCTs among AOD populations [294]. Education and behaviour change strategies focused on diet and exercise [212] have also been shown to be effective.

Table 21: Physical activity and sedentary behaviour guidelines for adults

Physical activity and sedentary behaviour guidelines for adults (18-64 years)

- Any physical activity is better than none. If there is currently none, start with a small amount and gradually build up to the recommended amount.
- Be active most days, and preferably every day.
- Each week, adults should do either:
    - 2½–5 hours of moderate intensity physical activity (i.e., out of breath but can still say a few words), such as a brisk walk, bike riding, swimming, mowing the lawn.
    - 1¼–2½ hours of vigorous intensity physical activity (i.e., out of breath, difficulty talking), such as soccer, hockey, netball, aerobics, jogging, fast cycling.
    - An equivalent combination of both moderate and vigorous activities each week.
- Incorporate muscle strengthening exercises (e.g., squats, lunges, push-ups, pull-ups, lifting weights) at least two days each week.
- Minimise the amount of time spent in prolonged sitting (e.g., consider walking meetings or sessions, using a standing desk, or going for a walk during lunch breaks).
- Break up long periods of sitting as often as possible (e.g., stand up and walk around when using the phone, do squats or lunges between meetings).
- Incorporate physical activity into daily routine (e.g., use the stairs instead of a lift or escalator, get off the bus one stop early and walk the rest of the way, walk to the park for lunch).

Adapted from the Australian Government Department of Health 2021 [315].

Despite the overwhelming evidence of poor physical health among those with mental health conditions, relatively few workers address the physical health of their clients as part of their practice [316]. This reluctance may be due in part to clinicians questioning whether health and wellness are achievable goals for people with mental health conditions, due to perceived lack of motivation, lifestyle challenges, and the side effects and complications of many medications (e.g., weight gain, glucose and lipid abnormalities, and cardiac side-effects) [316, 317]. Although some research suggests that clients may prefer to make simultaneous behavioural changes [318, 319], clinicians may feel ill-prepared to manage the physical health of clients, particularly with standard screening tools and assessments not addressing the importance of health screening among people with mental health conditions [317, 320, 321]. Similarly, clinicians may feel that addressing the physical health of clients is outside the scope of their role [316]. AOD workers may find the food and physical activity diary located in the **Worksheets** section of these Guidelines useful for identifying the links between clients' mood and feelings, their physical activity, and food.

Sleep

Sleep problems can be experienced in many ways, and range from difficulty falling asleep, maintaining sleep throughout the night, or waking too early or too often. Most people will experience some trouble sleeping at some point in their lives, with less sleep associated with long work days, commuting times, increases in evening or night work, and overuse of television, computers, or the internet [322–325]. Sleep disturbances have been associated with the use of, and withdrawal from, AOD; in particular, alcohol [326, 327], cannabis [327, 328], tobacco [329], caffeine [330, 331], opioids [327, 332], and cocaine [327, 333]. Moreover, AOD use is associated with a higher likelihood of developing sleep disorders such as insomnia, nightmares, sleep-related breathing disorders, and circadian rhythm disorders [334, 335]. Although some people report using substances to promote sleep [336], in general, the direction of the relationship is not well understood. It remains unclear as to whether sleep problems are an additional risk factor contributing to a person's AOD use, whether the use of AOD contributes to sleep disturbances, or both [337]. Sleep problems are also common among people with mental health conditions, including those with major depressive, generalised anxiety, post-traumatic stress, and bipolar disorders [338, 339].

Better understood are the poor health outcomes associated with insufficient sleep quality and duration. The quality and duration of sleep has been linked to chronic disease, with insufficient sleep and poor sleep quality associated with higher body mass [340, 341], weight gain [342–344], obesity [342, 343, 345], diabetes [346], CVD [347, 348] and premature mortality [349–351]. Recent research suggests that the ideal amount of sleep varies with age [352]. For adults aged between 18–64 years, the recommended duration of daily sleep is between seven and nine hours [353], with the risk of chronic diseases, obesity, diabetes, hypertension, and CVD associated with both too little (i.e., less than 6 hours) and too much sleep (i.e., more than 9 hours) [354–358].

Sleep quality and maintenance is equally as important as sleep duration. The American Academy of Sleep Medicine has identified four stages of sleep, the first three of which are non-rapid eye movement (NREM; N1-N3), and the fourth stage rapid eye movement (REM) sleep [359]. Slow wave, or deep sleep, occurs in N3 and is considered the most restorative stage of sleep for executive functioning, typically occurring earlier in the sleep cycle, within an hour of falling asleep [360]. With regard to interventions that may improve sleep quality and quantity, evidence from systematic reviews supports the use of exercise [361, 362], cognitive behaviour therapy (CBT [363–365]), acceptance and commitment therapy (ACT [366]), mindfulness meditation [367], psychoeducation focusing on sleep hygiene [368], smartphone applications targeting sleep disturbances (e.g., *CALM* [369, 370]), muscle relaxation [365], music [371], aromatherapy [372], and environmental modifications (e.g., the use of ear plugs and a sleep mask [365, 373]). Of these interventions, exercise, CBT, ACT, smartphone applications, and muscle relaxation have been evaluated among people with either mental and/or AOD use disorders. However, mindfulness meditation, psychoeducation focusing on sleep hygiene, music, aromatherapy, and environmental modification have yet to be evaluated among people with either of these disorders. Moreover, none of these interventions have been evaluated among people with co-occurring disorders.

The American Academy of Sleep Medicine [374] recommends the healthy sleep habits outlined in Table 22.

Table 22: Healthy sleep habits

Sleep tips
• Maintain a regular sleeping schedule on weekdays and weekends (i.e., go to bed around the same time each night, and wake at the same time each morning). • Ensure at least seven to eight hours sleep. • Do not go to bed unless tired. • Get out of bed if not asleep within 20 minutes but avoid electronic devices or too much light exposure. • Practise relaxing bedtime rituals (e.g., mindfulness, meditation, relaxation exercises). • Only use the bed for sleep and sex. • Ensure the bedroom is calm and relaxing, and maintain a cool, comfortable temperature. • Limit exposure to bright lights before bedtime. • Avoid electronic devices for at least 30 minutes before bedtime. • Do not eat large meals before bedtime. If hungry, have a light, healthy snack. • Exercise regularly. • Maintain a healthy diet. • Avoid caffeine in the afternoon and evening. • Avoid alcohol before bedtime. • Reduce fluid intake before bedtime.

Adapted from the American Academy of Sleep Medicine [374].

Multiple health behaviours

There have been several trials of multiple health behaviours and healthy lifestyles interventions among people with mental health disorders, all of which have included a smoking component. These interventions typically include strategies to address multiple health risk behaviours for CVD within the one intervention package, allowing for links between these behaviours to be drawn and addressed in context, and people to focus on one behaviour first (e.g., sleep), experience early success, and then apply that success to other health behaviours that they may be more reluctant to shift (e.g., smoking). Baker and colleagues [375] conducted a pilot trial to reduce CVD risk in 43 people with acute psychotic disorder, using MI with CBT, accompanied with NRT. The study found significant reductions in CVD risk and smoking, and participants indicated high levels of satisfaction with the program.

In a similar trial, Goracci and colleagues [376] implemented a three-month community healthy lifestyle intervention to people with either recurrent depression or bipolar disorder. The intervention involved weekly individual 45-60-minute sessions focusing on lifestyle factors such as sleep, exercise, nutrition, life balance, energy, and smoking cessation, although everyone in the trial was also receiving ongoing pharmacotherapy for their respective mental disorder. Compared to people receiving pharmacological maintenance augmented with clinical management visits, people who received the lifestyle intervention

were less likely to experience relapses of depressive and manic symptoms and demonstrated greater reductions in body mass index (BMI) and waist circumference. Relative to baseline, people receiving the intervention also experienced improvements in sleep quality [376].

In the only trial conducted among people with co-occurring mental disorders and AOD use, Juel and colleagues [377] evaluated a community lifestyle intervention encompassing smoking cessation guidance, dietary advice, and structured exercise. Relative to baseline, participants reported consuming fewer fast-food meals and caffeinated beverages, as well as improved quality of life, after the 24-month intervention. However, sleep duration decreased over the study period, and AOD use remained unchanged [377].

Kelly and colleagues [210] recently conducted an RCT to evaluate *Healthy Recovery*; an eight-session group-based intervention focused on addressing multiple CVD risk factors within an AOD treatment setting. The five-week intervention focused on reducing smoking, increasing fruit and vegetable intake and levels of physical activity, using a combination of health-focused psychoeducation, goal setting, monitoring, MI, and CBT. In evaluating the intervention, Kelly and colleagues [210] found that people randomised to receive *Healthy Recovery* significantly reduced the number of cigarettes smoked daily and increased the variety of fruit consumed relative to AOD treatment alone, though levels of physical activity and servings of fruit and vegetables did not change.

What does this mean for AOD workers?

There is strong evidence that supports the need for holistic approaches to health care and AOD treatment that deliver the appropriate services to clients at the right time. From their first encounters with clients – even those who appear physically healthy and not currently experiencing any issues relating to their medication, diet, sleep, physical exercise or smoking - AOD workers should proactively provide preventative information about all of these factors to support clients in maintaining good health. Holistic health care includes the involvement of multiple services in a coordinated client-centred approach. AOD workers should be prepared not only to address the mental and physical wellbeing of their clients, but also involve, and partner with, other services that can provide complete, individualised care.

From an AOD worker's perspective, it should be remembered that physical and mental health are fundamentally entwined. As such, be prepared to take steps to manage clients' physical and mental health: consult with clients and assist with strategies to reduce smoking; assist with the planning of healthy meals incorporating fruits and vegetables; encourage clients to become more physically active; and recommend healthy and regular sleep patterns. A case study example of the interrelatedness of physical and mental health is provided in Box 11.

Box 11: Case study K: Managing co-occurring physical, mental, and AOD use disorders: Con's story

Case study K: Con's story

Con, a 59-year-old who identified as male, first came into contact with AOD services when he was in his 20s and entering treatment for heroin dependence. At that time, he had been using heroin for about 10 years and was very unwell. Con had a history of psychosis dating back to his 20s, for which he was taking antipsychotics and had been managed by a community mental health team. In his 20s and 30s however, Con lived an itinerant lifestyle and moved around a lot. Despite the best efforts of mental health services, it was very difficult to maintain his engagement with services. During times of engagement, Con had not always been stable on his antipsychotics. He experienced several episodes of active psychosis where his outreach team were unable to complete their visits because he would not let them into the house and would be yelling and screaming incoherently. During those episodes, Con seemed genuinely terrified that he would be harmed, which resulted in the police being called and Con being hospitalised.

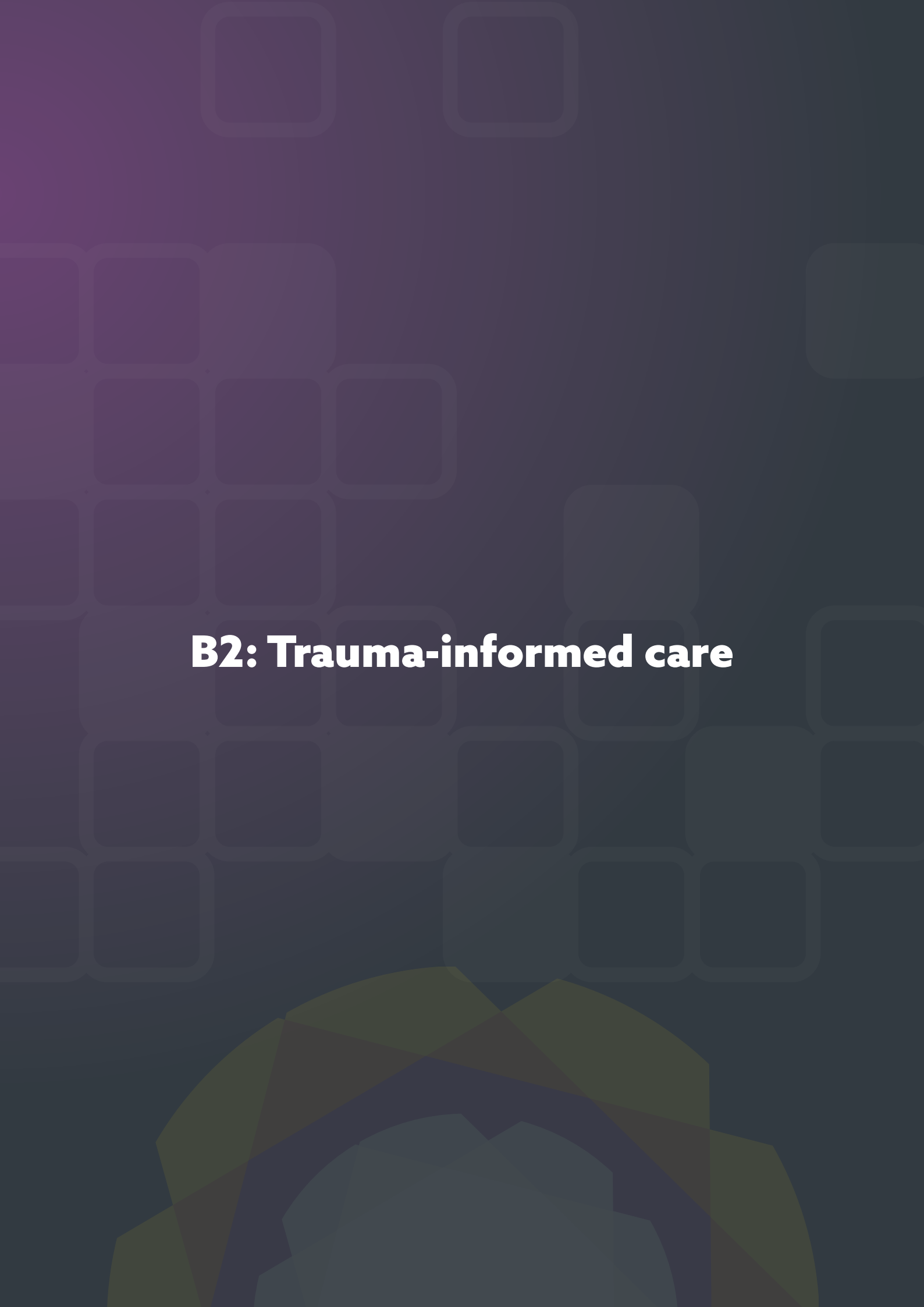
Twenty years later, Con was living in stable housing and taking antipsychotics. He was being managed in the community and still receiving methadone. Although he had some family, they were all based in Queensland and Con, living alone in NSW, was quite isolated. Over the past five years, Con had three strokes and while he had made good recovery, he still had difficulty with his memory and attention. He was also diagnosed with diabetes several years earlier, which was not well managed. As a result, Con had several toes amputated. Although he was receiving assistance from nursing services who were visiting him at home and dressing his wounds, they stopped their visits when Con was drunk during their visits one too many times. Con was also recently visited by the police after he called to report neighbourhood noise. On their arrival, they did not hear any noise and Con could not remember calling them. One of Con's mental health workers suspected that Con was hearing voices.

Key points:

- What are the primary concerns for Con?
- Where to from here?

Case study K continues in Chapter B5.

B2: Trauma-informed care



B2: Trauma-informed care

Key points

- A history of trauma exposure is almost universal among clients of AOD services.
- Trauma-informed care is a service delivery approach whereby AOD services recognise the high rates of trauma exposure among their clients and its potential impact; respond by integrating that knowledge into policies, procedures, and practices; and provide a safe environment (both physically and psychologically) that accommodates the needs of clients presenting with a history of trauma.
- The goal of trauma-informed care is to create treatment environments that are more healing and less re-traumatising for both clients and staff.
- A trauma-informed care approach has multiple layers, both at the level of the organisation (e.g., policies and procedures) and the individual (e.g., client-AOD worker interactions).
- An essential component of trauma-informed care is the provision of adequate training and support to AOD workers (e.g., supervision, peer support).
- It is also important for AOD workers to develop an awareness of their own vulnerabilities and maintain good self-care practices.

A history of trauma exposure (as defined in **Chapter A4**) among clients of Australian AOD treatment services is the norm rather than the exception, with more than 80% reporting having experienced a traumatic event in their lifetime [83, 137, 138, 378]. Most clients have experienced multiple traumas, and more than half have experienced trauma during childhood [83, 137, 138, 378]. The types of events experienced are many and varied, but the most commonly reported include having been physically or sexually assaulted, witnessing a serious injury or a death, being threatened with a weapon, or held captive [83, 137, 138]. Given these high rates of trauma it is not surprising that up to two-thirds of Australians entering AOD treatment services also experience PTSD [76]. Regardless of whether a person goes on to develop PTSD or any other mental disorder, traumatic events are often life-changing, and can redefine a person's views about themselves (e.g., feeling weak, bad, or worthless), the world around them (e.g., the world is not safe), and how they relate to it (e.g., people cannot be trusted). These beliefs may be particularly well-entrenched in those who have experienced childhood trauma [379].

A history of trauma exposure may be integrally linked with the person's current AOD use. A number of clients who have experienced trauma describe their AOD use as an attempt to self-medicate the thoughts and feelings they have experienced as a consequence of trauma, and there is evidence from a variety of studies to support such a relationship [30]. Although AOD use may provide short-term

relief, growing tolerance to the effects of AOD can lead to increased use in an effort to obtain sufficient symptom reduction. In the absence of AOD, PTSD symptoms may worsen, making it difficult for clients to maintain abstinence or reduced use [380]. It should be noted however, that, as with symptoms of depression and anxiety, on average, PTSD symptoms also decline in the context of well managed withdrawal [381–383]. Nonetheless, given the high rates of trauma exposure and PTSD among people with AOD use disorders, and the fundamental role that trauma symptoms may play in a person's recovery, experts have strongly advocated for trauma-informed care approaches to be adopted in AOD treatment settings [136, 141, 384].

What is trauma-informed care?

Trauma-informed care is a service delivery approach whereby AOD services: i) recognise the high rates of trauma exposure among their clients and its potential impact on clients' circumstances; ii) respond by integrating that knowledge into policies, procedures, programs and practices; and iii) create a safe environment that accommodates the needs of clients presenting with a history of trauma [141]. Physical and psychological safety are core to the fundamental goal of trauma-informed approaches, which is to create treatment environments that are more healing and less re-traumatising for both clients and staff [141].

A trauma-informed care approach has multiple layers, both at the organisational and individual level [385, 386]. Ideally, services will adopt a trauma-informed approach that is visible in all aspects of the organisation and reflected in policies and procedures. Such an organisational approach provides a framework that supports all service staff (e.g., administrative reception staff, cleaners, security and kitchen staff, management, board members), not just those involved in clinical care, to implement trauma-informed care at the individual level in all interactions and processes. That is, from when a potential client makes first contact with a service, all the way through treatment to discharge, and follow-up [385]. In this chapter, we focus on aspects of trauma-informed care that may be employed by AOD workers at the individual level and suggest that at a minimum, all staff working with AOD clients should: i) have an awareness of the extent of trauma exposure among their clients; ii) understand the consequences of trauma exposure and its potential to impact on recovery; iii) be able to recognise the signs and symptoms of PTSD and other mental disorders; and, iv) integrate that knowledge into their practice in ways that are relevant to their role and capacity [136, 387].

It should be noted that there is a distinction between trauma-informed care and trauma-informed practice. Trauma-informed practice involves the provision of psychological treatment for trauma-related symptoms by trained and accredited professionals [388]. While these treatments may form part of a trauma-informed care approach (i.e., they may form part of treatment planning), trauma-informed care can still be provided in their absence. It is nonetheless useful for AOD workers to be aware of the evidence base regarding effective treatments and options that may be available to clients should they wish to engage in these treatments. AOD workers are encouraged to read about this evidence base described in **Chapter B7**.

Recognising trauma and its impact

Given the high rates of trauma exposure among people entering AOD treatment, it is recommended that AOD workers and services adopt a 'universal precautions' approach; that is, operating on the assumption that all clients have experienced trauma [136, 385]. Operating under this assumption does not, however, negate the need to assess clients individually. Trauma exposure should be routinely assessed sensitively by suitably trained practitioners. Before conducting trauma assessments, workers should seek training and supervision in dealing with trauma responses.

Incorporating some questioning into most initial assessments signals that this is a standard process that is important in both understanding why people present to treatment and in determining appropriate treatment pathways; however, each AOD worker must use their judgement and expertise in determining when it is clinically appropriate to ask more detailed questions based on a client's presentation. In some situations, for example, it may be more beneficial to raise the issue of trauma some weeks after the initial assessment interview, once the client feels safer and a therapeutic relationship has been developed [389]. Further information on identifying client trauma histories is provided in Chapter B3.

Responding to trauma: Practitioner approaches, programs, and procedures

A number of models have been developed to guide organisations and individual workers in incorporating trauma-informed care into their policies, programs, procedures and practices. Links to some of these are available at the end of this chapter. Common to all of them are six guiding principles [385]:

i. **Safety:** Ensuring clients and staff feel physically and psychologically safe with respect to the physical setting and interpersonal interactions.

ii. **Trustworthiness and transparency:** Making decisions with transparency to build and maintain trust.

iii. **Peer support:** Promoting mutual support to aid in healing and recovery.

iv. **Collaboration and mutuality:** Leveling power differentials and recognising that everyone plays a role in recovery and care.

v. **Empowerment, voice, and choice:** Recognising and building upon individuals' experiences and strengths (including their strength in coming through their traumatic experiences and seeking help), and helping clients to establish a sense of control.

vi. **Cultural, historical, and gender issues:** Acknowledging and addressing the impact of historical trauma, overt discrimination, and implicit biases.

At the organisational level, creating a trauma-informed approach requires continual review of policies, procedures, and programs to identify possible areas of re-traumatisation [386]. AOD workers should similarly regularly undertake a review of their own individual practices to identify areas for potential improvement. Many common procedures and practices used in AOD services may potentially

re-traumatise. For example, aggressive or confrontational group techniques can trigger memories of past abuse, are counterproductive, and may lead clients who have been exposed to trauma to revert to previous coping strategies, for example dissociating or shutting down, and further AOD use. This may then lead to the client being labelled as 'treatment-resistant', with consequent feelings of failure and self-blame [136].

A focus on building trust is essential in AOD worker-client interactions. Many clients' traumas have occurred in the context of interpersonal relationships in which their trust, safety and boundaries have been violated. They may also have had personal information used against them in the past, making it difficult for them to trust others [390, 391]. Attention to boundaries, and the use of language that communicates the values of empowerment and recovery is important [392]. Clients of AOD treatment services with severe co-occurring mental health conditions may also have experienced traumatic events within the context of receiving health care (e.g., if they have been forcibly restrained or secluded in the context of receiving involuntary mental health treatment) [393]. These experiences can be deeply traumatic, trigger memories and feelings of past trauma, and have an ongoing impact on the person and their ability to trust healthcare providers.

For those who have experienced interpersonal trauma in particular, healthcare providers may also be seen as authority figures and some interactions may imitate the interpersonal dynamics that were evident in an abusive relationship. There is an inherent power imbalance in the helper–helped relationship and AOD workers must do their best to reduce this inequity [390, 394, 395]. Many clients also fear judgement on the part of their healthcare providers, so it is important that AOD workers adopt a non-judgemental attitude. People who have experienced trauma often feel a great deal of shame and guilt either in relation to the trauma itself or how they reacted to the trauma. Sometimes clients may have experienced stigmatisation from others due to their trauma experiences, mental health, and/or AOD use. Recognising clients for their resilience in the face of adversity is important, even if past adaptations and ways of coping, such as AOD use, are now causing problems. Understanding AOD use as an adaptive response can help to reduce a client's guilt and shame, and provides a framework for developing new skills to better cope with symptoms [384].

An additional part of the process of building a sense of trust and safety is helping clients to regain a sense of control, as both trauma and AOD use disorders are characterised by feeling out of control. For example, rather than telling a client that, *'It's time for your doctor's appointment'*, providing clients with choice and control by saying, *'It's time for your doctor's appointment, are you still ok to meet with them now?'*.

Stability is also key to establishing a sense of safety [396]. A structured program in which clients know what to expect and have clear transparent expectations can be helpful. Sometimes clients who have experienced trauma may be physically and mentally 'on guard', so it can be helpful to avoid surprises, use slow, calm movements, a gentle tone of voice, and not encroach on their personal space. It can also be helpful to advise clients what to expect in terms of their progress through treatment. As mentioned in **Chapter B7**, some clients experience an increase in trauma-related symptoms when AOD use is reduced or ceased. Preparing the client to expect that their trauma-related symptoms may increase, and normalising these reactions, may make it easier for clients to manage their symptoms.

Creating a safe environment

Creating a safe environment relates to creating an environment in which clients and staff have a sense of both physical and psychological safety. As such, it pertains to the services' physical surroundings, as well as practitioner approaches, programs, procedures, and policies that have been described earlier in this chapter, that can be modified to create a space that is safe and welcoming, and where the likelihood of re-traumatisation is minimised.

Many clients who have experienced trauma will feel on guard, fearing violence at the hands of another client, or other forms of unwanted attention. They may also fear that they will not be able to escape a situation in which they feel threatened, particularly if they are in secure or locked wards. These settings can be reminiscent of other times in their life when they have not been able to escape unsafe environments. It is important to pay attention to the physical environment, ensuring that there is [384, 392, 397]:

- Adequate lighting and common areas are well-lit.
- Sufficient space for comfort and privacy.
- Clear pathways to building entrances and exits.
- Sufficient staffing to monitor the behaviour of others that may be perceived as intrusive or harassing.
- No groups of people loitering at the entrances and exits.
- An absence of exposure to violent, sexual, or offensive material in common areas (e.g., magazines left in the waiting area; television programs, films or music that may be playing).
- Welcoming language is used on signage.

The ideal safe environment is one that is free from the risk of harm; however, it is unlikely that all potential environmental triggers can be completely eliminated. Triggers are highly variable and unique to individuals and their experiences, but they can be minimised and clients supported to use coping skills in the event that they are triggered [392].

A safe environment is also one in which clients feel that they are able, should they wish to, talk about their trauma, and their reactions to it, without judgement. If a client does become triggered or distressed by trauma symptoms, it is important that avoidance or suppression of thoughts or feelings is not encouraged, as avoidance symptoms, rather than re-experiencing symptoms, have been associated with the perpetuation of trauma-related symptoms [398]. Similarly, avoidance or suppression may also intensify feelings of guilt and shame. For those who have experienced abuse, it may closely re-enact the experience of being told to keep quiet about it [384]. This does not mean that clients should be pushed to revisit events or disclose information if they are not ready to do so. Rather, it means that it is understandable that the person may be upset by thoughts and feelings that may arise, and that they should be allowed to engage with them in order to help process the trauma emotionally. Ideally, clients will have developed good self-care skills, and will have skills to regulate their emotions, before they delve into their own traumatic experiences, or are exposed to the stories of others; however, choice and control should be left to the client [384]. Notwithstanding, even in the absence of details of a client's trauma, AOD

workers can help to reinforce a sense of safety by assisting clients in the use of anxiety management techniques such as breathing retraining, progressive muscle relaxation, and grounding techniques, to help manage their symptoms. These techniques are described in detail in **Appendix CC**.

Barriers to providing trauma-informed care

Despite its intuitive appeal, AOD services have been somewhat slow to adopt trauma-informed care at the organisational level, which presents a challenge for AOD workers wishing to adopt this approach fully into their practice. There may be several reasons for this, many of which are organisational, but some relate to AOD workers individually [399]; we highlight a selection of these barriers below.

Firstly, despite the pervasiveness of trauma exposure and PTSD among AOD clients, and the potential impact on treatment, both are largely unrecognised at the service level as few services systematically assess for a history of trauma exposure among their clients, with most preferring to put the onus on the client to raise the issue. However, for a multitude of reasons, including shame and an inability to trust, most clients are unlikely to volunteer information about their past trauma experiences unless specifically asked [400].

The reluctance to assess for trauma is often related to concerns regarding client safety, specifically, fears regarding the ability of clients to manage the emotions that may be elicited [401]. Although well-intentioned, this practice is likely to be doing more harm than good; while some people may become upset when talking about these events, talking about the trauma does not overwhelm or re-traumatise the majority of people, and most people describe the process as a positive experience, when it is conducted in an empathic manner [402]. Further, research has shown that these fears can be allayed with appropriate staff training in trauma inquiry [403].

Second, AOD workers may understandably be concerned about their capacity to respond. Trauma training is not a core feature of most certification courses. In Australia, it has been estimated that less than two-thirds of Australian AOD workers have undergone some form of trauma training [404], and AOD workers themselves have identified this as a priority training need [7].

There are also concerns regarding the potential impact of client trauma on the wellbeing of AOD workers themselves and the potential for secondary traumatic stress, discussed in **Chapter B8**. An essential component of providing trauma-informed care is the provision of adequate training and supports (e.g., supervision, peer support) to AOD workers, developing an awareness of one's own vulnerabilities, and maintaining good self-care practices (see **Chapter B8**) [385].

Finally, until recently, there was very little empirical evidence to guide treatment responses. There is, however, a growing body of evidence that supports the use of integrated trauma-focused treatments for PTSD and AOD use disorders, which is outlined in **Chapter B7**.

Is my service trauma-informed?

As mentioned previously, a number of models have been developed to guide organisations and individual workers in incorporating trauma-informed care into their policies, programs, procedures and practices. Tools that have been developed to support services in providing trauma-informed care include:

- Metro North Mental Health – Alcohol and Drug Service. (2019). *Model of Care: Trauma Informed Care and Practice for Alcohol and Drug Treatment.* Available at: **https://insight.qld.edu.au/shop/model-of-care-trauma-informed-care-and-practice-for-alcohol-and-drug-treatment**
- NSW Mental Health Coordinating Council (MHCC). (2018). *Trauma-informed Care and Practice Organisational Toolkit (TICPOT) + other associated resources.* Available at: **https://www.mhcc.org.au/resource/ticpot-stage-1-2-3/**
- Kezelman, C., & Stavropoulos, P. (2020). *Organisational guidelines for trauma-informed service delivery.* BlueKnot Foundation. Available at: **https://professionals.blueknot.org.au/resources/publications/organisational-guidelines-for-trauma-informed-service-delivery/**
- Substance Abuse and Mental Health Services Administration. (2014). *SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach.* HHS Publication No. (SMA) 14-4884. Rockville, MD: SAMHSA.
- Brown, V. B., Harris, M., & Fallot, R. (2013). Moving toward trauma-informed practice in addiction treatment: A collaborative model of agency assessment. *Journal of Psychoactive Drugs*, *45*(5), 386-393.
- Marsh, A., Towers, T., & O'Toole, S. (2012). *Trauma-informed treatment guide for working with women with alcohol and other drug issues.* Perth, Western Australia: Improving Services for Women with Drug and Alcohol and Mental Health Issues and their Children Project.

B3: Identifying co-occurring conditions

B3: Identifying co-occurring conditions

Key points

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

Despite high rates of mental health conditions among clients of AOD services, it is not unusual for these co-occurring conditions to go unnoticed [405], mostly because AOD workers are not routinely looking for them. Many of the signs and symptoms of common mental health conditions (e.g., depression) are not immediately obvious or visible, and may be overlooked if not specifically asked about. As mentioned in **Chapter A3**, all clients should be screened and assessed for co-occurring conditions as part of routine clinical care. This chapter describes methods of the screening and assessment for mental health conditions, which should form part of the case formulation process for all clients.

Assessing and identifying the client's needs is the first step. It is important to recognise whatever needs the client may have as such needs will undoubtedly impact upon AOD treatment. Early diagnosis and treatment of mental disorders can improve treatment outcomes [406–409]. Identification does not necessarily mean that the AOD worker has to personally treat the difficulty the client is experiencing; however, they do need to consider the impact of these difficulties, manage them accordingly, and engage other services where necessary.

It is often difficult to determine which symptoms are attributable to which disorders. Once symptoms are identified, more specialised assessment may be required by mental health providers, psychologists, or psychiatrists to determine whether the person has a diagnosable disorder (coordinating care is discussed further in **Chapter B5**). It is equally important that other issues identified (e.g., problems

involving employment, housing, medical care) are dealt with appropriately, as such issues may also require consultation with other services.

Case formulation

Case formulation involves the gathering of information regarding factors that may be relevant to treatment planning, and formulating a hypothesis as to how these factors fit together to form the current presentation of the client's symptoms [410, 411]. The case formulation process should be collaborative, in that the AOD worker contextualises the client's experiences and knowledge of themselves within their own clinical expertise [410]. The primary goal of AOD treatment services is to address clients' AOD use. However, in order to do so effectively, AOD workers must take into account the broad range of issues with which clients present. As discussed in **Chapter A2**, clients of AOD treatment services, and those with co-occurring conditions in particular, often have a variety of other medical, family, and social problems (e.g., housing, employment, welfare, or legal problems). These problems may be the product of the client's AOD and mental health conditions, or they may be contributing to the client's AOD and mental health conditions, or both. According to stress-vulnerability models (e.g., Zubin and Spring [412]), the likelihood of developing a mental health condition is influenced by the interaction of biological, psychological, and social factors. These factors also affect a person's ability to recover from these symptoms and the potential for relapse.

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

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

This information should be considered the first step to devising (and later revising) the client's treatment plan. There is no standardised approach to case formulation [413], but it is crucial that a range of different dimensions be considered. These include the history of presenting issue/s, AOD use history (type, amount and frequency, presence of disorder), physical/medical conditions, mental state, psychiatric history, trauma history, suicidal or violent thoughts, readiness to change, family history, criminal history, and social and cultural issues. Consideration also needs to be given to the client's age, gender identity, sexual orientation, ethnicity, spirituality, socioeconomic status, and cognitive abilities.

Given the high rates of co-occurring mental health conditions among clients of AOD treatment services, it is essential that routine screening and assessment be undertaken for these conditions as part of case formulation. Screening is the initial step in the process of identifying possible cases of co-occurring conditions [200, 414]. This process is not diagnostic (i.e., it cannot establish whether a disorder actually exists); rather, it identifies the presence of symptoms that may indicate the presence of a disorder. Thus, screening helps to identify people whose mental health requires further investigation by a professional trained and qualified in diagnosing mental disorders (e.g., registered or clinical psychologists, or psychiatrists).

Abstinence is not required to undertake the screening process [415]. The potential clinical issues that these conditions can present suggest that screening for co-occurring mental health conditions

should always be completed in the initial phases of AOD treatment. Early identification allows for early intervention, which may lead to better prognosis, more comprehensive treatment, and the prevention of secondary disorders [406, 416, 417].

Diagnostic assessment should ideally occur subsequent to a period of abstinence [418, 419], or at least when the person is not intoxicated or withdrawing [420]. While the length of this period is not well established, a stabilisation period of between two to four weeks is recommended [421, 422]. A lengthier period of abstinence is recommended for longer-acting drugs, such as methadone and diazepam, before a diagnosis can be made with any confidence, whereas shorter-acting drugs such as cocaine and alcohol require a shorter period of abstinence [39, 418]. If symptoms persist after this period, they can be viewed as independent rather than AOD-induced.

In practice, however, such a period of abstinence is rarely afforded in AOD treatment settings and, therefore, to avoid possible misdiagnosis, it has been recommended that multiple assessments be conducted over time [102, 423, 424]. This process allows the AOD worker to formulate a hypothesis concerning the client's individual case and to constantly modify this formulation, allowing for greater accuracy and flexibility in assessment.

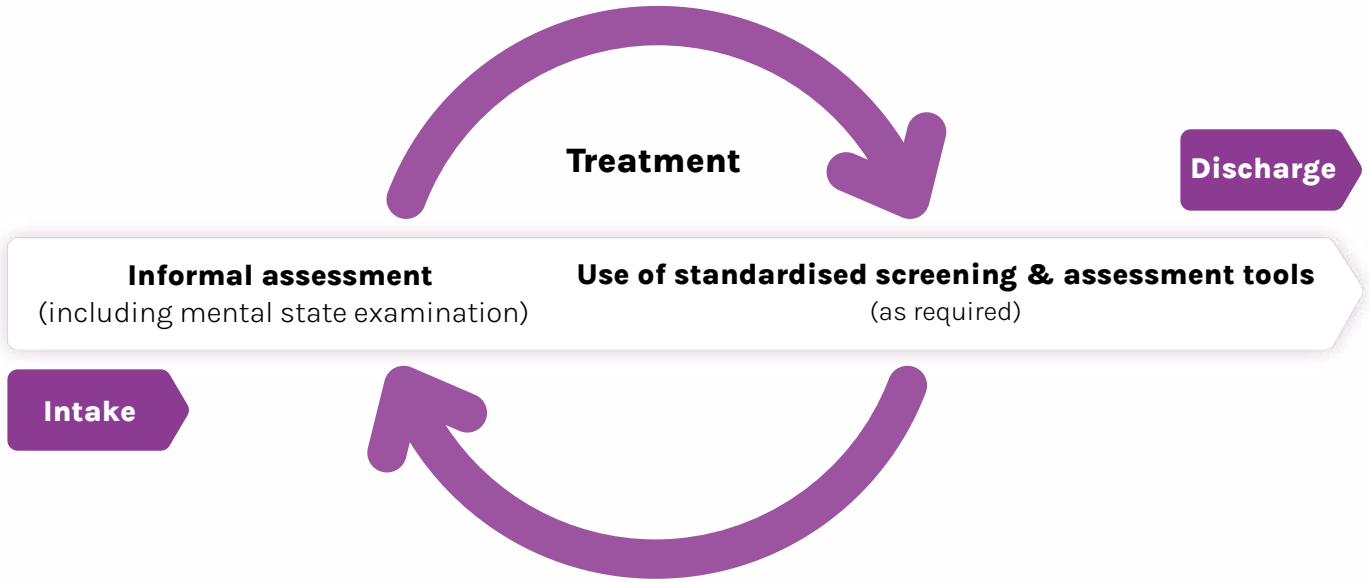
Screening and assessment are ongoing processes rather than one-off events, which involve the monitoring of clients' mental health symptoms. Ongoing screening and assessment are important because clients' mental health symptoms may change throughout treatment. For example, a person may present with symptoms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

Groth-Marnat [425] suggests that a combination of both informal and standardised assessment techniques is the best way to develop a case formulation, though some researchers also suggest that building a formulation framework using the 5Ps model may be useful [389, 426]. In this framework, case formulation is determined by identifying the '5Ps' [427]:

- **P**resenting issues.
- **P**redisposing factors.
- **P**recipitating factors.
- **P**erpetuating factors.
- **P**rotective factors.

Figure 12 depicts how both informal and standardised assessment techniques work together. In addition to these assessments, with the client's consent, it may be useful to talk with family members, friends, or carers; they can provide invaluable information regarding the client's condition which the client may not recognise or may not want to divulge, provide support to the client, and improve treatment outcomes (see **Chapter A3**) [428, 429].

Figure 12: The ongoing case formulation process



Note: Figure 12 illustrates the need for assessment to be repeated throughout treatment, from intake through to discharge, to inform the ongoing revision of a person's treatment plan.

An example of how the 5Ps model can be used to build a case formulation, with Lena's case study (Box 12) and the case formulation template (Appendix F), is illustrated in Table 23. This is just one example of how AOD workers may develop a case formulation, and not all client factors will necessarily apply to the template.

Box 12: Case study L: Example case formulation: Lena's story

Case study L: Lena's story

Lena is a 27-year-old who identified as female, who had been living in a major city for most of her life. She had been living in the family home with her younger brother since their mother died five years earlier; their father died by suicide when Lena was 12 years old. He was diagnosed with depression several years earlier. Lena was sexually assaulted several times by a male neighbour when she was 5 or 6.

Lena had been working as a programmer at a web-design company for the past 18-months but lost her job last week after several conflicts with her co-workers resulted in complaints being made against her, and for missing several important client meetings because she had overslept. The day Lena lost her job, she immediately went home, locked herself in her bedroom and self-harmed. Since that time, she had been drinking a couple of bottles of wine every day and was thinking about taking an overdose of her Aropax medication.

Seeing that Lena had not left her room in a week, her concerned brother coaxed her out and brought her to their local hospital emergency. Prior to the loss of her job, Lena's mood was stable, and she had

Box 12: Case study L: Example case formulation: Lena's story (continued)

not self-harmed or had any suicidal thoughts in the past two years. She was seeing a psychologist and a psychiatrist regularly, but had not maintained her routine appointments, preferring to have her GP prescribe her Aropax. Lena's psychiatrist had previously diagnosed her with co-occurring depression, BPD and alcohol use disorder.

Lena had a bachelor's degree in computer science. She used to play hockey but gave up last year after several injuries. She was in a one-year on/off relationship with a female partner who she had been friends with since University, and there had been recent arguments concerning the direction of their relationship. Lena described a fear of being abandoned in relationships and had very intense relationships with friends/family.

Adapted from PsychDB [430].

An example of how Lena's presenting issues, predisposing, precipitating, perpetuating and protective factors may be developed into a case formulation is illustrated in Table 23. As biological and social factors often influence psychological symptoms, it can be useful to complete the biological and social sections of the table first, followed by the psychological section last.

Table 23: Example of a case formulation for Lena

	Biological *(e.g., genetic factors, medications, physical health)*	**Psychological** *(e.g., resilience, personality, thoughts, feelings, behaviours)*	**Social** *(e.g., socioeconomic background, relationships, family, school, work, cultural factors, spirituality, community, social supports and connectedness)*
Predisposing factors *Factors over a person's lifetime that may have contributed to problem*	• Possible family history of mental disorders	• Fear of abandonment	• History of childhood trauma • Early death of father • Death of mother
Precipitating factors *Any triggers or events that have initiated or exacerbated problem*	• Increase in alcohol use	• Re-experiencing feelings of abandonment after loss of job	• Recent loss of job • Difficulties with interpersonal relationships

Table 23: Example of a case formulation for Lena (continued)

Perpetuating factors *Factors that may maintain problem or make it worse if not addressed*	• Current dose of paroxetine may be sub-therapeutic	• Lack of adaptive coping mechanisms led to use of self-harm to cope, and thoughts of suicide	• Ongoing disagreement in romantic relationship • Disengaged from psychologist and psychiatrist
Protective factors *Internal and external supports*	• Medically healthy	• University educated • Previous engagement with psychologist/ psychiatrist	• Good support from brother who brought her to hospital • Interest in being physically active

Adapted from PsychDB [430].

Informal assessment

The informal assessment takes the form of a semi-structured interview and should cover the following [389]:

- Mental state.
- Source of referral and current health care providers.
- Presenting issues.
- AOD use history.
- Current situation.
- Personal, medical, and family history.
- Risk factors for CVD and other health conditions.
- Trauma history.
- Psychiatric history.
- Risk assessment.
- Criminal history.
- Strengths and weaknesses.
- Readiness for change.
- Beliefs about self, others, and the world.

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

Mental state

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

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

The type of information sought in each of the above domains is outlined in Table 24. It should be noted that all of the factors above may be affected by intoxication or withdrawal from substances. The mental state examination should not consist of a series of direct questions, but rather should be based on an overall evaluation of the client during the assessment (or preferably a number of assessments). A record of the mental state examination should be completed after (rather than during) conversations with the client. In addition to noting unusual or abnormal client behaviours, it is also good practice to record normal behaviours (e.g., no speech disturbances noted, no unusual thought content noted) [389]. Observations regarding cognitive functioning, such as poor concentration or memory, should also be noted and may require referral to a neuropsychologist [389]. Appendix G provides a form which may be useful in guiding notetaking for the mental state examination.

Table 24: Assessment of mental state

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

Table 24: Assessment of mental state (continued)

Behaviour

How is the client behaving?

Motor activity – immobile, pacing, restless, hyperventilating.

Abnormal movements – tremor, jerky or slow movements, abnormal walk.

Bizarre/odd/unpredictable actions.

How is the client reacting to the current situation and assessor?

Angry/hostile towards assessor/others.

Uncooperative or withdrawn.

Over familiar/inappropriate/seductive.

Fearful, guarded, hypervigilant.

Speech and language

How is the client talking?

Rate – rapid, uninterruptible, slow, mute.

Tone/volume – loud, angry, quiet, whispering.

Quality – clear, slurred.

Anything unusual about the client's speech?

How does the client express themselves?

Incoherent/illogical thinking (word salad: communication is disorganised and senseless and the main ideas cannot be understood).

Derailment (unrelated, unconnected, or loosely connected ideas; shifting from one subject to another).

Tangentiality/loosening of associations (replies to questions are irrelevant or may refer to the appropriate topic but fail to give a complete answer).

Absence/retardation of, or excessive thought and rate of production.

Thought blocking (abrupt interruption to flow of thinking so that thoughts are completely absent for a few seconds or irretrievable).

Table 24: Assessment of mental state (continued)

Mood and affect

How does the client describe their emotional state (i.e., mood)?

Down/depressed; angry/irritable; anxious/fearful; high/elevated.

What do you observe about the client's emotional state (i.e., affect)?

Depressed – flat, restricted, tearful, downcast.

Anxious – agitated, distressed, fearful.

Irritable, hostile.

Labile – rapidly changing.

Inappropriate – inconsistent with content (e.g., laughs when talking about mother's death).

High/elevated – excessively happy or animated.

Thought content

What is the client thinking about?

Delusional thoughts (e.g., bizarre, grandiose, persecutory, self-referential).

Preoccupations: paranoid/depressive/anxious/obsessional thoughts; overvalued ideas.

Thoughts of harm to self or others.

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

Perception

Is the client experiencing any misinterpretations of sensory stimuli?

Does the client report auditory, visual, olfactory, or somatic hallucinations? Illusions?

Are they likely to act on these hallucinations?

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

Any other perceptual disturbances, such as derealisation (feeling one is separated from the outside world), depersonalisation (feeling separated from one's own personal physicality), heightened/dulled perception?

Table 24: Assessment of mental state (continued)

Cognition

Level of consciousness

Is the client alert and oriented to time, place, person?

Is the client attentive during the interview (drowsy, stuporous, distracted)?

Does the client's attention fluctuate during the interview?

Does the client present as confused?

Is the client's concentration impaired (can they count from 100 or say the months of the year backwards)?

Orientation

Does the client know:

Who they are? Who you are?

Where they are?

Why they are with you now?

The day of the week, the date, the month, and the year?

Memory

Can the client remember:

Why they are with you? (Immediate)

What they had for breakfast? (Recent)

What they were doing around this time last year? (Remote)

Are they able to recall recent events (memory and simple tasks; e.g., calculation)?

Insight and judgement

How aware is the client of what others consider to be their current difficulty?

Is the client aware of any symptoms that appear weird/bizarre or strange?

Is the client able to make judgements about their situation?

Adapted from NSW Department of Health [431] and Stone et al. [389].

Source of referral and current health care providers

Clients may have various sources of referral to treatment. For example, they may be referred by their GP, family or friends, or corrective services. In general, the most common form of referral is self-referral [432].

In addition to identifying the source of referral, it is important to identify all care and treatment providers currently involved in the person's care (e.g., counsellors, psychiatrists, prescribers, GP, probation/community offender service officers, case workers, social workers). Consistent with a coordinated approach to client care, the AOD worker should, with the client's permission, liaise with these providers regarding the person's treatment to ensure care coordination and continuity of care (see **Chapter B5**).

Presenting issues

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

AOD use history

It is important to gain an understanding of the range of substances currently used, the quantity and frequency of use, age of first use, duration of use, previous AOD-related problems, circumstances of use, risk behaviours related to use, and previous treatment/attempts to change (and why these were successful or unsuccessful). Clinicians should also gain an understanding of the development of the client's AOD use over time, including periods of abstinence, and how these were supported [389].

Enquire also about the use of any non-traditional or new psychoactive substances (substances produced to mimic the effects of illegal drugs), which may be referred to by a range of names including legal highs, herbal highs, research chemicals, analogues, and synthetics (more information can be found through the Drug Trends monitoring program [433]).

It can be useful to ask the client to describe a normal day, in order to help the client evaluate the ways in which their AOD use affects their health, relationships, legality, and livelihood (e.g., finances, work). The typical day situation is explained in greater detail in **Appendix E** on MI.

Current situation

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

Personal, medical, and family history

Exploring and discussing the client's background, from birth to the present, can help both the client and AOD worker to understand the beginnings of AOD use and mental health symptoms, and the impact on the client's life, as well as help the client develop self-compassion [389]. Enquire about:

- Family context (including family history of AOD use and mental disorders).
- Child and adolescent experiences.
- School experiences (e.g., academic performance, social experiences, bullying).
- Traumatic experiences.
- Work history.
- Leisure pursuits and personal interests.
- Financial and housing information.
- Sexual/marital adjustment.
- Legal issues and illegal behaviour.
- Medical history (including current and past medications, psychiatric medication).
- Current and past pharmacological/psychological treatment.

Risk factors for CVD and other health conditions

As described in **Chapter B1**, clients of AOD treatment services are at increased risk of physical health problems, with higher mortality rates than the general population. Identifying the presence of risk factors and behaviours of CVD and other health conditions, including, but not limited to sleep, diet, smoking, and physical activity is important to ensure that a client's holistic health needs are addressed.

Trauma history

It is important to identify whether the client has experienced any traumatic events in their life [389], as many clients presenting for AOD treatment report a history of trauma [137, 138, 378, 434]. As described in **Chapter A4**, the word trauma is widely used and can mean different things to different people. In these Guidelines, we use the word trauma to refer to an extremely threatening or horrific event, or a series of events, in which a person is exposed to, witnesses, or is confronted with a situation in which they perceive that their own, or someone else's, life or safety is at risk [10, 11]. Examples of potentially traumatic events include, but are by no means limited to, being involved in a road traffic accident; experiencing or being threatened with physical or sexual assault; being in a life-threatening car or other form of accident; combat exposure or being in a place of war or conflict; or witnessing any of these events. The most important factor in understanding a person's experience of an event is whether or not they perceived it to be a traumatic event; events that may be traumatic to some people may be perceived as relatively minor to others, and vice versa.

As described in **Chapter B2**, a history of trauma exposure may be integrally linked with the person's current AOD use; a number of people with AOD use disorders who have experienced trauma describe their use as an attempt to 'block out' or reduce the thoughts and feelings they have had since the trauma [30]. The presence of a trauma history also indicates that further investigation is required to determine whether the person may have symptoms of PTSD (described in **Chapter A4**).

Recognition and identification of past trauma is an important component of providing trauma-informed care (see **Chapter B2**). While identification of past trauma is important, questioning needs to be sensitive and should not be pursued if the client does not wish to discuss it. Each AOD worker must use their judgement and expertise in determining when it is clinically appropriate to ask trauma-related questions based on a client's presentation. In some circumstances, it may be better to raise the issue of trauma several weeks after the initial assessment interview, once the client feels safer and has developed a therapeutic relationship with the AOD worker [389].

Before conducting trauma assessments, workers should seek training and supervision in dealing with trauma responses. Some AOD workers may be reluctant to discuss trauma with their clients due to events that have happened in their own lives. These workers should seek assistance from their colleagues and should not be forced to conduct trauma assessments if they are not comfortable doing so.

Before questioning the client, the AOD worker should:

- Seek the client's permission to ask them about exposure to traumatic events, and advise the client that they do not have to talk about these experiences or provide any detail if they do not want to. Clearly communicate the reasons for asking about past trauma, and begin with general questions that become more specific as client comfort increases [156]. It may not be readily apparent to the client that their current situation may be related to their past [435, 436]. For example, clearly explaining to the client that the questions relating to trauma will help contextualise their substance use, and will also help gain a better understanding of the interplay between AOD use and trauma symptoms [389]. Ensure that the client has the opportunity to say if they feel uncomfortable.
- Advise the client that talking about traumatic events can be distressing; even clients who want to talk about their trauma history may underestimate the level of emotion involved [437]. It should be noted that studies have found that while some people may become upset when talking about these events, talking about the trauma does not overwhelm or re-traumatise the majority of people. On the contrary, even in the context of distress, most people describe the process as a positive, validating experience [402, 438, 439].
- Advise the client of any restrictions on confidentiality, for example, in relation to the mandatory reporting of children at risk or serious indictable offenses.

When broaching the subject of trauma, ask the client if they have ever experienced any traumatic events such as witnessing or experiencing car accidents or other types of accidents, natural disasters, war, adult/childhood physical or sexual assault, or having been threatened. Reliable reporting of events is best obtained by asking about specific event types. Under-reporting of exposure tends to occur when people are asked only broad questions such as 'Have you ever experienced a traumatic event?' [400, 440]. Standardised screening tools such as the Life Events Checklist (described later in this chapter) may be used to assess for a history of trauma exposure. Some clients find it easier to complete a self-report screening tool than to say aloud to the assessor that they have, for example, been raped [437], and research suggests that verbal disclosure of trauma via interview evokes more distress than completing a written questionnaire [402]. However, such screening tools should always be completed with an AOD worker present and should never be given to the client to complete at home.

It is important to understand that clients may be uncomfortable answering questions relating to past trauma because of the personal nature of such questions. Client discomfort may also be associated with distrust of others in general (or of service providers in particular), a history of having their boundaries violated, or fear that the information could be used against them [390, 391]. Clients may also fail to disclose their trauma due to an inability to recall it, feelings of loyalty towards their perpetrators, and dissociative responses in reaction to any inquiry about trauma [436].

During the trauma assessment it is essential that the AOD worker questioning the client does not 'dig' for information that is not forthcoming, as doing so may result in destabilisation [395, 437, 441]. For those who have experienced interpersonal trauma in particular, such pressure from an authority figure may imitate the interpersonal dynamics that were evident in an abusive relationship and exacerbate trauma symptoms. As described in Chapter B2, there is an inherent power imbalance in the helper–helped relationship and AOD workers must do their best to reduce this inequity [390, 394, 395]. Trauma and AOD use are both characterised by the loss of control, and it is important that the client feels able to regain a sense of control. In line with this, it can be useful to periodically check in with the client and make sure they are comfortable to continue the discussion [390].

The following are some additional guidelines on discussing traumatic experiences with clients during assessment and at other times during their treatment [442]:

- **Display a comfortable attitude if the client describes their trauma experience.** Some clients will have had experiences when people did not want to hear their account, especially when details of the experience are gruesome or horrific. The client should know that they can tell you anything.
- **Recognise the client's courage in having talked about what happened.** The client needs to know that you appreciate how difficult it is for them to talk about their trauma. Make it clear to the client that you respect and admire their strength in coming through the traumatic experience and in seeking help, but do not patronise them.
- **Normalise the client's response to the trauma and validate their experiences.** Many people who have experienced trauma (especially those with PTSD) feel that they are 'going crazy' because of the feelings they may have had since the trauma (e.g., re-experiencing the event, avoidance, hypervigilance). Just hearing from a professional that the reactions they are experiencing are common may help to normalise their experience, and also alleviate possible shame or guilt about not recovering sooner [443].
- **Utilise grounding and other techniques as necessary.** If a client is having a very strong emotional reaction to talking about their trauma, consider the use of techniques outlined for the management of trauma symptoms provided in Chapter B7 and Appendix CC.

Psychiatric history

Enquire as to whether the client has any current mental health symptoms (such as depression, anxiety, psychosis), whether they have experienced these in the past, whether they have ever been diagnosed

with a mental disorder, and whether they have ever received any treatment. If the client has experienced mental health symptoms or has been diagnosed with a mental disorder, ask about the timing and context of these symptoms:

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

If symptoms arise only in the context of intoxication or withdrawal, it is likely that they are substance induced [444, 445], and will resolve with a period of abstinence without the need for any direct intervention [35, 37, 102]. It is nonetheless important for symptoms to be managed to prevent the client from relapsing in the early stages (see **Chapter B6**). The duration of abstinence may vary depending on substances used; however, most people should start to experience considerable improvement over a period of one month [39, 418, 421].

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

Criminal history

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

Strengths and weaknesses

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

Readiness for change

It may be helpful to ascertain how motivated the client is to change their current AOD use. This process involves an exploration of the client's perception of the positive and negative aspects of continued AOD use. Prochaska and DiClemente [446] suggest that clients fall into one of six stages of change, which clients cycle through dynamically rather than in an ordered linear manner [389], indicating that the focus of treatment for people in the earlier stages of change should incorporate motivational interviewing/ motivation enhancement techniques to assist the person in progressing to further stages. In general, clients in the later stages of change have better AOD use and mental health treatment outcomes than

clients in earlier stages [447]. Table 25 summarises these stages and outlines some useful interventions and motivational strategies for each stage of change. The choice of treatment type can be informed in part by the client's readiness to change; for example, harm reduction may be an appropriate treatment for someone in the pre-contemplation stage, whereas goal setting or relapse prevention may be more suitable for someone in later stages (e.g., preparation or action stages) [389].

The stages of change model is also relevant in assessing the client's motivation to receive treatment for co-occurring mental health conditions. Just because a person has presented for treatment for their AOD use, this does not necessarily mean that they have the same readiness to receive mental health treatment. For example, just because the client is willing to consider reducing AOD use, this does not automatically mean that they are also ready to deal with the trauma-related symptoms they experience due to abuse experienced as a child. Appendix H provides a useful matrix for assessing motivation for both AOD and mental health treatment.

Table 25: Readiness for change

Stage	Description	Interventions	Motivational strategies
Pre-contemplation	Not yet considering behaviour change. Little awareness of, or concern for negative consequences. *E.g., 'I get out of breath, but I feel fine, so I don't think there's a problem with my smoking'.*	Aim to raise doubt about perceptions. Link behaviour with consequences. Reduce harm. Highlight negative consequences. Build confidence and hope.	Establish rapport, build trust, ask permission. Raise concern in the client about their behavioural patterns (feedback).
Contemplation	Considers change but rejects it. Ambivalence remains. Wavers between reasons to change and reasons to stay the same. *E.g., 'I see it would be better for me if I quit smoking, but it's the only time of the day I have for myself'.*	Motivational interviewing can assist in resolving ambivalence. Elicit reasons for change and risks of not changing.	Normalise ambivalence (reflect). Elicit change talk, self-motivational statements.

Table 25: Readiness for change (continued)

Stage	Description	Interventions	Motivational strategies
Preparation or determination	Balance tips towards change. Window of opportunity where client is preparing for change. *E.g., 'I really want to quit smoking, I just don't know how I would do it'.*	Goal setting, problem-solving, match to needs. Identify risks for relapse, including triggers. Build self-efficacy. Discuss treatment options.	Clarify goals and strategies for behaviour change (affirm). With the client's permission, offer information and guidance.
Action	Engage in behaviours designed to bring about change. May occur with or without assistance. *E.g., 'After my last appointment, I bought some NRT patches'.*	Support self-efficacy. Assist with coping and education. Reinforce positive behaviour. Avoid exposure to AOD use environment.	Reinforce the importance of changing.
Maintenance	Sustain change. Prevent relapse. *E.g., 'I've felt great the last few months, but I'm wondering if I still need to be using the NRT patches'.*	Reinforce positives and assist with lapses. Self-help groups. Provide relapse prevention techniques. Emphasise client alertness. Work towards longer-term goals.	Affirm the client's determination and self-efficacy.
Lapse/recurrence	Not so much a stage in itself, but rather a normal and expected part of the process. Any slip or lapse into any of the previous stages. *E.g., 'I slipped over the New Year's break and had a few ciggies while watching the fireworks'.*	Avoid demoralisation or judgement. Remain positive. Normalise the process of lapsing. Help re-start the stages of change and avoid being stuck in this stage. Help the client to learn from mistakes.	Explore meaning.

Adapted from Clancy and Terry [448], Fullerton [449], Figlie and Caverni [450], and Stone et al. [389].

Beliefs about self, others, and the world

Beliefs about how the client sees themselves and the world can provide insight into the client's self-esteem, sociability, and trust [389]. Client responses to questions about their worldview can also identify core maladaptive beliefs, such as emotional deprivation or defectiveness. Assessing early maladaptive schemas can assist with this process (e.g., Young and Brown [451]).

Standardised screening and assessment

The informal assessment process can be aided by a range of standardised screening and assessment tools. Standardised tools can be a useful means of gathering data by providing a reliable and valid view of the client's difficulties and current life situation [452, 453]. Furthermore, when conducted appropriately, the process of standardised assessment can be a source of rapport building [454, 455].

Groth-Marnat [425, 456] suggests that when conducting standardised assessment, it is important to:

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

Standardised assessment is an ongoing process, but should be completed upon entry into and exit from treatment, as well as at follow-up [102, 389]. Test results can provide useful clinical information (for both the client and AOD worker) on the client's case and an evaluation of how effective treatment has been. A variety of different tools are used, some of which are empirically established instruments, whilst others are purpose-built, internally designed tools with increased practicality and utility but unknown validity and reliability [457, 458]. Some helpful screening tools have been included in **Appendices J – Y**. Standardised tools cover a range of areas that may be relevant to AOD services, including global health, general health and functioning, and specific mental health conditions. Table 26 lists the standardised screening and assessment tools discussed in this section.

Table 26: Standardised screening and assessment tools

Instrument	Measures	Number of items	Administration	Where to access
General health and functioning				
Camberwell Assessment of Need (CAN) Client Version (CANSAS-P)	Comprehensive assessment and outcome of needs in 22 areas	22	Self or clinician	Appendix J
General mental health instruments				
Depression Anxiety Stress Scale (DASS)	Screening and outcomes for depression, anxiety, stress and general psychological distress	21 or 42	Self	Appendix K
Indigenous Risk Impact Screen (IRIS)	AOD problems and mental health risk Aboriginal and Torres Strait Islander specific	13	Clinician	Appendix L
Kessler psychological distress scale (K10)	Screening for psychological distress	10	Self or clinician	Appendix M
PsyCheck	Screening for general mental health, suicide/ self-harm, symptoms of depression and anxiety	25 or 29	Mixed	Appendix N

Table 26: Standardised screening and assessment tools (continued)

Instrument	Measures	Number of items	Administration	Where to access
Specific mental health instruments				
Adult ADHD Self-Report Scale (ASRS)	Symptoms of ADHD	18	Self or clinician	Appendix O
The Eating Disorder Examination (EDE)	Past month eating disorder psychopathology	Semi-structured interview	Clinician	http://www.credo-oxford.com/7.2.html
The Eating Disorder Examination Questionnaire (EDE-Q)	Past month eating disorder psychopathology	31	Self	http://www.credo-oxford.com/7.2.html
International Trauma Questionnaire (ITQ)	PTSD and Complex PTSD	18	Self or clinician	Appendix P
Iowa Personality Disorder Screen (IPDS)	Personality disorder	11	Self	https://help.valant.com/79967-measures/ipds-iowa-personality-disorder-screen
Life Events Checklist for DSM-5 (LEC-5)	Lifetime exposure to traumatic events	17	Self	Appendix Q
Primary Care PTSD for DSM-5 (PC-PTSD-5)	Probable DSM-5 PTSD	5	Self or clinician	Appendix R
PTSD Check List for DSM-5 (PCL-5)	PTSD symptoms	20	Self	Appendix S
Psychosis Screener (PS)	Psychosis symptoms	7	Clinician	Appendix T

Table 26: Standardised screening and assessment tools (continued)

Instrument	Measures	Number of items	Administration	Where to access
Standardised Assessment of Personality – Abbreviated Scale (SAPAS-SR)	Personality disorder	8	Self	https://hal.archives-ouvertes.fr/hal-01419303
General AOD instruments				
Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)	Screening for AOD use and risk (lifetime and recent use, specific AOD use, frequency, dependence, abuse, intravenous use)	8	Clinician	https://www.who.int/publications/i/item/978924159938-2
Alcohol Use Disorders Identification Test (AUDIT)	Screening and outcome of alcohol use (use, dependence and related problems)	10	Self or clinician	Appendix U
CAGE Questionnaire	Screening to identify problematic alcohol use	4	Self or clinician	Appendix V
Drug Abuse Screening Test (DAST-10)	Screening and assessment to identify problematic drug use over past 12-months	10	Self or clinician	Appendix W

Table 26: Standardised screening and assessment tools (continued)

Instrument	Measures	Number of items	Administration	Where to access
Drug Use Disorders Identification Test (DUDIT)	Screening and outcome of drug use (use, dependence and related problems)	11	Self or clinician	Appendix X
Michigan Alcohol Screening Test (MAST)	Screening and assessment to identify lifetime problematic alcohol use	24	Self or clinician	Appendix Y
Timeline Follow Back (TLFB)	Assessment and outcome tool to collect information on the quantity/ frequency/ duration of AOD use over specific time period	Dependent on time period	Varied	https://www.nova.edu/gsc/forms/timeline-followback-forms.html

General health and functioning

Camberwell Assessment of Need (CAN)

The **Camberwell Assessment of Need (CAN)** is one of the most widely used needs assessment and treatment outcome tools [459] and has evidence to support its use among people with mental health conditions [460–462]. It has also been validated for use in Australian populations [463], and can be used in clinical practice without staff training.

The CAN assesses need in 22 domains, including accommodation, food, self-care, capacity to look after the home, daytime activities, physical health, psychotic symptoms, mental health and treatment, psychological distress, risk to self and others, AOD use, social relationships, child care, education, transport, budgeting, and benefits [459, 464]. Several versions of the CAN exist, including:

- **Camberwell Assessment of Need Short Appraisal Schedule (CANSAS):** For use in clinical work. The CANSAS allows the perspective of staff, clients and carers to be separately recorded. However, due to discrepancies in clinician and client assessments of need, a client rated short-form measure has been developed and evaluated (CANSAS-P).

- **CANSAS-P:** A two-page version for clients to complete. Evaluation of the CANSAS-P found it was able to better identify the needs of clients, particularly unmet needs [459].
- **CAN-Clinical (CAN-C):** Detailed 22-page assessment, measuring the need rating, help received, and action plan for each domain.
- **CAN-Research (CAN-R):** Detailed 22-page assessment, measuring the need rating, help received and satisfaction for each domain [459].

The CANSAS-P has been recommended as the preferred needs assessment measure for client completion [459], and is available in Appendix J. Further information about each version can be obtained through the CAN webpage: https://www.researchintorecovery.com/measures/can/.

General mental health instruments

There is also a wide range of standardised tools that can be used to screen and assess specifically for co-occurring mental health conditions. Here we provide an overview of some of these tools, with focus given to those that require minimal training to use and are freely available. A range of additional screening tools are described in Appendix I. It should be noted that some of these tools require specialist training, or else mislabelling, misinterpretation, or inappropriate use may occur [389, 425, 465]. Some tools are copyright protected and need to be purchased, and/or require the worker to have specific qualifications. The requirements of each tool described here (and in Appendix I) are explained accordingly. It is important that workers are aware of what they are and are not trained to use and seek training where required. Readers are also referred to Deady's [466] comprehensive review of screening tools for use in AOD settings. This document is available online at http://www.nada.org.au/.

As mentioned earlier in this chapter, screening is designed only to highlight the existence of symptoms, not to diagnose clients. The possible presence of disorders needs to be assessed by a health professional who is qualified and trained to do so (e.g., a registered psychologist, or psychiatrist). Most of the measures described are those of self-report (i.e., they may be self-completed by the client). Others, however, need to be administered by the AOD worker.

The Depression Anxiety Stress Scale (DASS)

The **Depression Anxiety Stress Scale (DASS)** [467] has been shown to be a valid and reliable measure of the dimensions of depression, anxiety, and stress separately but also taps into a more general dimension of psychological distress [468, 469]. The DASS is available in two forms: the DASS-21 and the DASS-42. The use of either test is sufficient in the screening process (i.e., the use of both is unnecessary). The two forms have 21 and 42 items respectively and are each rated on a 4-point scale of how much each particular statement applies to the person. The DASS is a self-report instrument, and no special skills are required to administer or score it. However, decisions based on particular score profiles should be made only by experienced clinicians who have carried out an appropriate clinical examination [467]. Nevertheless, it is a useful tool for screening and assessment and the DASS-21 is included in Appendix K.

For all questions, the client circles the answer truest to them in the past week. Scores are summed for each scale (D = Depression, A = Anxiety, S = Stress), and the total for each scale multiplied by 2. A guide to interpreting DASS scores is provided in Table 27.

Currently, no studies have been conducted to validate the DASS as a measure of anxiety among people with AOD use disorders. However, one study has shown that the DASS can reliably screen for depression symptoms among people seeking treatment for AOD use [470]. Similarly, another study has shown that the DASS can be used as a reliable screen for symptoms of PTSD among people with AOD use disorders [471].

Table 27: Interpreting DASS scores

	Depression	Anxiety	Stress
Normal	0-9	0-7	0-14
Mild	10-13	8-9	15-18
Moderate	14-20	10-14	19-25
Severe	21-27	15-19	26-33
Extremely severe	28+	20+	34+

Adapted from Lovibond and Lovibond [467].

The Indigenous Risk Impact Screen (IRIS)

The **Indigenous Risk Impact Screen (IRIS)** [472] was developed by an expert group of Indigenous and non-Indigenous researchers in Queensland to assist with the early identification of AOD problems and mental health risks. This screening tool has been shown to be reliable, simple, and effective [473]. It has also been validated for use in Indigenous prison populations [474, 475]. The IRIS consists of 13 items which are asked by the AOD worker. The IRIS is made up of two sets of questions, with items 1–7 forming the 'AOD risk' component and items 8–13 forming the 'mental health and emotional wellbeing risk' component. The items assessing mental health and emotional wellbeing focus on symptoms of anxiety and depression. The client chooses the answer from a list of response options which best describes their current situation. After tallying up the corresponding numbers, a score of 10 or greater on the AOD component indicates problematic use of AOD is likely, while a score of 11 or greater indicates the need for further assessment or brief intervention regarding mental health and emotional wellbeing [473]. The IRIS is included in Appendix L.

Kessler psychological distress scale (K10)

The **Kessler psychological distress scale (K10)** [476] is a widely used, simple self-report measure of psychological distress which can be used to identify those in need of further assessment for anxiety and depression (Appendix M). This measure was designed for use in the general population; however, it may also serve as a useful clinical tool. The K10 comprises 10 questions that are answered using a five-point scale (where 5 = all of the time, and 1 = none of the time). For all questions, the client circles the

answer truest for them in the past four weeks. Scores are then summed with the maximum score of 50 indicating severe distress, and the minimum score of 10 indicating no distress. A guide to interpreting K10 scores is provided in Table 28.

A number of studies have been conducted to test the reliability and validity of the K10, and its brief version, the K6. Good reliability and validity have been found when these measures have been used among people with AOD use disorders, as well as in the general population [477–480].

Table 28: Severity of psychological distress according to K10 score

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

Adapted from Andrews and Slade [481].

PsyCheck

The Australian **PsyCheck** screening tool (Appendix N) has been shown to be a valid and useful resource for clinicians [482]. The screening tool has three sections:

- A general mental health screen, including history of treatment.
- Suicide/self-harm risk assessment.
- The Self Reporting Questionnaire (SRQ) [483], a 20-question screening tool that assesses for current symptoms of depression and anxiety. Clients are asked to indicate which symptoms they have experienced in the past 30 days, and of those, which have been experienced when not using AOD. The clinician should count the number of ticks and put the total number at the bottom of the page.

The PsyCheck manual [482] includes training on how to administer, score, and interpret the results of each section, and the subsequent steps to take according to the screening results. If the results of the screening tool indicate high levels of symptomatology, further assessment may be warranted. The PsyCheck screening tool has been shown to have good test-retest reliability among people using AOD services [484]. More information on the PsyCheck screening tool is available at **https://www.turningpoint.org.au/treatment/clinicians/screening-assessment-tools**.

Specific mental health instruments

Brief descriptions of selected instruments for specific mental health conditions are provided below. Further disorder-specific assessment measures can be found on the DSM-5 website: https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures.

Adult ADHD Self-Report Scale (ASRS)

The World Health Organisation developed the **Adult ADHD Self-Report Scale (ASRS)** as a means of assessing symptoms of ADHD in adults. The full version of the scale contains 18 items, but the short screener version contains 6 items and has been shown to outperform the original 18-item scale [485]. The 6-point scale involves respondents assessing the frequency of ADHD symptoms over the past six months, on a 5-item scale ranging from 'never' to 'very often'. The 6-item screening tool has been validated for use in AOD populations [486–488], demonstrating that it is an appropriately sensitive tool for screening for the presence of ADHD among people with co-occurring conditions. The ASRS is included in Appendix O.

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

The **Eating Disorder Examination (EDE)** [489] is a diagnostic interview. The EDE-Q is the questionnaire form of the EDE, and both are considered the 'gold standard' measures of ED psychopathology [490, 491]. As an interview, the EDE is designed to be administered by a clinician, and the developers recommend clinician training to ensure that all concepts being assessed are well-understood [492]. However, the EDE-Q is a self-report measure, which can be completed individually, or with the help of a clinician (explaining concepts such as binge eating).

Both measures assess past month cognitive subscales related to ED: restraint, eating concern, shape concern, and weight concern, as well as behavioural symptoms related to these concerns (e.g., frequency of binge eating, vomiting, use of laxatives or diuretics, and overexercise) [493]. A number of shorter versions of the EDE-Q have been validated for ED psychopathology [494–497]. The EDE-Q has been validated for use among people with AOD use disorders [498]. Both instruments are available for free download from https://www.credo-oxford.com/7.2.html.

The International Trauma Questionnaire (ITQ)

The **International Trauma Questionnaire (ITQ)** is a brief measure used to identify possible PTSD and CPTSD [499] as defined by ICD-11. An indicative diagnosis of PTSD requires that a person must endorse having experienced at least one symptom from each of the three core symptom clusters (re-experiencing in the here and now, avoidance, or sense of current threat) as 'moderately', 'quite a bit', or 'extremely' in the past month, as well as functional impairment associated with these symptoms. An indicative diagnosis of CPTSD requires that in addition to meeting criteria for a diagnosis of PTSD, a person must endorse having experienced at least one symptom from each of the three disturbances in self-organisation clusters (affective dysregulation, negative self-concept, disturbances in relationships). A person can receive an indicative diagnosis of either PTSD or CPTSD – not both (i.e., if criteria for CPTSD

is met, the person does not also receive an indicative diagnosis of PTSD [499]). At the time of writing, no studies have been conducted to validate the ITQ as a measure of PTSD or CPTSD among people with AOD use disorders. The ITQ is included in Appendix P.

The Iowa Personality Disorder Screen (IPDS)

The **Iowa Personality Disorder Screen (IPDS)** is a brief 11-item screen originally administered alongside a brief interview [500], but has since been adapted into a self-report measure [502]. The screening tool asks people to indicate whether or not they identify with common traits found among people with personality disorders, including both general personality disorder criteria as well as specific criteria. Research suggests that identifying with five or more of these traits is indicative of a probable personality disorder among people attending AOD treatment [503]. The IPDS has demonstrated good diagnostic accuracy, sensitivity, specificity, concurrent validity, and internal consistency among people attending AOD treatment [503, 504], as well as good psychometric properties among people attending mental health treatment [505]. A comparison of screening tools for personality disorders found that the IPDS is one of the most reliable and valid screening instruments for personality disorders [506]. The IPDS is available to download from https://help.valant.com/79967-measures/ipds-iowa-personality-disorder-screen.

Life Events Checklist for DSM-5 (LEC-5)

The **Life Events Checklist (LEC-5)** for DSM-5 is a self-report measure designed to screen for lifetime exposure to 17 potentially traumatic event types [507]. There is no formal scoring protocol or interpretation, other than identifying whether a person has experienced one or more of the events listed. For each event type, respondents indicate whether they experienced the event themselves, witnessed it, learned about it and/or experienced it as part of their job. The LEC-5 is commonly administered with the PTSD Checklist for DSM-5 (PCL-5). At the time of writing, no studies have been conducted to validate the LEC-5 among people with AOD use disorders. The LEC-5 is included in Appendix Q.

The Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)

The **Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)** [508] is a very brief 5-item screening tool designed for use in primary care and other medical settings to identify probable PTSD [508]. The tool includes an introductory sentence to cue respondents to traumatic events; however, the tool does not include a list of potentially traumatic events. While the PC-PTSD-5 has not yet been validated for use among people with AOD use disorders, the reliability and validity of its predecessor (used to screen for PTSD based on DSM-IV criteria) has been established among people with AOD use disorders [509, 510]. This scale is included in Appendix R.

PTSD Checklist for DSM-5 (PCL-5)

The **PTSD Checklist for DSM-5 (PCL-5)** is a 20-item self-report measure that assesses the 20 DSM-5 symptoms of PTSD [511]. Responses for each symptom are answered using a five-point scale (where 4 = extremely, and 0 = not at all). The PCL-5 can be administered in three formats: without Criterion A

(overview of instructions and items only), which is appropriate when trauma exposure is measured by some other method; with a brief Criterion A assessment; or with the LEC-5 and extended Criterion A assessment.

DSM-5 symptom cluster severity scores can be obtained by summing the scores for the items within a given cluster; that is, cluster B (items 1-5), cluster C (items 6-7), cluster D (items 8-14), and cluster E (items 15-20). These scores can be summed to obtain a total PTSD symptom severity score out of 80. Initial research suggests that a PCL-5 cut-off score between 31-33 is indicative of probable PTSD across samples [512]. A provisional PTSD diagnosis can be made by treating each item rated as 2 = 'Moderately' or higher as a symptom endorsed, then following the DSM-5 diagnostic rule which requires at least: 1 B item (questions 1-5), 1 C item (questions 6-7), 2 D items (questions 8-14), 2 E items (questions 15-20). At the time of writing, no studies have been conducted to validate the PCL-5 among people with AOD use disorders. The PCL-5 is included in **Appendix S**.

The Psychosis Screener (PS)

The **Psychosis Screener (PS)** [513] is an interview-style questionnaire rather than self-report and is therefore administered by the AOD worker (**Appendix T**). It uses elements of the Composite International Diagnostic Interview (CIDI) to assess the presence of characteristic psychotic symptoms. The PS has been shown to have a moderate ability to discriminate between those who meet diagnostic criteria for psychotic disorders and those who do not in community and prison samples [513, 514]. The PS consists of seven items; the first six items cover the following features of psychotic disorders: delusions of control, thought interference and passivity, delusions of reference or persecution, and grandiose delusions. The final item records whether a respondent has ever received a diagnosis of schizophrenia. While there is no official cut-off score, the screener may be useful as a guide in assessing for possible symptoms of psychosis. More information about the interpretation of scores can be found: **https://ndarc.med.unsw.edu.au/sites/default/files/ndarc/resources/TR.210.pdf**.

The Standardised Assessment of Personality – Abbreviated Scale (SAPAS-SR)

The **Standardised Assessment of Personality – Abbreviated Scale (SAPAS-SR)** is a brief screen originally administered alongside a brief interview [515], but has since been adapted into a self-report measure [501]. People are asked to indicate whether or not they identify with eight traits commonly found among people with personality disorders (e.g., dependence on others), with a score of three or higher indicating a likely personality disorder. The SAPAS-SR demonstrates good diagnostic accuracy, sensitivity, specificity, and internal consistency among people attending AOD treatment [503], as well as among people attending mental health treatment [516]. A comparison of screening tools for personality disorders determined that the SAPAS-SR is one of the most reliable and valid screening instruments for personality disorders [506]. The SAPAS-SR is available to download from **https://hal.archives-ouvertes.fr/hal-01419303**.

General AOD instruments

Although AOD workers are likely to be familiar with the range of tools available for screening and assessing for AOD use, we have included a brief overview for others who may be less familiar with these tools. As with the screening and assessment of mental health conditions, the screening process for AOD is not diagnostic, but can be useful for identifying those in need of further assessment and treatment [466].

Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST)

The **Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)** is an 8-item clinician administered tool to assess for problematic use of tobacco, alcohol, cocaine, cannabis, amphetamine-type stimulants, sedatives, inhalants, hallucinogens, opioids and other drugs [517]. The ASSIST was developed for the World Health Organisation to assess the frequency and recency of use, dependence and use-related problems, with a risk score for each substance indicating low, moderate or high risk [518]. The level of risk category determines the need for, and most appropriate intervention depending on level of use (none, brief or referral). The ASSIST tool and manual can be freely accessed https://www.who.int/publications/i/item/978924159938-2.

Alcohol Use Disorders Identification Test (AUDIT)

The **Alcohol Use Disorders Identification Test (AUDIT)** is a 10-item screening instrument developed by the World Health Organisation, which can be either self or clinician administered, and is designed to assess harmful alcohol use, abuse and dependence [519]. No specific training is required to administer or score the AUDIT. Scores on each of the 10 items are summed (questions 1 to 8 are scored on a 0 to 4 scale and 9 and 10 are scored 0,2,4), with a score of 8 or more indicating hazardous or harmful alcohol use [519]. The maximum score is 40. The AUDIT is included in Appendix U.

The CAGE Questionnaire

The **CAGE questionnaire** is a widely used screening tool to identify problematic alcohol use among adults [520]. The CAGE consists of 4-items which can be self-completed, or clinician administered. 'CAGE' refers to the four questions contained in the measure: **C**ut down, **A**nnoyed, **G**uilty, **E**ye-opener, with items scored 0 (no) or 1 (yes), and then summed. Higher scores in general indicate possible problematic alcohol use [520]. The CAGE is included in Appendix V.

The Drug Abuse Screening Test (DAST)

The **Drug Abuse Screening Test (DAST-10)** is a brief, 10-item version of the 28-item DAST measure. The DAST-10 can be self or clinician administered and is designed to identify problematic substance use over the past 12-months in a similar style to the MAST [521]. In addition to the original 28-item and 10-item DAST, a 20-item version has also been made available. In the 10-item instrument, 'Yes' responses are scored as 1, with the total summed apart from question 3, which is reverse scored (i.e., scored 1 for 'no') [521]. The DAST-10 is included in Appendix W.

The Drug Use Disorders Identification Test (DUDIT)

The **Drug Use Disorders Identification Test (DUDIT)** is an 11-item tool, which can be self or clinician administered, developed as a parallel to the AUDIT to identify problematic past year AOD use [522]. As with the AUDIT, items 1 to 9 are scored on a 0 to 4 scale, with the final two questions scored 0, 2, 4. The maximum score is 44. Scoring guidelines suggest that a score of 6 or more among men, and 2 or more among women, may be indicative of drug-use-related problems. A score of 25 points or more, regardless of sex, is strongly indicative of dependence [522]. The DUDIT is included in Appendix X.

The Michigan Alcohol Screening Test (MAST)

The **Michigan Alcohol Screening Test (MAST)** is a 24-item self-report tool designed to identify lifetime problems with alcohol use [523]. Several modified versions of the MAST have been developed, varying in length (e.g., the Short MAST or SMAST, containing 13-items; the Brief MAST or bMAST, containing 10-items), and for use in different population groups (e.g., MAST-Geriatric version, MAST-Adolescent version). The MAST can either be scored using a weighted scoring system or by assigning one point per item, with higher scores indicative of more problematic alcohol use in both methods. Treatment recommendations are based on weighted scores, with scores from 0 to 4 indicating no need for further action; 5 to 6 indicating a need for further evaluation by a healthcare professional; and 7 to 53 indicating a need for comprehensive AOD use evaluation by a healthcare professional [524]. The MAST is included in Appendix Y.

The Time Line Follow Back (TLFB)

The **Time Line Follow Back (TLFB)** is designed for collecting self-reported, retrospective estimates of AOD use and is extensively used to assess daily AOD use in research and practice [525]. The TLFB can be used as a weekly tool to assess daily AOD use during treatment, as well as assisting people identify patterns in their daily routines and relationships between AOD use and other areas of their lives [526]. When using the TLFB, a designated period of time, such as a week or several months, is specified with the use of a calendar. Respondents are asked to fill out the amount of AOD used each day of the calendar in the specified time frame (e.g., if asking about alcohol, the number of standard drinks each day). To assist with recall, respondents are encouraged to use diaries or appointment books, and reflect on AOD use during different times of the week (e.g., weekday vs weekend). Sample calendars and instructions can be freely accessed for clinical purposes: https://www.nova.edu/gsc/forms/timeline-followback-forms.html.

Feedback

Following completion of assessment procedures, it is important to interpret the results for the client in a manner that the client can understand (i.e., not just giving them numerical test scores). When feeding back assessment results, consider the following [389, 527]:

- Focus first on the client's strengths.
- Gently and tactfully outline the client's difficulties.

- Phrase the assessment in terms that are appropriate for the client.
- Focus on the pattern of results rather than just an overall score.
- Interpret the results in the context of the client's personal history.
- Pull the assessment results together and offer hope for the future by discussing a treatment plan.

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

If mental health symptoms are identified, it is important to discuss with the client what they may expect to experience in relation to these symptoms should they reduce or stop AOD use. As discussed in **Chapter A4** and **Chapter B7**, if symptoms are substance-induced, they are likely to dissipate if the person reduces or stops their use. On the other hand, the client's mental health symptoms may increase when they reduce or stop using, particularly if they have been using to self-medicate their symptoms. It is important that the client knows that you will be monitoring these symptoms to determine whether further treatment may be required. AOD workers may find the wellbeing plan located in the **Worksheets** section of these Guidelines useful for helping clients identify strategies for managing their triggers and warning signs. In addition, the wellbeing plan may help clients identify things that are important to them, trusted people they can talk to, and what professional support they can access.

B4: Assessing risk

B4: Assessing risk

Key points

- This chapter focuses on two areas of risk: suicide and domestic or family violence.
- Clients of AOD treatment services are at high-risk of suicide, which is further increased by the presence of co-occurring mental health disorders.
- Risk of suicide may increase in response to significant life events and may fluctuate throughout treatment.
- It is vital that suicide risk assessments are an ongoing process, with all AOD staff trained to detect the direct and indirect warning signs of suicide, as well as the assessment and management of suicidality. AOD workers should utilise their clinical skill and expertise when incorporating screeners and assessments into their practice.
- Clients of AOD treatment services are also at increased risk of domestic and family violence.
- Risk of domestic and family violence should be incorporated into assessment practices, and AOD workers should be familiar with organisational policies and procedures for responding to family violence.
- Responding to domestic and family violence within AOD services requires a broad, comprehensive, coordinated approach involving multiple services.

Risk assessment

It is important to assess the risk a client poses to themselves or others in the informal assessment interview (described in Chapter B3) and to monitor this throughout treatment. This chapter focuses on two areas of risk: suicide and domestic or family violence. It should be borne in mind, however, that there are several other areas of risk that should be assessed and monitored throughout treatment, including self-harm, homicidal thoughts/attempts, and child welfare, as well as the evaluation of safety regarding sexual practices, injecting practices, and other high-risk behaviours as appropriate. In any situation where the risk of harm to self or others is perceived to be significant, other services may need to be enlisted (e.g., police, ambulance, crisis teams).

Suicidality

The term ‘suicide’ is used in reference to any self-inflicted injury resulting in death, where death was the deliberate intention [528]. Suicidality therefore relates to any behaviours, thoughts, or intentions which precede this act or suggest that death may be desired (e.g., self-harming, risk-taking behaviour, suicidal thoughts, previous attempts, current plans). The term ‘commit’ suicide is a remnant from when the act of suicide was a criminal offence and also has religious associations (i.e., to ‘commit’ a crime or a sin). The last Australian jurisdictions to decriminalise suicide were the Australian Capital Territory in 1990 and the

Northern Territory in 1996 [529]. Just as non-stigmatising language should be used when referring to a person with an AOD use disorder or a mental disorder (e.g., not using the terms 'addict' or 'schizophrenic'), it is important that discussions involving suicide remain non-stigmatising. Clients of AOD treatment services are at high-risk of suicide [530–532]. The presence of co-occurring mental disorders further increases this risk [533–537]. A thorough assessment of suicide risk should take place in the initial consultation phase. However, suicide risk should also be assessed and monitored throughout treatment, particularly at pivotal points in treatment and at times of increased risk (e.g., during periods of instability, when experiencing additional stressors), as suicide risk is a dynamic process that is subject to change over time [389]. If a person presenting to treatment is not at risk of suicide at intake, it should not be assumed their low level of risk will remain the same. How to assess for suicide risk, and appropriate responses to varying levels of risk, is explained in depth below. Table 29 outlines the dos and don'ts in regard to the management of suicidality.

Table 29: Dos and don'ts of managing a client who is suicidal

Do:	
✓	Ensure the client has no immediate means of self-harm; remove weapons and potentially dangerous objects.
✓	Talk to the client alone – without any family or friends present.
✓	Allow sufficient time to discuss the issue.
✓	Discuss limits of confidentiality.
✓	Introduce suicide in an open, yet general way (e.g., 'sometimes people feel so overwhelmed they think about suicide, is this something you've thought about?').
✓	Ask the client about suicide directly. An indirect question may be misunderstood.
✓	Use clear unambiguous language that is non-threatening (e.g., 'thinking about suicide', 'killing yourself').
✓	Be non-judgemental and empathetic.
✓	Emphasise that there is help available.
✓	Validate the client's feelings and emphasise the fact that speaking with you is a positive thing.
✓	Consider what the predominant concern is for the client, and how you might be able to help remedy this concern (e.g., removal of stresses, decreasing social isolation).
✓	Contact the local mental health crisis team if the client appears to be at high-risk.

Table 29: Dos and don'ts of managing a client who is suicidal (continued)

Don't:
Invalidate the client's feelings (e.g., 'All you have to do is pull yourself together', 'Things will work out').
Panic if someone starts talking about their suicidal feelings. These feelings are common and talking about them is an important, encouraging first step.
Be afraid of asking about suicidal thoughts. Most clients are quite happy to answer such questions.
Worry that questions about suicide may instil the idea in the client's mind or embarrass the client.
Leave a high-risk client unattended.

Adapted from NSW Department of Health [431] and Stone et al. [389].

The assessment of suicide risk is a process through which an AOD worker directly enquires about suicidal thoughts (frequency, intensity, plans, intent), history of suicidal behaviour and self-harm, current stressors, hopelessness, and protective factors (e.g., family, friends, other services). While self-harming behaviour is a risk factor for suicide, it should be noted that self-harm may not always be indicative of suicide risk. For some people, self-harm may function as a mechanism for coping with distress without there being an intention to die. Irrespective of intention, it is important to consider the lethality of self-harm behaviours in assessing risk.

Discussing suicide with clients is vital and does **not** increase the risk of suicidal behaviour [389, 538, 539]. Rather, sensitive questioning by a healthcare worker can be a relief for clients who have been harbouring thoughts of self-harm or suicide, and provides an opportunity to manage this risk appropriately, either within the AOD service, or in collaboration with mental health and emergency services [540, 541].

Despite the need for suicide risk assessments, research suggests that many AOD services either have no written suicide risk assessment policy, unclear procedures regarding assessment and/or intervention, or policies and procedures of which AOD staff are not aware [542, 543].

In response to the need for AOD staff to have access to resources that will assist with the identification and management of suicide risk, the *Suicide Assessment Kit (SAK)* was developed [544, 545]. The *SAK* is a comprehensive assessment and policy package, specifically developed to help AOD services assess and manage suicide risk. It contains four key resources for AOD staff and managers (see Table 30):

- A suicide risk screener.
- A suicide risk formulation template.
- A safety plan.
- A suicide policies and procedures pro forma.

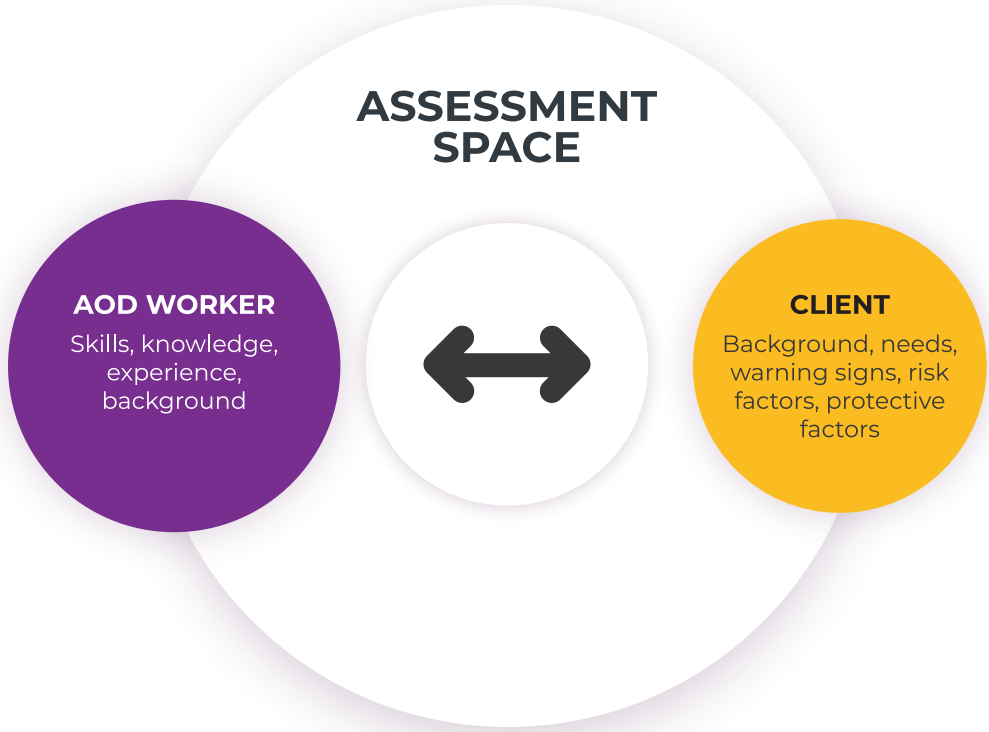
Table 30: Suicide Assessment Kit key resources

Resource	Purpose
Suicide risk screener	Designed for use at specific time points in treatment (i.e., admission, transition points, discharge), or when the client is suspected to be at increased risk of suicide.
Suicide risk formulation template	Designed to help AOD workers develop a comprehensive picture of background factors that may contribute to a client's risk of suicide, as well as strengths and protective factors that can be incorporated into management and treatment.
Safety plan	Designed to help AOD workers develop a plan with a client on how to manage suicidal thoughts when they occur.
Suicide policies and procedures pro forma	Designed to help agencies develop policies and procedures for the assessment and management of suicide risk, as well as documentation regarding file and resource sharing, referral sources, and procedures.

A number of other supporting resources are included in the *SAK*, which may be useful to AOD workers in the identification and management of suicide risk. These, along with the full *SAK* resource (including training videos), may be downloaded from the *SAK* webpage: **https://ndarc.med.unsw.edu.au/suicide-assessment-kit**.

It should be emphasised that although these resources can be incorporated into AOD workers' everyday practice, it is vital that risk assessments are not conducted according to a checklist or flowchart procedure. All clinicians bring a wealth of knowledge, background, skills, and experience, all of which should inform the evaluation and assessment of an individual client's level of risk. The screeners and templates included in this section (and in **Appendix Z**) rely on AOD workers incorporating their knowledge, judgement, expertise, and skill in the assessment of risk. Figure 13 illustrates a shared assessment space, where both the AOD worker and client bring their respective backgrounds, and the AOD worker draws upon their expertise to conduct the assessment.

Figure 13: Shared risk assessment space between AOD workers and AOD clients



Suicide Risk Screener

As mentioned, the Suicide Risk Screener was developed as part of the *SAK* in response to research that highlighted the need for improved assessment and management of suicide risk in AOD residential rehabilitation programs Australia-wide [543]. It can be used to assist in assessing clients' level of risk, determining what intervention and management strategies are required, and in developing a safety plan to reduce risk [545]. The Suicide Risk Screener, scorer, and interpretation are located in Appendix Z.

When to complete the Suicide Risk Screener

It is vital that suicide risk assessment be conducted at various points throughout treatment, and should not be viewed as a one-off event. Assessing risk should be conducted at particularly significant transition points within treatment (e.g., intake, discharge), as well as times when crisis is clearly visible [389, 545]. In addition to conducting risk assessments at fixed points throughout treatment, it is important that AOD workers respond to their own informal assessment and conduct additional screening depending on a client's presentation, behaviour, personal situation and/or circumstances, or ominous statements [545].

Warning signs for suicide

Research has identified the importance of both warning signs and risk factors for suicide in conducting suicide risk assessments [546, 547]. Warning signs for suicide are specific to the current state of the person (e.g., behaviours preparing for suicide), and indicate a heightened risk in the near-term (e.g., minutes, hours, or days). In contrast, risk factors are often long-lasting and increase suicide risk over time (e.g., lifetime psychiatric diagnoses, past suicide attempts) [546, 547].

Warning signs may be immediately apparent at intake or may arise during treatment. The presence of warning signs indicates that screening and information gathering regarding suicidality is required. Warning signs can be either direct, requiring immediate attention, or indirect, which are less identifiable [546–548]. Direct signs include [545, 549]:

- Suicidal communication: A client threatening to hurt or kill themselves or talking about wanting to do so. Suicidal communication also includes speaking ominously, such as talking about going away, or of others being better off without them.
- Seeking access to a method: A client looking for ways to kill themselves by seeking access to pills, rope, or other means.
- Making plans: A client talking or writing about death, dying, or suicide, when these behaviours are out of the ordinary for the person.

Indirect warning signs are less easily identifiable, and require a heightened level of awareness, particularly as many indirect signs may also occur in AOD clients who are not suicidal [545, 546]. Any changes in normal thoughts, emotions, or behaviours can indirectly indicate that a client is in crisis [389, 548], but the most common of these changes are sleep disturbances, anxiety, agitation, and hopelessness [548]. These factors are critical in assessing level of suicide risk. The mnemonic 'IS PATH WARM' (see Table 31) may be useful in assisting AOD workers remember common warning signs [550], with each letter corresponding to a specific warning sign experienced or reported in the last few months [551].

Table 31: IS PATH WARM model for common suicide warning signs

Mnemonic	Warning sign	Explanation
I	**I**deation	Has the client expressed a desire to kill themselves, with a method that they have access to, or can access (e.g., weapon, pills), or an intention to obtain a method for the purpose of killing themselves?
S	**S**ubstance use	Has the client recently relapsed?
P	**P**urposelessness	Does the client express a lack of purpose in life, or reason for living?

Table 31: IS PATH WARM model for common suicide warning signs (continued)

Mnemonic	Warning sign	Explanation
A	**A**nger	Does the client express feelings of rage, uncontrolled anger, or revenge-seeking?
T	**T**rapped	Does the client feel trapped in a terrible situation from which there is no escape?
H	**H**opelessness	Does the client have a negative sense of self, others, and the future, with little chance of positive change?
W	**W**ithdrawal	Does the client indicate a desire to withdraw from significant others, or have they already begun withdrawing?
A	**A**nxiety	Does the client feel anxious, agitated, unable to relax, and/or report disturbances in sleep?
R	**R**ecklessness	Does the client act recklessly without thinking or considering the consequences?
M	**M**ood changes	Does the client report dramatic shifts in emotions?

Adapted from Juhnke et al. [551] and Deady et al. [545].

Other mnemonics that AOD workers may find useful include 'SIMPLE STEPS', for assessing the severity of suicide ideation [552, 553], and 'SHORES', for assessing protective factors [554]. These mnemonics are illustrated in Table 32 and Table 33.

Table 32: SIMPLE STEPS model for assessing severity of suicidal ideation

Mnemonic	Warning sign	Explanation
S	**S**uicidal	Is the person expressing suicidal ideation?
I	**I**deation	What is their suicidal ideation?
M	**M**ethod	How detailed is the person's suicidal method and is their method accessible?
P	**P**erpetuation	How intense is their emotional pain?

Table 32: SIMPLE STEPS model for assessing severity of suicidal ideation (continued)

Mnemonic	Warning sign	Explanation
L	**L**oss	Have they experienced actual or perceived losses (e.g., relationships or material objects)?
E	**E**arlier attempts	Have there been previous suicide attempts? What did they involve? What happened afterwards?
S	**S**ubstance use	Is the person currently using substances or have they recently relapsed?
T	**T**rouble shooting (lack of)	Are they able to see any alternatives or options other than suicide?
E	**E**motions and diagnosis	Assessment of emotional factors and diagnoses commonly associated with suicide (e.g., hopelessness, helplessness, worthlessness, loneliness, depression).
P	**P**rotective factors (lack of)	Internal or external factors that might reduce the risk of suicide (e.g., individual resilience, family/community support).
S	**S**tressors and life events	Evaluation of current and previous stressors.

Table 33: SHORES model for assessing protective factors

Mnemonic	Factor	Explanation
S	**S**kills and strategies to cope	Emotional regulation, adaptive thinking, engaging in interests or hobbies.
H	**H**ope	Hope and goals for the future, in addition to a sense of purpose to obtain those goals.
O	**O**bjections	Moral, cultural or spiritual beliefs that may protect against suicide.
R	**R**easons to live and **R**estricted means	Reasons to stay alive include family or carer responsibilities (e.g., to a person's children). Restricted means refers to reducing access to methods which might be used in suicide (e.g., medications, poisons).

Table 33: SHORES model for assessing protective factors (continued)

Mnemonic	Factor	Explanation
E	**E**ngaged care	Active engagement in a therapeutic relationship.
S	**S**upport	Involvement in supportive relationships, including family, community, friends.

The risk of suicide can increase during times of significant events, stress, upheaval, or trauma. It is likely that warning signs will be more pronounced during such times. These risk factors might include [389, 545, 550]:

- Relationship break-up/significant relationship problems.
- Trauma.
- Impending legal event.
- Child custody issues.
- Past history/family history of suicide or suicide attempt, or recent suicide of friend.
- Loss of a loved one.
- Financial crisis, job loss, employment set back.
- Family conflict or breakdown.
- Chronic pain or illness.
- AOD relapse.
- AOD intoxication.
- Recent discharge from treatment service.
- Social isolation.

Direct warning signs indicate a need for immediate assessment and intervention and, although the presence of indirect warning signs may not indicate acute suicide risk, there is the need for follow-up questions to determine whether suicidality is indicated. This requires a degree of judgement and skill by the AOD worker. Careful elicitation of suicidal ideation does not increase the risk of suicide [389, 538, 539]. When in doubt, it is critically important that workers ask clients directly.

As mentioned previously, it is critical that suicide risk assessment be an ongoing process and not a one-off event. Clients' suicidality may change throughout treatment to reflect the changes in their AOD use, mental health, or personal circumstances, and there is a need for AOD workers to monitor and assess for any such changes. Whenever suicide risk is at all suspected, it is essential that AOD workers enquire as to the presence of suicidal thoughts and/or feelings. Regular assessment of suicidality and a therapeutic relationship in which a client feels they can talk openly will help clinicians gather the best possible estimate of suicide risk [555].

Protective factors

In conducting a suicide risk assessment, it is also important to consider protective factors [556]. Protective factors can be any values, beliefs, supports or reasons that a person may have for living. Protective factors can vary, but their existence offers protection against suicide, with more stable factors offering greater protection than fewer unstable factors [545]. For example, a person with hopeful plans for the future, with good physical health and a stable daily routine may be less likely to attempt suicide than an isolated, physically unwell person with no social support. It is critical to note, however, that no single protective factor is a reliable indicator that a person is completely safe [545]. The mnemonic 'SHORES' (see Table 33) may be useful in assisting AOD workers remember protective factors.

Some examples of protective factors include [545]:

- Strong social connections (i.e., one or more people that a person feels comfortable confiding in) which may be family, a partner, peers or a community a person feels part of. For this to be an effective protective factor, the person must be willing to seek help from their social supports if needed (i.e., their existence alone is not protection).
- Stability across multiple areas of a person's life, such as housing, employment, daily routine, physical health, religious or cultural values.
- Hopeful plans for the future.
- Personal skills and attributes which may offer protection against suicidal thoughts and behaviours, such as resilience, problem solving skills, strong self-esteem, self-worth, optimism, and empathy.

Safety plan

As described in the *SAK*, a safety plan is a strategy put in place between a healthcare practitioner and client on how to manage suicidal thoughts [545]. Some strategies that might be included in a safety plan are:

- Identifying warning signs.
- Preparing safety strategies, including identifying protective factors.
- Strategies for staying safe.
- Names and emergency contacts of supportive people, AOD workers, other key agencies involved in treatment.

Responding to chronic suicidality

An additional challenge for AOD workers is managing and responding to chronic suicidality, which is experienced by some clients, particularly those who have experienced complex trauma [135, 389, 557]. Chronic suicidality may vary in intensity over time, and the difficulty for clinicians is to determine when to intervene. It is important for clinicians to be able to identify and distinguish the differences between acute and chronic suicidality, as chronic suicidality is managed slightly differently [135, 389]. The NHMRC

[555] suggests:

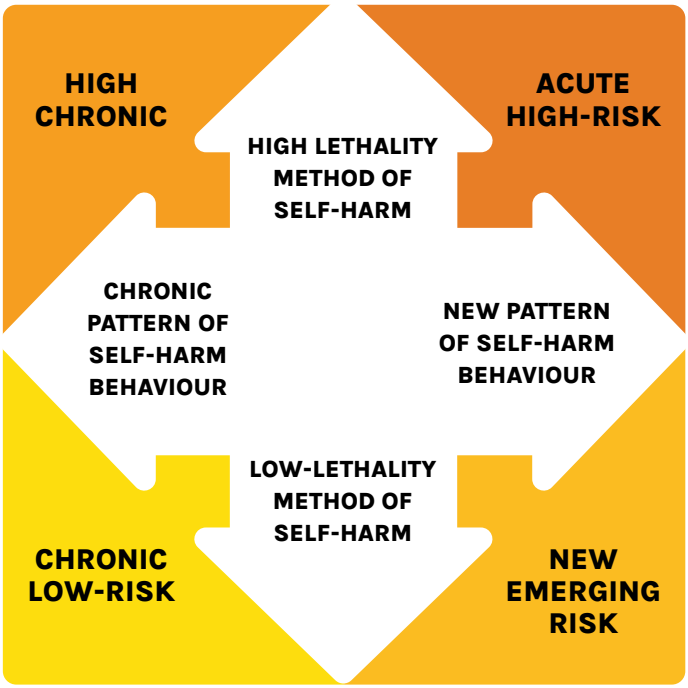
- It can be unhelpful, or even escalate behaviour, if chronically suicidal clients are hospitalised or closely observed in attempts to prevent suicide.
- As quality of life improves, intensity of suicidality may lessen. As such, counselling should focus on factors that may improve quality of life.
- People who are at immediate, acute high-risk of suicide are likely to need interventions to ensure their immediate safety (e.g., short-term hospitalisation).

Strategies that might assist workers to determine whether the risk of suicide in a person with chronic suicidality might escalate to becoming acute include [555]:

- Changes in the usual pattern or type of self-harm.
- Significant change in mental state (e.g., sustained and severe depressed mood, worsening of a major depressive episode, severe and prolonged dissociation, appearance of psychotic states).
- Worsening of AOD use disorder.
- Presentation to health services in a highly regressed, uncommunicative, or withdrawn state.
- Recent discharge from psychiatric facility (within last few weeks).
- Recent discharge from psychiatric treatment due to breach of treatment contract.
- Recent adverse life events (e.g., loss or breakdown of significant relationship, legal, employment or financial problems).

Figure 14 provides a guide to help estimate the level of risk in chronically at-risk clients. Changes to levels of risk are indicated by changes in the pattern of risk behaviour (i.e., frequency, type, or severity).

Figure 14: Estimating the probable level of suicide risk



Source: NHMRC [555], adapted from Spectrum: http://www.spectrumbpd.com.au/

In terms of responding to the differing levels of risk presented in Figure 14 [555]:

- If a client is at chronic low-risk (the bottom left-hand quadrant of Figure 14), they are at relatively low-risk of suicide and workers should focus on factors associated with improving quality of life.
- If a client at chronic low-risk begins to use more lethal methods of self-harm over a longer term, they become at chronic high-risk of suicide (top left-hand quadrant of Figure 14). Hospitalisation at this point will probably not be appropriate, because the chronic high-risk will likely continue beyond the conclusion of hospital admission. Rather, clinicians should focus on improving quality of life and assisting clients to manage issues that are driving their suicidality.
- If a client who has been chronic low-risk begins to demonstrate new symptoms or behaviours (bottom right-hand quadrant of Figure 14), they should be closely assessed, additional risk factors should be assessed, and clinicians should focus on improving quality of life. Hospitalisation is not appropriate unless new behaviours suggest immediate risk of suicide.
- If a client at high chronic risk of suicide begins to demonstrate new symptoms (behavioural or mental health issues that indicate immediate risk of suicide; top right-hand quadrant of Figure 14), the person's immediate safety should be ensured. A brief period of inpatient admission may be indicated, followed by counselling on discharge focused on improvement of quality of life and monitoring suicidality.

Domestic and family violence

AOD use has been associated with both the perpetration and victimisation of domestic and family violence including physical, sexual and emotional abuse [558–563]. There has also been increasing recognition of coercive control as a form of domestic and family violence.

Evidence suggests that up to two thirds of women attending AOD treatment have experienced violence [564]. Although domestic and family violence is commonly characterised as males using violence against females, this is not the only form of family violence. Other relationships can experience family violence, including same-sex, non-spousal, and carer relationships, and can involve children [563, 565, 566].

The high prevalence of AOD clients who have experienced domestic and family violence highlights the need for AOD workers to conduct thorough and effective assessments and respond to the problem. Key factors that have implications for AOD workers are illustrated in Table 34.

Table 34: Key issues in domestic and family violence and implications for AOD workers

Key factor	Significance	Implication for AOD worker
AOD use	The relationship between AOD use and family violence is thought to be bi-directional (i.e., AOD use can increase the risk of violence and vice versa) [567–569].	Attempt to identify power and control strategies employed by those using violence, whilst supporting and preserving the abused person's safety [570, 571].
Gender	In general, women and children are victimised more than men, and men are more likely than women to use violence in relationships. Women are also more likely than men to be injured through family violence, and therefore express fear [572–574].	Family violence also occurs in non-spousal, same-sex, and carer relationships, and can involve children [565, 566]. Risk assessment is warranted for all clients, which should include exposure to, and use of, violence in relationships [563, 565, 575].
Co-occurring conditions	Not all families with AOD and mental health conditions have family violence, but families with AOD and mental health conditions and family violence are at increased risk of experiencing other problems, such as co-occurring psychiatric conditions, physical health problems, housing and/or employment problems, socioeconomic disadvantage, and social isolation [563, 576].	Responding to AOD and mental health conditions needs to be broad, comprehensive, and involve multiple services in a cohesive, coordinated response (see Chapter B5).

AOD workers should also have an understanding of the dynamics and complexities involved in domestic and family violence, and the reasons why many people remain in violent relationships. These reasons include [577, 578]:

- Fear, arising from the violent person's threats or behaviour, that the person subjected to violence will face further violence, increased danger, or loss of life.
- Fear of stalking or abduction.
- Isolation or rejection from family, friends, and community.
- Loss of home, income, pets, and possessions, or having a reduced standard of living.
- Negative impacts on children such as loss of school, friends, community, relationship with parent or family.
- Grief for loss of partnership.

- Feelings of guilt and self-blame.
- Fear of losing children or having children removed.

Additionally, some people may have difficulty recognising that they are in a violent relationship, may have maladaptive internal beliefs about relationships, or may fear reinforcing negative racial stereotypes [579]. Domestic violence may also be normalised within some cultures, which can make it difficult for those involved to recognise the behaviours as abuse [577]. It is also important to recognise that many of these internal beliefs may not fall within a person's conscious awareness. For all of these reasons, leaving a violent relationship has been described as a process that takes time, rather than being a one-off event [579].

The strategies listed in Table 35 may be helpful for AOD workers managing clients experiencing domestic or family violence. It should be noted that clients may be reluctant to disclose issues relating to domestic or family violence for a number of reasons, such as a desire for privacy, anxiety about the consequences of disclosure (e.g., from the perpetrator or society), anxiety about the impact of disclosure on parental custody, new services being intimidating, and lack of trust in practitioners [580]. AOD workers should be familiar with their organisational policies and procedures relating to domestic and family violence, with access to supervision if needed, and knowledge of appropriate referral and clinical pathways. Further information on domestic and family violence and child protection guidelines specific to each Australian jurisdiction can be found via state and territory websites.

Table 35: Dos and don'ts of managing a client experiencing domestic and family violence

Do:	
✓	Be open, approachable, and trustworthy.
✓	Take the client seriously. Tell them you believe them and emphasise that it is not their fault.
✓	Affirm the perpetrator's responsibility for their violence, even in the presence of AOD use. Let the client know how much you appreciate how difficult it is to talk about.
✓	Seek to build the client's confidence and empower them – it takes courage and strength to survive violence.
✓	Let the client dictate the pace and encourage their progress.
✓	Listen to what the client says about what they want, and how they view their level of danger. Most people only reveal a small amount of the abuse they have endured – only they know how much danger they are in.
✓	Explore options and choices, including ways of increasing the client's safety and the safety of any children – whether they choose to leave the situation or not.
✓	Establish ways to maintain contact safely.

Table 35: Dos and don'ts of managing a client experiencing domestic and family violence (continued)

Don't:	
✗	Undermine the client by making them feel inadequate for not seeking help earlier. Remember they may have sought help earlier or may not have been able to.
✗	Patronise or speak down to the client.
✗	Give your own opinion, be judgemental, or decide who in the relationship is to blame.
✗	Rush the client or tell them what they should do.
✗	Give up or display frustration if things are taking longer than you think they should. It may be frustrating seeing the client hurt or subjected to violence, but their actions and choices are their decision.

Adapted from the Stella Project [578], ATODA [581], and Heward-Belle et al. [570].

Safety plan

Safety planning is an essential component of assisting people who experience domestic or family violence. As having a physical copy of a safety plan could be risky for a person experiencing violence, a copy of the plan should be kept in the client's files and reviewed regularly [581, 582]. The safety plan should:

- Include emergency contact numbers.
- Identify a friend/neighbour/family member who can provide assistance.
- Identify one or more places of safety, means of getting there safely, as well as secure locations to store valuables, emergency items, and documents.
- Identify safe ways to access finances in an emergency.
- Encourage the client to establish a distress code to be used with trusted friends/family members that will trigger them to call emergency services.

B5: Coordinating care

B5: Coordinating care

Key points

- People with co-occurring mental health and AOD use disorders often present to treatment with various issues that need to be addressed during the course of treatment (e.g., physical health, housing, employment, education and training, legal, and family issues).
- Evidence has linked coordinated care with improved treatment outcomes. Specifically, the coordination of health responses into a cohesive approach has been found to prolong client retention, increase treatment satisfaction, improve quality of life, and increase the use of community-based services.
- Although coordinated care may be facilitated by a coordinator or case manager, they are not expected to provide all of the necessary services themselves, but rather refer to, and manage the engagement of, appropriate services.
- The principles of coordinated care can be adopted into referrals and discharge practices, with an emphasis placed on the importance of communication, consultation, and interagency support.
- AOD services and AOD workers should develop links with a range of local services and engage them in clients' treatment where appropriate.
- Discharge planning in close consultation with the client is integral to the treatment process.

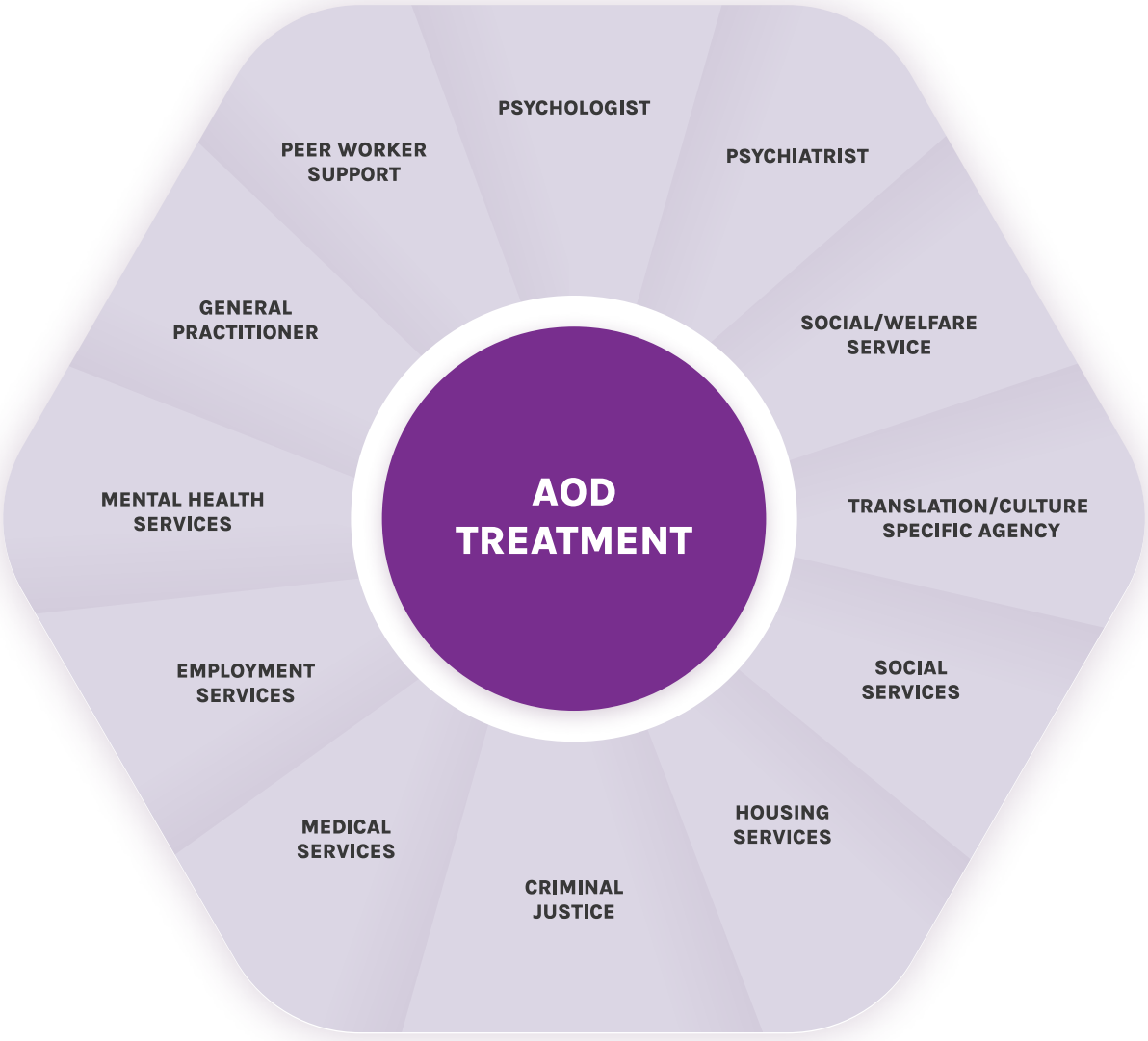
There has been increased recognition of the need for a holistic approach to health care, which is better able to incorporate services that reflect a person's need for housing, employment, education, training, community, justice, and other support services in the delivery of appropriate mental health care [583, 584]. As described in **Chapter B1** and **Chapter B3**, people with co-occurring mental health and AOD use disorders often present to treatment with numerous additional issues that need to be addressed during the course of treatment, including physical health, housing, employment, education and training, legal, and family issues. These issues can often be interrelated, such as difficulty obtaining employment due to a lack of secure housing and/or childcare [585]. It can be extremely difficult for a person to maintain progress in relation to their mental health or AOD use if they do not know where they are going to live, or how they are going to feed themselves or their family. Therefore, addressing these fundamental issues as part of treatment is essential, and is also in line with the approach of 'treating the person, not the illness' [9, 389, 586].

Engaging with other services is best thought of as a consultative process. GPs are of particular importance as, in many cases, they have a prior relationship with the client, and they are often the client's only consistent form of contact with the health care system. Most importantly, consultation with other services should be based on the most essential and desired needs of the client. Although some clients may benefit from treatment by mental health professionals, they may not be ready for such treatment, and it should not be forced at the risk of alienating them (unless they pose a risk to themselves or

others). MI (discussed in Appendix E) can help clients gain willingness to receive treatment, but others may not be ready even after such attempts are made. Each client is different and will manage their situation differently – the key is to support and guide clients and facilitate treatment and access to services as required.

Peer workers also play an important role in supporting clients with AOD and mental health conditions. Peer support can facilitate program engagement, and the delivery of programs by peers has been found to enhance treatment outcomes [587]. Data from qualitative interviews conducted among people attending treatment for their co-occurring disorders also suggests that peer support provides opportunities for community integration, aids in building social confidence, provides a safe space, improves feelings of being accepted, and helps people to not feel alone [124, 125, 588]. Figure 15 illustrates some of the services that may need to be incorporated into a coordinated approach to clinical care.

Figure 15: Services that AOD workers may need to engage in client care



Coordinated care increases the likelihood that clients will receive specialised assistance where it is needed and facilitates client engagement in treatment. There is evidence to suggest that care coordination is effective in increasing treatment engagement and retention, increasing treatment satisfaction, improving quality of life, increasing the use of community-based services, and decreasing the cost of healthcare [589–595]. Treatment retention has been consistently associated with better treatment outcomes among people with AOD use disorders [594, 596–598].

Evidence suggests that clients place a high degree of importance on interagency cooperation in terms of coordinated care and case management, with higher levels of service integration associated with clients reporting that their needs have been better met [599]. Clients have described the optimal service as one that delivers a coordinated, holistic approach, where staff are aware of the needs of clients and are proactive in following them up, and work with other services to deliver seamless care [599]. Superior treatment outcomes have similarly been associated with coordinated care when there is frequent in-person contact, close interaction between primary care providers and case managers, and culturally responsive practices [600, 601]. Conversely, a lack of coordinated care and service integration can have a negative impact on clients. Distress may arise from the need for clients to continuously retell upsetting stories or rehash details to multiple service providers. Confusion may also result from having a number of different health care workers involved in the care of one person without coordination [599].

Despite the need for integrated service approaches to respond to complex problems, the practical implementation may not be so straight-forward. The primary challenge may lie in structural barriers, service silos, and older models of mental health support, which prevent the effective provision of holistic care [602]. In turn, many people with mental health conditions experience a lack of coordinated care, or service integration, and consequently fall 'between the gaps' [102, 602].

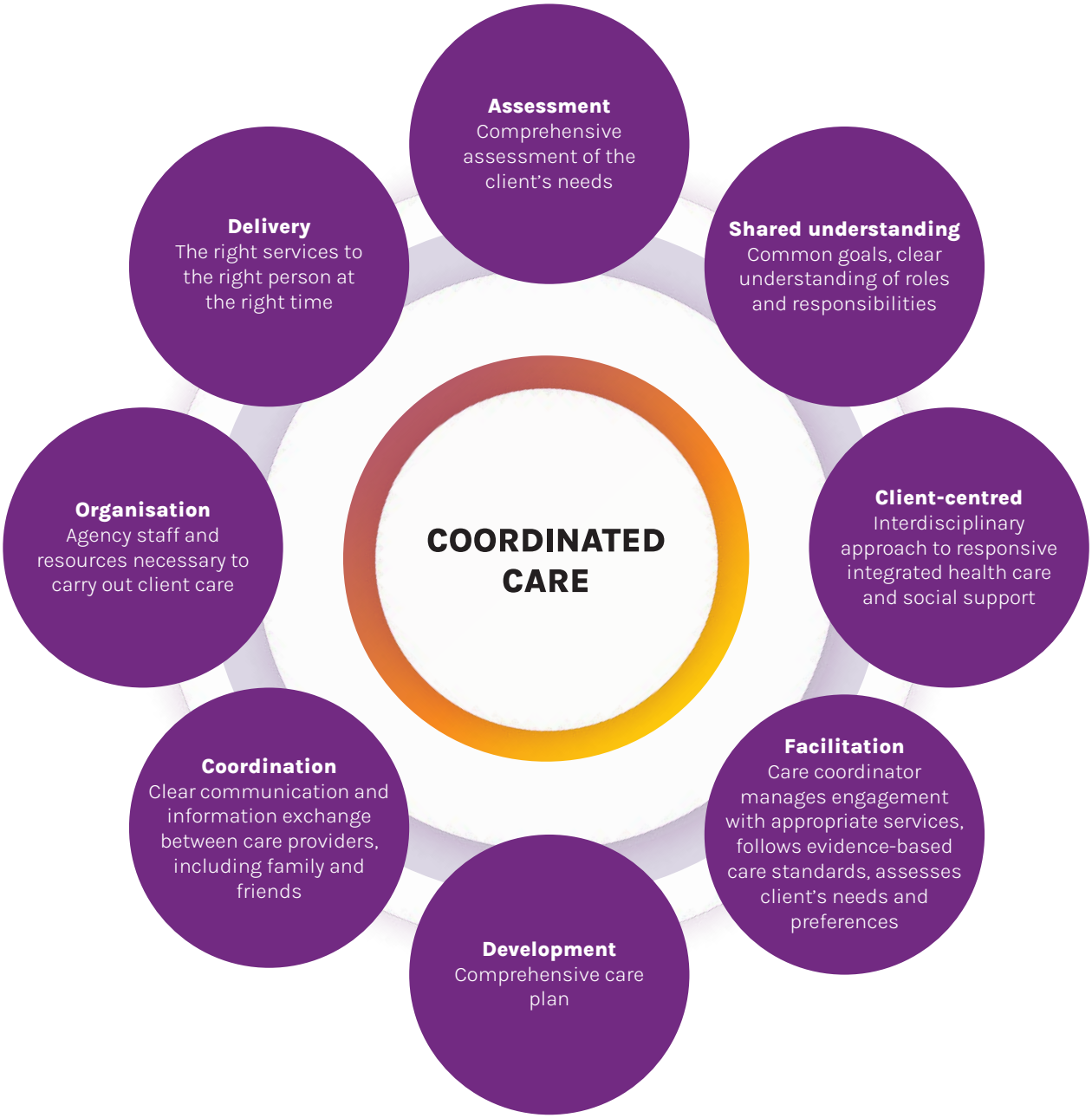
What is coordinated care?

Innovative models of health care are not only focused on providing physical or mental health care, but seek to incorporate services that are reflective of a person's broader needs (e.g., employment, housing, education, training, community, and justice health services) [603–605]. The actual definition of coordinated care can vary between services, and can include case management, collaborative care, shared care, team coordination, and multidisciplinary care. In practice, coordinated care should involve the coordinated delivery of individual services across multiple sectors, which is perceived as a seamless service system by clients, and results in overall improved client outcomes [102, 599, 602, 605, 606]. Despite differences in terminologies, the core elements remain the same. Figure 16 illustrates the core elements of care coordination.

Although coordinated care is facilitated by an identified coordinator or case manager, they are not expected to provide all of the necessary services themselves, but rather refer to, and manage the engagement of, appropriate services [389]. The challenge for a holistic health care approach to co-occurring conditions is in the active engagement of multiple services and service providers, with a mixture of professional and non-professional support [605, 607]. AOD workers in particular are in primary

positions to coordinate care and incorporate the many services that reflect the particular needs of clients, to deliver the best quality mental health services. Box 13 illustrates the continuation of case study K, following Con's story after one of his mental health workers suspected Con was hearing voices.

Figure 16: Core elements of coordinated care



Adapted from McDonald et al. [608], Ehrlich et al. [609], Brown et al. [610], and NSW Mental Health Coordinating Council [611].

Box 13: Case study K: Managing co-occurring physical, mental, and AOD use disorders: Con's story continued

Case study K: Con's story continued

It was apparent to the mental health outreach workers that Con was experiencing a relapse of symptoms of psychosis, and Con was readmitted to an inpatient mental health unit. During Con's admission, the social worker assigned to him applied for a National Disability Insurance Scheme (NDIS) package to provide Con with an increased level of support to assist with maintaining his living in the community. The increase in support provided enough for a cleaner and support worker who visited Con every day and took him to his medical appointments, all of which was overseen by a care coordinator. With the additional support, Con was able to reduce his drinking and keep his house clean. Con's support team were also able to ensure his nutritional needs were being met and provided additional social contact by taking him to and from the shops. Con's community mental health team continued to visit him and manage his psychotic disorder.

Key points:

- There is a need for AOD workers to place more emphasis on physical health as a priority (bearing in mind the years of life lost in this population).
- Once the health needs of clients are recognised, holistic health care interventions such as physical activity, smoking cessation, healthy eating, and healthy sleep patterns can follow. The importance of adherence with physical health medications (e.g., blood pressure and diabetes medications) should also be emphasised.
- Many clients may require more assertive follow-up, including long-term practical support (e.g., phone or text reminders, or someone to accompany the client to appointments).
- Communication between AOD workers, mental health services, and GPs is essential.

Barriers to effective coordinated care

Despite the need for holistic approaches to complex problems, there are several practical barriers that prevent effective care coordination between services. These include structural barriers, geographic barriers (e.g., working with rural/remote services), difficulty reconciling treatment approaches between services, lack of clear communication, and competition between traditionally separate services, all of which make collaboration difficult [612, 613]. Moreover, both primary care providers and insurers currently identify the lack of a viable financial model as one of the major barriers to widespread coordinated care [614].

With coordinated approaches requiring the involvement of services and service providers in working partnerships, there is the potential for a lack of clarity regarding roles and responsibilities of different stakeholders [615, 616], making communication between services even more important. Further, the nature of competitive tendering arrangements between services to determine government funding, and focus on occupied bed days, creates tension and competition between agencies who must work together to provide collaborative health care [605]. For some services, this working environment may foster creativity; others may find their collaborative efforts stifled, and the associated difficulties overwhelming [605].

An additional barrier that may prevent effective collaboration between services is the lack of an existing model to follow [617]. Some common principles that can be incorporated into care coordination include [389, 600, 607, 618, 619]:

- Cross-disciplinary training and involvement of external service providers in case review meetings.
- Effective communication between services and service providers.
- Culturally responsive practices.
- Clear roles and accountability within and across services and service providers.
- Shared respect for the client and their health needs, and a common work culture that incorporates collaboration as a key aim.
- Routine evaluation of client care outcomes, including adherence.
- Centralised access to care, including designating a single point of contact to coordinate care for clients. If a single point of contact is not possible, clear communication with the client about who to contact for varying aspects of their care.
- Recognition that co-location alone does not result in effective service coordination or increase communication.
- Recognition of barriers to referral pathways, which include staff turnover, client confidentiality, and competition between services and service providers, which in turn requires dedication and commitment to overcome.

Stigma and discrimination

Stigma and discrimination can be barriers to coordinated care. Stigma is usually based on stereotypes, assumptions or misconceptions, that discriminate, disparage, or devalue a person or a group of people [620, 621]. Stigma and discrimination are particularly evident in relation to both mental health and AOD use and can result in people being excluded from or denied health services [622]. Some people view those with AOD use conditions as being personally responsible for their problems and therefore less deserving of sympathy and treatment. Although some headway has been made in relation to societal attitudes toward other mental health conditions, some people continue to view people with AOD use disorders as immoral [623–626]; or potentially dangerous, violent, or manipulative [627, 628].

There is evidence that stigma and discrimination are commonly experienced across healthcare settings by people with co-occurring AOD and mental health conditions and are significant barriers to people accessing health services [622, 624]. Those who have experienced stigma or discrimination, or perceive that stigma exists, are less likely to access treatment services or seek help [624]. Unfortunately, these negative experiences can deter or delay future help-seeking [629].

Stigma and the attitudes of some providers can also impact the quality of healthcare provided, particularly among clinicians who believe people with co-occurring conditions are responsible for their own problems and are therefore less deserving of treatment than other people. For example, a person experiencing co-occurring conditions in need of a liver transplant may be perceived as less deserving than a person without co-occurring conditions [630]. These biases may also impact upon clinicians' interactions with clients, insofar as clinicians with these attitudes may be more likely to patronise, scold or blame clients, provide opinion-based (as opposed to evidence-based) advice and care [631], or deny treatment altogether [624, 632].

Lack of practitioner knowledge, discriminatory workplace policies, practices, and structures may also intentionally or unintentionally deter people from seeking help [632, 633]. For example, workplace cultures that normalise stigmatising language or behaviours can impact whether clients are treated with dignity and respect [634].

As described in **Chapter A3**, **Chapter B3** and **Chapter B4**, the language used when working with co-occurring conditions is vitally important; equally important is the use of respectful, person-centred, non-judgemental language when discussing clients with other healthcare providers, family members, or members of the public. Useful language guides developed by NADA and NUAA, in collaboration with people with lived experience, provide suggestions for non-stigmatising language, and examples of how such language can be utilised in clinical practice. More information about the *Language Matters* resource is available via NADA: **https://nada.org.au/resources/language-matters/**. There is preliminary evidence for organisational interventions aimed at reducing stigma among service providers [635, 636], which should include the identification of structural factors within workplaces and organisations that may contribute to the perpetuation of stigma, and consultation with the workforce [634, 637, 638].

Referrals

Some circumstances may necessitate the consideration of referring a client to other clinicians or services. This may be to obtain additional services, or because the clinician feels that the client requires responses that are beyond their own level of skills and expertise [389]. As mentioned in **Chapter A3**, it is vital that AOD workers can appreciate their level of expertise and training but also have the ability to recognise their own limits and work within their own capacity. Referring a client to a more suitable clinician is an ethical practice that ensures appropriate treatment needs will be met, and requesting supervisor support can be useful in this process [389].

Referrals can involve transferring a client temporarily, permanently, or sharing client care [389]. Whenever possible, clients should be retained in AOD treatment whilst accessing other services, rather than excluded from AOD services and referred to others. For example, a client entering residential

rehabilitation who has been identified as having a bipolar disorder may be retained in AOD treatment, but it may be useful to obtain an appointment with a psychiatrist who can undertake an assessment, provide a diagnosis, and prescribe medications; the client's condition can then be managed while they are in the residential service. Increasingly, a number of employment, welfare, and medical services are providing consultation times within AOD services to facilitate client access to these services.

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

One of the biggest risks in the referral of clients to external services is the potential for clients to 'fall through the gaps' and disappear from treatment altogether. People with co-occurring conditions in particular often have difficulty navigating their way through the available services, and many are lost during the referral process [389]. The act of trying to navigate the health care system has been likened to a roundabout with many points of entry and many options regarding the direction to be taken [85]. Therefore, it is crucial that the referral process focuses on linking the client with services as smoothly as possible. This process may be assisted by the development of formal links between services regarding consultation, referral pathways, and collaboration, such as a memorandum of understanding.

Where referral is non-urgent (e.g., not requiring urgent medical or psychiatric attention), the referral process may be passive, facilitated, or active (see Table 36). In the case of clients with co-occurring conditions, active referral is recommended over passive or facilitated referral. Active and timely referrals have been associated with improved AOD and mental health outcomes [639, 640], whereas passive referrals are considered to be one of the reasons for low engagement in continuing care [641].

When referring a client to an outside service, it is crucial that AOD workers consult with the referral agency to determine whether the client kept the appointment, whether assistance was provided and what progress was made. This process of assertive follow-up is particularly crucial in cases where the referral is related to a high-risk situation (e.g., suicidal intent). With clients' permission, families and carers should be involved in the referral process wherever possible, as they will often need to facilitate clients' access to other services. Families and carers should also be informed of services available to them in the form of advocacy and support groups (e.g., Family Drug Support, SMART Family and Friends).

Table 36: Referral processes

Passive referral
Passive referral occurs when the client is given the details of the referral agency in order to make their own appointment. This method is almost never suitable for clients with co-occurring conditions.

Table 36: Referral processes (continued)

Facilitated referral
Facilitated referral occurs when the client is helped to access the other service; for example, with the client's permission, the worker makes an appointment with the other service on their behalf.
Active referral
Active referral occurs when the worker telephones the other agency in the presence of the client and an appointment is made. The worker, with the client's consent, provides information that has been collected about the client with their professional assessment of the client's needs. Such referral is necessary when clients are unmotivated, unlikely, or unable to do so themselves. This method of referral is recommended for clients with co-occurring conditions.

Adapted from Clemens et al. [642] and Rastegar [643].

Communicating with other services

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

- You obtain the client's consent before sharing any information.
- The client is kept informed during this process.
- Confidentiality is maintained (e.g., obtain client's written permission for release of case notes and avoid faxing confidential information).

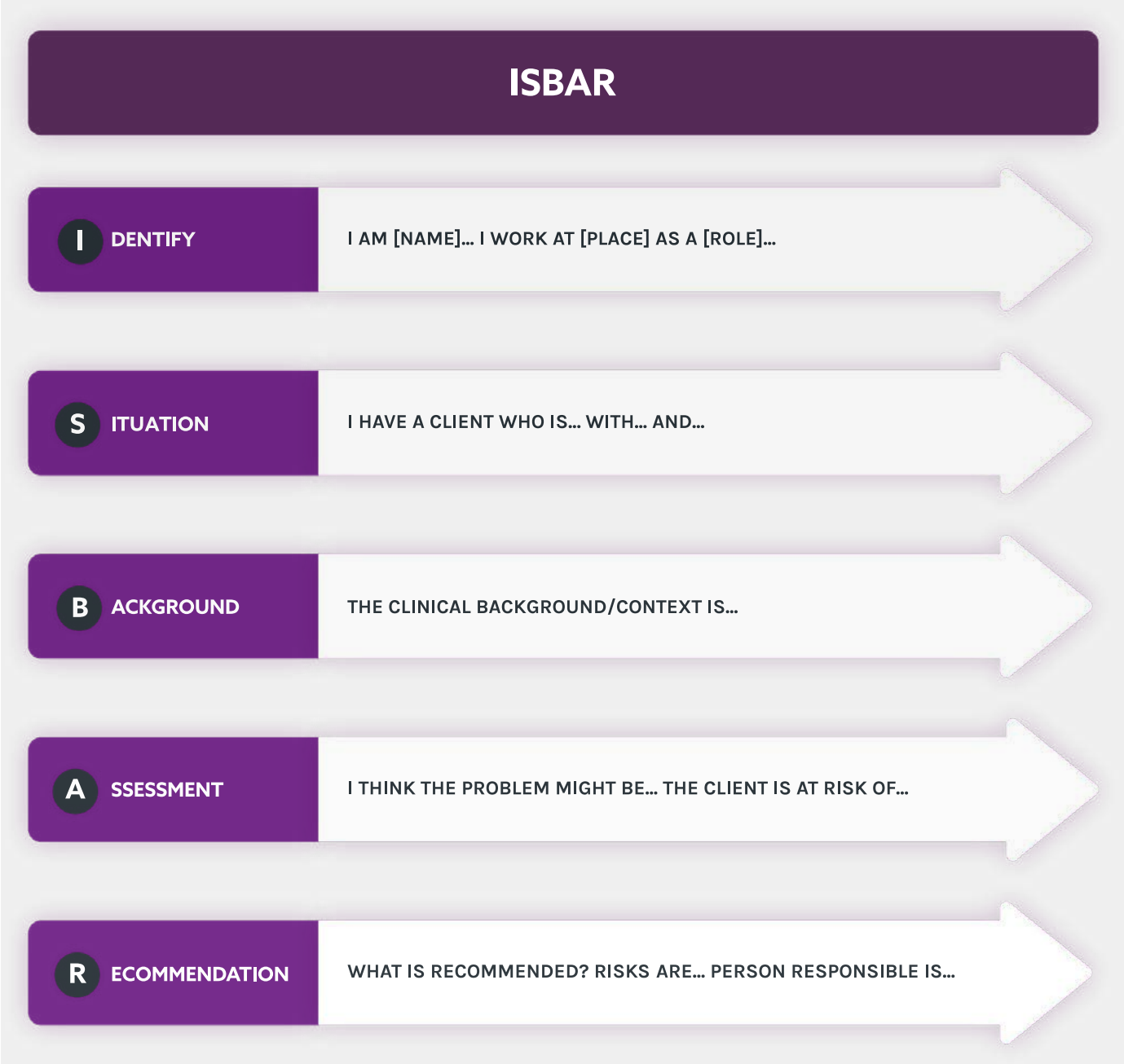
When consulting with or referring clients to other services, assessment reports are often requested by those services. When writing an assessment report for an external party, the following should be considered [389]:

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

A pro forma which may be useful in the referral process is included in **Appendix BB**.

In an attempt to increase communication, teamwork, and safety, a model of standardised communication has been introduced in various healthcare settings, modelled on aviation approaches to standardised safety processes [644]. The model, ISBAR, is a standardised cross-professional tool for enhancing communication, organised in a clear and concise format (see Figure 17) [645]. Although commonly used in clinical handover, ISBAR may also be useful in referral and discharge, with clinicians communicating with other services and agencies about client care.

Figure 17: ISBAR model of effective communication



Adapted from Scotten et al. [646] and SA Health [647].

South Australia Health has developed an ISBAR toolkit to assist with the safe transfer of client information in handover and discharge. They recommend that ISBAR be adapted for use to fit within each clinical practice and is an opportunity for different health care teams to determine which client information is always handed over and discussed as routine practice [647].

Some examples of how to modify ISBAR to your clinical practice include [647]:

- **I**dentify: Include client's medical record number if available, their full name and date of birth.
- **S**ituation: What was the reason for the client's initial presentation? What is their diagnosis? Are they on current pharmacotherapy? What other treatments have they had, and when?
- **B**ackground: Include relevant previous history (e.g., homeless, unemployed, living with abusive ex-partner).
- **A**ssessment: When was their last clinical assessment/investigation? What do you think they may be at risk for?
- **R**ecommendation: Actions required after handover/discharge.

The NSW Ministry of Health have made ISBAR a mandatory component of referring patients to hospital drug and alcohol clinical liaison services [648, 649].

Communicating with the client about referral

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

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

Continue to provide support to the client until an appointment with the new clinician or agency has been arranged. If the client expresses reservations about working with a new clinician or agency, it may be useful to treat the client in collaboration with the new clinician for a period of time, where appropriate [389].

Discharge planning

It is important to prepare clients ahead of time for the cessation of treatment. This is known as the process of discharge planning and is focused on equipping the client with the skills and contacts to continue the positive progress of treatment and avoid relapse. Clients being discharged from residential AOD services in particular can struggle to find housing, employment, and engage with outpatient services [650]. It is important to involve clients in their discharge planning and make them fully aware of their options [234]. While it may be useful to arrange or plan follow-up consultations to monitor how well the client is maintaining the progress made during therapy, a client has the right to refuse further follow-up; if this situation occurs, note the refusal in the client's record and avoid judgemental reactions [234].

Attempt to link the client with further treatment or support and provide emergency assistance numbers. Communicate with relevant service providers where necessary as outlined above. As with all other steps in the treatment process, the discharge plan should be documented in the client's record. Research has indicated that the increasing number of health workers involved in managing complex clients creates challenges for maintaining effective communication between all involved [651]. The likelihood of an adverse event is increased when clients are frequently handed over, transferred or discharged, making the importance of effective communication and accurate case notes even more vital [652, 653]. Challenges for busy health care staff include [654, 655]:

- Multitasking.
- Shift changes.
- Gaps in information transfer.
- Interruptions.
- Previous handover lacks detail or is inconsistent.

It is also important to consider such aspects as stability of accommodation and social support when planning for discharge and, with the client's consent, to involve family and carers as they will play an important role in maintaining treatment outcomes [389, 656, 657]. It is useful to discuss relapse prevention and other strategies (e.g., problem solving, goal setting, and relaxation) with the client during discharge planning and provide the client with skills to manage high-risk situations, lapses and symptoms of mental health conditions that may occur. **Chapter B6** provides useful information regarding relapse prevention, support and self-help groups, and other management techniques that clients may benefit from. **Appendix BB** and **Appendix CC** provide useful CBT and anxiety management strategies.

B6: Approaches to co-occurring conditions

B6: Approaches to co-occurring conditions

Key points

- Four models of care have been identified in the treatment of co-occurring conditions: sequential treatment, parallel treatment, integrated treatment, and stepped care.
- Integrated treatment presents a number of advantages over other treatment approaches; however, there is limited evidence to suggest that any one model is better than another.
- Both psychological and pharmacological interventions have been found to have some benefit in the treatment of many co-occurring conditions.
- When pharmacotherapy is used, this should be accompanied by supportive psychosocial interventions.

This chapter aims to provide AOD workers with an overview of models of care and approaches that are commonly used in the treatment of both AOD and mental health disorders. In **Chapter B7**, we discuss the evidence regarding the efficacy of these approaches in relation to the management and treatment of specific co-occurring mental disorders.

Models of care

Prior to discussing specific treatment options, mention needs to be made of the various models that have been proposed to treat co-occurring conditions. Four approaches have been suggested (see Table 37):

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

There has been much discussion of models of care for clients with co-occurring conditions, but very little research is available to determine which models may be better suited for which conditions. AOD workers may need to make pragmatic decisions as to which model is most appropriate for individual clients.

It should be noted that there are several ways in which the term ‘integrated’ is used with regard to AOD and mental health. In these Guidelines, we use the term ‘integrated treatment’ to refer to the simultaneous treatment of a person’s AOD use and mental health by a single provider or service, which is distinct from the concept of ‘integrated services’ (combining different services such as mental health and AOD) and ‘integrated systems’ (combining service policies, funding, budgets or administrations) [111]. The idea of integrated treatment for two disorders has considerable intuitive appeal and presents

a number of advantages over other treatment approaches. Integrated treatment by a single provider or service helps to ensure that there is a single point of contact (the client does not 'fall through the gaps'), there are common objectives, treatment is internally consistent, the relationship between AOD use and mental health conditions may be explored, and communication problems between agencies do not interfere with treatment [658].

While applying an integrated approach to the treatment of co-occurring conditions is appealing, there has been very little research undertaken directly comparing this approach to parallel or sequential models [659, 660]. Many studies examining the efficacy of integrated treatments compare them to 'treatment as usual' or other forms of treatment for either the AOD use or the mental health condition alone. Although the findings from these studies are promising, these designs cannot establish the efficacy of integrated treatment relative to parallel or sequential treatment [659, 661–669]. Similarly, while there is intuitive appeal to applying a stepped-care approach to co-occurring conditions, few studies have examined stepped-care interventions for co-occurring conditions and these approaches have not been compared to other models. More research is needed to guide treatment approaches in this space.

Table 37: Models of care for co-occurring AOD and mental health conditions

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

Approaches to co-occurring conditions

This section provides a brief introduction to different approaches to the treatment of co-occurring AOD use and mental disorders. It does not attempt to provide detailed information relating to the implementation of these approaches, but rather, an overview of the options available. Where appropriate, readers are referred to existing literature and resources for more detail about the use of particular interventions.

AOD workers are likely familiar with traditional psychological and pharmacological approaches to the treatment of co-occurring conditions. Other approaches include ECT, self-help groups, e-health interventions, physical activity, and complementary and alternative therapies. It is essential to consider the whole person and accept that one approach is not necessarily going to work for all clients. Different clients present with unique biological, psychological, and sociodemographic backgrounds and it is important to take these factors into consideration when deciding on an approach, or combination of approaches, with the client.

Psychological approaches

There are a number of psychological treatment approaches that are commonly used in the treatment of many mental disorders [102]. These approaches have predominantly been delivered face-to-face, but delivery via telehealth (e.g., telephone or videoconferencing) has expanded considerably in response to the COVID-19 pandemic. Psychological approaches include:

- Acceptance and commitment therapy (ACT).
- Behavioural activation.
- Cognitive behavioural therapy (CBT).
- Contingency management.
- Dialectical behavioural therapy (DBT).
- Exposure therapy.
- Mindfulness training.
- Motivational interviewing (MI).
- Psychosocial group therapy.
- Relapse prevention.

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

Acceptance and commitment therapy (ACT)

ACT is a behavioural approach, which has been referred to as one of the 'new wave' or 'third generation' cognitive behavioural therapies [670]. ACT applies six core processes (acceptance, cognitive defusion, being present, self as context, values, and committed action) to develop psychological flexibility – that is, the ability to remain in the present moment; be mindful of experiences, thoughts, emotions and sensations; and consciously behave in ways that align with chosen values [671]. Using mindfulness techniques, ACT is focused on addressing the reluctance to feel negative experiences, thoughts, emotions, and sensations, and accepting negative thoughts and feelings rather than striving to change or eradicate them. Strategies such as cognitive defusion ultimately help clients commit to and pursue their goals by encouraging clients to adopt a more non-judgemental and mindful approach to themselves and their surroundings [670].

ACT has been shown to be effective at reducing the quantity and frequency of AOD use [672–674], as well as associated stigma and shame [675]. It has been found to reduce psychiatric symptoms among people with single disorder anxiety [676, 677], OCD [678], depression [677, 679, 680], psychosis [681, 682], ADHD [683], and PTSD [684, 685]. Although evidence for ACT among people with co-occurring disorders is limited, ACT has been shown to improve abstinence among people with co-occurring affective disorders and AOD use [686], improve PTSD symptoms, and reduce frequency and quantity of AOD use among people with co-occurring PTSD and AOD use [687]. It has also been successfully adapted into e-health interventions [676, 679].

Behavioural activation

Originally developed in the 1970s, behavioural activation is a manualised approach based entirely on behavioural strategies [688]. Behavioural activation aims to improve mood and resilience by enabling a person to focus on their core values and increase engagement in activities that align with those values [689]. The therapy is based on the notion that problems in the lives of vulnerable people reduce their ability to experience positive reward from their environments, leading to symptoms and behaviours characteristic of depression. Behavioural activation aims to activate clients in specific ways that will increase rewarding experiences in their lives. It also focuses on processes that reduce activation, such as escape and avoidance behaviours including AOD use.

Behavioural activation has been shown to be effective at reducing the quantity and frequency of AOD use as well as depressive symptoms, among people with co-occurring depression and AOD use [690]; effective at improving abstinence from AOD use among those with single disorder AOD use [691, 692], and as effective as CBT [693] and antidepressants [694] at treating depressive symptoms among those with depression as a single disorder.

Cognitive behavioural therapy (CBT)

CBT emphasises the important role of thinking in how we feel and how we behave. CBT aims to identify and modify maladaptive thought processes and behaviours through cognitive restructuring and behavioural techniques to achieve change. There is considerable evidence supporting the use of CBT for the treatment of depressive, anxiety, and AOD use disorders [695–697] delivered in a variety of formats

(e.g., in-person, multimedia, online) [696, 698]. **Appendix BB** describes a number of CBT techniques that may be used in the management and treatment of mental health and AOD use conditions, including cognitive restructuring, pleasure and mastery events scheduling, goal setting, and problem solving. A more detailed discussion of CBT may also be found in Baker and colleagues [699] and Graham [700]. A number of the interventions designed for specific co-occurring disorders, such as *Seeking Safety* (for PTSD and substance use [701, 702]) and *Dual Focus Schema Therapy* (for personality disorders and AOD use [703, 704]), are in part based on these CBT techniques. Interventions for specific co-occurring conditions are discussed in more detail in **Chapter B7**.

Contingency management

Contingency management may be used as part of a treatment approach for people with AOD use disorders, that involves rewarding or reinforcing desired behaviour in the client in a supportive manner [705]. Examples are providing vouchers for negative urine samples, for treatment attendance, or for medication adherence. There is evidence that contingency management techniques can be used successfully to facilitate AOD treatment goals, such as reduced use or abstinence [706–709]. Studies have also found contingency management to be effective in promoting abstinence from cannabis among people with co-occurring psychosis [710, 711]; cocaine and opiates among buprenorphine-maintained clients with co-occurring major depression [712]; cocaine among homeless clients [713]; as well as reducing substance use [714], and substance use and psychiatric symptoms, among people using stimulants with serious mental illness [715].

Dialectical behavioural therapy (DBT)

DBT combines behaviour-change strategies from CBT and acceptance strategies from Zen philosophy into an approach that focuses on client validation and behavioural change [716, 717]. Originally developed for the treatment of adults with BPD who were also chronically suicidal, DBT has become the 'gold standard' evidence-based treatment for both BPD and suicidality [716, 718, 719]. The primary principles underpinning DBT are increasing interrelatedness, synthesising acceptance and change, and teaching coping skills to deal with change [720]. Strategies to address changes in behaviour consist of behavioural analyses, skills training, contingency management, cognitive restructuring, and exposure-based strategies to reduce avoidance. Acceptance strategies include mindfulness and validation. A strong therapeutic alliance and improvements in emotion regulation skills appear to be particularly important for positive treatment outcomes [721, 722]. DBT has been found to be efficacious in treating personality disorders (including those co-occurring with AOD use) [723, 724], AOD use disorders (including those co-occurring with personality disorders) [723, 725], and there is emerging research supporting its use for ED that are co-occurring with AOD use disorders [726, 727] (see **Chapter B7**).

Exposure therapy

Exposure therapy involves repeated, prolonged, and systematic confrontation with certain objects or situations that trigger anxiety or fear responses, and learning to tolerate the anxiety associated with these triggers without engaging in avoidance or safety behaviours (i.e., behaviours which reduce the anxiety) [728, 729]. The triggers that induce anxiety can be objects (e.g., food), situations (e.g., open

spaces), cognitive (e.g., memories, intrusive thoughts), or physiological (e.g., dizziness) [730]. The nature of the exposure therapy can be in vivo (e.g., physically touching a light switch), in the imagination (e.g., confronting images of loved ones dying), or recalled (e.g., details of a specific memory). In cases where in vivo is not possible or feasible, due to either a lack of access to the situations associated with anxiety or safety concerns, exposure via virtual reality may be used [729].

There are different types of exposure therapy which have been tailored for the treatment of specific disorders, such as exposure response therapy (ERP) for OCD and prolonged exposure (PE) for PTSD [729]. Regardless of the type of exposure therapy, this technique concurrently weakens the association between triggers and anxiety arousal, and avoidance or safety behaviours and anxiety reduction (i.e., exposure therapy seeks to weaken the idea that anxiety will only reduce once avoidance or safety behaviours are performed [731–733]). Exposure therapy aims to help people tolerate the distress associated with triggers without engaging in avoidance or safety behaviours (e.g., AOD use; repetitive behaviours), and provides corrective feedback to challenge the fear response [730–732]. Common elements of exposure therapies include psychoeducation, building a stimulus or fear hierarchy (i.e., rating anxiety-provoking stimuli based on the amount of anxiety generated), and using this hierarchy to guide treatment intensity [730, 732].

Exposure therapy can be used to successfully treat OCD [731, 734], ED [735, 736], anxiety disorders (including those co-occurring with AOD use [737, 738]), and PTSD (including those co-occurring with AOD use [739–741]). Exposure therapy has also been used successfully to reduce relapse and cravings among people with alcohol dependence [742, 743], and reduce cravings among people who use cannabis [744], methamphetamines [745], and opiates [746]; however, this evidence is mixed and often limited by methodological factors (e.g., lack of active control groups [742, 743]). Clinicians wishing to deliver exposure therapies require specialised training before implementing.

Mindfulness training

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

Mindfulness is a meditative technique that encourages the person to pay attention in the present moment, without judgement, rather than allowing the mind to wander automatically (often to negative thinking) [747, 748]. Regular practice of mindfulness allows a person to develop the capacity to interrupt automatic thought patterns, and be accepting, open, and curious of that experience [749]. Although mindfulness can be a useful practice for everyone, it can be particularly helpful for people with co-occurring AOD and mental disorders by assisting with the development of greater awareness of automatic thinking patterns which can often maintain the mental-health-AOD-use cycle [109, 750]. In general, mindfulness practices involve deliberately focusing on the physical sensations associated with routine activities that are carried out automatically (e.g., walking, eating, and breathing). Mindfulness-

based stress reduction and mindfulness-based cognitive therapy are two specific group therapies based on mindfulness techniques [751]. For a more detailed discussion of mindfulness, readers are referred to Ostafin and colleagues [748].

There is evidence of the efficacy of mindfulness for assisting with relapse prevention in AOD use [752], as well as reducing cravings, AOD-related problems, the quantity and frequency of AOD use [753], and avoidance-based coping strategies among people with AOD use disorders [754]. There is also evidence of the efficacy of mindfulness in the treatment of mental disorders [755, 756].

Motivational interviewing (MI)

MI for AOD use disorders involves a non-judgemental collaborative discussion, which explores specific medical, social, interpersonal, or psychiatric effects that AOD use has had on the client's life. Just as clients may be resistant to the idea of changing their AOD use, they may also be resistant to the notion of addressing their co-occurring mental disorder (see **Chapter B3** for a discussion of readiness to change). MI may be used to increase the client's motivation in this regard [757]. MI is a directive client-centred counselling process that assumes equity in the client-AOD worker relationship and emphasises a client's right to define their problems and choose their own solutions. It is, in this sense, a counselling style (as opposed to a set of techniques) based on collaboration rather than confrontation, evocation rather than education, and autonomy instead of authority [757–759], that aims to increase a person's motivation and commitment to change [758, 759].

The strategy involves a non-confrontational conversation seeking out the ambivalence in the client's attitudes that can be used as encouragement for them to think about further change. For example, a client may say they are not really interested in dealing with their social anxiety but agree that it is a problem. Probing around this 'problem' and exploring ambivalence may lead to the client contemplating further ways to address the problem. The strategy is to use available openings to help the client advance towards a decision to make changes that will benefit their mental health. There is considerable evidence supporting the use of MI for treating mental and AOD use disorders [760–763]. Examples of MI strategies and techniques are provided in **Appendix E**, along with a number of useful resources for MI.

Psychosocial group therapy

Psychosocial groups within the AOD treatment setting are also much appreciated by clients with co-occurring conditions [764]. Evidence suggests that clients who attend groups consistently and for a longer time period (e.g., for a year) achieve the best results, although positive outcomes can nonetheless be achieved by attending shorter-term groups [765, 766]. Similarly, incorporating creative elements into group interventions, with multiple activities conducted within shorter group sessions, appear to improve treatment outcomes among people with mental health conditions [767]. It is important that such groups are facilitated in such a way as to avoid confrontation. Sustained emotional distress can worsen a number of mental health conditions and a confrontational treatment approach may be harmful to clients with co-occurring conditions [162, 768]. It is important to assess whether the client experiences social anxiety or impairments in social judgement and social skills, as they may appear and feel awkward in group settings [769, 770]. Readers are referred to Mueser and colleagues [770] for a more detailed discussion on the use of group interventions for co-occurring disorders.

Relapse prevention

Clients with both mental health conditions and AOD use disorders can potentially experience a relapse of either condition, which is likely to worsen the symptoms of the other. Even after full remission, clients with co-occurring conditions are vulnerable to relapse due to various risk factors, including exacerbation of mental health symptoms, a lack of social support, social pressures within neighbourhoods or AOD-using networks, a lack of meaningful activity, or a lack of treatments for co-occurring mental and AOD use disorders [771]. As such, the goal of relapse prevention is to enable clients to recognise the factors which increase their own risk of relapse, and intervene at earlier points in this process [102].

Relapse prevention strategies that are already used in AOD treatment can also be used to reduce risk of relapse of the mental health condition. For example, relapse prevention for AOD use has been shown to be effective in reducing PTSD symptom severity [772], and the quantity, frequency, and severity of AOD use among people with co-occurring PTSD and AOD use [772, 773]. Some simple strategies that can be useful in helping a client reduce the risk of relapse include [102, 774–777]:

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

Pharmacological approaches

The use of pharmacotherapies is common practice in the treatment of both AOD use and mental disorders. It is recommended, however, that when pharmacotherapy is used, it should be accompanied by supportive psychosocial interventions [778–781]. Symptoms are less likely to return on completion

of psychological treatment compared to pharmacotherapy, where relapse upon cessation is common [782]. Pharmacotherapies are beneficial, however, in helping people to manage symptoms and obtain maximum benefit from psychotherapeutic interventions.

The introduction of pharmacotherapies must be carried out in consultation with a medical practitioner, preferably a psychiatrist. Initial intake should establish past medication history as well as any current medications (see **Chapter B3**). When prescribing medications, the following should be taken into account:

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

If clients are placed on medication, it is important that they understand the reason for the medication being prescribed, and the likely benefits and risks as well as its interactions with AOD. Clients should also be made aware of the possibility of delayed responses to the medication, potential side effects, as well as the possibility of trying other medications if the one prescribed does not suit them.

Medication adherence

Many clients who have been identified as having a co-occurring mental disorder will likely have been prescribed medication for that disorder (such as antidepressants, mood stabilisers, anti-anxiety agents, or antipsychotics). Medications can be extremely helpful in managing mental health symptoms; however, their effectiveness relies upon them being taken as prescribed. There are many factors that may facilitate medication adherence including having strong social supports, a strong therapeutic alliance with healthcare providers, and insight and understanding of one's mental health condition [783–785]. Conversely, factors that may adversely impact upon medication adherence include experiencing negative side effects and cognitive deficits [783–785].

Some people experience unpleasant and distressing side effects of varying levels of severity from psychiatric medications. These side effects may lead to reduced adherence, and some people will choose to live with some symptoms of the mental disorder rather than take medication [786]. It is important for clients to be aware that in most instances there is a choice of medication, but it may take time to establish which medication is best suited to their needs. Finding the best fit is particularly important for people with severe mental disorders such as psychotic, bipolar, and severe depressive disorders, as psychosocial interventions alone may not be sufficient.

When medications have been prescribed, it is important to assist the client adhere to medication scheduling, irrespective of whether a person experiences memory problems or other cognitive difficulties. In other illnesses such as diabetes and hypertension, medication adherence is recognised as an important issue in regaining good health and it is addressed proactively by the use of simple techniques to remind the client when they need to take their medication. MI, contingency management and cognitive

behavioural techniques have been shown to be particularly useful in improving medication adherence, as have medication regime management and pharmacist consultations [787–789]. Community pharmacists may be able to assist in the preparation of dosage administration aids (e.g., Webster-paks), which may be especially useful for clients who have trouble remembering what medications/dosages should be taken and when. The SIMPLE model [790] is a useful tool for remembering different evidence-based interventions that can enhance medication adherence:

S	**Simplifying regimen characteristics.** Adjust timing, frequency, and dosage. Match regime to client's daily activities (e.g., mealtimes). Use adherence aids (e.g., pill boxes, alarms).
I	**Imparting knowledge.** Clearly discuss the medication as appropriate with the client using simple everyday language. Do not overwhelm the client with information or instructions. Supplement verbal information with written materials or pamphlets.
M	**Modifying patient beliefs.** Assess the client's beliefs, intentions, and perceived ability to adhere to the medication regime. Encourage behaviour change by ensuring that the client perceives their condition to be serious, believes in the positive effects of the treatment, perceives themselves to have the skills required to stick to the medication regime, and has channels to express fears or concerns.
P	**Patient and family communication.** Include the client in decisions about treatment. With the client's consent, send reminders via mail, e-mail, or telephone. Actively listen to the client and avoid interrupting them. Involve family or social networks where appropriate.
L	**Leaving the bias.** Studies have found small or no relationships between medication adherence and race, sex, education, intelligence, marital status, occupation, income, and ethnic or cultural background.
E	**Evaluating adherence.** Ask the patient simply and directly, without judgement, about their medication adherence. Pill counting, measuring serum or urine drug levels can also be used.

Adapted from Atreja et al. [790].

Medication interactions

It is important for AOD workers to be aware of the complex and dynamic relationship between AOD use, mental disorders, and prescribed medication (i.e., the potential interactions between AOD use and prescribed medications and the ways in which AOD use and prescribed medication can affect each other). During the assessment phase, workers should explore the influence of prescribed medication on AOD use and vice versa. This clarification will contribute to a comprehensive management and treatment plan, with appropriate goals [389].

Table 38 provides some of the interactions between AOD and prescription medication, but this list is not exhaustive. For example, the selective serotonin reuptake inhibitors (SSRIs) fluoxetine and fluvoxamine have been shown to affect the metabolism of methadone and buprenorphine, with the discontinuation

of fluvoxamine associated with opiate withdrawal [791]. In cases where withdrawal is unexpected, it is possible that the client may engage in other AOD use (or decrease treatment adherence) to cope with withdrawal symptoms, highlighting the need for worker awareness of the potential for such interactions. Similarly, central nervous system depressants not only increase the potential for overdose and respiratory depression when taken with each other (e.g., benzodiazepines, alcohol, opiates), but also increase the risk of overdose when taken with medication [792]. As described in **Chapter B1**, the compounds found in tobacco smoke can increase the rate some psychiatric medications, such as olanzapine and clozapine, are metabolised. This means people who smoke may need to be prescribed higher doses to achieve the required therapeutic dose of these medications, while those who are intending to reduce or quit smoking need to be carefully monitored and their doses reduced to avoid potential toxicity [230–232].

Interactions are also possible with other non-psychiatric medications. For example, alcohol increases the potential for stomach ulcers and bleeding when combined with steroids or other anti-inflammatory medications due to the combined toxic effects on the stomach lining [793]. Interactions with dietary supplements are also possible: as mentioned in **Chapter B7**, St John's Wort has been shown to have significant interactions with a range of other medications including SSRIs and related drugs, oral contraceptives, some anticoagulants, immunosuppressants, and some cardiac medications [794].

Table 38: Drug and medication interactions

Drug type	Potential medication interaction	Implications
Depressants		
Central nervous system depressants • Alcohol • Benzodiazepines • Opiates • Antipsychotics	TCAs MAOIs SSRIs	The likelihood of overdose is significantly increased. The sedative effects of benzodiazepines are increased with concurrent use of alcohol. Possibility of reduced effects of prescribed medications.
Alcohol intoxication or withdrawal	Lithium carbonate	Potential for electrolyte imbalances. Potential for lithium toxicity.
Benzodiazepine or alcohol withdrawal	Antipsychotics Antidepressants	Lowered seizure threshold with increased potential for seizures.

Table 38: Drug and medication interactions (continued)

Drug type	Potential medication interaction	Implications
Stimulants		
Stimulants (e.g., amphetamines, tobacco, caffeine, cocaine, ecstasy)	MAOIs	Can lead to hypertension (high blood pressure) crisis.
Stimulants	Antidepressants	Effects can be inhibited.
Ecstasy	Antidepressants	Linked to high levels of serotonin, associated with hallucinations, mania, hypertension, nausea, muscle rigidity, tremor (serotonin syndrome).
Cannabinoids		
Cannabinoids	Antipsychotics	Increases intensity and frequency of psychosis.
Cannabis	TCAs Benzodiazepines	Increases the sedative effects.
Cannabis	Newer (atypical) antidepressants	Can cause symptoms of mania, confusion, and psychosis.

TCAs = tricyclic antidepressants; MAOIs = monoamine oxidase inhibitors; SSRIs = selective serotonin reuptake inhibitors. Adapted from NSW Department of Health [431].

As such, when managing and treating clients with co-occurring AOD and mental health conditions, AOD workers need to take into account the level and type of AOD used (especially alcohol), as these may [795]:

- Alter the metabolism of prescribed medication.
- Decrease the effectiveness and/or increase the potential for side effects.
- Warn the client about potential interactions between substances of misuse and prescribed medication.
- Discuss the problems and potential dangers of using non-prescribed AOD to counteract the effects or side effects of prescribed medication.

It is important to note that polydrug use, and the variation in compounds contained in drugs that are manufactured illegally, may make it difficult to clarify and assess potential drug interactions [431, 796,

797]. In instances where workers are unable to determine if a medication will interact with AOD use, medication should be titrated, starting with a low dose [798].

Electroconvulsive therapy (ECT)

Electroconvulsive therapy (ECT) has long been associated with a history of cruelty, fear, and stigmatisation, despite evidence of its efficacy for many people with severe mood and psychotic disorders. Although the exact mechanisms as to why ECT is effective are not well understood, contemporary ECT remains a safe and effective approach, that does not need to be a treatment of last resort [799]. During ECT treatment, an electric current stimulates seizure activity in the brain via electrodes applied to the scalp. Throughout treatment, the person receiving treatment is anaesthetised and given muscle relaxants to prevent body spasms [800]. There are notable adverse effects associated with ECT, which are most commonly related to executive function, attention, and memory [799]. Memory loss (including forgetting past information, or retrograde amnesia, as well as difficulty retaining new information, or anterograde amnesia) is typically greater with longer courses of ECT. There is evidence that the majority of adverse cognitive effects are temporary, although there is variability in how different people respond and recover [799]. Other adverse effects are associated with general anaesthesia and are less common (e.g., cardiac events), or other neurological events (e.g., stroke) [801]. More contemporary approaches to ECT, including electrode placement, have substantially reduced these risks [799]. The number of ECT sessions depends on a client's progress but is usually between six and twelve sessions [800]. Clinicians may wish to refer to patient accounts and experiences with ECT for more information; for example, Wells and colleagues [802], where patients describe both positive and negative experiences.

The effectiveness of ECT in the treatment of depression, catatonia, mania, and schizophrenia is well documented [799, 803–806], but ECT remains underutilised [807]. There is evidence supporting the use of ECT for treatment resistant depression, mania, and schizophrenia [799], as well as a potential first-line treatment when rapid improvement in clinical symptoms is required (e.g., for clients at high risk of medical complications or suicide risk) [808].

Self-help groups

Reviews of the research literature suggest that some clients of AOD services will benefit from joining a self-help group such as Alcoholics Anonymous, Narcotics Anonymous, SMART Recovery, or alternative self-help groups [725, 809, 810]. 'Dual diagnosis' support groups are also an option, specifically for people with co-occurring mental and AOD use disorders [811, 812]. One recent Cochrane review concluded that there is high quality evidence to suggest that manualised forms of self-help groups (such as Alcoholics Anonymous and 12-step facilitation) are more effective than established treatments, such as CBT, at increasing abstinence [809]. As with other psychosocial groups, there is also evidence that longer attendance at self-help groups and higher levels of social support have a positive impact on outcome [813–817].

As with all interventions, it may take a few attempts to find the group that suits a person's needs and it is possible that one group may not suit the client but the next will—even in the same type of self-help

group. As mentioned with regard to psychosocial groups, it is important to assess whether the client experiences social anxiety or impairments in social judgement and social skills, as they may appear and feel awkward in group settings [769]. It should be noted that some groups, particularly those that adopt a 12-step philosophy, may be disapproving of the use of any medication [818]; yet clients with co-occurring mental disorders are often prescribed medication to help treat their mental health condition [819]. Some clients with co-occurring conditions, particularly those who experience religious delusions, may also have difficulty with the strong spiritual focus of many self-help groups [820].

E-health and telehealth interventions

E-health is the provision of health services and/or information via the Internet or associated technologies [821]. Examples of e-health interventions include those delivered online or via smartphone, programs with multimedia components, text message-support, gaming, virtual reality, biofeedback and wearable devices [822]. Since its relatively recent appearance, e-health has been referred to as one of the most important revolutionary additions to modern healthcare [821, 823]. Telehealth on the other hand, refers to the delivery of healthcare via online or other telecommunication methods. Telehealth is particularly important for those in rural and remote areas, and for people who have difficulty attending or accessing local services. The uptake of digital mental health services in Australia increased by over 100% for most services (e.g., online courses, clinician registrations) during the recent COVID-19 pandemic [824, 825]. Telehealth service consultations in Australia have similarly increased by up to 34% since the introduction of telehealth items to the Medicare Benefits Schedule [826].

E-health interventions overcome many of the traditional barriers to treatment that often prevent people seeking help, including social or cultural prejudices, stigma, difficulties accessing services, finding appropriate available services, as well as financial and geographical barriers [827–829]. E-health interventions also have the capacity to overcome difficulties associated with face-to-face treatment, including gender differences [827, 830], the inclusion of more marginalised socioeconomic and cultural groups [831], and reducing the costs and increasing the standardisation of traditional treatments [832–835]. Despite their benefits, e-health interventions are often underutilised by mental healthcare services in Australia, which is partly driven by clinician reluctance [836].

Advances in technology over the past decade have enabled e-health interventions to include strategies such as self-monitoring and assessment, psychoeducation, goal setting, skill building, and feedback through the use of telephone and videoconferencing, mobile phones, sensors and wearable devices, social media, virtual reality, biofeedback, and gaming [837, 838]. E-health interventions can also be used to supplement psychotherapy, or as an alternative for people who do not want, or are not suitable for pharmacotherapy [833, 839]. Therapy can be conducted at home and has 24-hour availability. Research has demonstrated that e-health interventions allow for the delivery of clinically effective, cost-effective treatment, based on gold standard programs, which are highly engaging [840–843]. A number of e-health interventions have been developed for AOD and specific mental disorders, and a systematic review of the efficacy of computer-based interventions at improving AOD use and mental health outcomes found that relative to baseline, several programs were effective at reducing AOD use, anxiety, social phobia, depression, stress, and improving quality of life [844]. Interventions that were CBT-based were found to

be particularly effective, demonstrating significantly greater improvements in alcohol use, anxiety, and quality of life compared to waitlist and psychoeducation controls [844].

Physical activity

As discussed in **Chapter B1**, people with AOD use disorders are at increased risk of physical health problems, such as cardiovascular, respiratory, metabolic, and neurological diseases [845], all of which have been associated with unhealthy lifestyles (e.g., smoking, obesity, lack of exercise, poor diet) [846, 847]. As such, treatment interventions that are either based on nutrition, exercise, or include these as adjunctive interventions, are promising approaches for addressing co-occurring physical conditions [848]. Research has found that people with psychiatric conditions who engage in regular exercise report better health-related quality of life [849] and benefits have been demonstrated across a wide range of activities (e.g., frisbee, tennis, cycling, aerobic/gym activities, tai chi, yoga [850]).

General population studies have also found significant relationships between mental health and physical activity, with regular exercise significantly associated with decreased prevalence of major depression, bipolar, panic disorder, agoraphobia, social anxiety, specific phobia, and AOD use disorders [310, 851–853]. People who engaged in regular physical activity were more likely to experience symptom improvement over a three-year follow-up study [852].

Although the mechanisms of action are not entirely clear, research findings indicate that exercise induces changes in neurotransmitters (e.g., serotonin and endorphins) [854, 855] which relate to mood, and can improve reactions to stress [856, 857]. There is also some indication that exercise reduces chronic inflammation, which is commonly found among people with mental disorders [858]. Exercise has also been associated with several psychological benefits, including changes to body and health attitudes and behaviours, social reinforcement, distraction, and improved coping and control strategies [859, 860]. A number of physical health interventions for AOD and specific mental disorders are described in **Chapter B7**.

Complementary and alternative therapies

Complementary and alternative therapies are practices and products that are traditionally outside the realm of conventional medicine, but are more natural and economical than traditional pharmacotherapy, sometimes with fewer side effects [861]. They include, but are not limited to, acupuncture, dietary and nutritional supplements, and herbal remedies. Research has indicated that there has been an increase in the use of complementary and alternative therapies, particularly among people seeking to treat their depression or anxiety, often in combination with conventional medication [862]. The use of complementary and alternative therapies may be rising in popularity due to their ability to fill a major gap in mental health service delivery, particularly in areas with reduced rates of services [863]. It is beyond the scope of these Guidelines to provide an extensive and comprehensive list of available complementary and alternative therapies; however, attention is drawn to some promising interventions for which there is emerging evidence (see **Chapter B7**).

B7: Managing and treating specific disorders

B7: Managing and treating specific disorders

Key points

- Symptoms of co-occurring mental health conditions can be managed and controlled while the client undergoes AOD treatment.
- Good treatment requires a good therapeutic alliance.
- Motivational enhancement, simple CBT-based strategies, relaxation and grounding techniques can be useful in managing AOD use as well as mental health conditions.
- Some interventions have been designed for the treatment of specific co-occurring conditions; however, these interventions have generally not been well researched.
- Where there is an absence of research on specific co-occurring disorders, it is generally recommended that best practice is to use the most effective treatments for each disorder. In some cases, this can be carried out at the same time for both disorders, but in others it must be carefully calibrated.
- Both psychological and pharmacological interventions have been found to have some benefit in the treatment of many co-occurring conditions.
- When pharmacotherapy is used, this should be accompanied by supportive psychological interventions, and workers should be aware of the potential of interactions between medications, and other substances.
- E-health interventions, physical activity, as well as complementary and alternative therapies may also be considered in developing a person's treatment plan.

This chapter provides a discussion of current best practice and evidence regarding the management and treatment of the more common co-occurring mental disorders seen among clients of AOD services. Symptoms of mental disorders may be identified through screening and assessment processes (described in **Chapter B3**), or they may arise spontaneously during the client's treatment. There is a distinction between the management of co-occurring mental health conditions and their treatment. The goal of management is to allow AOD treatment to continue without mental health symptoms disrupting the treatment process, and to retain clients in treatment who might otherwise discontinue such treatment. Without further treatment, these techniques on their own may not provide long-term relief from symptoms; however, they may allow the client's AOD use to be treated in the interim. One advantage of managing mental health symptoms is that no diagnosis is required prior to their use (i.e., symptoms are managed rather than disorders being treated). Readers are encouraged to read **Chapter A4** of these Guidelines to familiarise themselves with the signs and symptoms of mental disorders.

AOD workers have widely varying roles, knowledge and experience; therefore, it is not expected that all AOD workers should be able to implement the treatments described. We do not provide detailed

information relating to the implementation of these treatment options, but rather an overview of the available options. Where appropriate, readers are referred to existing literature and resources for more detail about the use of particular interventions. This information may nonetheless be used by all AOD workers to improve their understanding of best practice, and it may encourage workers to consider further training to improve their skills in these approaches.

It should also be remembered that the provision of treatment for AOD use alone has positive effects for those with co-occurring mental disorders [97–99, 102, 864, 865]. As discussed previously, it is important to note that, for many people, symptoms of depression and anxiety will subside after a period of abstinence and stabilisation, without the need for any direct intervention [866–868]. However, if the mental health symptoms started prior to the onset of AOD use, if symptoms persist even during periods of abstinence, or if there is a family history of the particular disorder, the client may have a condition that is independent of their AOD use, which may require treatment [869].

In terms of clients' AOD use, the goal of abstinence is usually favoured, particularly for those whose mental health conditions are exacerbated by AOD use. Abstinence is also preferred for people with more severe mental disorders (or cognitive impairment) as even low-level substance use may be problematic [132]. Those taking medications for mental health conditions (e.g., antipsychotics, antidepressants, mood stabilisers) may also find that they become intoxicated even with low levels of AOD use due to the interaction between drugs. Although abstinence is favoured, many people with co-occurring conditions prefer a goal of moderation. In order to successfully engage with the client, AOD workers should accommodate a range of treatment goals and adopt a harm reduction approach [133, 134].

It is fundamentally important to discern the client's preferences regarding treatment for their mental health. Just because the client has sought treatment for their AOD use does not necessarily mean that they are ready to address their mental health condition. It is important that the client is not forced to undergo treatment for their mental health if they are not ready to, as this may jeopardise the therapeutic relationship. Ultimately, it is up to the client to decide whether they want to address the issue and how they would like to go about doing so.

The recommendations in this section are based on a combination of expert opinion and evidence from research. People with AOD use disorders are commonly excluded from trials of psychotherapies and pharmacotherapies for mental disorders. Some interventions have been designed for the treatment of specific co-occurring conditions; however, these interventions generally have not been well researched. In the absence of specific research on co-occurring disorders, it is generally recommended that best practice is to use the most effective treatments for each disorder. It should be noted that the research evidence is based on trials of treatments for mental disorders (see **Chapter A4** for disorder descriptions); however, these treatments may also be useful for those who do not meet diagnostic criteria but experience symptoms that cause significant distress or impairment.

Psychological and pharmacological interventions have been found to have some benefit in the treatment of many co-occurring mental disorders. As mentioned in **Chapter B6**, it is recommended that when pharmacotherapy is used, this should be accompanied by supportive psychological interventions [870, 871]. Symptoms are less likely to return on completion of psychological treatment compared to pharmacotherapy, where relapse upon cessation is common [782]. Pharmacotherapies are beneficial,

however, in helping people to manage symptoms and obtain maximum benefit from psychotherapeutic interventions.

Pharmacotherapies for mental health disorders can only be prescribed by a medical practitioner, preferably a psychiatrist. However, it is important that AOD workers establish clients' past medication history as well as any current medications (see **Chapter B3**). AOD workers should also be aware of:

- Possible interaction effects between prescribed and non-prescribed substances.
- The presence of medical problems such as liver dysfunction related to long-term AOD use or hepatitis, which may be exacerbated by certain medications.
- The abuse potential of medications prescribed.
- Potential contraindications.

ADHD

Attention-deficit/hyperactivity disorder (ADHD)

ADHD and AOD use frequently co-occur, and there is evidence to suggest that the presence of ADHD is a primary risk factor for the development of AOD use disorders [872, 873]. Research suggests that untreated ADHD is associated with a more problematic course of AOD use disorder, with clients less likely to gain benefits from treatment, adhere to treatment, and achieve and maintain abstinence [874–876]. ADHD is also associated with an earlier age of first substance use, higher rates of poly-substance use, greater substance dependence, and increased risk of relapse [873, 877–879]. However, evidence suggests that responding early to ADHD through the provision of appropriate evidence-based treatments can prevent the development of AOD use disorders among adolescents, and reduce the risk of AOD relapse among adults [877, 880].

Difficulties can be faced when assessing and screening for the presence of co-occurring ADHD, as symptoms can be masked or even resemble those of intoxication or withdrawal (see **Chapter A4**) [878, 881, 882]. Although some experts recommend an abstinence period of one month or more to assist with diagnosis [102, 883, 884], this strategy is not supported by the broader evidence base, or the majority of experts [883, 885–887].

To assist with clinical decision making, it may be useful to involve family members or friends, who can provide further information and clarification regarding the presence of attention problems, impulsivity, and restlessness over the person's lifetime [884].

Clinical presentation

ADHD represents a persistent pattern of developmentally inappropriate levels of inattention, hyperactivity, and/or impulsivity [10, 11]. Although estimates vary, research conducted in the last decade indicates that, on average, 55% of children and adolescents diagnosed with ADHD in childhood will continue to have the disorder in adulthood [888]. Attentional difficulties in particular are more likely to persist into adulthood, whilst impulsivity and hyperactivity tend to diminish over time [889]. Adult symptoms are expressed differently to the way in which they are expressed in childhood, and may include [10, 11]:

- Difficulties paying close attention to detail.
- Difficulties maintaining focus.
- Easily distracted.
- Difficulties completing tasks or projects.
- Disorganisation.
- Procrastination.
- Lack of motivation.
- Difficulties concentrating or studying (which may present as academic underachievement).
- Occupational or workplace difficulties.

- Forgetfulness, including the frequent loss of possessions.
- Restlessness.
- Difficulties with time management.
- Difficulties sleeping, and/or fatigue.
- Irritability, frustration, or anger.
- Problems forming and maintaining relationships.
- Difficulty obtaining and/or maintaining stable employment.
- History of imprisonment or frequent contact with police.

Some symptoms which clients may present with, such as problems sleeping, irritability and fatigue, are not unique to ADHD, but are common to many mental disorders.

Managing ADHD symptoms

Research indicates that people diagnosed with ADHD in adulthood may require additional psychosocial support to assist them to come to terms with their diagnosis, and reframe their past [890]. The techniques outlined in Table 39 can help AOD workers manage clients with ADHD symptoms.

Table 39: Dos and don'ts of managing a client with symptoms of ADHD

Do:	
✓	Reduce or remove distracting stimuli.
✓	Consider using visual aids to convey information.
✓	Assist the client plan activities and encourage the use of appropriate tools (e.g., smartphone, activity journal) to organise prompts, reminders, and important information.
✓	Encourage stress-reduction methods, such as progressive muscle relaxation.
✓	Encourage physical exercise.
✓	Involve family members and friends – educating them about the condition and treatment will provide long-term benefits.
✓	Offer to help the client engage with education courses or training, which can assist with attention training.

Table 39: Dos and don'ts of managing a client with symptoms of ADHD (continued)

Don't:
Get visibly upset or angry with the client.
Confuse the client by conducting unstructured, unfocused sessions.
Overwhelm the client by conducting lengthy meetings or verbal exchanges.

Adapted from Gournay [891], SAMHSA [102], and Zulauf [892].

Treating ADHD

There are several options available for the treatment of ADHD, including psychotherapy, pharmacotherapy, e-health interventions, physical activity, as well as complementary and alternative therapies (e.g., dietary supplements). The evidence base surrounding each of these treatments is discussed below. There is a general consensus that the treatment of co-occurring ADHD and AOD use should use an integrated multimodal approach, with components of individual and/or group psychotherapy, psychoeducation, as well as peer and family support, to enhance the effect of treatment [9, 884, 893–895]. In general, evidence suggests that treatments focusing on either ADHD or AOD use in isolation are not effective at treating both disorders [896]. However, there is some recent evidence to suggest that reducing AOD use, or maintaining abstinence following AOD treatment, may improve ADHD symptoms [897, 898]. Evidence from the broader ADHD literature suggests that an approach combining psychotherapy and pharmacotherapy may result in better outcomes for ADHD symptoms than either psychotherapy or pharmacotherapy alone [781, 886, 892, 899–901], however, this approach has yet to be rigorously evaluated among people with co-occurring ADHD and AOD use.

Psychotherapy

Psychotherapy is recommended as a critical component of a multimodal approach targeted towards co-occurring ADHD and AOD use [884, 894, 902]. Evidence suggests that CBT is the most effective psychological approach for ADHD, when delivered in conjunction with pharmacotherapy [781, 884, 892, 903]; however, positive outcomes have also been associated with the use of other approaches, such as meta-cognitive group therapy [904, 905], structured skills training [906, 907], virtual remediation therapy [908], and cognitive remediation, both as therapist-led programs [909] and self-directed interventions [910].

Common therapeutic elements include psychoeducation, a focus on problem solving and planning, strategies to improve attention, impulsivity management, and cognitive restructuring [893, 903]. Evidence suggests that a structured format of repetitive skills practising and reinforcement of coping strategies for core ADHD symptoms are key components for the effective treatment of ADHD [911, 912]. However, these interventions have yet to be evaluated among people with co-occurring AOD use. DBT-based skills training may be a promising treatment for co-occurring ADHD and AOD use. In a small

feasibility study conducted among Swedish men in compulsory care for severe AOD use disorders, self-reported ADHD symptoms, general wellbeing, and externalising behaviours improved after six weeks of manualised, structured skills training groups [913]. While the lack of control group and low treatment acceptability and feasibility suggest more research is needed, these findings are encouraging.

To date, only one integrated psychotherapeutic approach for co-occurring ADHD and AOD use has been rigorously evaluated, which compared CBT for AOD use with an integrated CBT program for ADHD and AOD use [914]. The integrated CBT program consisted of motivational therapy, coping skills training and relapse prevention for AOD use, planning and problem-solving skills, and dealing with emotions; whereas the CBT for AOD use focused only on AOD use. While those in the integrated CBT group demonstrated greater reductions in ADHD symptoms compared to those who received CBT for AOD use alone, there was no difference between groups in relation to AOD use or other outcomes [914]. While more research is needed to support conclusive recommendations, these findings are promising.

Lastly, there is preliminary evidence to support the use of behavioural interventions focused on academic training for adolescents with ADHD and AOD use disorders, but further research is needed [875].

Pharmacotherapy

There are two main types of pharmacotherapies used in the treatment of ADHD: psychostimulants and non-stimulants. Table 40 lists some of the pharmacological treatments for ADHD. For ADHD as a single disorder, the first line pharmacotherapies are the psychostimulants lisdexamfetamine and methylphenidate [885, 915]. Despite robust findings regarding the effectiveness of these pharmaceuticals among people with ADHD alone, findings among people with co-occurring AOD use disorders have been less promising. While these medications have been associated with modest reductions in ADHD symptoms, few studies have found them to demonstrate superiority over placebos [916, 917]. Nonetheless, psychostimulants, in combination with psychotherapy, are safe, are associated with reductions in ADHD symptoms, and remain the first line recommendation for the treatment of ADHD among people with AOD use disorders [884, 916, 917]. Some trials also indicate that more meaningful reductions in ADHD symptoms among people with AOD use disorders may be achieved with higher doses of psychostimulants [884, 918]. Irrespective of dose, it is essential that a medical assessment be conducted prior to the prescription of psychostimulants to ensure that the person does not have cardiovascular or other conditions that may contraindicate psychostimulant prescription [919].

While there has been some concern regarding the use of psychostimulants among people with AOD use disorder due to their potential for misuse and diversion [920], it is important to note that this view is not supported by the evidence. Psychostimulant medications, particularly longer acting formulations such as lisdexamfetamine or extended-release methylphenidate, have low abuse potential [884, 921]. Nonetheless, it has been suggested that prescribers may wish to consider the use of non-stimulants if extra-medicinal use of psychostimulants is of great concern [916]. In view of the fact that non-stimulants are less efficacious than psychostimulants in treating ADHD, and in the absence of evidence of any misuse of long-acting stimulants in clinical trials, there is a need to balance the potential risk of misuse and diversion, against the risk of untreated or inadequately treated ADHD [922].

Atomoxetine, a non-stimulant noradrenaline reuptake inhibitor, is recommended for those who

cannot tolerate, or do not respond to, lisdexamfetamine or methylphenidate [885]. As is the case with psychostimulants, it appears that atomoxetine may not be as effective among people with AOD use disorders compared to those with single disorder ADHD, but this body of research is small [916]. Close monitoring for signs of any depressive symptoms during the first few months of atomoxetine administration is recommended (including agitation, self-harm behaviours, and suicidal ideation) as there have been some reports of increased risk among children [919]. Preliminary research has also been conducted on the non-stimulants bupropion (norepinephrine reuptake inhibitor), guanfacine and clonidine (alpha 2- adrenoceptor agonists); but conclusions regarding their efficacy cannot be made at this time [884, 916].

Table 40: Pharmacotherapy medications for ADHD

Drug name	Brand name	Drug type
Methylphenidate	Artige, Concerta, Ritalin	Psychostimulant
Dexamphetamine	Aspen	Psychostimulant
Lisdexamfetamine	Vyvanse	Psychostimulant
Atomoxetine	Strattera	Noradrenaline reuptake inhibitor

Adapted from Zalauf et al. [892], Pérez de los Cobos et al. [886] and the Better Health Channel [923]. For a full list of generic brands available, see the Therapeutic Goods Administration website (https://www.tga.gov.au).

E-health and telehealth interventions

Emerging e-health programs combine elements from successful CBT treatments for single disorder ADHD into internet-based interventions. These interventions, aimed at assisting people with ADHD structure and organise their lives, incorporate aids such as calendars, schedules, timers, reminders, shopping lists, and cleaning and laundry schedules, all of which are easily accessible on smartphones [924, 925]. Smartphone features such as text messages, cameras, GPS, and voice memos, may also be useful.

One RCT has evaluated an internet-based course teaching people with single disorder ADHD to use smartphone applications to improve their everyday organisational skills [925]. The course, delivered with therapist support, teaches participants how to effectively use their smartphone applications to better organise their lives. Compared to a wait-list control, participants randomised to receive the course illustrated a significantly larger decrease in ADHD symptoms, including inattention and hyperactivity. One-third of participants (33%) were deemed to have made a clinically significant improvement in organisation and attention over the study period, as assessed by clinicians. Although this research has yet to be conducted among people with co-occurring ADHD and AOD use, the findings from this RCT are promising.

Physical activity

Although ADHD treatment is primarily focused on psychotherapy and pharmacotherapy, there is emerging evidence to suggest that physical activity may have beneficial effects similar to those of psychostimulant medications, and more beneficial effects on some treatment outcomes compared to psychotherapies such as CBT [926, 927]. Research indicates that exercise interventions (frequent aerobic exercise in particular) may assist with the management of ADHD symptoms, particularly intrusive thoughts, worry, and impulsivity [928]. One meta-analysis has suggested that moderate-intensity aerobic exercise may reduce symptoms of hyperactivity, impulsivity, anxiety, and inattention, and improves executive functioning among young boys aged 8 to 13 years with ADHD [929]. As such, exercise may be a useful adjunct to pharmacotherapy and psychotherapy for ADHD; however, this approach has yet to be rigorously evaluated in adults with co-occurring ADHD and AOD use [928].

Complementary and alternative therapies

Dietary supplements

There has been very little research examining the use of dietary supplements for ADHD. However, two meta-analyses have concluded that omega-3 supplementation is associated with modest ADHD symptom improvement for single disorder ADHD in children and adolescents [930, 931]. Moreover, another study has reported that omega-3 and omega-6 fatty acids have similar benefits to, and may improve the tolerability of, methylphenidate in single disorder ADHD [932]. In contrast, however, an RCT examining the role of omega-3 and omega-6 supplementation over 12 weeks in children with ADHD did not find any significant treatment effects on aggression, impulsiveness, depression, or anxiety symptoms relative to placebo [933]. Findings from these studies suggest that intervention length may moderate treatment effects, and that omega-3 and omega-6 supplements may require dosing durations of up to 6 months before any symptom benefits become evident [933]. While these findings have yet to be replicated among adults, and among people with co-occurring ADHD and AOD use, they point to potential avenues of future research.

Mindfulness

Mindfulness interventions for single disorder ADHD have been evaluated in three meta-analyses, which found reductions in ADHD and depressive symptoms, and improvements in executive functioning among children, adolescents, and adults, with larger effects for adults than children [934–936]. Some research suggests that, among adults, mindfulness exerts similar effects to other established treatment strategies (e.g., structured skills training [906]). However, this research is yet to be conducted among people with co-occurring ADHD and AOD use.

Summary

For those with co-occurring ADHD and AOD use, reviews of the evidence recommend an integrated, multimodal approach, with components of individual and/or group psychotherapy, psychoeducation, as well as peer and family support [9, 884, 893–895]. The use of structured psychotherapies, including CBT with a focus on goals, with active AOD worker involvement and effective social support, is likely to

be the most beneficial [884, 892] and, as with the treatment of other co-occurring disorders, treating both conditions concurrently is more likely to produce a positive treatment outcome than treating either disorder alone [102, 896, 922]. Box 14 illustrates such a multimodal approach through the continuation of case study A, after Sam's ADHD was identified.

Box 14: Case study A: Treating co-occurring ADHD and AOD use: Sam's story continued

Case study A: Sam's story continued

Based on Sam's symptoms, the AOD worker thought it would be beneficial for her to see a psychiatrist who specialised in adult ADHD, and asked Sam if she would be willing to see a psychiatrist who would be able to assess her further and help develop a treatment plan. The AOD worker told Sam that they would be happy to keep seeing her and liaise with both her GP and the psychiatrist. Sam thought this was a good plan and consented to the sharing of information between these services.

The AOD worker helped Sam make an appointment to see the psychiatrist and her GP, and helped Sam put these appointments into her phone calendar, setting reminders. Sam also organised a follow-up appointment to see the AOD worker after her appointments with the GP and psychiatrist. With Sam's permission, the AOD worker invited Sam's partner into the consultation room and let them know about the upcoming appointments so they could remind Sam and help her arrive on time. Sam had agreed to the AOD worker discussing her condition with her partner, as she understood they would be able to provide additional information about her condition and be helpful and supportive of her ongoing treatment.

The psychiatrist who assessed Sam diagnosed her with ADHD, and noted the range of inattention, hyperactivity and impulsivity symptoms that were present. The psychiatrist also mentioned that the way Sam responded to her use of Ritalin and methamphetamines, where she did not experience a 'high' but instead felt calm and relaxed, was significant. The psychiatrist explained that psychostimulants are one of the primary treatments for ADHD, which are carefully prescribed and monitored. After Sam's GP conducted a thorough medical assessment, the psychiatrist prescribed her with psychostimulant medication and advised Sam that it was important for her not to use any other substances, because of the possibility of interactions between drugs. The AOD worker told Sam she would be available for a phone or Zoom call every day during Sam's first week taking the psychostimulants, to see how she was going.

Sam continued with her treatment and recommenced NRT. In addition to regular monitoring and some minor adjustments to the psychostimulant dosage, Sam attended individual sessions with her AOD worker, where she was provided with a range of evidence-based interventions to help her with her alcohol, methamphetamine and cannabis use. These began with psychoeducation and information about the substances Sam had been using, focusing on the way in which they affected her ADHD and how her ADHD symptoms impacted on her substance use. The AOD worker also suggested some relaxation exercises for occasions when she became tense, that Sam began to practice and enjoy.

Box 14: Case study A: Treating co-occurring ADHD and AOD use: Sam's story (continued)

Sam also re-enrolled in a part-time TAFE course, and started working part-time in a fabric shop, which aligned well with her studies in design. An important component of her treatment plan was helping Sam organise activities which were part of her everyday life. The AOD worker helped Sam set up a daily calendar, and use different functions on her smartphone (i.e., setting alarms for important events, scheduling meetings and appointments). Sam's partner also helped her keep a schedule and maintain reminders and appointments in her phone.

Key points:

- Treatment for ADHD and AOD use should be concurrent and multimodal.
- Providing education about the nature of the ADHD, AOD use and their relationship, is essential – for both the client, friends and family.
- Treatment requires long-term planning and follow-up and more general efforts at rehabilitation, including further education.

Psychosis

Psychosis

Clinical presentation

Acute psychosis represents one of the most severe and complex presentations, and one of the most intrusive when attempting to treat co-occurring AOD use [937]. During an acute episode of psychosis, a person's behaviour is likely to be disruptive and/or peculiar. Symptoms of psychosis include [938]:

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

It is important to note that mood swings, agitation, and irritability without the presence of hallucinations or delusions does not mean that the person is not psychotic. Workers should respond to these clients in the usual way for such behaviour (described in this chapter), such as providing a calming environment so their needs can be met [541].

People in AOD settings commonly present with low-level psychotic symptoms, particularly as a result of cannabis or methamphetamine use. These clients may display a range of low-grade psychotic symptoms such as [541]:

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

Co-occurring AOD use adds to diagnostic uncertainty in presentations where there are symptoms of psychosis. For many people who experience psychotic symptoms as a direct effect of intoxication (auditory or visual hallucinations, paranoia) these experiences will resolve when the drug has left the body. These experiences may be considered by people who use AOD as a 'bad trip'. If symptoms persist

for periods beyond intoxication, however, it is important to consider whether they may be part of an emerging or underlying psychotic episode. This becomes likely where symptoms are persistent and distressing for at least one week (see **Chapter B3**). Although approximately one third of psychotic disorders are initially diagnosed as substance-induced [939], 25% are later revised to schizophrenia [38, 940]. Substance-induced psychosis may be virtually indistinguishable from an independent psychotic disorder at initial presentation [941], and longitudinal observation under abstinence conditions may be necessary to distinguish between them [102, 942]. The identification, management and treatment of substance-induced disorders are described in more detail later in this chapter. Irrespective of whether a person's psychotic symptoms are substance-induced or not, early identification and intervention is key to optimal outcomes [943–945].

Managing symptoms of psychosis

Table 41 presents some strategies for managing acute psychotic symptoms. Some clients may be aware that they are unwell and will voluntarily seek help; others may lack insight into their symptoms and refuse help. If the active-phase psychosis is putting the client or others at risk of harm, it may be necessary to contact mental health services. It is also true that many people with psychotic illness are vulnerable to manipulation, including interpersonal violence, financial and sexual exploitation.

It should also be remembered that there is much stigma and discrimination associated with both psychotic spectrum disorders and AOD use, and some people may attempt to conceal either one or both of their conditions. Many people with co-occurring psychosis and AOD use are frightened of being imprisoned, forcibly medicated, or having their children removed [778, 795]. Take the time to engage the person, developing a respectful, non-judgemental relationship with hope and optimism. Use a direct approach but be flexible and motivational [795].

Table 41: Dos and don'ts of managing a client with symptoms of psychosis

Do:
✓ Ensure the environment is well lit to prevent perceptual ambiguities.
✓ Ensure discussions take place in settings where privacy, confidentiality, and dignity can be maintained.
✓ Try to reduce noise, human traffic, or other stimulation within the person's immediate environment (e.g., reduce clutter).
✓ Ensure the safety of the client, yourself, and others.
✓ Allow the person as much personal space as possible.
✓ Be aware of your body language – keep your arms by your sides, visible to the client.
✓ Ignore strange or embarrassing behaviour if you can, especially if it is not serious.
✓ Listen attentively and respectfully.

Table 41: Dos and don'ts of managing a client with symptoms of psychosis (continued)

Do:	
✓	Appear confident, even if you are anxious inside – this will increase the client's confidence in your ability to manage the situation.
✓	Be empathic. Psychotic experiences are typically frightening and distressing.
✓	Speak clearly and calmly, asking only one question or giving only one direction at a time.
✓	Present material in simple and concrete terms, with examples.
✓	Use a consistently even tone of voice, even if the person becomes aggressive.
✓	Limit eye contact as this can imply a personal challenge and might prompt a hostile, protective response.
✓	Point out the consequences of the client's behaviour. Be specific.
✓	Ensure both you and the client can access exits – if there is only one exit, ensure that you are closest to the exit.
✓	Have emergency alarms/mobile phones and have crisis teams/police on speed dial.
✓	If psychosis is severe, arrange transfer to an emergency department for assessment and treatment by calling an ambulance on 000.

Don't:	
✗	Get visibly upset or angry with the client.
✗	Confuse and increase the client's level of stress by having too many workers attempting to communicate with them.
✗	Argue with the client's unusual beliefs or agree with or support unusual beliefs – it is better to simply say 'I can see you are afraid, how can I help you?'
✗	Use 'no' language, as it may provoke hostility and aggression. Statements like 'I'm sorry, we're not allowed to do that, but I ***can*** offer you other help, assessment, referral…' may help to calm the client whilst retaining communication.
✗	Use overly clinical language without clear explanations.
✗	Crowd the client or make any sudden movements.
✗	Leave dangerous items around that could be used as a weapon or thrown.

Adapted from NSW Department of Health [431], Canadian Guidelines [778], Jenner et al. [541], SAMHSA Guidelines [102], and UK NICE Guidelines [795].

Some clients with psychotic disorders may present to treatment when stable on antipsychotic medication and thus may not be displaying any active symptoms. These clients should be encouraged to take any medication as prescribed, and supported to maintain an adequate diet, relaxation, and sleep patterns because stress can trigger some psychotic symptoms [946].

Despite the risk of further psychotic episodes, some people may continue using substances that can induce psychosis. In such cases, the following strategies may be helpful [541]:

- Talk to the client about 'reverse tolerance' (i.e., increased sensitivity to a drug after a period of abstinence) and the increased chance of future psychotic episodes.
- Try and understand whether there is a pattern between AOD use and psychotic symptoms. Some people may use AOD to block out distressing symptoms; others may continue to use for the positive effects of substances despite the knowledge they will also experience the negative effects such as psychotic symptoms.
- Encourage the client to avoid high doses of drugs and riskier administration methods (e.g., injecting in the case of methamphetamine).
- Encourage the client to take regular breaks from using and to avoid using multiple drugs.
- Help the client recognise early warning signs that psychotic symptoms might be returning (e.g., feeling more anxious, stressed or fearful than usual, hearing things, seeing things, feeling 'strange'), and encourage them to immediately stop drug use and seek help to reduce the risk of a full-blown episode.
- Inform the client that the use of AOD can make prescribed medications for psychosis ineffective.

Social stressors can be an added pressure for clients with psychotic conditions and the client may require assistance with a range of other services including accommodation, finances, legal problems, childcare, or social support. With the client's consent, it can be helpful to consult with the person's family or carers and provide them with details of other services that can assist in these areas. Family members and carers may also require reassurance, education, and support. See **Chapter B5** for strategies on how to incorporate other service providers in a coordinated response to clients' care.

Treating psychotic spectrum disorders

In general, if a person is well maintained on medication for their psychotic disorder, then management for AOD use should proceed as usual. Although AOD workers may feel daunted at the prospect of treating this often severe and complex clinical group, it is crucial to remember that treatment and care should reflect a person's needs and preferences, whilst taking into account the evidence base.

People with co-occurring psychotic spectrum and AOD use disorders should have the opportunity to participate and make informed choices about their treatment, in consultation and partnership with their health care providers [778]. UK and Canadian guidelines on the management of co-occurring psychosis and AOD use recommend that, when planning treatment, workers take into account the severity of both disorders, the person's social and treatment context, and their readiness to change [778].

There are several options available for the treatment of co-occurring psychotic disorders and AOD use, including psychotherapy, pharmacotherapy, ECT, e-health interventions, physical activity, and complementary and alternative therapies. Clinical guidelines in Australia and internationally currently recommend the use of integrated treatment programs addressing both psychosis and AOD use, and suggest that a combination of antipsychotic pharmacotherapy with psychosocial interventions focused on AOD use may produce the best outcomes [444, 778, 779, 942]. The evidence base surrounding each of these approaches is discussed below.

Psychotherapy

A Cochrane review [947] of RCTs examining psychosocial treatments for co-occurring severe mental illness (predominantly psychotic spectrum disorders) and AOD use concluded that there is no clear evidence supporting the use of any one approach to psychological treatment over standard care, with many studies reporting mixed findings. The authors note, however, that it is difficult to draw any firm conclusions from the current evidence base due to methodological differences between studies. The only clear finding was an association between MI and greater reductions in alcohol use relative to standard care [947].

Barrowclough and colleagues [948] suggest that MI techniques may need to be adapted for clients with psychotic disorders because disorganised thoughts and speech may make it difficult for AOD workers to understand what the client is trying to say, and psychotic symptoms (combined with AOD use and heavy medication regimes) may impair clients' cognitive abilities. For this reason, it is recommended that therapists:

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

While acknowledging the lack of robust evidence, in addition to MI, the Royal Australian and New Zealand College of Psychiatry (RANZCP) guidelines for the management of schizophrenia and related disorders nonetheless recommend the use of integrated therapies that combine CBT, lifestyle interventions and case management for the treatment of co-occurring schizophrenia and AOD use [444].

CBT for psychosis is a well-recognised evidence-based treatment for symptoms of psychosis [444]. Several studies have examined the efficacy of CBT on symptoms of psychosis and AOD use [949, 950]; again, evidence regarding the efficacy of CBT in treating co-occurring psychotic disorders and AOD problems is mixed. Naeem and colleagues [950] found that although CBT led to better outcomes for symptoms of psychopathology, there were no differences between CBT and treatment as usual groups on AOD use outcomes. Similarly, Edwards and colleagues [949] found no significant differences between the CBT and psychoeducation groups for the key outcomes of cannabis use or psychopathology.

Recent research has identified assertive community outreach as one integrated approach that may be particularly beneficial for clients with co-occurring psychosis and AOD use. Assertive community outreach utilises specialised outreach teams to provide integrated and intensive treatment within a community setting (e.g., the client's home), and includes mental health treatment, housing support, and rehabilitation [951]. Several studies examining the effectiveness of assertive community outreach for people with co-occurring psychosis and AOD use have found improvements in psychotic symptoms [952, 953], reduced frequency of AOD use [954], improved housing stability [952, 955, 956], fewer hospital readmissions [952, 957], improved psychological wellbeing [955], and general functioning [956] relative to baseline and treatment as usual control conditions.

Recent research has also demonstrated that, relative to standard care for psychosis and co-occurring AOD use, skills-based training and peer supported social activities delivered alongside standard care, leads to improved outcomes in relation to symptoms of psychosis, AOD use, as well as functional outcomes [958]. Cognitive remediation therapy has also been found to be beneficial in addressing cognitive and functional deficits (e.g., relating executive function, attention, memory, social cognition) among people with psychotic disorders [959] and shows promise as an adjunctive treatment for people receiving AOD treatment [960]; however, research among people experiencing both conditions is in its infancy [961].

Contingency management may also be a useful adjunct to other treatments for psychotic spectrum disorders and AOD use. As discussed in **Chapter B6**, contingency management involves the use of reinforcement to encourage particular behaviours (and discourage undesired behaviours). A meta-analysis examining the effect of contingency management for people with co-occurring psychotic and AOD use disorders concluded that contingency management improves abstinence from AOD use, although effects on psychotic symptoms were not examined [962]. These findings are consistent with a review of earlier research [963].

The popularity of mindfulness-based interventions has increased in recent years. To date, however, no studies have evaluated mindfulness in the context of co-occurring psychosis and AOD use. Studies of single disorder psychosis have found mindfulness beneficial in reducing both negative [964, 965] and positive psychotic symptoms [965]; and mindfulness has been found to reduce the frequency and amount of AOD use, AOD-related problems [966], cravings [754, 966], and depressive symptoms [754], relative to control groups (which included treatment as usual, CBT, and support groups), among people with AOD use disorders as single disorders. Together these findings suggest that mindfulness may be beneficial for people experiencing both conditions.

Pharmacotherapy

Despite the high rates of AOD use among people with psychosis, most trials of pharmacotherapy for psychotic spectrum disorders have excluded people with AOD use disorders [779]. International clinical guidelines typically conclude that there is limited evidence to recommend the use of one antipsychotic over another among people with co-occurring AOD use disorders [778]; however, growing literature and corresponding reviews indicate that some antipsychotics show more promise than others. Most of the research to date has focused on those with a diagnosis of schizophrenia, but some studies have

included people experiencing first-episode psychosis or diagnosed with other psychotic disorders (e.g., schizoaffective disorder, psychosis in the context of bipolar disorder, substance-induced psychosis).

Two main findings can be drawn from the research to date. Firstly, 'atypical' second generation antipsychotics appear to be more effective relative to 'typical' first generation antipsychotics (e.g., haloperidol), with reference to both psychiatric and AOD-related outcomes [967, 968]. It has been theorised that the increased AOD use found among those with psychotic disorders relates to dopamine dysfunction which is better addressed by the newer atypical antipsychotic agents than the older typical agents [969]. Atypical antipsychotics may also be preferred by clients as they are associated with fewer extrapyramidal side effects such as involuntary movements [778]. Furthermore, there has been some suggestion that typical antipsychotics may actually increase AOD use and craving [968]. Table 42 lists the names of some of the more common antipsychotics.

There is some evidence to suggest that clozapine [779, 942, 968, 970–972], paliperidone [973–976], and aripiprazole [967, 976–978] are most promising with respect to a variety of outcomes, including improvements in symptoms of psychosis and/or AOD use. AOD use has not been found to influence the efficacy of quetiapine, olanzapine, risperidone, or ziprasidone, for people with psychotic disorders [979]. Preliminary evidence suggests that ziprasidone shows similar efficacy relative to other antipsychotics, though may be more tolerable with fewer side effects [972].

The second main finding that can be drawn from studies to date is that the use of long-acting injectables (LAI), also refered to as depot medication, appear to produce better treatment outcomes among people with AOD use disorders relative to oral antipsychotics. Specifically, LAIs are associated with a lower rate of relapse to psychosis and longer time to relapse [980]. Paliperidone, aripiprazole and risperidone are specific medications where there is some evidence to suggest that the LAI form may be more effective (with respect to producing improvements in severity of psychosis and/or AOD use) relative to their corresponding oral preparation [973, 974, 976, 978, 981, 982]. People receiving monthly paliperidone LAI have also been shown to demonstrate greater treatment adherence, have lower rates of inpatient days, outpatient visits, long-term stays, and lower medical costs; relative to people receiving a range of other oral atypical antipsychotics [973–975]. While both paliperidone LAI and aripiprazole LAI have been linked with reductions in the severity of psychotic symptoms, aripiprazole has also been found to produce improvements in AOD cravings and quality of life [976].

There is also some evidence to suggest that some medications may be more effective than others depending on the type of AOD used. For example, olanzapine, risperidone and haloperidol may be particularly effective in improving symptoms of psychosis and reducing cannabis use among people with cannabis use disorder, while haloperidol and olanzapine have been recommended for those with cocaine use disorders [983]. For those with polydrug use disorder, atypical antipsychotics, in particular, olanzapine, may be more effective than typical antipsychotics [983]. It should be noted, however, that head-to-head comparison studies are rare and tend to be conducted over relatively short follow-up periods. A good approach to management is to tailor the choice of antipsychotic to the individual based on response, side-effect profile, and means of administration (oral versus LAI).

Regarding amphetamine-induced psychosis specifically, findings have been mixed. A review of aripiprazole, haloperidol, quetiapine, olanzapine, and risperidone concluded that they were safe and

effective in reducing both positive and negative symptoms of psychosis, but found no clear evidence for the superiority of one antipsychotic over another [984]. However, a subsequent review and meta-analysis of the efficacy of these drugs and paliperidone extended-release concluded that olanzapine and quetiapine are more efficacious than risperidone; and olanzapine, quetiapine, haloperidol, and paliperidone extended-release are more efficacious than aripiprazole, at reducing symptoms of amphetamine-induced psychosis [985].

Table 42: Antipsychotic medications

Newer (atypical) antipsychotics	
Drug name	**Brand names**
Amisulpride	Amipride, Amisolan, Solian, Sulprix
Aripiprazole	Abilify, Abyraz, Tevaripiprazole
Asenapine	Saphris
Brexpiprazole	Rexulti
Carbamazepine	Tegretol
Cariprazine	Reagila
Clozapine	Clopine, Clozaril, Versacloz
Olanzapine	Olanzacor, Ozin, Pryzex, Zypine, Zyprexa
Lithium	Lithicarb, Quilonum
Lurasidone	Latuda
Paliperidone	Invega
Quetiapine	Delucon, Kaptan, Quetia, Seroquel, Syquet, Tevatiapine
Risperidone	Ozidal, Rispa, Risperdal, Rispernia, Rixadone
Sodium valproate	Epilim, Valprease, Valpro
Ziprasidone	Zeldox, Ziprox

Traditional (typical) antipsychotics	
Drug name	**Brand names**
Chlorpromazine	Largactil
Droperidol	Droleptan
Flupentixol	Fluanxol
Haloperidol	Serenace
Periciazine	Neulactil
Zuclopenthixol	Clopixol

Adapted from the Australian Government Department of Health [986] and the Therapeutic Goods Administration [987]. For a full list of generic brands available, see the Therapeutic Goods Administration website (https://www.tga.gov.au).

Electroconvulsive therapy (ECT)

ECT has long been used as an adjunctive treatment for people who do not have an adequate response to antipsychotics [808]. A Cochrane review that examined the efficacy of ECT among people with treatment-resistant schizophrenia as a single disorder concluded that, when combined with standard care, ECT may lead to greater improvements compared with antipsychotics alone; however, the available evidence was too weak to determine whether ECT is superior or inferior to other controls for the management of treatment resistant schizophrenia [988].

E-health interventions

Although research pertaining to the use of e-health interventions for psychosis is in the early stages, findings to date are promising. A review of internet and mobile-based interventions for psychosis concluded that they appear to be acceptable and feasible and have the potential to improve clinical and social outcomes [989]. Specifically, the interventions reviewed showed promise in improving positive psychotic symptoms, hospital admissions, socialisation, social connectedness, depression, and medication adherence. Interventions included web-based psychoeducation; web-based psychoeducation plus moderated forums for patients and supporters; integrated web-based therapy, social networking and peer and expert moderation; web-based CBT; personalised advice based on clinical monitoring; and text messaging interventions.

Physical activity

To date there is no evidence about the use of exercise for psychotic disorders other than schizophrenia, or co-occurring psychosis and AOD use disorder, though results of a meta-review suggest physical activity is a promising adjunctive treatment for people with either schizophrenia or AOD use disorders [990]. Research conducted among people with single disorder schizophrenia has found that physical exercise may be useful in terms of improving cognitive functioning (e.g., short-term memory), promoting healthy lifestyles, managing medication side-effects [991–996], as well as reducing symptoms of psychosis [997–999]. Studies that have examined the efficacy of exercise interventions among people with schizophrenia have included a range of physical activities, including basketball [1000], aerobic exercise [992, 998, 1001], cycling [997], and yoga [995, 1002, 1003]. Based on the evidence to date, aerobic activity has the most support [992, 994, 998, 1004–1009], but there is also some support for resistance training as an adjunct to other exercise [996, 1001, 1010, 1011]. In particular, endurance programs of at least 12-weeks, 3 sessions per week, of general aerobic endurance training lasting at least 30 minutes in duration are recommended [1012].

Complementary and alternative therapies

Research examining complementary therapies for co-occurring psychosis and AOD use is rare. One RCT has examined the effects of auricular acupuncture as an adjunct to antipsychotics among people with co-occurring schizophrenia and AOD use [1013]. In this study, auricular acupuncture (which involves the placement of acupuncture needles in the ears) was given 4-6 times a week, for 20-40 minutes a session, for up to 20 sessions. Relative to people who received antipsychotics alone, those also receiving

acupuncture showed improved treatment adherence to antipsychotics after 10 sessions. Relative to baseline levels, all participants also showed decreases in AOD cravings after 10 sessions, and further decreases in AOD cravings after 20 sessions. However, there were no differences in psychiatric symptom severity from baseline for either group and psychotic symptoms were not examined. These findings require replication to be sure of their effectiveness.

While there has been little research examining complementary and alternative therapies for people with co-occurring psychosis and AOD use, there have been some promising treatment outcomes for people with single disorder psychotic disorders for horticultural therapy [1014], music therapy [1015], yoga [1016], and a gluten-free diet [1017]. It should be noted however, that the majority of participants in these studies were also receiving antipsychotic medication and as such, the utility of these complementary and alternative approaches as standalone therapies for people with single disorder psychotic disorders has not been established.

Summary

In summary, existing research suggests that there is no 'one size fits all' approach for treating co-occurring psychotic spectrum and AOD use disorders [1018], and that combinations of different therapeutic approaches may be necessary for each individual client. Further, therapist flexibility is incredibly important in the treatment of this group. Box 15 illustrates the continuation of case study B, following Amal's story after his psychotic symptoms appeared to worsen.

Box 15: Case study B: Treating co-occurring psychosis and AOD use: Amal's story continued

Case study B: Amal's story continued

The inpatient detoxification team immediately organised for Amal to have an assessment by the team psychiatrist, who admitted Amal to the inpatient mental health unit for further assessment and stabilisation. Amal's AOD team continued to provide advice and support for his ongoing detoxification during his inpatient mental health stay. During this time, Amal's family were asked to meet with the treating team and provide additional information. Amal's father told the team that Amal had experienced previous episodes of hallucinations and delusions; he did not think these had all occurred when Amal had used methamphetamines but couldn't be sure. Amal's mother said that her mother had experienced 'mental health problems' and been hospitalised many times when she was younger, but she didn't know the exact nature of her condition.

Amal stayed at the mental health unit for a period of time, during which it was established that while his substance use may have contributed to and exacerbated his symptoms, it was likely that he had an independent psychotic disorder. He was stabilised on antipsychotics, started receiving psychotherapy and began working with a case manager who liaised with the outpatient AOD team and made a plan for his discharge. It was explained to Amal that his methamphetamine use would likely exacerbate or cause a relapse in his psychotic disorder. As such, an important part of his discharge plan included relapse

Box 15: Case study B: Treating co-occurring psychosis and AOD use: Amal's story (continued)

prevention strategies and the provision of ongoing support from the AOD service. Amal also had a longer-term goal of wanting to move out of his parents' house and live independently, which his case manager worked into his treatment goals.

Key points:

- Chronic illness does not equate to untreatable illness. Psychotherapy may provide symptom relief and improved quality of life, and all treatment approaches need to be carefully integrated.
- Involvement of family, carers or friends is often critical to providing a full picture but also needs to be carefully and sensitively managed.
- Medication adherence needs long-term attention.
- A holistic approach, assessing a person's accommodation and employment needs in addition to their mental, physical, and AOD use disorders, is vital.

Bipolar disorders

Bipolar disorders

Clinical presentation

It can be particularly challenging to treat people with bipolar disorder due to the broad range of emotions experienced, which can impact on the relationship between the client and the therapist [133]. Depending on which phase of the disorder a client is in, they may present with either symptoms of depression or mania/hypomania. If the person is in between episodes, they may appear to be completely well. People with bipolar disorder predominantly present to services during the depressive phases of the disorder rather than during periods of elation.

If experiencing a depressive episode, the client may present with low mood; markedly diminished interest or pleasure in all, or most activities; sleep disturbances; appetite disturbances; irritability; fatigue; psychomotor agitation or retardation; poor concentration; feelings of guilt, hopelessness, helplessness and worthlessness; and suicidal thoughts. When experiencing mania/hypomania however, a client's mood is persistently elevated, and symptoms of grandiosity, flights of ideas, hyperactivity, decreased sleep, psychomotor agitation, talkativeness, and distractibility may be present. Mania and hypomania may lead to a loss of insight, which can place the person at risk, and impact negatively on medication adherence.

Managing symptoms of bipolar

In general, if the client presents during a depressive episode, management of symptoms should follow the guidelines for the management of depressive symptoms (see Table 43). As previously mentioned, low mood is often a trigger for relapse to AOD use and addressing depressive symptoms is an important component of relapse prevention [1019]. If, however, the client is experiencing a manic episode or symptoms of psychosis, consultation with a medical practitioner is recommended for the prescription of appropriate pharmacological interventions.

The techniques outlined in Table 44 may assist in the management of a person experiencing symptoms of mania or hypomania. Some clients may be aware that they are unwell and will voluntarily seek help; others may lack insight into their symptoms and refuse, or not perceive the need for, help. In some instances, a person's manic symptoms can put both the client and others at risk of harm. In such circumstances mental health services should be contacted, whether the client wants such a referral to be made or not.

Table 43: Dos and don'ts of managing a client with depressive symptoms of bipolar

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

Don't:	
✗	Make unrealistic statements or give unrealistic hope, like 'everything will be fine'.
✗	Invalidate the client's feelings.
✗	Be harsh, angry, or judgemental. Remain calm and patient.
✗	Lose hope or become frustrated.
✗	Act shocked by what the client may reveal.

Adapted from Scott et al. [1020], Clancy and Terry [448] and Headspace [1021].

Table 44: Dos and don'ts of managing a client experiencing mania/hypomania

Do:
Ensure the safety of the client, yourself, and others.
Assist the client identify early warning signs that they may become unwell.
Help to reduce triggers that aggravate the person's symptoms (e.g., reduce stimulation such as noise, clutter, caffeine, social gatherings).
Speak clearly and calmly, asking only one question or giving only one direction at a time.
Answer questions briefly, quietly, calmly, and honestly.
Use a consistently even tone of voice, even if the person becomes aggressive.
Encourage regular sleep, exercise and eating patterns.
Be cautious about becoming swept up by the person's elevated mood.
Point out the consequences of the client's behaviour. Be specific.
If the person is well enough, discuss precautions they can take to prevent risky activities and negative consequences (e.g., give their credit cards and/or car keys temporarily to a trusted family member or friend to prevent reckless spending and driving).
If promiscuity or socially inappropriate behaviour is a problem, encourage the person to avoid situations in which their behaviour may lead to negative consequences.
Encourage the person to postpone acting on a risky idea until their mood is stable.
Ensure both you and the client can access exits – if there is only one exit, ensure that you are closest to the exit.
Have emergency alarms/mobile phones and have crisis teams/police on speed dial.
If the person is placing themselves at risk, or they are experiencing severe symptoms of psychosis, arrange transfer to an emergency department for assessment and treatment by calling an ambulance on 000.

Table 44: Dos and don'ts of managing a client experiencing mania/hypomania (continued)

Don't:	
✗	Argue, criticise, or behave in a threatening way towards them. Consider postponing or avoiding discussion of issues that aggravate the client for the time being. Try to talk about more neutral topics.
✗	Get visibly upset or angry with the client. Remain calm and patient.
✗	Confuse and increase the client's level of stress by having too many workers attempting to communicate with them.
✗	Get drawn into long conversations or arguments with the person as these can be overstimulating and upsetting. People with elevated moods are vulnerable despite their apparent confidence, and they tend to take offence easily.
✗	Leave dangerous items around that could be used as a weapon or thrown.
✗	Laugh (or let others laugh) at the person.
✗	Act horrified, worried, or panic.

Treating bipolar disorders

There are several options available for the treatment of bipolar disorders, including psychotherapy, pharmacotherapy, ECT, e-health and telehealth interventions, as well as complementary and alternative therapies (e.g., dietary supplements). The evidence base surrounding each of these treatments is discussed below. Despite a small evidence base regarding the treatment of bipolar disorder in the context of co-occurring AOD use disorders, most of which has focused on pharmacological treatments, experts recommend an integrated multidisciplinary approach to treating these conditions [1022, 1023].

Psychotherapy

Research on psychological treatments for co-occurring bipolar disorder and AOD use is minimal and has largely been limited to small studies of CBT approaches. In line with Australian and international guidance on the treatment of bipolar disorder [1024–1027], these studies have examined the use of psychotherapies as adjuncts to pharmacotherapy, not as monotherapies. The intervention that has received most investigation to date is *Integrated Group Therapy (IGT)*, an integrated, 12- or 20-session psychosocial group treatment program that focuses on similarities between recovery and relapse processes in bipolar disorder and AOD use disorder. One pilot non-randomised trial and two small RCTs have shown more positive findings in relation to AOD use outcomes relative to group counselling control conditions, but not in relation to mood [1028–1030]. It has been suggested that the consistent

superiority of *IGT* over group drug counselling indicates that the efficacy of drug treatment for people with co-occurring bipolar disorder is enhanced when treatment is provided in the context of mood disorder treatment, but additional strategies may be needed for mood management [871].

Preliminary studies have also been conducted on several other integrated treatments delivered as adjuncts to pharmacotherapy, but again, these have been limited to small RCTs with mixed findings. Schmitz and colleagues [1031] compared an individual integrated CBT treatment for bipolar and AOD use delivered in combination with medication monitoring to medication monitoring alone. No significant differences were found in relation to AOD use; findings in relation to mood were mixed but appeared promising. A further two intensive 6-month long programs that involved clients' families, the *Integrated Treatment Adherence Program* based on ACT for adults [1032] and the *Family Focused Treatment* for adolescents [1033], have also undergone preliminary evaluations with promising findings in relation to symptoms of bipolar disorder, but not in relation to AOD use.

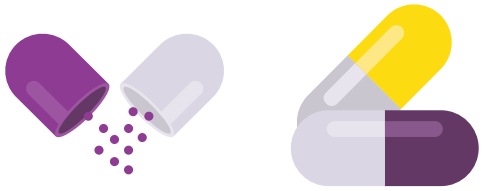
Other integrated interventions that have undergone preliminary evaluation and found to be acceptable, feasible, and potentially efficacious in reducing either AOD use and/or symptoms of bipolar disorder include *HABIT*, a manualised integrated group therapy that combines CBT with mindfulness-based relapse prevention [1034], and an integrated individual therapy that combines CBT and MI [1035]. Further research is needed to determine their effectiveness.

Pharmacotherapy

Pharmacotherapy is the first-line approach to treating bipolar disorders as single disorders [1024–1027]. It is therefore not surprising that the vast majority of research regarding the treatment of co-occurring bipolar and AOD use disorders has focused on pharmacotherapies. Nevertheless, the evidence base is limited making it difficult to draw firm conclusions. Most studies have been conducted with a small number of people, lacked comparison groups, and involved the use of a variety of concomitant medications, making it difficult to clearly attribute effects to the medication examined [1023, 1036]. Multiple medications are often used to treat each specific disorder, such as the use of mood stabilisers (see Table 45), antipsychotics (see Table 42), and/or antidepressants (see Table 47) for the bipolar disorder, in conjunction with medication specifically to treat the AOD use disorder (e.g., naltrexone for alcohol use disorder) [1037], but care should be taken to avoid unnecessary polypharmacy due to the potential for interaction effects.

Table 45: Mood stabiliser medications

Drug name	Brand names	Drug name	Brand names
Aripiprazole	Abilify, Abyraz, Tevaripiprazole	Quetiapine	Delucon, Kaptan, Quetia, Seroquel, Syquet, Tevatiapine
Asenapine	Saphris	Risperidone	Ozidal, Rispa, Risperdal, Rispernia, Rixadone
Carbamazepine	Tegretol	Sodium valproate	Epilim, Valprease, Valpro
Lamotrigine	Lamictal, Lamidus, Lamitan, Lamotrust, Logem, Reedos, Torlemo	Ziprasidone	Zeldox, Ziprox
Lithium	Lithicarb, Quilonum		
Olanzapine	Olanzacor, Ozin, Pryzex, Zypine, Zyprexa		
Paliperidone	Ivenga		



Adapted from Khoo [1038]. For a full list of generic brands available, see the Therapeutic Goods Administration website (https://www.tga.gov.au).

Research to date has largely focused on the use of quetiapine among people with co-occurring bipolar and alcohol use disorders. Although initial open-label uncontrolled trials largely found quetiapine to have a positive impact on both psychiatric symptoms and AOD use, most RCTs have demonstrated that these improvements tend to be no greater than those achieved with a placebo [1036]. A similar pattern has been observed for sodium valproate among people with co-occurring bipolar and alcohol, cocaine and/or cannabis use disorders; although findings from one RCT suggest that greater reductions in alcohol use may be obtained by adding sodium valproate to lithium and individual counselling [1039].

Lithium itself has been examined in a small RCT conducted among adolescents which found significantly greater reductions in AOD use and depressive symptoms among those who received lithium relative to those who received placebo [1040]. A further study demonstrated that lithium had an impact on reducing cannabis and cocaine use among people with co-occurring bipolar disorder, but it is difficult to generalise the findings of this study due to less than one-quarter of the original sample completing the stabilisation phase and continuing into the main portion of the study [1041].

Lamotrigine has been shown to have mixed results in uncontrolled trials with regard to symptoms of bipolar, cocaine and alcohol use, but the only RCT conducted to date found no significant differences in outcomes for those who received lamotrigine compared to those who received a placebo medication [1036]. Topiramate has also been examined in an RCT and was not found to be superior to placebo

with respect to reductions in AOD use and mood [1036]. Aripiprazole, olanzapine, and asenapine have all undergone preliminary testing, and all have been associated with reductions in cravings and improvements in bipolar symptoms but are yet to be examined in controlled trials [1036]. Over the past several years, studies have widened their focus to include non-traditional pharmacotherapies, such as memantine (an NMDA-receptor agonist typically used in the treatment of Alzheimer's disease) [1042] and ondansetron (an antiemetic usually used in the treatment of nausea) [1043]. Although this is an area that is still developing, some promising findings have emerged.

It is also important to bear in mind that people with a co-occurring bipolar disorder may be less likely to take their medication if they lack insight, do not recognise their manic episodes, or enjoy their manic episodes. Measures to increase medication adherence may be particularly pertinent (discussed in Chapter B6). Other strategies to promote medication adherence among clients with co-occurring bipolar disorder include the *Integrated Treatment Adherence Program* described earlier in this chapter, which is an adjunctive psychosocial approach designed to improve treatment adherence [1032].

Electroconvulsive therapy (ECT)

While ECT has been suggested as a second-line treatment option for single disorder bipolar in very severe cases (e.g., treatment-resistant or acute mania, depression, suicidality) [1026, 1027], to date, few research studies have assessed the efficacy of ECT in treating co-occurring bipolar and AOD use disorders.

Of the research that has been conducted, one study conducted a retrospective analysis of Swedish medical records of people with bipolar and depression, both as single disorders and co-occurring with AOD use, who had previously received ECT [1044]. ECT was found to improve remission rates from baseline for people with single disorder bipolar, at a similar rate to people with unipolar depression (35% for bipolar vs. 45% for unipolar depression). However, people with co-occurring mood disorders and AOD use had lower remission rates compared to people without co-occurring AOD use (26% to 29% vs. 42% to 47% respectively) [1044].

In a second study conducted among 190 adolescents and young people aged 16 to 25 with depressive, psychotic and bipolar disorders, a course of five ECT treatments was found to reduce AOD use outcomes, such as cravings and problematic behaviour associated with substance use, relative to baseline [1045]. Following these treatments, people also demonstrated reductions in the frequency of depressive and psychotic symptoms, as well as self-harm ideation [1045]. However, it should be borne in mind that bipolar disorders made up only a very small subsample of this study (14%). While these studies may be promising, more conclusive evidence for the use of ECT among people with co-occurring bipolar and AOD use is needed.

E-health and telehealth interventions

There are several online interventions to support the mental health of people with bipolar disorders, including *MoodSwings* [1046, 1047], *Living With Bipolar* [1048], *Beating Bipolar* [1049], the *Bipolar Education Programme* [1050], *HealthSteps for Bipolar Disorder* [1051], *LiveWell* [1052], *ORBIT* [1053], *ERPonline* [1054], and *OpenSIMPLe* [1055]. However, only some of these have been, or are in the early stages of being, evaluated. Feasibility and preliminary studies of *Living With Bipolar* [1048], *Bipolar Education Programme* [1050], and *OpenSIMPLe* [1055] are promising.

One online program, *Therapeutic Education System (TES)*, developed for people with AOD use was recently evaluated among 95 people, a subsample of whom were experiencing co-occurring bipolar disorder [1056]. *TES* comprises 65, 15-minute modules, covering substance use-related topics, such as problem solving and drug-refusal skill training. Compared to those in the treatment as usual control group, those enrolled in *TES* reported greater perceived usefulness of treatment and better emotional regulation, although the groups did not differ in subsequent enrolment rates in AOD treatment programs, self-reported cravings, number of drug-related dreams, or satisfaction with treatment. Outcomes related to bipolar symptoms were not examined.

Physical activity

A small number of studies with relatively small samples have examined the effect of exercise on bipolar disorders. Ng and colleagues [1057] conducted a small, retrospective chart review, and found that depression and anxiety improved among people with bipolar disorder who participated in a voluntary 40-minute, supervised group walking activity whilst in a psychiatric facility, every weekday morning, compared to non-walkers. However, there was no clinical difference in overall improvement between walkers and non-walkers [1057]. A small open trial examining the short-term effects of aerobic training on depression and bipolar disorder found that aerobic training slightly improved symptom severity for people with bipolar disorder [1058]. Another small RCT examined the effect of a short-term, maximum endurance exercise program as an accompanying treatment to pharmacotherapy, and found that, relative to control (gentle stretching and relaxation), depression scores were significantly reduced among the exercise group [1059]. In a systematic review of the literature, it was similarly concluded that physical activity is associated with reduced depressive symptoms among people with bipolar, as well as improved quality of life [1060]. The optimal dose for exercise among people with bipolar has not yet been determined; however, guidelines for mood disorders from the RANZCP suggest that exercise should be regular (two to three times per week) and vigorous (requiring sustained effort) to maximise the chance of deriving health benefits [1027]. Similarly, although the optimal dose and exercise type for people with bipolar have yet to be determined, aerobic and resistance-based exercises are recommended for people with mood disorders in general [1027].

Although the aforementioned studies provide evidence to suggest that regular physical activity can assist in the reduction of depressive symptoms, there is preliminary research pointing to the existence of possible exacerbation of mania among some people [1060–1062]. Although exercise may be beneficial in redirecting excess energy for some, others found their manic symptoms were aggravated, potentially risking a cycle of manic and hypomanic symptoms [1063]. It has been suggested that the exacerbation of manic symptoms may be due to direct effects on mood, or indirectly on excessive goal-focused activities, which can be a risk pathway for bipolar disorder [1064, 1065]. However, these preliminary findings originate from a small qualitative study and require further empirical evidence, with some participants in the study finding exercise calming [1061]. No research has been conducted to examine the efficacy of exercise among people with co-occurring bipolar and AOD use; however, given the unknown and potentially risky relationship with mania, physical activity among people with co-occurring disorders should be closely monitored.

Complementary and alternative therapies

Dietary supplements

There have been few reviews that have examined the evidence for the safety and efficacy of dietary supplements for bipolar disorders. Although research has found some benefit with regards to both depressive symptoms (e.g., omega-3 and -6 supplementation, icariin, citicoline [1066–1070]), and mania symptoms (e.g., magnesium supplementation [1071–1073]), many therapies have the potential to induce mania or interact with pharmacotherapies (e.g., St John's Wort [1074–1077]); the extent to which needs further in-depth examination.

Summary

Several psychological and pharmacological approaches for the treatment of co-occurring bipolar disorder and AOD use appear promising, however, further research is required to establish which therapeutic approaches are particularly effective for these co-occurring disorders. Box 16 illustrates the continuation of case study C, following Scott after his initial visit with the AOD worker.

Box 16: Case study C: Treating co-occurring bipolar disorder and AOD use: Scott's story continued

Case study C: Scott's story continued

During the comprehensive assessment with the AOD worker, Scott described other periods where he had felt elated. His girlfriend said that he would sometimes come home after two weeks at work and start a new project in a 'frenzy', often staying up all night or only coming to bed at 2 or 3am, but rarely finished any of them before moving on to something new. During these periods, Scott's girlfriend said he was like a different person - he was full of energy, talked non-stop, would do all the housework and didn't seem to need much sleep. Scott excitedly told the AOD worker that he just started rebuilding a motorbike in his garage. Scott's girlfriend expressed her frustration that their house was full of half-completed projects, with 'stuff everywhere'.

Recognising a probable bipolar disorder, the AOD worker organised for Scott to see a psychiatrist, who confirmed this diagnosis. Scott's AOD worker told him that if he wanted to work on his AOD use, they would work together with his psychiatrist to manage both conditions together. Scott agreed this was a good idea and was prescribed a mood stabiliser by his psychiatrist. A concurrent approach to Scott's mental health and AOD use began, which involved regular meetings with Scott and the professionals involved in his mental health care and AOD treatment.

In addition to psychotherapy and medication, the team helped Scott with financial management and provided him with some strategies to help with his spending. They also discussed Scott's lifestyle and in particular, the nature of his fly-in-fly-out employment. The first time this was raised, Scott became extremely angry. Refusing to believe there was any problem or connection between the long shift work, numerous consecutive working days, his AOD use and mental health symptoms, he told the treatment

Box 16: Case study C: Treating co-occurring bipolar disorder and AOD use: Scott's story (continued)

team to 'butt out' and stormed out of the meeting. Very late that evening, Scott's girlfriend was contacted by a friend who had found Scott passed out in a local park – he was naked and his feet were bare and bloodied. It appeared that he had consumed a large quantity of alcohol and had been wandering around. His girlfriend picked Scott up and she and the friend took him to emergency, where he was admitted overnight.

Over the next few days, Scott's mood had settled, and he started to think more about his life and work, and the things that were important to him. In the next treatment team meeting, he listened to the concerns raised, and said he loved his job but could see why the type of work he had been doing may be contributing to making things worse and would think about it some more. He was grateful that his team was being patient with him, listening to him think things through without judging him. Scott started going to the gym again and joined the local soccer team.

Key points:

- In cases of bipolar disorder co-occurring with AOD use, treatments need to be coordinated and carefully integrated. Strategies to address medication adherence, particularly over the long-term, are a pertinent aspect of treatment.
- Without addressing the familial and social consequences of longstanding bipolar disorder, the client's quality of life will remain much diminished. As such, integrating the rehabilitative aspects of treatment may have long-term benefits.
- Physical activity and exercise have physical and psychological benefits and may also help address some of the side effects of medications used to treat bipolar disorder.

Depression

Depression

Clinical presentation

Depressive symptoms include low mood; markedly diminished interest or pleasure in all or most activities; sleep disturbances; appetite disturbances; irritability; fatigue; psychomotor agitation or retardation; poor concentration; feelings of guilt, hopelessness, helplessness and worthlessness; and suicidal thoughts (refer to **Chapter A4**).

Managing depressive symptoms

Negative mood is often a trigger for relapse, and therefore addressing depressive symptoms is also an important part of relapse prevention [1078, 1079]. The techniques outlined in Table 46 may help AOD workers to manage clients with depressive symptoms. A number of simple strategies based on CBT may also be useful for clients in managing depressive symptoms, including [482, 1080, 1081]:

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

These techniques are discussed in greater detail in **Appendix BB**.

It is important to note that many depressive symptoms (and many anxiety symptoms) will subside after a period of abstinence and stabilisation [1082–1084]. It is useful to explain to clients that it is quite normal to feel depressed (or anxious) when entering treatment but that these feelings usually improve over a period of weeks [1082, 1083, 1085]. During and after this time, constant monitoring of symptoms will allow the AOD worker to determine if the client requires further treatment for these symptoms.
If the client has a history of depressive episodes in circumstances when they are not intoxicated or withdrawing, they may have an independent depressive disorder. For these clients, it is unlikely that their depressive symptoms will resolve completely with abstinence—indeed their symptoms may even increase. In such cases, clients should be assessed for a depressive disorder and the treatment options described in this chapter should be considered.

Table 46: Dos and don’ts of managing a client with depressive symptoms

Do:	
✓	Encourage and emphasise successes and positive steps (even just coming in for treatment).
✓	Take everything they say seriously.

Table 46: Dos and don'ts of managing a client with depressive symptoms (continued)

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

Don't:	
✗	Make unrealistic statements or give unrealistic hope, like 'everything will be fine'.
✗	Invalidate the client's feelings.
✗	Be harsh, angry, or judgemental. Remain calm and patient.
✗	Act shocked by what the client may reveal.

Adapted from Scott et al. [1020] and Clancy and Terry [448].

Treating depressive disorders

There are several options available for the treatment of depressive disorders, including psychotherapy, pharmacotherapy, ECT, e-health, physical activity, as well as complementary and alternative therapies (e.g., omega-3). The evidence base surrounding each of these treatments is discussed below.

Psychotherapy

Research on psychological therapies provides support for the use of integrated psychological treatments for co-occurring depression and AOD use disorders [228, 665, 1086, 1087]. However, the small number of studies, methodological limitations (e.g., lack of randomisation to treatment conditions), variation in study results, and small sample sizes used in these studies highlight the need for larger trials to be conducted in this area [665, 1088].

The majority of studies to date have examined the use of integrated treatments that adopt a CBT approach [122, 665, 1089]. Reviews of the literature have shown that integrated CBT approaches yield superior results for depression and AOD use when compared to no treatment or treatment as usual comparison groups [1088, 1090], but there is insufficient evidence demonstrating that any one psychological therapy is more effective than another for these co-occurring conditions [1091].

In a 2019 Cochrane review, Hides and colleagues [1091] identified there was limited evidence to suggest that integrated CBT (ICBT) results in higher rates of abstinence at 6- to 12-months follow-up compared to 12-step facilitation therapy. Both approaches appeared to be similarly effective in terms of depressive symptoms at follow-up, however, reductions appeared more quickly with 12-step facilitation therapy than ICBT and Hides and colleagues [1091] caution that these findings are based on low-quality evidence. As a way of enhancing CBT, it has been suggested that CBT be combined with other evidence-based psychological strategies, such as contingency management (see **Chapter B6**). The addition of contingency management to CBT-based approaches has been shown to lead to superior outcomes in terms of AOD abstinence and depressive symptoms relative to CBT-based approaches alone [1092, 1093].

Another approach showing promise in the treatment of co-occurring AOD use and depression is behavioural activation (described in **Chapter B6**). There is empirical evidence illustrating that behavioural activation is as effective in treating depression as cognitive and behavioural techniques (with or without antidepressants) and more effective than antidepressant medication alone [693, 694, 1094]. The efficacy of behavioural activation in treating co-occurring AOD use and depression has been examined in several RCTs across a variety of AOD treatment settings (community-based clinics, residential treatment, specialist addiction clinics). A systematic review of these trials concluded that, although the research to date is promising, further research is needed [690].

Lastly, although still in the early stages, there is preliminary support for the use of mindfulness-based approaches in the treatment of co-occurring depression and AOD use. These approaches include mindfulness-based relapse prevention [1095, 1096] and mindfulness-based cognitive therapy [1097], which have been associated with greater reductions in depressive symptoms and AOD craving relative to treatment as usual for AOD.

Pharmacotherapy

There is consensus amongst experts that pharmacotherapy (i.e., antidepressants; see Table 47) for co-occurring depression and alcohol use disorders can be effective, provided an individualised approach is used [1098, 1099]; however, it has been suggested that using pharmacotherapy to treat only depression or only AOD use is not likely to be sufficient to achieve improvements for both conditions [1100].

A number of systematic reviews have examined the effectiveness of antidepressant medication among people with co-occurring AOD use disorders and depression [1100–1103]. Most studies to date have focused on alcohol use disorders, but other AOD use disorders examined include cocaine use disorder, opiate use disorder, and nicotine use disorder [1101].

Systematic reviews and meta-analyses have shown that, while their effect on AOD has been mixed, the effect of antidepressants on depression among people with AOD use disorders is comparable to that observed among people with single disorder depression [34, 1100–1102]. There is some evidence to suggest that their effectiveness may vary depending on the type of AOD use disorder a person presents with. For example, although studies of co-occurring alcohol dependence and major depression support the use of antidepressants [1102], most studies of cocaine and opiate dependent clients do not [1101].

The majority of studies to date have examined the use of SSRIs and few have directly compared the effectiveness of different types of antidepressants among people with AOD use disorders. As such, there is insufficient evidence to recommend the use of one over another [1102]. Despite a lack of comparative research, there is some evidence to suggest that particular antidepressants may be more effective in treating depression among people with AOD use disorders than others. In a systematic review of pharmacotherapy among people with co-occurring AOD use and depressive disorders (either major depressive disorder or dysthymia), Stokes and colleagues [1101] found that imipramine (a tricyclic antidepressant, TCA) improved depressive symptoms among people with co-occurring alcohol dependence and opiate dependence, however, SSRIs showed no effects on depression. The lack of effects for SSRIs was observed both when SSRIs were used alone and in combination with other relapse prevention medications (e.g., naltrexone). Consistent with these findings, the addition of citalopram to naltrexone and case management has not been shown to confer any added benefit over naltrexone and case management among people with either independent or substance-induced depression and alcohol dependence [1104]. Antidepressants that do not come under the umbrella of SSRIs or TCAs have been found to be effective in single studies, with improvements observed on outcomes such as depression, alcohol consumption, cravings, and time to relapse [1100].

It has also been suggested that different types of antidepressants seem to be suitable for different types of substance use disorders [1105]. In particular, people with AOD use disorders tend to respond better to antidepressants that have a similar direct or side effect profile to their substance use. Hence, the more sedating antidepressants such as doxepin or paroxetine are more effective among people who use alcohol, heroin, and sedatives, and the more stimulating antidepressants such as desipramine and bupropion have greater efficacy among those with depression who use stimulants and nicotine. As there is insufficient evidence for the use of antidepressants for treating depression among people who use psychostimulants such as amphetamines and ecstasy [1106, 1107], the use of the more stimulating antidepressants for these clients provides the best guidance at this time.

As with any medication, the choice of antidepressant used should be made with the client and take into consideration the safety and tolerability of the medication, and any potential contraindications. SSRIs and other atypical antidepressants are typically better tolerated, associated with fewer adverse effects, and are safer in overdose relative to TCAs [1102, 1108, 1109]. For all AOD clients, extreme caution should be taken when prescribing monoamine oxidase inhibitors (MAOIs). These medications are potentially

dangerous because of the dietary and medication restrictions involved [1105, 1106]. Hypertensive crisis with intracranial bleeding and death can occur if combined with a tyramine-rich diet or contraindicated medications (including opioid and psychostimulant substances, such as over-the-counter cold and flu medications) [1110, 1111]. Further MAOIs have a number of possible/theoretical interactions with alcohol (tyramine in some wines/beers) and other drugs of abuse [1105]. For these reasons, MAOIs should only be used when other antidepressant medication options have failed.

Esketamine, an NMDA-receptor antagonist recently approved for the treatment of depression by the Australian Therapeutic Goods Administration, is another pharmacotherapy that may be considered for people who have not demonstrated an adequate response to at least two other antidepressants [1112]. Caution should be used however, due to its abuse potential and significant adverse effects (e.g., dizziness, nausea, dissociation) [1113–1116]. Relative to placebo, people are more likely to discontinue esketamine due to the intolerability of these side effects [1116].

Suicide risk should be carefully monitored when a person commences any antidepressant, given ongoing uncertainty and controversy regarding initiation of antidepressants and increased suicide risk; in particular, suicide attempts within the first three to four weeks of acute treatment [1117, 1118]. Thus, although it is suggested that the benefits of antidepressant use outweigh the risks, and appropriate use actually protects depressed patients from suicide, it is important to maintain appropriate monitoring of suicidality [1098, 1109].

It is important to note that it can take up to four weeks for an antidepressant to reach therapeutic levels. Responses to antidepressants are typically noticeable within two to four weeks, with continued improvement in symptoms for up to 12 weeks [1098]. With these issues in mind, early follow-ups after initiation of an antidepressant medication are recommended [1098]. If little or no improvement in mood occurs over the induction time specified by the drug manufacturer, and the medication is being taken as prescribed (usually a minimum of three weeks), consideration should be given to increasing the dose within the recommended range. If still little or no improvement is observed, switching or augmenting with another antidepressant may be considered. It is recommended that there be at least one within-class switch before considering augmentation or other options, keeping in mind the potential for drug interactions, and the adverse effects of some antidepressants [1098].

Thase and colleagues [1099] comment on the sometimes over-restrictive attitudes towards pharmacological treatments for depressive disorders among people with AOD use disorders, where clients can present in a state of physical and emotional despair that requires immediate intervention. Considering the safety of most of the newer antidepressants such as SSRIs, such caution as waiting for a minimum number of weeks of abstinence cannot be justified. This would particularly apply where a client has a history of depression during periods of abstinence, or where the person has had successful antidepressant intervention in the past.

Some clients may be reluctant to take SSRIs due to the misconception that they are ‘addictive’. SSRIs are not habit-forming; however, people may experience a discontinuation syndrome if medication is stopped abruptly [1109]. Symptoms typically appear within three to four days of stopping and are similar to some of those experienced during alcohol and opiate withdrawal (e.g., flu-like symptoms, light-headedness, headache, nausea) [1109]. When discontinuing SSRIs, the dose should be gradually tapered.

Table 47: Antidepressant medications

Drug type and name	Brand names
Tricyclic antidepressant (TCA):	
Amitriptyline	Endep, Entrip, Lupin
Clomipramine	Anafranil, Placil
Dosulepin (dothiepin)	Dothep, Mylan
Doxepin	Deptran
Imipramine	Tofranil
Nortriptyline	Allegron, NotriTABS
Monoamine oxidase inhibitor (MAOI):	
Phenelzine	Nardil
Tranylcypromine	Parnate
Reversible inhibitor of monoamine oxidase A (RIMA):	
Moclobemide	Amira, Aurorix, Clobemix
Selective serotonin reuptake inhibitor (SSRI):	
Citalopram	Celapram, Cipramil, Talam
Escitalopram	Cilopam, Escicor, Esipram, Lexam, Lexapro, Loxalate
Fluoxetine	Fluotex, Lovan, Prozac, Zactin
Fluvoxamine	Faverin, Luvox, Movox
Paroxetine	Aropax, Extine, Paxtine, Roxtine
Sertraline	Eleva, Sertra, Setrona, Zoloft
Serotonin and noradrenaline reuptake inhibitor (SNRI):	
Desvenlafaxine	Desfax, Desven, Pristiq
Duloxetine	Cymbalta, Depreta, Duloxecor, Dytrex, Tixol
Venlafaxine	Efexor, Elaxine, Enlafax

Table 47: Antidepressant medications (continued)

Drug type and name	Brand names
Noradrenaline and specific serotonergic agent (NaSSA):	
Mirtazapine	Avanza, Axit, Mirtanza, Mirtazon
Tetracyclic antidepressant:	
Mianserin	Lumin
Noradrenaline reuptake inhibitor (NRI):	
Reboxetine	Edronax
Melatonergic antidepressant:	
Agomelatine	Domion, Valdoxan
N-methyl-D-aspartate (NMDA) receptor antagonist:	
Esketamine	Spravato

Adapted from Australian Government Department of Health [1119]. For a full list of generic brands available, see the Therapeutic Goods Administration website (https://www.tga.gov.au).

Naltrexone and acamprosate, medications commonly used in the treatment of alcohol use disorders, have shown moderately positive outcomes in depression as a single disorder [1120]. However, in a 2019 review of trials examining the use of alcohol medications among people with co-occurring alcohol dependence and depression, naltrexone and acamprosate produced mixed findings. As such, the authors concluded that their efficacy for alcohol use disorder and depression together remains unclear [1100]. More promising results have been found in relation to the use of disulfiram in this population, which has been associated with improvements in both depression and alcohol-related outcomes in some studies [1100, 1103]. While both acamprosate and naltrexone are available on the Pharmaceutical Benefits Scheme for alcohol dependence, disulfiram is expensive and only available with a private prescription.

Recent reviews have noted emerging evidence of the efficacy of anticonvulsants/antiepileptics for alcohol abstinence in people with co-occurring depression [1100, 1103], and recent trial results have demonstrated that a single high-dose of buprenorphine may rapidly reduce depression and suicidal ideation in people with opiate dependence and co-occurring depression [1121, 1122]. These findings suggest that buprenorphine may prove to be an especially useful pharmacotherapy for this sub-group, however, further research is needed.

Electroconvulsive therapy (ECT)

The 2019 RANZCP clinical practice guidelines for the treatment of depression note that ECT is a highly efficacious treatment with a strong evidence base, particularly for patients with severe or psychotic depression, catatonia, high risk of suicide, or who have not responded to adequate trials of medication or psychotherapy [808]. However, only one study to date has assessed the efficacy of ECT in treating co-occurring depression and AOD use disorders [1123]. This study, a retrospective chart review comparing depressed patients with and without co-occurring AOD use disorders, found that patients with co-occurring alcohol use disorders experienced similar improvements in their depressive symptoms following ECT as those with mood disorders alone [1123]; however, patients with both co-occurring alcohol and drug use disorders experienced smaller improvements post-ECT than those with mood disorders alone [1123].

E-health interventions

Research examining e-health interventions based mostly on CBT strategies has found evidence for modest, yet positive effects on depression outcomes [833, 1124], and their use as a low-intensity, initial treatment for adults experiencing mild symptoms of depression has been recommended by the RANZCP guidelines [1098]. A small number of e-health interventions specifically designed to treat co-occurring depression and AOD use have been developed and evaluated in Australia.

The *SHADE* program, consisting of nine sessions of interactive exercises based on MI and CBT, has been associated with moderate to large reductions in alcohol consumption and significant reductions in depression scores over 12-month follow-up [1125, 1126]. More recently, a brief (four-session) early intervention program called the *DEAL Project* was developed, targeting young people experiencing depression with harmful patterns of alcohol use [110]. The program is undertaken entirely online with no clinician support. In evaluating the intervention, Deady and colleagues [1127] found that individuals randomised to receive the *DEAL Project* demonstrated a greater reduction in symptoms of depression and alcohol use compared to individuals randomised to an attention-control condition. At the time of writing, both *SHADE* and the *DEAL Project* are freely available via the eCliPSE portal **http://www.eclipse.org.au**.

There are also several Australian-based online programs for depression as a single disorder, including *MindSpot Wellbeing Course*, *moodgym*, *myCompass*, and *This Way Up Depression Course* [1128, 1129]. The majority have been evaluated in clinical trials, and demonstrated small to moderate positive effects on symptoms of depression [833, 1124, 1130–1132]. The *ReachOut* website includes a comprehensive list of apps recommended by clinicians **https://au.reachout.com/tools-and-apps**.

Physical activity

There is increasing evidence to suggest that regular physical exercise has psychological benefits, with more active people illustrating lower levels of depression than sedentary people [1133–1135]; and, conversely, more physical inactivity found among people who are depressed [1136]. As mentioned previously, exercise is relatively low-risk, associated with a wide range of physical health benefits, and research has demonstrated exercise to be as effective in reducing depressive symptoms as psychotherapy and antidepressants [272, 1137]. A Cochrane review examining the effect of exercise on depressive symptoms concluded that physical activity (defined as aerobic, mixed, or resistance) was moderately more effective than control interventions for treating depression, with exercise equally as effective as psychotherapy or pharmacotherapy [1138]. The UK NICE Guidelines for mild to moderate depression recommend 45 minutes to 1 hour duration of structured, supervised physical activity programs, three times a week over 10 to 14 weeks [1139].

A number of systematic and meta-analytic reviews have examined the effects of physical exercise on elevated symptoms of depression and/or diagnosed depressive disorders among people with AOD use disorders. A systematic review by Giménez-Meseguer and colleages [306] found that both physical fitness and body-mind interventions have positive effects on depression, quality-of-life, and cravings among people with an alcohol use or other drug use disorder. Similarly, a meta-analysis of 22 studies examining the use of physical exercise of varied intensity (from light to vigorous, aerobic-based activities, mind-body practices such as Tai chi, qigong) as a treatment for AOD use disorders found improvements in abstinence rates, withdrawal symptoms, and depression [305]. However, some reviews have pointed toward differential effects depending on the type of activity. Specifically, among people with alcohol use disorders, aerobic exercise or strength training has been found to result in reduced depressive symptoms but not a reduction in daily alcohol consumption, compared to control conditions [1140]. Among people with AOD use disorders more broadly, another review found highly mixed outcomes in relation to depression and AOD use with anaerobic exercise (i.e., high intensity, interval training) [1141].

Yoga

Yoga is a complex mind–body intervention involving spiritual practice, physical activity, breathing exercises, mindfulness and meditation [1142, 1143]. Although the traditional goal of yoga is to unite body, mind, and spirit and achieve self-awareness, yoga has become a popular method of maintaining physical and mental health [1142–1144]. Yoga practice commonly involves postures to improve strength and flexibility, breathing exercises to focus the mind and assist with relaxation, and meditation to calm the mind [1144].

Several systematic reviews have been conducted to assess the efficacy of yoga as an intervention for depression. These studies have found limited to moderate support for short-term improvements in severity of depression in yoga with meditation-based practice (as opposed to exercise-based practice) [1145–1148]. Further, yoga has been shown to result in similar remission rates compared to ECT, and similar short-term improvements in symptoms compared to antidepressant medication [1145]. However, the current evidence base is hampered by the limited number of RCTs comprising small samples.

Reviews of yoga efficacy among people with various standalone AOD use disorders have highlighted equivalent or superior improvements in AOD use and psychosocial outcomes when compared to controls (e.g., attention, waitlist, physical exercise). There is also evidence to suggest that it may enhance the effects of other evidence-based psychological treatments, such as CBT [1149, 1150]. However, only one study to date has examined the effect of yoga breathing (Sudarshana Kriya Yoga) on depressive symptoms among people with alcohol dependence [1151]. This study found that the yoga intervention was associated with reduced depressive symptoms compared to the control group. Although the effectiveness of yoga as a treatment for people with co-occurring AOD and depressive disorders needs further investigation, these findings indicate that yoga may be considered as an additional treatment for clients with co-occurring AOD use and depression.

Complementary and alternative therapies

Omega-3

There has been much research conducted examining the relationship between omega-3 and depressive disorders, with some limited evidence that omega-3 fatty acids (primarily found in fish and seafood) have antidepressant effects [1152–1154]. Although there are some indications that omega-3 fatty acids have a beneficial role in reducing dependence, cravings, and stress among people with AOD use disorders [1153], findings are inconsistent and most research to date has been conducted on animals [1152, 1154]. Further, the role of omega-3 fatty acids among people with co-occurring AOD use and depression has not been rigorously examined.

St John's Wort

St John's Wort is the common name for the plant *Hypericum perforatum*, the extracts of which are commonly used to treat depression, sometimes in order to avoid the side-effects involved with prescription antidepressant medication [1155]. Systematic reviews of studies examining the efficacy of St John's Wort found significantly greater reductions in mild to moderate symptoms of depression among those taking St John's Wort compared to placebo, and equivalent reductions compared to antidepressant medications [1156, 1157]. However, the long-term side effects, particularly among pregnant women, are unknown.

Although there is some evidence of efficacy in mild to moderate depression, as described in **Chapter B6**, the use of St John's Wort has been shown to have significant interactions with a range of other medications, including SSRIs and related drugs, oral contraceptives, some anticoagulants, and some cardiac medications [794].

Although the use of St John's Wort among people with co-occurring AOD and depressive disorders has not been examined, AOD workers should ask their clients specifically about their use of St John's Wort and other complementary medicines, taking note of the potential for interactions between medications.

Summary

While these findings indicate that several psychological, pharmacological, and alternative approaches for the treatment of co-occurring depression and AOD use disorders appear promising, further research is required to establish which therapeutic approaches are particularly effective. It is suggested that clinical efforts be focused on the provision of client-centred, evidence-based treatment, taking into account the client's needs and preferences, in a collaborative partnership. Box 17 illustrates the continuation of case study D, following Sheryl after the identification of her co-occurring depressive and AOD use disorder.

Box 17: Case study D: Treating co-occurring depression and AOD use: Sheryl's story continued

Case study D: Sheryl's story continued

When Sheryl's GP received her blood test results, they showed Sheryl had an underactive thyroid, for which her GP immediately organised medication. Sheryl's GP contacted the local addiction medicine specialist to advise on the most appropriate method of benzodiazepine titration and withdrawal and organised an appointment for Sheryl. One of Sheryl's daughters accompanied her to the appointment. Through the AOD service, Sheryl heard about a group therapy that is run on Tuesday evenings that didn't sound too bad, and with the encouragement of her daughter, started attending.

After a few weeks taking thyroxin medication, Sheryl's energy increased but she continued experiencing very low mood. Upon telling her GP of her continued periods of depression, they discussed treatment options including psychological therapy and medications. Sheryl was reluctant to take another medication and preferred to see a psychologist. She was referred to a clinical psychologist who began CBT. Sheryl's GP began organising regular case management meetings between herself, Sheryl, the addiction medicine specialist, the clinical psychologist and Sheryl's daughters. It was decided in the first meeting that given Sheryl's medical condition her GP was the appropriate person to take on the role of the primary case manager. At one of these meetings, Sheryl asked to revisit the idea of taking antidepressants. Although she was making progress, Sheryl was still feeling very low and was having trouble fully engaging in therapy.

As part of Sheryl's psychotherapy, Sheryl was encouraged to rediscover things she was genuinely interested in and re-establish a sense of purpose. Over time, she reconnected with her friends and enrolled in some online classes through her local community college.

Key points:

- People with co-occurring disorders may not necessarily present in obvious ways. The need for careful history taking regarding AOD use cannot be overemphasised.
- Underlying medical conditions may resemble or disguise symptoms of mental disorders, and it is vital to conduct comprehensive medical assessments.
- It is common for symptoms of both AOD and mental health conditions to be exacerbated by major life events.

Anxiety

Anxiety

Clinical presentation

Anxiety is a normal reaction to stress, and in moderation, can help to improve performance [1158]. Anxiety can become problematic however, when the fear or worry is excessive, or a person has difficulty controlling their worry, and/or repetitive intrusive thoughts or actions. Symptoms of anxiety include poor concentration, an inability to relax, sleep disturbances, depersonalisation, and physical symptoms such as dizziness, faintness, headaches, nausea, indigestion, loss of sexual pleasure, breathing difficulties, sweating, tension and muscle pain, and heart palpitations.

Managing symptoms of anxiety, panic, or agitation

The presence of an anxiety disorder can significantly increase the risk of relapse to AOD use [1159, 1160]. Techniques for managing clients with symptoms of anxiety are outlined in Table 48. Clients may also be encouraged to try relaxation techniques to manage the distressing and distracting symptoms of anxiety [103, 1161, 1162].

Some useful relaxation methods include:

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

Each method works best if practiced daily for 10–20 minutes; however, not every technique may be appropriate for every client. These techniques are described in detail in **Appendix CC**. Some of the cognitive behavioural techniques described in **Appendix BB** (i.e., cognitive restructuring, structured problem solving, and goal setting) may also be useful in managing symptoms of anxiety [1163–1166], but again, no one strategy is effective for everyone. If the client experiences unpleasant effects from any strategy, they should discontinue its use.

As with depressive symptoms, many anxiety symptoms will subside after a period of abstinence and stabilisation [777, 866–868]. It may be useful to explain to clients that it is quite normal to feel anxious when entering treatment but that these feelings usually improve over a period of weeks. During and after this time, constant monitoring of symptoms will allow the AOD worker to determine if the client requires further treatment. If the client has a history of anxiety in circumstances when they are not intoxicated or withdrawing, they may have an independent anxiety disorder. For these clients, it is unlikely that their anxiety symptoms will resolve completely with abstinence – indeed their symptoms may even increase. In such cases, clients should be assessed for an anxiety disorder and the treatment options should be considered.

Table 48: Dos and don'ts of managing a client with symptoms of anxiety

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

Don't:	
✗	Crowd or pressure the client.
✗	Get frustrated or impatient.
✗	Panic. The more relaxed you are, the more relaxed the client is likely to feel.
✗	Act shocked by what the client may reveal.

Adapted from NSW Department of Health [431], SAMHSA [102], and Clancy and Terry [448].

Treating anxiety disorders

As with depression, much of the anxiety exhibited by clients entering AOD treatment will subside following a period of abstinence and stabilisation without the need for any direct attention [866-868], but some may require further treatment. Research relating to co-occurring anxiety and AOD use is sparse [1158, 1167]; however, there are several options available for the treatment of anxiety disorders as single disorders, including psychotherapy, pharmacotherapy, e-health interventions, physical activity, and complementary and alternative therapies (e.g., dietary supplements). The evidence base surrounding these treatments in relation to each of the different anxiety disorders is discussed below.

Broadly speaking, the RANZCP clinical practice guidelines for the treatment of GAD, panic disorder, and SAD recommend an approach that begins with psychoeducation and lifestyle advice, followed by CBT, pharmacotherapy (SSRIs or SNRIs) augmented with graded exposure, or a combination of CBT and pharmacotherapy [1158].

There is also growing evidence suggesting that integrated treatment approaches may be effective at reducing symptoms of anxiety [669, 1168, 1169], depression, stress [1168], and AOD use [669, 1168–1171], as well as improving quality of life [669], among people with co-occurring anxiety and AOD use; but the evidence is mixed.

If the anxiety is acute and disabling and interfering with a response to AOD treatment, then consideration should be given to pharmacotherapy, either for the substance use (in the case of alcohol – naltrexone, acamprosate, or disulfiram), the anxiety, or both. Although research examining the treatment of co-occurring anxiety and AOD use is scarce [1172], it would be reasonable to draw similar conclusions for these co-occurring groups as for those experiencing co-occurring depression and AOD use – namely, use of a medication such as an SSRI (which has anxiolytic properties), with a good side-effect profile, proven efficacy in the mental health disorder and minimal negative interactions with the substance of abuse [1110, 1173]. Commonly prescribed anti-anxiety medications include some of the SSRIs (and other antidepressants, e.g., venlafaxine) listed in Table 47, and those listed in Table 49.

Despite their proven effectiveness in relieving anxiety, the use of benzodiazepines is not recommended due to their abuse liability [1158, 1174, 1175]. Benzodiazepines should only be prescribed among patients with a history of problematic AOD use if there is a compelling reason to use them, there is no good alternative (i.e., other psychological and medication options have failed), close follow-up and supervision is provided, and monitoring for misuse is in place. If benzodiazepines are used, the client should only be prescribed the lowest possible dose for only a short period of time (no more than one month [1110]).

Table 49: Anti-anxiety medications

Drug name	Brand names
Selective serotonin reuptake inhibitor (SSRI):	
Citalopram	Celapram, Cipramil, Talam
Escitalopram	Cilopam, Escicor, Esipram, Lexam, Lexapro, Loxalate
Fluoxetine	Fluotex, Lovan, Prozac, Zactin
Fluvoxamine	Faverin, Luvox, Movox
Paroxetine	Aropax, Extine, Paxtine, Roxtine
Sertraline	Eleva, Sertra, Setrona, Zoloft
Serotonin and noradrenaline reuptake inhibitor (SNRI):	
Duloxetine	Cymbalta, Depreta, Duloxecor, Dytrex, Tixol
Venlafaxine	Efexor, Elaxine, Enlafax

Table 49: Anti-anxiety medications (continued)

Drug name	Brand names
Benzodiazepines:	
Alprazolam	Alprax, Kalma
Clobazam	Frisium
Clonazepam	Paxam, Rivotril
Diazepam	Antenex, Ranzepam, Valium, Valpam
Lorazepam	Ativan
Oxazepam	Alepam, Murelax, Serepax
Tricyclic antidepressant (TCA):	
Amitriptyline	Endep, Entrip, Lupin
Clomipramine	Anafranil, Placil
Imipramine	Tofranil
Monoamine oxidase inhibitor (MAOI):	
Phenelzine	Nardil
Antipsychotics:	
Quetiapine	Delucon, Kaptan, Quetia, Seroquel, Syquet, Tevatiapine

Adapted from Lampe [1176], the Australian Government Department of Health [1119], and the Therapeutic Goods Administration [987]. For a full list of generic brands available, see the Therapeutic Goods Administration website (http://www.tga.gov.au).

Generalised anxiety disorder (GAD)

Psychotherapy

There is very little evidence regarding the effectiveness of psychological therapies for co-occurring GAD and AOD use disorders [1086]. Kushner and colleagues [1169] developed an integrated group CBT program for co-occurring anxiety and alcohol use disorders to address symptoms of anxiety, as well as the association between anxiety and the motivation to drink alcohol. The treatment was evaluated in an RCT of individuals in a residential treatment program for alcohol use disorders with co-occurring GAD, panic disorder, or SAD. Those randomised to receive the CBT program treatment experienced considerably better alcohol outcomes relative to the control group who received progressive muscle

relaxation training, and both groups demonstrated a reduction in anxiety symptoms. However, only 38% of the sample had a principal diagnosis of GAD. Buckner and colleagues [1171] similarly developed an individual integrated CBT program for people with co-occurring anxiety and cannabis use disorders. In an RCT evaluating this program, people who received the integrated intervention were more likely to be abstinent from cannabis and reported greater reductions in anxiety severity following treatment compared to a control group receiving motivation enhancement therapy, and both groups used less cannabis, and reported fewer cannabis-related problems. However, only 25% of the sample had a principal diagnosis of GAD. Mindfulness-based interventions, comprising elements addressing relapse prevention, non-reactivity, and non-judgemental awareness have also shown promise among people with stimulant dependence and GAD [1178].

Based on a large body of evidence, the RANZCP guidelines recommend 8-12 sessions of face-to-face or guided digital CBT as the first-line treatment for GAD [1158]. Individual or group therapy have been found to be equally effective, but there is evidence to suggest that individual therapy is associated with greater treatment adherence, and greater and faster gains in worry reduction. Although other psychological therapies have been tested (e.g., applied relaxation, cognitive therapy, mindfulness and acceptance-based interventions, meta cognitive and psychodynamic therapies) there is insufficient evidence to recommend their use in the treatment of GAD at this time. For those experiencing moderate or severe GAD, or those who do not demonstrate sufficient improvement in response to CBT, the use of pharmacotherapies may be considered as an alternative or adjunctive treatment [1158].

Pharmacotherapy

As with CBT for GAD, there is a strong evidence base to support the use of SSRIs (in particular, sertraline, escitalopram, and paroxetine) and SNRIs (venlafaxine and duloxetine) in the treatment of GAD [1158]. The RANZCP guidelines suggest that SSRIs or SNRIs may be considered as an alternative to CBT for cases in which the response to CBT has been inadequate or if the person has a preference for medication. Similarly, the combined use of CBT and an SSRI or SNRI may be considered in cases of severe GAD, or where the response to either CBT or pharmacotherapy alone has been insufficient. SSRIs have been found to be associated with reductions in alcohol use among people with anxiety and depression [1179].

Other pharmacotherapies that have demonstrated some effectiveness in treating GAD as a single disorder include pregabalin, agomelatine, buspirone, and imipramine; however, both buspirone and imipramine are associated with significant side effects and therefore only recommended when alternatives have been ineffective [1158]. Of these medications, only buspirone has been found to be effective in producing improvements in anxiety, drinking outcomes and treatment retention in people with GAD and alcohol use disorders [1172, 1180]. However, it should be noted that at the time of writing, buspirone was not listed by the Australian Register of Therapeutic Goods nor in the MIMS Australia.

The RANZCP guidelines provide guidance on dose titration and switching within- and between- classes of anti-depressants and other medications depending on treatment response. It is important to note however, that treatment response is typically slow (at least four weeks) and it is therefore important to allow time for appreciable effects to be discerned, which may be difficult for clients who are seeking immediate relief from their symptoms.

Panic disorder

Little research has examined the treatment of panic disorder when it co-occurs with AOD use disorders. In the absence of this evidence, the use of similar strategies to those found to be efficacious in the treatment of panic disorder alone is appropriate. The RANZCP guidelines recommend a stepped-care approach that begins with psychoeducation and lifestyle advice (e.g., in relation to healthy eating, sleep, exercise patterns and limiting the use of caffeine, tobacco and alcohol), followed by either CBT, pharmacotherapy (SSRIs or SNRIs) augmented with graded exposure, or a combination of CBT and pharmacotherapy as necessary, depending on the severity of symptoms [1158].

Psychotherapy

Based on a large body of evidence, the RANZCP guidelines recommend 8-12 sessions of face-to-face or guided digital CBT as the first-line treatment for panic disorder [1158]. Outcomes for individual or group therapy appear to be comparable, and the effects have been shown to be long-lasting. Although other psychological therapies have been tested (e.g., mindfulness, ACT, and psychodynamic therapies) there is insufficient evidence to recommend their use in the treatment of panic disorder at this time. For those experiencing moderate or severe panic disorder, or those who do not demonstrate sufficient improvement in response to CBT, the use of pharmacotherapies may be considered as an alternate or adjunctive treatment [1158].

The small amount of literature relating to the treatment of both panic disorder and AOD use has concentrated on CBT and should be regarded as preliminary. In an RCT of people with panic disorder receiving inpatient treatment for alcohol dependence, Bowen and colleagues [1181] examined CBT for panic disorder in addition to a regular alcohol treatment program. They found that, although there were improvements in anxiety symptoms and alcohol use, there was no additional benefit of the CBT treatment component. Kushner and colleagues [1169] similarly evaluated an integrated group CBT program for co-occurring anxiety and alcohol use disorders in a RCT of individuals in a residential treatment program for alcohol use disorders with co-occurring GAD, panic disorder, or SAD. Those randomised to receive the CBT program experienced considerably better alcohol outcomes relative to the control group who received progressive muscle relaxation training, and both groups demonstrated a reduction in anxiety symptoms. However, as only 17% of the sample had a principal diagnosis of panic disorder, the degree to which the findings reflect this client population is uncertain. In a third RCT, Buckner and colleagues [1171] similarly evaluated an individual integrated CBT program for people with co-occurring anxiety and cannabis use disorders which was delivered as an outpatient treatment. People who received the integrated intervention were more likely to be abstinent and report greater reductions in the severity of anxiety symptoms following treatment compared to the control group (who received motivation enhancement therapy), and both groups used less cannabis, and reported fewer cannabis-related problems. However, only 18% of the sample had a principal diagnosis of panic disorder.

Pharmacotherapy

There is a dearth of research exploring the pharmacological treatment of co-occurring panic and AOD use disorders; however, there is a large body of evidence demonstrating the efficacy of SSRIs, SNRIs, TCAs,

and benzodiazepines for the treatment of panic disorder as a single disorder [1158, 1182, 1183]. Although SSRIs, TCAs and benzodiazepines are considered to be equally effective, SSRIs and SNRIs (in particular, venlafaxine) are recommended by the RANZCP as first-line pharmacotherapies due to their superior safety and side-effect profiles relative to TCAs and benzodiazepines. As mentioned previously, TCAs are poorly tolerated, potentially lethal in overdose, and cause significant adverse effects when combined with other central nervous system depressants. Current evidence does not support the use of one SSRI over another [1158].

The RANZCP guidelines suggest that SSRIs or SNRIs may be considered as an alternative to CBT for cases in which the response to CBT has been inadequate or if the person has a preference for medication. Similarly, the combined use of CBT and an SSRI or SNRI may be considered in cases of severe panic disorder, or where the response to either CBT or pharmacotherapy alone has been insufficient. As mentioned previously, it is important that practitioners explain to clients who are prescribed SSRI or SNRI antidepressants, that they may experience an initial exacerbation of anxiety, particularly where there is a history of panic attacks [1158]. To reduce the likelihood of this occurring, it is recommended that clients start with a low dose and titrate slowly to a required therapeutic dose.

The RANZCP guidelines provide guidance on dose titration and switching within- and between- classes of anti-depressants and the other previously mentioned medications depending on treatment response. It is important to note however, that treatment response is typically slow (at least four weeks) and it is therefore important to allow time for appreciable effects to be discerned, which may be difficult for clients who are seeking immediate relief from their symptoms.

Social anxiety disorder (SAD)

There has been more research conducted on the treatment of co-occurring SAD and AOD use disorders than any other anxiety disorder, but it is nonetheless limited to a small number of studies among people with alcohol use disorders and findings have been mixed. For social anxiety as a single disorder, the RANZCP guidelines recommend a stepped-care approach that begins with psychoeducation and lifestyle advice (e.g., in relation to healthy eating, sleep, exercise patterns and limiting use of caffeine, tobacco and alcohol), followed by either CBT, pharmacotherapy (SSRIs or SNRIs) augmented with graded exposure, or a combination of CBT and pharmacotherapy as necessary, depending on the severity of symptoms [1158].

Psychotherapy

Three RCTs have examined the effectiveness of CBT-based therapies for SAD among people with alcohol use disorders with mixed findings. The first, conducted by Randall et al. [1184], compared the efficacy of CBT for alcohol use alone with CBT for both alcohol use and social anxiety. The latter was delivered in the same session but not in an integrated fashion (i.e., the first half of the session was dedicated to alcohol, the second half to social anxiety). Contrary to expectations, this study found that although both groups demonstrated improvements in relation to alcohol use and social anxiety, the combined condition did not demonstrate greater improvements in social anxiety, and in fact demonstrated poorer alcohol-related outcomes.

The second study by Schadé et al. [1185] examined the efficacy of providing CBT for social anxiety as an adjunct to relapse prevention. Alcohol-related outcomes were comparable to those found among people who only received relapse prevention for alcohol use, but those who received the adjunctive CBT for social anxiety were found to have greater improvements in relation to anxiety. More recently, an Australian study examined the efficacy of an integrated program comprised of CBT and motivational enhancement for alcohol and social anxiety relative to CBT for alcohol use alone [669]. This study similarly found that while both groups demonstrated improvements in relation to both drinking and social anxiety, the integrated treatment was found to produce greater improvements in social anxiety and quality of life.

A third study by Kushner and colleagues [1169] examined an integrated group CBT program for co-occurring anxiety (GAD, panic disorder, or SAD) and alcohol use disorders among people in a residential treatment program (45% of whom had a principal diagnosis of SAD). Those randomised to receive the integrated program experienced considerably better alcohol outcomes relative to the control group who received progressive muscle relaxation training, and both groups demonstrated a reduction in anxiety symptoms.

In a further RCT, Buckner and colleagues [1171] examined an outpatient treatment involving an individual integrated CBT program for people with co-occurring anxiety and cannabis use disorders (67% of whom had a principal diagnosis of SAD). People who received the integrated intervention were more likely to be abstinent and experienced greater reductions in the severity of anxiety symptoms following treatment compared to the control group (who received motivation enhancement therapy), and both groups used less cannabis, and reported fewer cannabis-related problems.

Collectively, this research suggests that either integrated or adjunctive treatment of social anxiety and alcohol use disorder may be of greater benefit than treatment for alcohol use alone, but further research is needed. Further research is also needed regarding the efficacy of other types of psychotherapy which to date, has concentrated on CBT. This focus is not surprising however, as there is a strong evidence-base for the use of CBT for social anxiety as a single disorder, but little evidence to support the use of other psychotherapies [1158].

Pharmacotherapy

There is some evidence that SSRIs can be effective at treating co-occurring SAD and AOD use disorders, although their effectiveness at reducing AOD use may be limited [1184, 1186, 1187]. In a double-blind, placebo-controlled trial, paroxetine was found to reduce symptoms of social anxiety and reliance on alcohol for self-medication of anxiety symptoms, but it did not reduce actual quantity and frequency of drinking [1186, 1187].

There is a large body of evidence demonstrating the efficacy of SSRIs, SNRIs, and MAOIs (in particular, phenelzine) for the treatment of SAD as a single disorder [1158]. Although comparative research is lacking, SSRIs and SNRIs are recommended by the RANZCP as first-line pharmacotherapies due to their superior safety and side-effect profiles relative to MAOIs. As mentioned previously, MAOIs may cause significant adverse effects and the person must adhere to strict dietary restrictions [1158]. Other medications that have demonstrated some level of effectiveness include pregabalin and gabapentin. It is recommended that beta blockers, buspirone and antipsychotics should be avoided [1158].

The RANZCP guidelines suggest that SSRIs or SNRIs may be considered as an alternative to CBT for cases in which the response to CBT has been inadequate or if the person has a preference for medication. Similarly, the combined use of CBT and an SSRI or SNRI may be considered in cases of severe SAD, or where the response to either CBT or pharmacotherapy alone has been insufficient. As mentioned previously, it is important that practitioners explain to clients prescribed SSRI or SNRI antidepressants that they may experience an initial exacerbation of anxiety [1158]. To reduce the likelihood of this occurring, it is recommended that clients start with a low dose and titrate slowly to a required therapeutic dose.

The RANZCP guidelines provide guidance on dose titration and switching within- and between- classes of anti-depressants and the other previously mentioned medications depending on treatment response. It is important to note however, that treatment response is typically slow (at least four weeks) and it is therefore important to allow time for appreciable effects to be discerned, which may be difficult for clients who are seeking immediate relief from their symptoms.

E-health and telehealth interventions

As noted in previous sections, there has been an expansion of research into e-health and telehealth interventions, with growing evidence to support their use in managing and treating various disorders. Many smartphone apps exist for the treatment of anxiety as a single disorder and have been shown to be effective at reducing symptoms compared to waitlist or online peer support controls [1188]. A systematic review and a meta-analysis found no differences between videoconferencing or face-to-face therapy in the treatment of anxiety as a single disorder [1189, 1190]. Further, a systematic review and meta-analysis examining e-health interventions for GAD found significant post-treatment improvements for generalised anxiety and pathological worry [1191]. Indeed, the efficacy of e-health interventions was found to be equivalent to that of CBT interventions delivered face-to-face. For these reasons, the RANZCP guidelines recommend either face-to-face or digital CBT as first line treatment options for GAD, panic disorder, and SAD [1158]. The Richards et al. [1191] review further concluded that online CBT-based interventions have a stronger evidence-base and greater efficacy compared to online psychodynamic-based interventions.

Wolitzky-Taylor and colleagues developed a group-based computerised CBT program for people with co-occurring anxiety and AOD use disorders [1192]. Evaluated among a small sample of people with GAD, SAD, panic disorder, agoraphobia or specific phobia attending AOD treatment, those randomised to receive six-sessions demonstrated greater reductions in anxiety symptoms and substance use compared to those attending AOD treatment only, with reductions in anxiety maintained up to six-months [1192].

With the exception of Wolitzky-Taylor and colleagues [1192], only one other e-health intervention has been developed for addressing co-occurring anxiety and AOD use. Stapinski and colleagues [1193] developed *Inroads*, based on an integrated evidence-based CBT program for social anxiety and alcohol use (previously discussed in relation to SAD [1194]). *Inroads* is a five-module web-based integrated intervention for young adults aged 17 to 24 years, with personalised weekly therapist support provided in addition to two optional text/phone sessions following modules one and four [1194]. Evaluated among a small community-based sample of young adults with moderate to severe anxiety symptoms and high

levels of alcohol use, those randomised to receive *Inroads* demonstrated significantly greater reductions in relation to social anxiety symptoms, as well as binge and hazardous drinking, which were sustained to the six-month follow-up compared to those receiving information about alcohol and safe drinking guidelines. The completion of more modules was associated with greater improvements in all outcomes [1194].

An Australian program called *Mental Health Online* (formerly *Anxiety Online*) provides psychoeducation about AOD use [1195]. *Mental Health Online* comprises five e-therapy programs for GAD, SAD, panic disorder, PTSD, and OCD. Definitive evidence regarding the efficacy of this program is lacking; however, preliminary findings from two naturalistic studies show promise, reporting that participation in *Mental Health Online* was associated with reductions in severity of all five disorders, and increased confidence in managing one's own mental health care [1195, 1196]. Significant improvements in quality of life were also consistently observed for GAD, SAD, and PTSD e-therapy programs, but not the OCD or panic disorder program [1195, 1196]. Overall, treatment satisfaction was good across all five e-therapy programs [1195].

Physical activity

The evidence base for the efficacy of physical exercise in reducing anxiety symptoms is smaller than that for depression; but nonetheless indicates that exercise is efficacious in alleviating symptoms of anxiety [1158, 1175, 1197]. In particular, exercise is thought to help manage the physical symptoms of anxiety by reducing overall arousal [1158]. Aerobic and non-aerobic exercise have been found to be as effective as CBT [1198], with reductions in anxiety, tension, and irritability observed among those with GAD who participated in resistance training and aerobics [1199, 1200]. Regular walking has also been found to enhance the efficacy of CBT across different anxiety disorders [1201]. Regular exercise has been found to produce greater reductions in anxiety than relaxation for those with panic disorder [1202], but is less effective than pharmacotherapy [1203] or group delivered CBT [1204]. The RANZCP guidelines recommend that people with anxiety disorders exercise three times a week, for 30 minutes at a time [1158].

Two reviews reporting secondary psychological outcomes of studies examining the effect of physical activity among people with AOD use found improvements in both AOD use and anxiety [272, 307]. Findings indicate that both aerobic and anaerobic training may be effective, over an optimal duration of nine weeks [1205]. An additional meta-analysis concluded that aerobic exercise effectively decreases AOD-related withdrawal symptoms and reduces anxiety among people with AOD use [305]. However, there is mixed evidence regarding the optimal intensity, with some studies finding support for light to moderate exercise, and others finding larger effects with higher intensity training [307].

Yoga

Although the effectiveness of yoga as an intervention for anxiety has been evaluated in a number of studies, the poor quality of the evidence makes it difficult to draw conclusions. Earlier systematic reviews found minimal evidence for the efficacy of meditation therapy [1206] or mindfulness-based meditation [1207], but two systematic reviews concluded that meditative therapies reduced anxiety symptoms [1208, 1209]. No research has evaluated yoga for people with co-occurring anxiety and AOD use.

Complementary and alternative therapies

Acupuncture

Several studies have examined the efficacy of acupuncture for people with co-occurring anxiety and AOD use, with mixed findings. Auricular acupuncture (inserting acupuncture needles into the ears [1210–1212]) and electroacupuncture (inserting acupuncture needles into fatty tissue [1213]), have both involved manual or electrical stimulation of the needles, and have been examined as monotherapies [1210–1212] or combined with pharmacotherapy (escitalopram [1213]). Relative to baseline, one study reported that 20 sessions of auricular acupuncture delivered over 10 weeks reduced symptoms of anxiety and AOD cravings, equally as well as a relaxation control [1210]. Similarly, four weeks of electroacupuncture was found to reduce anxiety symptoms and AOD cravings at post-treatment relative to baseline, with greater reductions observed among those in the treatment group compared to those in control [1213]. However, two further studies examining auricular acupuncture have not found any effect on symptoms of anxiety or AOD cravings relative to baseline [1211, 1212].

Repetitive Transcranial Magnetic Stimulation (rTMS)

Two studies have examined rTMS as a treatment for people with co-occurring anxiety and cocaine use disorder [1214, 1215]. rTMS involves receiving repeated electrical pulses to specific areas of the brain (the dorsolateral prefrontal cortex) for 20 sessions delivered over two to eight weeks, and was combined with exposure to AOD-related cues in one study [1215]. Relative to baseline, rTMS significantly reduced anxiety symptoms and cocaine cravings, and improved abstinence from cocaine use in both studies.

Biofeedback

The results of a single study suggest that receiving heart rate variability feedback training may be an effective treatment for people with co-occurring anxiety and AOD use disorders [1216]. In this study, biofeedback training involved participants being provided with visual feedback (in the form of a balloon) about heart rate variability while receiving breathing instructions, with additional regular signals indicating whether they achieved pre-set breathing targets. Relative to people receiving usual care at an inpatient rehabilitation centre, people who received biofeedback experienced greater reductions in anxiety and AOD cravings, as well as more improved vasomotor function, following the intervention.

Dietary supplements

Some people with anxiety disorders may prefer herbal or nutritional supplements, either in addition to, or instead of, psychological or pharmacological therapies. Systematic reviews have found limited evidence for the efficacy of several ‘phytomedicines’, including *Passiflora* extract, *Kava*, and combinations of l-lysine and l-arginine [1217–1219]. Despite its popularity, there is no convincing evidence supporting the use of homeopathy in the treatment of anxiety disorders [1220]. Further, none of these supplements have been evaluated among people with co-occurring anxiety and AOD use disorders.

Summary

While research concerning both psychological and pharmacological treatments for co-occurring anxiety and AOD use disorders is sparse [1172, 1221], there is increasingly promising evidence for integrated treatments that target both disorders [669, 1169, 1171, 1222]. In the absence of research examining treatments for co-occurring anxiety and AOD use disorders, it may be useful to seek guidance from treatment approaches to single disorders. More rigorous research is required in order to determine whether the same approach for treating single disorders is equally efficacious in the treatment of co-occurring disorders. Box 18 illustrates the continuation of case study E, following Declan's story after his heart attack.

Box 18: Case study E: Treating co-occurring anxiety and AOD use: Declan's story continued

Case study E: Declan's story continued

Declan started seeing a psychologist at his local AOD service, who diagnosed him with social phobia with panic attacks. Declan also started seeing a cardiologist. A treatment plan was developed in consultation with Declan, and his psychologist suggested that they try CBT for the treatment of his anxiety and AOD use. In addition to CBT, Declan started using a mindfulness app, which he found annoying at first, but after a few weeks started to incorporate into his physical fitness routine and started to find more beneficial.

Declan's CBT helped him understand the reasons for his panic and fear. His psychologist also organised for Declan to attend weekly sessions of a local relapse prevention program run by their AOD service. His psychologist helped him address avoidance behaviours with a program of gradual exposure to situations that he had previously found anxiety provoking. While Declan continued to respond well to treatment, he and his psychologist agreed that he should remain in contact with the psychologist over the long-term, but the frequency of sessions gradually reduced over time.

Key points:

- Treatments for anxiety and AOD use may require client contact over a period of months, rather than weeks.
- Without addressing AOD use, psychological treatments for anxiety may be rendered ineffective.
- The use of apps or other e-health interventions can be a useful adjunct to psychotherapy.

OCD

Obsessive compulsive disorder (OCD)

Clinical presentation

As mentioned in **Chapter A4**, previously classified as an anxiety disorder, OCD (and related disorders) is now a separate category of disorder in the DSM-5-TR and ICD-11.

A person with OCD may be significantly distressed by their symptoms, and their ability to function may be impaired. They may be plagued with persistent thoughts or impulses that are intrusive and unwanted (referred to as obsessions or ruminations) and they may feel compelled to perform repetitive, ritualistic actions that are excessive and time consuming (referred to as compulsions or rituals). A person with OCD may present with either obsessions or compulsions alone, or a combination of both. Symptoms of obsessions may include:

- Fear of germs, dirt, or poisons.
- Harm from illness or injury to self or others.
- Intrusive thoughts about sex or sexual acts.
- Excessive concerns with symmetry or orderliness.
- Needing to know or remember things.
- Hoarding or saving and collecting things.

Anxiety about obsessions may lead to vigilance about possible threats, and a compelling need for control. A person may feel annoyed, discomforted, distressed, or panicked about their obsessions, and may feel driven to perform repetitive mental or physical acts in response to alleviate their anxiety. Symptoms of compulsions may include:

- Excessive hand washing, showering, tooth brushing.
- Excessively checking locks, appliances, other safety items.
- Repeating activities or routines (e.g., opening a door, switching a light on and off).
- Repeating mental acts (e.g., counting, and repeating words silently).
- Applying rules to the placement of objects.
- Inability to throw out excessive collections of items (e.g., newspapers, clothes).

OCD may often go under-detected among people with AOD conditions. This is thought to be due to both a lack of training for AOD workers in the recognition of OCD, and a lack of disclosure by clients who may experience shame or embarrassment and be intent on hiding their symptoms [1223–1226].

Managing symptoms of OCD

Many people may have mild symptoms that are associated with stressful life events or situations which often improve without the need for specific treatments. It should also be noted that many people experience some obsessions or compulsions, but these do not interfere with functioning. However, those

who experience the severity, distress and impairment associated with more chronic and enduring OCD may benefit from some form of treatment [1227].

The techniques outlined in Table 50 may help AOD workers to manage clients with obsessive-compulsive symptoms, whether they are transient or more entrenched.

Table 50: Dos and don'ts of managing a client with obsessive compulsive symptoms

Do:	
✓	Ignore strange or embarrassing behaviour if you can, especially if it is not serious.
✓	Approach the client in a calm, confident and receptive way.
✓	Move and speak at an unhurried speed.
✓	Be patient in order to allow the client to feel comfortable to disclose information.
✓	Minimise the number of staff present and attending to the client.
✓	Minimise surrounding noise and distractions to reduce stimulation.
✓	Explain the purpose of interventions.
✓	Remain with the client to calm them down.
Don't:	
✗	Crowd or pressure the client.
✗	Become frustrated or impatient.
✗	Laugh (or let others laugh) at the person.
✗	Act horrified, worried, embarrassed or panic.
✗	Confuse and increase the client's level of stress by having too many workers attempting to communicate with them.
✗	Argue with the client's unusual beliefs or agree with or support unusual beliefs – it is better to simply say 'I can see you are anxious; how can I help you?'
✗	Use 'no' language, as it may provoke hostility and aggression. Statements like 'I'm sorry, we're not allowed to do that, but I ***can*** offer you other help, assessment, referral…' may help to calm the client whilst retaining communication.
✗	Use overly clinical language without clear explanations.

Adapted from NSW Department of Health [431], Clancy and Terry [448], Jenner and Lee [541], Arch and Abramowitz [1228], and Davis et al. [1229].

Treating OCD

Despite evidence from the general population indicating that roughly one in ten people with an AOD use disorder have co-occurring OCD (see **Chapter A2**), the treatment of these co-occurring disorders has not been rigorously investigated. Whether or not a person is in need of treatment will largely depend on the intensity and duration of symptoms, the impact of symptoms on their everyday life, whether or not there are any other co-occurring conditions (e.g., depressive or anxiety disorders), and whether there have been any other treatment attempts in the past. As with all treatment decisions, this decision should be informed by the relevant evidence-base, and decisions made in partnership with the client.

Although there is very little evidence regarding the treatment of co-occurring OCD and AOD use, the evidence which does exist suggests that treating both OCD and AOD use leads to better treatment outcomes than treating AOD use alone [1230]. There are several options available for the treatment of OCD, including psychotherapy, pharmacotherapy, e-health, physical activity, and complementary and alternative therapies. The evidence base surrounding each of these treatments is discussed below. Although the evidence is mixed, there is some evidence to suggest that the combination of psychotherapy and pharmacotherapy may be more effective than either approach in isolation, particularly among those with severe OCD [1227, 1231, 1232].

Psychotherapy

Evidence regarding the treatment of OCD among people with AOD use disorders is lacking, with most studies of OCD treatment excluding people with AOD use disorders [102]. Only one RCT has examined the concurrent treatment of OCD and AOD use. In this study, Fals-Stewart and Schafer [1233] examined the efficacy of CBT with exposure response therapy (ERP), for the treatment of OCD among people attending residential rehabilitation for their AOD use.

CBT incorporating ERP has long been considered an evidence-based treatment for OCD as a single disorder and continues to be recommended as a first-line treatment option [731, 1234, 1235]. Evidence-based psychological treatments should be given an adequate trial before pharmacological treatments are considered. ERP involves repeated, prolonged and systematic exposure with certain objects or situations that trigger obsessional responses (exposure) and resisting the compulsive urges that arise in response to the triggers (response prevention) [728]. The nature of the exposure therapy can be in vivo (e.g., physically touching a light switch) or in the imagination (e.g., confronting images of loved ones dying). In this way, ERP can teach people to tolerate the distress associated with obsessions without engaging in maladaptive behaviours like compulsions, and can provide corrective feedback that challenges the fear response [731, 732]. Fals-Stewart and Schafer [1233] found that clients who received concurrent CBT with ERP for their OCD remained in treatment longer, and had lower OCD symptom severity and higher abstinence rates during treatment and at the 12-month follow-up, compared to those who received AOD treatment alone or AOD use plus progressive muscle relaxation.

Based on the limited evidence regarding the treatment of co-occurring OCD and AOD use [1233], and evidence pertaining to the treatment of OCD and AOD use as single disorders, Klostermann and Fals-Stewart [1230] recommend five steps for treating people with co-occurring OCD and AOD use. The five steps include:

- Assessment of both OCD and AOD use: This can be difficult if clients are attempting to conceal their symptoms for fear of embarrassment, and OCD can often be confused with other psychiatric illnesses (e.g., phobia, depression, and psychosis).
- Assessment of symptom type and quality using validated assessment tools: For example, intrusive thoughts, feelings and behaviours, detailed description of the anxiety-provoking stimuli typically experienced, and the ritualistic behaviours performed in response.
- Psychoeducational therapy.
- Creation of a fear or stimulus hierarchy.
- Treatment: Concurrent delivery of ERP and AOD use treatment.

Although these findings and recommendations are promising, more evidence is clearly needed. In particular, the cyclical nature between OCD and AOD use suggests there is a need for the development of integrated treatments that simultaneously address both disorders [1236, 1237]. Stewart and O'Connor [1237] suggest that such an integrated approach may consist of psychoeducation to explore the cyclical relationship between OCD symptoms and AOD use; targeting AOD use during ERP treatment if it is identified as a safety behaviour (a behaviour that temporarily relieves the distress associated with obsessions); and therapeutic work focused on increasing self-efficacy, in order to help the client believe they can cope without AOD use [1237].

There is also a need to investigate alternative approaches to ERP. While ERP continues to be recommended as the first line psychotherapy for OCD as a single disorder, recent reviews have demonstrated that other approaches including behavioural and cognitive therapies may be equally effective [1231, 1232, 1238]. Other approaches that show promise for single disorder OCD include ACT and EMDR [1236].

Psychotherapy has consistently been found to be more effective than pharmacotherapies for treating single disorder OCD; however, it should be noted that most psychotherapy trials have included patients who were taking stable doses of antidepressants [1232]. Furthermore, the superiority of psychological therapies is marginal when compared to adequate doses of pharmacotherapy for OCD [1238].

Pharmacotherapy

There has been little research examining the efficacy of pharmacotherapy interventions among people with co-occurring OCD and AOD use. A Cochrane review of pharmacotherapy for anxiety and co-occurring alcohol use disorders found no rigorously conducted trials of medication treatment for co-occurring OCD and alcohol use [1172]. In view of the lack of evidence for pharmacological interventions for co-occurring OCD and AOD use, clinicians may be guided by the body of research that has been conducted for single disorder OCD.

Evidence from systematic reviews and meta-analyses examining RCTs of pharmacotherapies for single disorder OCD have found that the SSRIs citalopram, escitalopram, fluoxetine, fluvoxamine, paroxetine, and sertraline; the SNRI venlafaxine; and the TCA clomipramine, to be associated with reductions in symptom severity and improvements in health-related quality of life [1227, 1232, 1239–1247]. There is some evidence that the use of the second-generation antipsychotics are associated with reductions in OCD

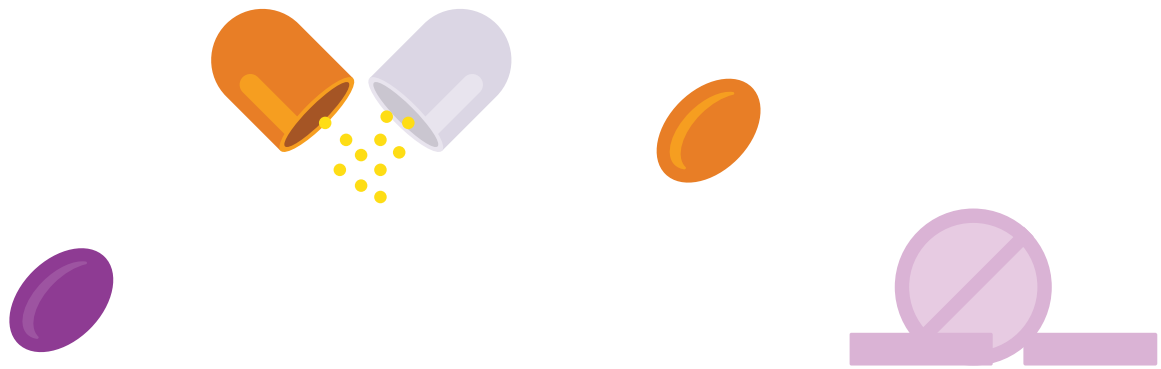
symptoms [1248]; however, adverse side effects may limit their utility.

Evidence-based guidelines for the treatment of single disorder OCD recommend that SSRIs be used as the first line of pharmacotherapy, and further suggest that the combination of psychological and pharmacological treatments is likely to be superior to either approach in isolation, particularly among those with severe OCD [1227, 1232]. Research has found a positive dose-response relationship for SSRIs, with greater symptom improvements found among those who are taking higher doses of SSRIs [1238]. Table 51 provides a list of SSRIs for the pharmacological treatment of single disorder OCD. It should be noted that there is commonly a delay in the onset of effect of up to 12 weeks, although depressive symptoms improve more quickly [1235].

Table 51: Selective serotonin reuptake inhibitor (SSRI) medications

Drug name	Brand names
Citalopram	Celapram, Cipramil, Talam
Escitalopram	Escicor, Esipram, Lexam, Lexapro, Loxalate
Fluoxetine	Fluotex, Lovan, Prozac, Zactin
Fluvoxamine	Faverin, Luvox, Movox
Paroxetine	Aropax, Extine, Paxtine, Roxtine
Sertraline	Eleva, Sertra, Setrona, Zoloft

Adapted from Australian Government Department of Health [1119] and the Therapeutic Goods Administration [987]. For a full list of generic brands available, see the Therapeutic Goods Administration website (http://www.tga.gov.au).



E-health and telehealth interventions

Although there have yet to be any e-health interventions developed specifically for co-occurring OCD and AOD use, there have been several e-health interventions developed for OCD as a single disorder, some of which include CBT and ERP-based videoconferencing and telehealth programs, smartphone, internet, computer, and virtual reality-based interventions [1249]. A meta-analysis examining remote CBT programs for OCD symptoms delivered via telephone, videoconference, computer and the internet found evidence of effectiveness [1250], with effects similar to those found in clinician-delivered CBT sustained up to four months [1250–1254].

There is evidence to suggest a dose-response relationship with regards to computerised CBT programs, with greater symptom improvements found among those who have completed more homework [1255]. However, studies have found that clinician-assisted programs are associated with greater adherence, lower dropout rates, and better outcomes than computerised programs with no human contact [1256]. There are also a number of self-guided CBT-based programs which have been developed for single disorder OCD, including smartphone applications and internet-based programs [1257]. Although there is limited evidence suggesting that some self-guided programs may reduce OCD symptoms from baseline to post-completion [1258–1261], the evidence-base underpinning many of these programs remains unclear.

Several self-help and therapist-delivered e-health programs based on ERP have also been developed; however, the findings from studies examining the efficacy of computerised ERP interventions are mixed. A computerised ERP intervention called *BT Steps/OC Fighter* was found to be less efficacious in reducing OCD symptoms than a more expensive clinician-delivered ERP, but more efficacious than relaxation training [1255]. The findings from this study suggest that the primary benefit of having a clinician was to ensure people maintain their engagement in the exposure process [1236]. Given these findings, the UK NICE Guidelines recommend that *BT Steps/OC Fighter* should not be used in the treatment of OCD [1262].

Another ERP program, *iCBT*, has been found to be more efficacious in reducing OCD and depressive symptoms, and improving general functioning compared to both an active control (online, non-directive supportive therapy) [1252], and baseline symptoms and functioning [1263]. Data from a further two trials assessing *LiveOCDFree* and *nOCD* also found that ERP-based smartphone applications significantly decreased symptoms of OCD compared to baseline, among those with single disorder OCD [1264, 1265]. Evidence from a randomised trial similarly suggests that using either of two smartphone applications targeting cognitive flexibility for a week reduced OCD symptoms relative to a control, among people with single disorder OCD [1266]. Additional research suggests that virtual reality may be a promising avenue for treatment, with significant reductions in OCD symptoms evident after engaging in 12 virtual ERP sessions relative to pre-treatment, and effects sustained up to four months post-treatment [1267]. Although encouraging, further research is needed.

Physical activity

There is preliminary evidence to suggest that physical exercise may be beneficial for people with single disorder OCD. Several pilot studies have demonstrated that the combination of a six to 12-week moderate aerobic exercise program with psychotherapy or pharmacotherapy reduced OCD symptom severity,

which was maintained up to six months follow-up [1268–1270]. One study found that significantly lower OCD symptoms, anxiety and negative mood levels were reported immediately following each 20-40 minute exercise session [1271]. Similarly, another RCT found that a 12-week aerobic exercise program was effective at reducing compulsions, mood and anxiety, to a greater extent than psychoeducation, though obsessions did not change, among adults with single disorder OCD [1272]. Further, the severity of OCD symptoms did not significantly differ between groups directly following the intervention [1273]. While promising, more rigorous research is necessary to evaluate the benefits of physical exercise, and there is no evidence to date on the efficacy of physical exercise for the treatment of co-occurring OCD and AOD use disorder specifically.

Complementary and alternative therapies

As mentioned previously, SSRIs are associated with various dose-dependent side effects, including nausea, diarrhoea, dizziness, headaches, insomnia, sedation, anxiety, sexual dysfunction, and decreased libido [1274, 1275]. As the dose required for a clinically significant improvement in OCD symptoms is typically higher than is required in the treatment of depressive disorders, the potential for unwanted side effects is substantially increased [1276, 1277]. As such, several studies have examined alternative therapies in the treatment of single disorder OCD.

In systematic reviews of complementary and alternative approaches, there is some evidence that health-based games [1278], art therapy, sports therapy, recreational therapy [1279], mindfulness meditation, electro-acupuncture, yoga, nutrient glycine, borage, and milk thistle may have a positive impact on OCD symptoms [1280]. However, it is important to note that a number of these studies used methodologically weak designs, and none examined use of these therapies among people with co-occurring OCD and AOD use.

Neurofeedback

Neurofeedback involves providing auditory or visual feedback for suppressing or producing certain brain waves, enabling people to self-regulate their brain activity. One systematic review and meta-analysis suggests that neurofeedback effectively reduces OCD symptoms among those with single disorder OCD compared to control conditions [1281]. While promising, it should be noted that included studies varied in terms of their design and validity, and drawing conclusions is therefore difficult. Further, the effects of neurofeedback are yet to be evaluated among people with co-occurring OCD and AOD use.

Deep brain stimulation

Deep brain stimulation is a neurosurgical procedure which involves embedding microelectrodes in brain areas involved in single disorder OCD treatment, and using an electric current to directly stimulate the embedded microelectrodes and associated brain regions [1282]. Several reviews provide evidence that deep brain stimulation effectively reduces OCD symptoms by 20-46% [1282–1284] compared to control conditions. Deep brain stimulation may be particularly useful for people with treatment resistant OCD [1282]. However, one-third of people who receive deep brain stimulation experience serious adverse side effects such as brain haemorrhage and infection [1283], and to date there is no evidence on the efficacy of deep brain stimulation among people with co-occurring OCD and AOD use.

Summary

There are currently no evidence-based integrated treatments for co-occurring OCD and AOD use disorders, and evidence from only one RCT among people with co-occurring OCD and AOD use favouring the concurrent treatment of these disorders [1233]. Although there is limited evidence for the treatment of co-occurring OCD and AOD use, results from single disorder OCD studies suggest there is strong and consistent evidence to recommend the use of ERP, behavioural and cognitive therapies as the first line of treatment in single disorder OCD. Box 19 illustrates the continuation of case study F, following Ayla's story.

Box 19: Case study F: Treating co-occurring OCD and AOD use: Ayla's story continued

Case study F: Ayla's story continued

The AOD worker conducted a suicide risk assessment and although Ayla spoke of ending her life, she was not at immediate risk for suicide. The AOD worker organised for Ayla to see a clinical psychologist who specialised in ERP, along with a psychiatrist who specialised in OCD. Ayla's AOD worker coordinated the treatment approach, and together with Ayla's GP, the clinical psychologist, psychiatrist, Ayla and her parents devised a treatment plan. Ayla's treatment consisted of concurrent pharmacotherapy and CBT with ERP, which addressed her OCD and cannabis use. Ayla's treatment took place over several months, with long-term plans for ongoing monitoring and support put in place to ensure Ayla was able to maintain her treatment gains.

Key points:

- Symptoms of OCD can be mistaken for anxiety.
- People with OCD commonly use substances that reduce their levels of anxiety, but may not necessarily reveal their use of AOD to health professionals.
- There is a need to monitor ongoing physical health complications of co-occurring OCD.

Trauma, PTSD and complex PTSD

Trauma, post traumatic stress disorder (PTSD), and complex PTSD

Clinical presentation

As described in Chapter A4, trauma is a term that is widely used and may mean different things to different people. It can include a myriad of extremely threatening or horrific events, or a series of events, in which a person is exposed to, witnesses, or is confronted with a situation in which they perceive that their own, or someone else's, life or safety is at risk [10, 11].

Most people will experience some emotional or behavioural reactions following exposure to a traumatic event such as anxiety or fear, aggression or anger, depressive or dissociative symptoms. These emotional and behavioural responses are to be expected and are a completely normal response to an adverse event. For the majority of people, these emotional and behavioural reactions will subside and/or reduce in intensity over time without the need for any intervention; for some people however, these reactions may be prolonged, leading to significant distress, as well as impairment in social, occupational and other areas of functioning [102, 156, 157]. Symptoms may be especially long-lasting or complex when the trauma is interpersonal and intentional (e.g., torture, sexual violence), and if the trauma occurred in childhood [157, 1285].

Approximately one in ten Australians who experience a traumatic event develop PTSD [157] (described in Chapter A4). Symptoms of PTSD include:

- Recurrent 're-experiencing' of the traumatic event, through unwanted and intrusive memories, recurrent dreams or nightmares, or 'flashbacks'.
- Persistent avoidance of memories, thoughts, feelings or external reminders of the event (such as people, places or activities).
- Persistent negative alterations in cognitions and mood, including guilt and hopelessness; feeling a distorted sense of blame of self or others; feeling detached from others; a persistent inability to experience positive emotions; and reduced interest in activities.
- Persistent symptoms of increased physiological arousal and reactivity, including hypervigilance towards distressing cues, sleep difficulties, exaggerated startle response, irritability, increased anger, and concentration difficulties.

Some people develop a more complicated form of PTSD referred to as complex PTSD, in which they also experience pervasive difficulties with emotional regulation, self-concept, and relationship difficulties across a variety of contexts (described in Chapter A4). Research among people with AOD use disorders indicates that 85% of those who meet criteria for PTSD experience it in this more complex form [1286]. Although complex PTSD may arise in relation to any trauma, it is typically associated with prolonged or repeated interpersonal traumas that occur during childhood [158].

Managing trauma-related symptoms

The provision of trauma-informed care in AOD treatment settings is essential and described in more detail in Chapter B2. Given that substances are often used to self-medicate trauma-related symptoms [30], it is not surprising that many people report experiencing an increase in trauma-related symptoms when they reduce or stop using substances [380]. Evidence to date however, indicates that, as with symptoms of depression and anxiety, on average, PTSD symptoms also decline in the context of well managed withdrawal [381–383].

As described in Chapter B2, it is important to note that avoidance symptoms, rather than re-experiencing symptoms, have been associated with the perpetuation of trauma-related symptoms [398, 1287–1291]. It is therefore crucial that if a person does experience an exacerbation of trauma-related symptoms, that they are not encouraged to avoid or suppress these thoughts or feelings. Telling a person not to think or talk about what happened may also intensify feelings of guilt and shame. For those who have experienced abuse, it may closely re-enact their experience of being told to keep quiet about it [136]. This does not mean that clients should be pushed to revisit events or disclose information if they are not ready to do so. Rather, it means that it is understandable that the person may be upset by these thoughts and feelings that may arise, and they should be allowed to engage with these feelings in order to help process the trauma emotionally.

Chapter B3 provides guidance on how to discuss trauma with clients. As mentioned previously, it is crucial that clients are not forced to discuss any details about past events if they do not wish to. It is preferable that clients develop good self-care and have skills to regulate their emotions before they delve deeply into their traumatic experiences or are exposed to the stories of others; however, choice and control should be left to the client [136]. In-depth discussion of a person's trauma experiences should only be conducted by someone who is trained in dealing with trauma responses [135].

Even without knowing the details of a client's trauma, AOD workers can use the techniques outlined in Table 52 to help clients manage their symptoms. Encouraging clients for their resilience in the face of adversity is important even if past adaptations and ways of coping are now causing problems (e.g., AOD use). Understanding AOD use as an adaptive response reduces the client's guilt and shame and provides a framework for developing new skills to better cope with symptoms [384].

Table 52: Dos and don'ts of managing a client with trauma-related symptoms

Do:	
✓	Give the client your undivided attention, empathy and unconditional positive regard.
✓	Use relaxation and grounding techniques where necessary.
✓	Display a comfortable attitude if the client chooses to describe their trauma experience.
✓	Normalise the client's response to the trauma and validate their feelings.

Table 52: Dos and don'ts of managing a client with trauma-related symptoms (continued)

✓	Recognise the client's resilience in the face of adversity.
✓	Recognise the client's courage in talking about what happened.
✓	Let the client know what to expect if they undergo detoxification (e.g., possible changes in trauma-related symptoms).
✓	Maximise opportunities for client choice and control over treatment processes.
✓	Monitor depressive and suicidal symptoms.
Don't:	
✗	Rush or force the client to reveal information about the trauma.
✗	Engage in an in-depth discussion of the client's trauma unless you are trained in trauma responses.
✗	Judge the client in relation to the trauma or how they reacted to the trauma.
✗	Abruptly end the session.
✗	Encourage the client to suppress their thoughts or feelings.
✗	Engage in aggressive or confrontational therapeutic techniques.
✗	Be afraid to seek assistance.
✗	Use overly clinical language without clear explanations.

Adapted from Ouimette and Brown [1292], Elliot et al. [384], SAMHSA [102], Marsh et al. [135], and Mills and Teesson [136].

Brief psychoeducation about common reactions to trauma and symptom management has also been found to be of benefit to AOD clients who have experienced trauma [1293]. It is important to normalise clients' feelings and convey that such symptoms are a typical and natural reaction to an adverse traumatic event; they are not 'going crazy'. Letting them know that their reactions are quite normal may also help to alleviate some of the shame and guilt they have been feeling about not recovering from the trauma sooner. It is also important that people who have experienced trauma hear that what happened was not their fault, especially for those who have experienced sexual assault. An information sheet for clients on common reactions to trauma is provided in the **Worksheets** section of these Guidelines. Clients may also find the relaxation techniques described in **Appendix CC** useful for managing trauma-related symptoms. Many common procedures and practices may re-trigger trauma reactions. For example, aggressive or confrontational group techniques can trigger memories of past abuse. Such

techniques are counterproductive; those who have been exposed to abuse in particular may revert to techniques used to cope during the trauma such as dissociating or shutting down emotionally. Engaging in these strategies may then lead to the client being labelled as 'treatment resistant' and, consequently, feelings of self-blame. **Chapter B2** also provides guidance on other aspects of service provision to consider in providing a trauma-informed approach to care.

As discussed in **Chapter B8**, it is also essential that workers attend to their own responses to working with traumatised clients through self-care. Hearing the details of others' trauma can be distressing, and in some cases may lead to vicarious traumatisation or secondary traumatic stress [404, 1294]. By attending to one's own self-care and engaging in clinical supervision, the likelihood of developing secondary traumatic stress may be reduced. **Chapter B8** provides more detail on strategies for promoting and enhancing AOD worker self-care and reducing burnout.

Treating PTSD

People with co-occurring PTSD and AOD use can benefit from a variety of treatments. It is important to emphasise that while there is a strong evidence base for certain treatments, the need for individualising a treatment plan to suit the particular client is of paramount importance.

Due to the inter-relatedness of PTSD and AOD use, experts recommend that these conditions be treated in an integrated fashion [102, 141, 739, 1295, 1296]. Some clinicians maintain the view that the AOD use must be treated first, or that abstinence is necessary before PTSD diagnosis and management can be attempted. In practice, however, this approach can lead to clients being passed between services with little coordination of care [1297]. Moreover, clients express a preference for integrated interventions that treat both disorders concurrently [141, 1298]. Ongoing AOD use may impede therapy, but it is not necessary to achieve abstinence before the commencement of PTSD treatment [1299]. Improvements can be obtained even in the presence of continued substance use [1300, 1301].

There are several options available for the treatment of PTSD, including psychotherapy (e.g., past- and present-focused therapies), pharmacotherapy, e-health interventions, physical activity, and complementary and alternative therapies (e.g., yoga). The evidence base surrounding each of these treatments is discussed below.

As complex PTSD is a new diagnosis there is no direct evidence about how to treat it; however, given the high prevalence of complex PTSD [1286], it is likely that a high proportion of participants in the PTSD treatment trials described in this section were experiencing PTSD in its complex form. A meta-analysis that retrospectively assessed PTSD psychotherapy trials to determine if they included patients with complex PTSD has also found beneficial effects of standard trauma-focused treatments in reducing PTSD symptoms as well as some symptoms specific to complex PTSD (i.e., negative self-concept, disturbances in relationships) [1302]. Given that complex PTSD is comprised of a greater number and diversity of symptoms, its treatment may nonetheless require additional treatments and/or treatment of a longer duration compared to those with PTSD [1303].

Psychotherapy

A number of psychotherapeutic interventions have been developed for the treatment of co-occurring PTSD and AOD use, and an increasing number are undergoing evaluation. Although there is some contention regarding the naming conventions, existing approaches may be divided into two types: i) past-/trauma-focused therapies; and ii) present-/non-trauma-focused therapies [1304–1306]. The main distinction is that the former involves the revisiting of trauma memories and their meaning, while the latter focus on the development of coping skills in the present.

Several reviews have concluded that there is support for individual past-/trauma-focused psychological interventions that utilise exposure-based approaches, particularly in relation to PTSD outcomes, but that there is very little evidence to support the use of non-trauma-focused individual or group-based interventions over treatment as usual for AOD use [739, 1296, 1307, 1308].

It should be noted that there are diverging views as to whether or not psychotherapy for PTSD, and complex PTSD in particular, should be undertaken using a phase-based approach [1309]. A phase-based approach proposes that it is necessary for a person to undertake interventions that focus on stabilisation in the first phase of treatment (i.e., establishing safety, symptom management, improving emotion regulation and addressing current stressors) prior to moving on to processing the trauma memory, followed by reintegration (i.e., re-establishing social and cultural connection and addressing personal quality of life) [1310]. However, the evidence to date suggests that this approach is neither necessary nor recommended, as it may lead to unnecessary delays or restrictions in access to effective past-/trauma-focused therapy [1309, 1311, 1312]. Indeed, studies comparing the efficacy of a phased-based approach relative to past-/trauma-focused treatment have found that recovery may be faster for those who receive past-/trauma-focused treatment [1311, 1312]. That is not to say that the components incorporated in phase one are not important, but rather, that they can be integrated throughout the treatment process alongside the past-/trauma-focused work [1313]. The vast majority of past-/trauma-focused therapies described in this chapter incorporate phase one components in their programs.

Past-/trauma-focused therapies

Past-/trauma-focused therapies are typically delivered individually and involve various exposure-based techniques in which the client revisits, and seeks to make meaning of, the traumatic events they have experienced and their consequences. Of these, prolonged exposure (PE) has received the most empirical attention. Alongside other past-/trauma-focused therapies, including cognitive processing therapy (CPT), and EMDR, PE is considered a first-line treatment for PTSD in the absence of AOD use [1303, 1308].

Prolonged exposure (PE)

Similar to exposure for phobias, PE for PTSD involves exposure to the feared object or situation; in this case, traumatic memories (imaginal exposure) and physical reminders of the trauma (*in vivo* exposure). Traditionally, PE for PTSD was considered inappropriate for use with people experiencing AOD use disorders based on concerns that the emotions experienced may be overwhelming and could lead to relapse or further deterioration [1314]. However, the evidence suggests that this is not the case; PE does not lead to an exacerbation of AOD use, cravings, or increase the severity of the AOD use disorder [741,

1314]; in fact, it may be protective against relapse [1315]. Trials examining the efficacy of PE (in its original form, as well as modified or enhanced versions) delivered alongside treatment-as-usual for AOD use report positive outcomes including significant reductions in PTSD symptoms [741, 1316, 1317]. Contingency management has also been shown to be an effective adjunct to PE among people with opioid use disorders, leading to greater treatment retention and greater reductions in PTSD symptoms [1318]. One RCT has also examined the efficacy of PE and concurrent naltrexone in treating PTSD and alcohol use disorders. Exposure therapy was not found to be superior to supportive counselling in reducing PTSD symptoms; however, it was associated with reduced risk of relapse to alcohol use at 6-month follow-up [1315].

A number of clinical researchers have investigated the efficacy of integrated exposure-based programs that address PTSD and AOD use simultaneously. Typically these programs involve psychoeducation regarding each disorder and their interrelatedness, coping skills training, relapse prevention, and exposure to traumatic memories and/or reminders; and they are sometimes delivered in combination with other therapeutic techniques [739]. Support for these programs is growing, with an increasing number of studies providing evidence for their safety and efficacy, including two Australian trials [1300, 1301]. Participants in these studies did not demonstrate a worsening of symptoms or high rates of relapse; on the contrary, they demonstrated improvements in relation to both AOD use and PTSD outcomes [739, 1296, 1307].

The majority of research in this area has focused on the efficacy of an integrated treatment called *Concurrent Treatment of PTSD and Substance Use Disorders Using Prolonged Exposure (COPE)* [442]. Since the first RCT of this intervention was completed in Australia [1300], a further three have been undertaken in the United States [772, 1319, 1320]. Collectively, these studies have found that, while decreases in substance use are comparable to control conditions, with respect to PTSD symptom reduction, *COPE* outperforms treatment-as-usual for AOD use, relapse prevention, and a present-/non-trauma focused therapy (*Seeking Safety*). A modified version of the *COPE* program is currently being examined among Australian adolescents [1321, 1322]. Another integrated exposure-based program for adolescents that has shown promise in reducing PTSD symptoms, AOD use and risk behaviours is *Risk Reduction Through Family Therapy (RRFT)*, which combines trauma-focused CBT and multisystemic therapy [1323, 1324].

Cognitive processing therapy (CPT)

CPT focuses on challenging and modifying unhelpful trauma-related beliefs (e.g., beliefs surrounding safety, trust, power, control, esteem, and intimacy) that are having a negative impact on a person's life via written exposure and cognitive restructuring. Despite CPT being a first line treatment for PTSD, few studies have examined its effectiveness for people with co-occurring AOD use disorders. CPT, and CPT integrated with CBT for substance use, have shown promise among people with AOD use disorders; however, the predominance of this research has been conducted on veteran samples. Studies comparing outcomes of CPT for veterans with and without co-occurring AOD use disorders have found no significant differences between groups [1325, 1326]. Subsequent open label trials of CPT combined with CBT for substance use have also reported reduced PTSD symptoms, depressive symptoms, and AOD-related outcomes [1327–1329].

Eye movement desensitisation and reprocessing (EMDR)

In EMDR, a person focuses on the imagery of a trauma, negative thoughts, emotions and body sensations whilst following guided eye movements led by a therapist. Although EMDR is a first line treatment for PTSD only a small number of studies have examined its effectiveness for people with co-occurring AOD use disorders. Two small pilot trials have found that EMDR, alongside treatment-as-usual for AOD use, produces significantly greater reductions in PTSD symptoms compared to treatment-as-usual for AOD use alone [1330, 1331]. Although case series have described benefits in relation to AOD use as well [1332], these trials did not find any between-group differences [1330, 1331]. There is some very preliminary evidence to suggest that EMDR combined with schema therapy for PTSD and AOD use disorders may be effective in reducing both PTSD and AOD use [1333]. Two additional studies of EMDR for people with either PTSD or a history of trauma and co-occurring AOD use are currently underway [1334, 1335].

Present-/non-trauma-focused therapies

Present-/non-trauma-focused therapies are typically integrated CBT-based treatments which focus on providing clients with coping skills to live in the present without revisiting the traumatic event [1336]. These interventions are typically delivered in individual or group formats. As mentioned previously, three reviews have concluded that there is little evidence to support the use of present-/non-trauma-focused individual or group-based interventions relative to providing treatment-as-usual for AOD use [739, 1296, 1307]. They are, nonetheless, an important treatment option for clients who are not wishing to undergo past-/trauma-focused therapies. Several present-focused treatments have, and continue to be, developed [1336–1339], but the program which has undergone the most extensive evaluation is *Seeking Safety* [702, 1340].

Seeking Safety focuses on examining the impact of trauma without delving into the trauma narrative [1341]. The treatment has been conducted in group and individual formats in a variety of settings (e.g., outpatient, inpatient, residential, prisons) and populations (e.g., women, veterans, adolescents). RCTs and meta-analyses have found that, while PTSD and AOD use treatment outcomes for people who receive *Seeking Safety* are better than those who receive no treatment, they are comparable to those who receive alternate treatments such as relapse prevention, treatment-as-usual for AOD use, or health education [773, 1342–1344].

An emerging alternative present-centred therapy is integrated CBT (*ICBT*). *ICBT* addresses PTSD, substance use, and their interaction through three core components: cognitive restructuring, centring and breathing retraining, and psychoeducation [1345]. Two RCTs have examined the efficacy of *ICBT* relative to usual care and individual addiction counselling. Neither reported significant differences for PTSD outcomes [667, 1346], but one reported better AOD-related outcomes [667].

Mindfulness-based programs have also shown promise in early pilot studies [1347–1349] and one RCT which found greater improvements in PTSD symptoms, AOD cravings, and negative affect among those randomised to receive *Mindfulness Oriented Recovery Enhancement* relative to *Seeking Safety* [1177]. Research examining the efficacy of ACT for PTSD and AOD use is in its early stages, but has been associated with improvements in PTSD symptoms and alcohol-related outcomes among veterans [687].

Pharmacotherapy

Pharmacotherapies are not a recommended first line treatment for PTSD due to their limited efficacy. There is also little evidence to suggest that combining psychological and pharmacological interventions leads to improved outcomes. Nonetheless, Australian and international guidelines for the treatment of PTSD [1308, 1350] recommend that pharmacotherapies be used as an adjunct to trauma-focused psychotherapy if the person has not gained benefit from psychological treatment, or if they express a preference for pharmacotherapy [1308, 1350–1352]. When pharmacotherapies are considered, SSRIs are the recommended first line option, particularly fluoxetine, paroxetine, and sertraline [1303, 1308], followed by the SNRI venlafaxine (see Table 47).

Trials of pharmacotherapy for PTSD co-occurring with AOD use disorders have examined the use of sertraline and paroxetine (SSRI antidepressants), desipramine (TCA), prazosin (alpha^{1}-adrenergic receptor agonist), aprepitant (neurokinin-1 receptor antagonist), topiramate and zonisamide (anticonvulsants), N-acetylcysteine (mucolytic agent), naltrexone (opioid antagonist), and disulfiram (alcohol antagonist).

Early work by Brady and colleagues examining the use of sertraline provided initial evidence of safety and evidence of efficacy among people with less severe alcohol dependence and earlier onset PTSD [1353, 1354]. More recently, Hien and colleagues [780] investigated the use of sertraline in combination with the psychotherapy *Seeking Safety*. In this study, *Seeking Safety* plus sertraline was found to be superior to *Seeking Safety* with placebo in reducing PTSD symptoms, though improvements in alcohol use and dependence were equivalent between groups.

Petrakis and colleagues [1355] conducted an RCT comparing the efficacy of desipramine and paroxetine with and without adjunctive naltrexone among veterans with PTSD and alcohol dependence. Both groups of antidepressants produced a significant decrease in PTSD symptoms, with greater reductions in alcohol use seen among those who received desipramine. Adjunctive use of naltrexone was associated with greater reductions in cravings but did not provide any advantage over placebo in terms of alcohol use.

The limited research that has been conducted among people with co-occurring PTSD and AOD use disorders in relation to prazosin and aprepitant suggests that these agents are no more effective than placebo in relation to either PTSD or alcohol-related outcomes [1356], whereas topiramate [1357], zonisamide (as an adjunct to CPT) [1358], and N-acetylcysteine (as an adjunct to CBT for substance use) [1359] have been associated with greater reductions in PTSD symptom severity and alcohol-related outcomes relative to placebo [1357]. Naltrexone, disulfiram, and the combination of these two medications have been associated with greater reductions in alcohol-related outcomes but not PTSD symptoms, relative to placebo; however, unwanted side effects were more common among people who received the combination of naltrexone and disulfiram [1315, 1360].

In recent years there has been growing interest in the use of psychedelic substances such as MDMA, psilocybin, and ketamine to enhance psychotherapy for the treatment of PTSD and AOD use disorders (alcohol in particular) as single disorders. Despite there being considerable enthusiasm about the potential of these substances bringing a long-awaited breakthrough in psychiatry, to date the predominance of research is limited to small, uncontrolled trials [1361–1364]. Further research is needed to determine clinical efficacy and safety for single, as well as co-occurring conditions.

E-health and telehealth interventions

Currently, there are two e-health programs which have been developed to target co-occurring AOD use and PTSD among veterans. *Thinking Forward* is a self-directed online CBT program, comprising 12 interactive modules, developed for people with PTSD engaging in hazardous alcohol use. Findings to date have been mixed with one RCT reporting an association between *Thinking Forward* and reductions in heavy drinking but not PTSD symptoms, and another finding reductions in PTSD symptoms but not alcohol use [1365, 1366]. Similarly, *VetChange*, a CBT and MI-based online program for veterans with clinical levels of PTSD and at-risk alcohol use, has demonstrated significant post-treatment reductions in alcohol use and PTSD symptoms relative to baseline [1367–1369]. These reductions were more pronounced for *VetChange* participants compared to those randomised to a waitlist control [1367]. *VetChange* has also been adapted into a mobile app (**https://mobile.va.gov/app/vetchange**), which is yet to be evaluated.

Although there are few internet programs targeting co-occurring PTSD and AOD use, many evidence-based interventions exist for PTSD as a single disorder. Two meta-analyses support the benefit of e-health interventions, finding that they lead to greater improvements in PTSD symptoms compared to usual care, waitlist, and active controls [1370, 1371]. Improvements were observed regardless of whether individualised feedback was provided alongside the e-health intervention [1370]. Programs shown to have moderate treatment effects often incorporated CBT techniques, in the form of psychoeducation, exposure (e.g., writing about one's trauma experience), anxiety management, and cognitive restructuring [1350].

Two promising internet programs – *PTSD Online* and *The PTSD Course* – have been developed in Australia and provide psychoeducational resources about AOD use [1195, 1372]. *PTSD Online* is a 10-week therapist-assisted program incorporating psychoeducation and CBT-based components. Several uncontrolled studies have found promising results, including high levels of treatment satisfaction and significant post-treatment improvements in PTSD symptoms, psychological distress, and quality of life relative to baseline [1195, 1196, 1373, 1374]. Similarly, *The PTSD Course* (formerly *PTSD Program*) is an online intervention including seven lessons based on elements of psychoeducation, CBT, and exposure therapy. People accessing the program are able to discuss relevant issues in forums moderated by therapists and message clinicians. One small RCT found significantly greater reductions in PTSD symptom severity among people randomised to receive *PTSD Course* compared to a waitlist control [1372]. People who accessed *PTSD Course* also reported high levels of satisfaction with the treatment.

There are several smartphone apps designed to treat PTSD as a single disorder. *PTSD Coach*, developed by the US Department of Veterans Affairs, is based on CBT and incorporates psychoeducation, self-assessment, treatment and referral resources, and social support tools, which can together be used as a stand-alone or supportive app during therapy [1375]. An online version of the app is also available (**http://www.ptsd.va.gov/apps/PTSDCoachOnline**). When compared to a waitlist control, Kuhn and colleagues [1376] found people accessing *PTSD Coach* reported greater reductions in PTSD symptoms [1376]. Miner and colleagues [1377], on the other hand, found no difference in post-treatment PTSD symptom scores [1377]. *PTSD Coach* has also been adapted into *PTSD Coach Australia* for Australian veterans [1378]. Qualitative feedback from participants provided promising support for this adaptation [1379].

Physical activity

A number of uncontrolled pilot studies have found aerobic exercise to be associated with improvements in PTSD symptoms [1380–1384]. Promising findings were also provided by a small controlled trial which found greater reductions in PTSD symptoms among people randomised to receive exposure therapy with exercise augmentation compared to those randomised to receive exposure therapy alone [1385]. Another small controlled trial reported greater reductions among people with PTSD as a single disorder following 12 weeks of aerobic and resistance exercises, compared to people randomised to a wait-list control [1386]. A more rigorous evaluation of the impact of exercise on PTSD symptoms was completed in Australia. Rosenbaum and colleagues [1387] compared the efficacy of a 12-week exercise program (consisting of three 30-minute resistance-training sessions per week and a walking program) provided as an adjunct to inpatient care for PTSD, to inpatient care alone, in an RCT. People randomised to receive the exercise program demonstrated significantly greater reductions in PTSD symptom severity compared to those randomised to receive inpatient care alone.

In a more recent RCT, veterans with PTSD as a single disorder participated in 12 weeks of supervised exercise training, including aerobic, balance, strength, and flexibility exercises, three days a week [1388]. Relative to veterans randomised to a wait-list control, those who received the exercise intervention reduced their PTSD symptoms by an average of 16% (compared to 7% in the control group), and also reported greater decreases in negative cognitions, negative mood, depressive symptoms, and improvements in sleep quality. While further research is needed examining the optimal dose, frequency and intensity of exercise, these findings provide preliminary support for the use of exercise as an adjunct to evidence-based PTSD treatments. Research has yet to examine the impact of physical exercise in people with co-occurring PTSD and AOD use disorders.

Yoga

A review of the literature concluded that yoga appears to have benefits for people with PTSD, particularly in relation to hyperarousal symptoms [1389]. The predominance of research to date has consisted of small, uncontrolled pilot studies; however, one RCT provides stronger evidence in support of yoga as an alternative therapy for PTSD. Van der Kolk and colleagues [1390] compared the efficacy of a 10-week yoga program to supportive health education (both delivered for one hour per week) among women with chronic treatment-resistant PTSD. Significantly greater reductions in PTSD symptom severity were observed among those randomised to undertake yoga compared to the supportive health education program, with effect sizes comparable to those observed for well-established psychological and pharmacological interventions. At the end of the program, 52% of those in the yoga group no longer met criteria for PTSD compared to 21% in the control group. The authors suggest that yoga may improve the functioning of traumatised people by helping them to tolerate physical and sensory experiences associated with fear and helplessness and to increase emotional awareness and affect tolerance [1390]. A long-term follow-up of this trial illustrated that the benefits of yoga relative to a control group were no longer evident 18 months after study completion, though an increased frequency of yoga practise was associated with reduced PTSD symptoms in both conditions [1391]. These findings are similar to those from a more recent RCT, which compared a holistic yoga intervention to a wellness lifestyle program among veterans and civilians with PTSD as a single disorder [1392]. People randomised to the yoga

intervention experienced greater decreases in PTSD symptom severity directly following the intervention relative to people randomised to the lifestyle program, but these differences were no longer significant seven months after the study.

Studies examining the efficacy of yoga among people with co-occurring PTSD and AOD use disorders are lacking; however, there is some evidence to suggest that yoga may be beneficial among people with these co-occurring disorders. A small Australian RCT comparing a multicomponent yoga breath program to waitlist control among heavy drinking male veterans found a significantly greater reduction in PTSD symptoms in the yoga group compared to waitlist control, and a corresponding small, non-significant reduction in alcohol use [1393]. Another small trial of women with subthreshold and diagnostic levels of PTSD examined the impact of yoga on AOD use. Reductions in risky AOD use were observed; however, this study excluded women with AOD use disorders [1394]. One further qualitative study examined yoga among women in AOD treatment, most of whom reported a history of trauma [1395]. Women included in this study reported a wide variety of benefits for yoga, including improved mental health, emotional expression, improved sleep, and increased strength. Further research among people with co-occurring PTSD and AOD use disorders is needed, as well as research to determine the best style of yoga, and the optimal frequency and duration of practice.

Complementary and alternative therapies

Music therapy

A single study examined the efficacy of music-therapy as an adjunct to outpatient AOD treatment among 12 people with PTSD and AOD use disorders, where music therapy involved psychoeducation, breathing/singing exercises, and attentional control training. In this trial, Hakvoort and colleagues [1396] found that six, one-hour sessions of music therapy reduced PTSD symptoms relative to before treatment. Moreover, 83% of people remained abstinent at the end of treatment, with no reports of relapse or AOD cravings, although 50% of people dropped out of the study.

Summary

The importance of providing trauma-informed care in the context of AOD treatment is now well recognised. Due to the inter-relatedness of PTSD and AOD use, an integrated approach to the treatment of these disorders is recommended. Several psychotherapeutic interventions have been developed for the treatment of co-occurring PTSD and AOD use. The evidence to date suggests that individual past-/trauma-focused psychological interventions delivered alongside AOD treatment are more efficacious than those that are present-/non-trauma focused. It is, however, important that both options be considered in the context of tailoring a person's treatment to their individual needs and preferences. Findings from pharmaceutical trials indicate that pharmacotherapies (SSRIs in particular) may be a useful adjunctive treatment if sufficient benefit has not been gained from psychological interventions. E-health interventions, physical exercise, yoga and music therapy also appear to convey benefit; however, further research is needed to determine efficacy in PTSD populations and people with co-occurring AOD use disorders in particular. Box 20 illustrates the continuation of case study G, following Julie's story after identification of her PTSD disorder was made.

Box 20: Case study G: Treating co-occurring PTSD and AOD use: Julie's story continued

Case study G: Julie's story continued

The AOD worker organised for Julie to speak with one of the team's psychologists. Over a series of sessions with her treating psychologist, Julie began to talk more about how the traumatic events in her life had affected her. She reported a mix of re-experiencing, avoidance and hyperarousal symptoms in relation to both the physical and sexual assaults she had experienced as a child and as an adult and became visibly upset - at times shaking - when she discussed the events. It also became apparent that Julie felt a great deal of guilt, shame and self-blame surrounding the events.

Throughout treatment, the psychologist continued to normalise Julie's symptoms, providing psychoeducation and self-management techniques, and was able to explore the relationship between Julie's trauma-related symptoms and her substance use. Julie was also able to recognise how these events had played a deciding role in how she viewed herself and others, and her relationships. Although distressing, over time Julie recognised that addressing these issues would be an important part of her treatment and worked with her psychologist on deciding on an evidence-based approach that she felt comfortable with. Julie struggled to reduce her substance use during this time and with the support of the psychologist, decided to commence opiate substitution therapy to further support her in reducing her substance use whilst still undertaking sessions with her psychologist. Both Julie and her psychologist were aware that it may take time, but they would both work together to help her work through the traumatic events she had experienced to achieve her long-term treatment goals.

Key points:

- Symptoms of PTSD and other mental disorders may only become apparent during AOD treatment.
- Many clients have experienced multiple traumas and re-victimisation.
- It is recommended that treatments for PTSD and AOD use should be carefully integrated.

ED

Eating disorders (ED)

EDs (i.e., anorexia nervosa, bulimia nervosa, binge eating disorder) and AOD use frequently co-occur [1397]. The co-occurrence of ED and AOD use disorders is particularly complex and challenging, in terms of assessment and treatment, associated physical health complications, and the potential negative cognitive impacts of both disorders [1398]. Assessment can be made even more difficult as the minimisation or denial of symptoms can form part of some eating disorder presentations; either due to a lack of self-awareness, shame, or as a result of some EDs being experienced by the person as 'valuable' to them and something they must protect [428, 1399]. It is however, important that co-occurring ED and AOD use is identified; the consequences of ED and AOD use are severe, and can include medical complications [1400, 1401], additional severe psychiatric conditions [1402–1404], suicidal ideation and attempts [1405, 1406], and mortality [1407].

It is vital for AOD workers to be able to recognise the clinical and subthreshold signs of ED and have some knowledge about simple management strategies.

Clinical presentation

EDs are characterised by disturbances in eating behaviours and food intake that impair psychosocial functioning and/or physical health. These disturbances may involve:

- Food restriction (e.g., limiting the amount of food eaten each day by reducing portion size, going long periods of time without food [>4 hours at a time], eliminating food types such as fats or carbohydrates, or not eating at all).
- Compensatory behaviours in reaction to consuming food (e.g., overexercising, vomiting and/or purging, laxative use).
- Binge eating (i.e., consuming an objectively large amount of food in a short period of time, accompanied by a sense of feeling out of control).

The majority of physical symptoms associated with ED are related to the effects of starvation, bingeing, purging, and/or overexercising [1408–1410]. People with ED, particularly bulimia nervosa, may show few outward signs of their disorder [1411, 1412], and may also hide symptoms of their ED (e.g., by wearing loose fitting clothing) [428]. Any visible physical signs of the ED may be complicated by AOD use. For example, AOD use can influence features that are usually associated with the assessment of ED, such as weight, appetite and food restriction [1412]. Furthermore, people with an ED may experience eating-related symptoms which are similar to those associated with AOD use, such as cravings and patterns of compulsive use [10]. Further, for some with ED and AOD conditions, alcohol may serve as the main source of nutrition. AOD workers should therefore endeavour to maintain a direct, non-judgemental approach during assessment, and seek to obtain as much additional information as possible (e.g., from family and/or friends with the client's consent) [1413]. The level of care required will depend on illness severity, the presence of any medical complications, dangerousness of behaviours, and any other psychiatric comorbidities (e.g., depression, anxiety) [1408, 1414]. In more complex presentations of ED, consultation with additional interdisciplinary professionals may be required, including dieticians, exercise therapists, social workers, family therapists, and psychiatrists [1408].

AOD workers should also be aware of the potential interactions between co-occurring ED and AOD use and consider this interplay when conducting assessments. There may be AOD use related to the ED; for example, the use of tobacco, stimulants, diet pills, laxatives, diuretics, or caffeine to control weight or suppress appetite [1400]. As such, assessment should include a focus on the use of AOD as a weight loss mechanism, as well as the role it may have in emotion regulation [1415].

Symptoms of ED

Anorexia nervosa

The most profound clinical feature of anorexia nervosa is extreme caloric restriction to induce weight loss. People can have anorexia nervosa even when at normal weights; it is the restriction and the weight loss rather than actual body weight that are the key features. Anorexia nervosa can be conceptualised as a disorder of control and denial where low body weight is mistakenly perceived to be normal or excessive and is central to a person's self-worth [11]. In many instances, the rigid control of food intake and weight can be best thought of as an attempt to cope with, cause or prevent a life event or mood (e.g., prevent puberty, reduce anxiety, deter abuse) [423]. Although not all physical symptoms will be noticeable, AOD workers should be aware of the potential for medical complications, many of which may improve or be reversed with early intervention [1409]. Physical signs a person may present with may include [1409, 1414, 1416]:

- Bradycardia (slowed heart rate).
- Low blood pressure.
- Abdominal pain, discomfort and/or constipation.
- Peripheral oedema (swelling of lower legs or hands).
- Bruising and/or broken blood vessels.
- Loss of menstruation (in females), and low testosterone levels (in males).
- Fatigue.
- Lethargy or hyperactivity.
- Cold sensitivity or intolerance.
- Loss or thinning of hair.
- Acne.
- Xerosis (dry skin).
- Lanugo hair on the body (fine hairs on the back, face, arms).
- Dehydration.

Other complications may include neurological abnormalities, changes in cardiac structure (e.g., ventricular atrophy), decreased bone density or osteoporosis, hypoglycaemia or diabetes, liver enzyme abnormalities, and elevated cortisol levels.

A thorough assessment of anorexia nervosa needs to include a comprehensive physical exam in order to identify any potential medical complications or other abnormalities that require immediate medical attention [1414, 1417].

Bulimia nervosa

Bulimia nervosa is characterised by a cycle of binge eating and purging behaviours. Binge eating involves a discrete time period where a person feels a loss of control over their eating, as they consume more or different food than usual, and do not feel able to stop eating or limit their intake [10, 11, 1408]. Bingeing is often followed by compensatory behaviours designed to prevent weight gain (e.g., vomiting, use of laxatives, fasting or excessive exercising). As with anorexia nervosa, a person's perception of their value and self-worth is disproportionately influenced by their body weight, size, and shape [10].

The cycle of bingeing and purging is maintained by the belief that control over one's eating, weight, and shape will increase a person's self-worth, and that by restricting and compensating after a binge they are effectively managing weight. However, restricting food intake leads to binge eating which then results in compensatory behaviours [1414]. Negative mood states such as sadness, frustration, anger, fear, or loneliness, can exacerbate this cycle [1418, 1419].

As described in **Chapter A4**, people with bulimia nervosa may present with symptoms of extreme dietary restrictions and/or exercise plans without purging behaviours [1408]. Further, people with bulimia nervosa are often ashamed of their eating behaviours, and attempt to hide or conceal their symptoms [428, 1420]. Some people even report deliberately selecting certain compensatory behaviours, such as vaping, because they are easy to conceal [1421]. As such, bulimia nervosa can be an isolating disorder [1414]. As with anorexia nervosa, the outward symptoms can be difficult to observe, particularly as people with bulimia nervosa may not display the same dramatic loss in weight. Physical signs a person may present with may include [1410, 1414, 1422]:

- Fatigue.
- Bloating and constipation.
- Gastric acid reflux, which can lead to difficulty swallowing or indigestion.
- Abdominal pain and distension.
- Calloused knuckles.
- Hoarse voice.
- Delayed digestion.
- Electrolyte abnormalities, such as hypokalaemia (low potassium).
- Muscle spasms.
- Heart palpitations.
- Nausea.
- Poor kidney function.

- Dental erosion.
- Enlarged glands.
- Poor colon function.

Binge eating disorder

Binge eating disorder is characterised by recurrent episodes of binge eating which occur without compensatory weight control methods. As with bulimia nervosa, an episode of binge eating occurs within a discrete time period during which a person feels a loss of control over their eating, where they consume more or different food than usual, and do not feel able to stop eating or limit their food intake [10, 11, 1408]. As described in **Chapter A4**, binge eating disorder differs from bulimia nervosa as episodes of binge eating are not regularly followed by compensatory behaviours to prevent weight gain (e.g., strenuous exercise, self-induced vomiting, misuse of laxatives). Care should be taken not to confuse binge eating disorder (a psychiatric condition) with obesity (a medical condition), even though they may physically resemble each other and can co-occur. Symptoms include [1414]:

- Obesity.
- Hyperlipidaemia (elevated lipids in the blood).
- Type 2 diabetes.

Common to anorexia nervosa, bulimia nervosa, and binge eating disorder is a dysfunctional and distressing system of evaluating a person's self-worth which, rather than being based on personal qualities and achievements across various domains (e.g., academic accomplishments, athletic ability, work achievements, values, relationship qualities), is focused on weight, size, shape, and appearance [159, 160, 1423]. People with bulimia nervosa and binge eating disorder are distressed by the loss of control over their eating, and the perception of overeating, and are at increased risk of additional psychiatric comorbidities [1408]. In bulimia nervosa, binge eating is thought to come about from severely restricting food intake as well as a mechanism for emotion regulation, but those with binge eating disorder do not illustrate the same intake restrictions between episodes of binge eating [1414].

Managing ED

Despite the differences between ED in terms of clinical characteristics and observable symptoms, there are common strategies that AOD workers can utilise to manage these disorders. The general principles of managing and treating ED should include the establishment of a trusting, collaborative, therapeutic relationship, taking care to avoid any potential power struggles [1424, 1425]. The techniques outlined in Table 53 may help AOD workers to manage clients with ED symptoms.

Table 53: Dos and don'ts of managing a client with symptoms of eating disorders

Do:
✓ Encourage and emphasise successes and positive steps (even just coming in for treatment).
✓ Take everything the client says seriously.
✓ Approach the client in a calm, confident and receptive way.
✓ Be direct and clear in your approach.
✓ Use open-ended questions such as 'So tell me about…?' which require more than a 'yes' or 'no' answer. This is often a good way to start a conversation.
✓ Constantly monitor suicidal thoughts and talk about these thoughts openly and calmly.
✓ Encourage the client to express their feelings.
✓ Focus on feelings and relationships, not on weight and food.
✓ Be available, supportive, and empathetic.
✓ Encourage participation in healthy, pleasurable, and achievement-based activities (e.g., exercise, hobbies, or work).
✓ Encourage, but do not force, healthy eating patterns.
✓ Assist the client to set realistic goals.
✓ Involve family or friends in management or treatment strategies.
✓ Be patient in order to allow the client to feel comfortable to disclose information.
✓ Explain the purpose of interventions.

Don't:
✗ Act shocked by what the client may reveal.
✗ Be harsh, angry, or judgemental. Remain calm and patient.
✗ Use statements that label, blame or shame the client.
✗ Invalidate the client's feelings.
✗ Make comments (either positive or negative) about body weight, appearance, or food – these will only reinforce their obsession.
✗ Express any size prejudice or reinforce the desire to be thin.

Table 53: Dos and don'ts of managing a client with symptoms of eating disorders (continued)

✗	Engage in power struggles about eating.
✗	Criticise the client's eating habits.
✗	Trick or force the person to eat.
✗	Get frustrated or impatient.

Adapted from NSW Department of Health [431], Clancy and Terry [448], and World Health Organisation; Collaborating Centre for Evidence in Mental Health Policy [1410].

Treating ED

EDs are complex psychiatric illnesses that impair psychological, social, and physical functioning. It has been argued that the treatment of co-occurring ED and AOD use should be provided using an integrated approach to minimise the potential for deterioration in one disorder when symptoms of the other improve [726, 1415, 1426]. Regardless of the eventual treatment plan, the assessment of ED should involve a multidisciplinary team of health and mental health workers, and include a thorough physical exam (with blood and urine tests) to identify complications that may need immediate attention and/or hospitalisation for medical stabilisation [1414, 1415, 1427, 1428].

There are several options available for the treatment of ED alone, including psychotherapy, pharmacotherapy, e-health and telehealth interventions, physical activity-based interventions, as well as complementary and alternative therapies. The evidence base surrounding each of these treatments is briefly discussed below, with regards to each ED. A detailed summary of the evidence relating to each disorder is also provided in a systematic review undertaken by the Australian National Eating Disorders Collaboration [1429].

There is limited evidence about the treatment of co-occurring ED and AOD use disorders specifically, due to the exclusion of people with AOD use disorders from the majority of ED treatment trials [1430]. The preliminary evidence that does exist, however, suggests that structured programs incorporating elements of established psychotherapies such as CBT, family-based treatment (FBT), and DBT, including individual psychotherapy sessions, family therapy, group therapy, and nutritional planning, may effectively reduce symptoms of ED among people with co-occurring AOD use in ED treatment programs [1404, 1431, 1432]. There is also some evidence to suggest that treating a person's AOD use disorder may lead to improvements in ED symptoms [1430].

Treating anorexia nervosa

The treatment of anorexia nervosa should begin with a comprehensive assessment, evaluating a person's nutritional, medical and psychological needs [1424]. This process should be ongoing throughout treatment, as clinical needs and priorities of the client may change [870]. Clinical practice guidelines on the treatment of ED from the RANZCP [870, 1424, 1433] recommend that the initial assessment of anorexia nervosa incorporate the following information:

- Collection of a thorough history (including dietary restrictions, weight loss, disturbances in body image, fears about weight gain, bingeing, purging, excessive exercise, use of medications or AOD to lose weight or suppress appetite).
- Investigate medical complications and assess level of risk (physical exam to assess BMI, heart rate, blood pressure, temperature, metabolic tests, kidney function).
- Co-occurring psychiatric conditions.
- Cognitive changes due to starvation (e.g., slowed thought processing, difficulty concentrating).
- Possible contributing factors (e.g., family history of ED, developmental difficulties, dieting, or other weight loss causes).

It is suggested that these assessment factors be incorporated into a case formulation (discussed in **Chapter B3**), with treatment priorities based on a thorough risk assessment. Clinical guidelines recommend that treatment priorities follow client engagement (including psychoeducation, with family involvement, and MI), medical stabilisation, reversal of the cognitive effects of starvation, and psychological treatment [870, 1427]. Where possible and practicable, it is recommended that people with anorexia nervosa requiring admission be treated at specialist ED units, or by professionals specialising in ED.

Psychotherapy

To date, there are no evidence-based psychotherapies for treating co-occurring anorexia nervosa and AOD use specifically. Australian and international clinical practice guidelines for single disorder ED recommend the inclusion of psychotherapy as an essential component of treatment for anorexia nervosa [870, 1434]; however, it is recommended that, where indicated, more intense psychological therapies be initiated only after medical stabilisation and the cognitive effects of starvation have improved [870].

The effectiveness of existing psychotherapies is moderate at best, which may be due, in part, to high rates of treatment dropout and poor treatment retention [1429, 1435]. Regardless of the approach used, strategies to engage the client and maintain the therapeutic relationship throughout treatment may be beneficial to address high rates of treatment dropout. The interventions with the most theoretical and empirical support include family-based therapy (i.e., Maudsley family therapy), particularly among young people; CBT and CBT-enhanced (CBT-E). Other treatments with some evidence of low to moderate effect include focal psychodynamic therapy; interpersonal psychotherapy (IPT); cognitive analytic therapy; specialist supportive clinical management (SSCM); the Maudsley model of anorexia nervosa treatment for adults (MANTRA), MI, and psychodynamic approaches [870, 1429, 1435]. Table 54 provides a brief description of these approaches.

Research comparing different approaches has been limited and findings mixed (e.g., [1436–1443]); as such, there is no clear guidance for clinicians to suggest that one therapeutic approach is better than the other [1435, 1436, 1444]. In general, for children and adolescents with single disorder EDs, the best evidence is for Maudsley FBT and, for adults, the best evidence is for CBT or psychotherapy of a longer duration. As such, Australian clinical guidelines suggest that specialist-led manualised-based approaches (e.g., CBT approaches) that have the strongest evidence-base should be first line options, but do not stipulate any specific therapies as a first line treatment option [870].

Table 54: Brief description of psychotherapy approaches to ED

Cognitive behavioural therapy – enhanced (CBT-E)
CBT-E is an extension of CBT focused on educating clients about being underweight, starvation and the initiation and maintenance of regular eating patterns. Included in the therapy are components that focus on self-efficacy and self-monitoring, which are thought to be crucial to the treatment [1440]. CBT-E also addresses other features that often co-occur with eating disorders, including low self-esteem, clinical perfectionism, mood intolerances, and interpersonal difficulties [1423, 1445].
Integrative cognitive-affective therapy (ICAT)
ICAT is focused on the relationship between emotions and bulimic symptoms as well as adaptive eating [1446]. The relationship between symptoms and factors that maintain bulimic behaviours are addressed in four phases of treatment: treatment ambivalence and emotions; adaptive coping strategies; problem areas believed to maintain bulimic symptoms; healthy lifestyle and relapse prevention.
Focal dynamic therapy
Focal dynamic therapy focuses on therapeutic alliance, pro-anorectic behaviour, self-esteem, behaviours viewed as acceptable, associations between interpersonal relationships and eating, and the transfer back to everyday life [1440].
Cognitive interpersonal therapy (MANTRA)
MANTRA (Maudsley model of Anorexia Nervosa Treatment for Adults) is a social-cognitive interpersonal treatment that draws on MI, cognitive remediation, and the involvement of family and carers. It focuses on addressing intrapersonal and interpersonal processes that are thought to be fundamental to the maintenance of the disorder [1429].
Family-based treatment (FBT/Maudsley therapy)
FBT, first developed at the Maudsley Hospital in London, is a treatment program for anorexia nervosa in young people. In Maudsley Therapy, the family is actively involved in treatment, which is primarily focused on weight gain, and families are encouraged to take control over refeeding. Later stages of treatment involve handing back control over eating to the young person, and addressing other issues [1429].
Specialist supportive clinical management (SSCM)
SSCM combines features of clinical management and supportive psychotherapy including education, care, support, fostering of a therapeutic relationship, praise, reassurance, and advice. A central feature of SSCM is a focus on the abnormal nutritional status and dietary patterns typical of anorexia nervosa. Clients are provided with information on a range of strategies to promote normalisation of eating and restoration of weight [1429].

Table 54: Brief description of psychotherapy approaches to ED (continued)

Interpersonal psychotherapy (IPT)
IPT targets interpersonal issues which are believed to contribute to the development and maintenance of ED. Four interpersonal problem areas are addressed: grief, relationship difficulties and deficits, and role transitions [1429].

Adapted from Peckmezian et al. [1429]. Note this is not an exhaustive list of all psychotherapies available for the treatment of ED. For a more comprehensive overview of approaches, see the Peckmezian and colleagues [1429] Evidence Review.

Pharmacotherapy

To date, there are no evidence-based pharmacotherapies for treating co-occurring anorexia nervosa and AOD use. Guidelines suggest that pharmacotherapy alone should not be the primary treatment for single disorder anorexia nervosa, and there is little consistency between guidelines with regard to recommendations relating to specific medications [870, 1428, 1434].

Although atypical antipsychotics and SSRIs (olanzapine and fluoxetine in particular) have been used in clinical settings, research indicates that there is no conclusive evidence of any effect on the primary psychological features of anorexia nervosa or weight gain, but they may assist in treating other psychological symptoms (e.g., depression) that may co-occur with anorexia nervosa [1414, 1429, 1447, 1448]. Nonetheless, it has been suggested that olanzapine is currently the best pharmacotherapy available for anorexia nervosa, particularly for those who cannot access other intensive treatments [1449, 1450]. A comprehensive review of pharmacotherapy for single disorder anorexia nervosa found that olanzapine increased weight gain and improved depression, anxiety, aggression and obsessive-compulsiveness [1451]; however, the evidence remains weak and there is the possibility of adverse side effects [870].

Treating bulimia nervosa

As with the approach to treating anorexia nervosa, the Australian clinical practice guidelines for single disorder ED recommend that treatment for bulimia nervosa begins with a comprehensive assessment which includes [870]:

- Enquiry into behaviours; especially binge eating (i.e., uncontrolled episodes of overeating excessive amounts of food), weight control behaviours that may compensate for binge eating (e.g., self-induced vomiting, laxative/diuretic use, restricting food intake, overexercising, use of AOD to control weight).
- Cognitions of weight/shape overvaluation, and preoccupations with body image and/or eating.

The increased risk of medical complications, particularly hypokalaemia, cardiac issues, obesity, Type 2 diabetes, and hypertension, makes physical assessment among those with suspected bulimia nervosa essential [1424]. As with the physical assessment of those with anorexia nervosa, this assessment should include weight, height, pulse rate, blood pressure and BMI. Additional tests should be undertaken

to assess for hypokalaemia and dehydration (associated with purging behaviours), cardiac function (e.g., electrocardiogram), glucose levels, and kidney function, as indicated [870, 1424]. If psychological treatment is being provided by a clinician without medical training, the Australian clinical practice guidelines for single disorder ED recommend the inclusion of a GP to assist with assessment and ongoing care [870].

Psychotherapy

There is very little evidence about the concurrent treatment of AOD use and bulimia nervosa. There is, however, some evidence to suggest that treating a person's AOD use disorder may lead to improvements in bulimia nervosa [1430, 1452].

There are currently several evidence-based treatments available for bulimia nervosa as a single disorder, including CBT and CBT-E; IPT; FBT; DBT; and integrative cognitive-affective therapy (ICAT); in addition to multidisciplinary and combined therapies [1453]. Unlike anorexia nervosa, overall, these treatments have been shown to produce moderate to large reductions in symptomology [1454]. On average, an estimated 30-40% of people treated with these psychotherapies attain binge-purge abstinence, and effects appear to be maintained over the longer term after treatment has ceased [1453, 1454].

Most psychotherapy research to date has been conducted in relation to CBT [1444]. There is robust evidence supporting CBT treatment approaches (in particular those that are specific to ED, such as CBT-E [1453–1455]), with both national and international clinical guidelines recommending the use of CBT approaches as the first line of treatment [870, 1428, 1429, 1434, 1456]. These typically comprise of 16–20 clinician-led sessions. There is some evidence to suggest that self-guided CBT is effective, but less so than clinician-led CBT [1453].

Pharmacotherapy

Unlike psychotherapy, the impacts of pharmacological treatments for bulimia nervosa are small to moderate and have not been found to continue after cessation of medication [1454]. However, studies that have examined the combined use of pharmacotherapies (mostly SSRIs) and psychotherapies (mostly CBT), have generally found this combined approach to demonstrate similar effectiveness to psychotherapy alone, but results are not consistent [1454].

Most treatment guidelines for single disorder bulimia nervosa recommend the use of SSRIs (specifically fluoxetine) in combination with psychotherapy [1434, 1457]. Although meta-analyses and other reviews have found that SSRIs appear to be less effective than TCAs and MAOIs (such as those listed in Table 47) [1454, 1458, 1459], their side effect profile is often more tolerable [1449]. As mentioned previously, extreme caution should be used when prescribing TCAs and MAOIs.

In addition to antidepressants, Australian guidelines for the treatment of ED recommend the use of the antiepileptic topiramate when psychological treatment is not available [870]. There is also some evidence from open label trials of lamotrigine, a mood stabiliser, showing positive outcomes on ED symptoms when given in conjunction with DBT [1460].

Treating binge eating disorder

The Australian clinical practice guidelines for single disorder ED recommend the same comprehensive assessment for binge eating disorder as described for bulimia nervosa [870].

Psychotherapy

To date, there are no evidence-based psychotherapies for treating co-occurring binge-eating disorder and AOD use. Similar to bulimia nervosa, the first line of recommended treatment for addressing single disorder binge eating disorder is CBT [870, 1429, 1461]. CBT has been found to outperform most comparison therapies and has been found to be more effective than pharmacological interventions for the treatment of binge eating disorder [1462, 1463]. Other psychological therapies found to be effective in the treatment of binge eating disorder include IPT, psychodynamic therapy, and DBT [1429, 1464].

Pharmacotherapy

Australian clinical guidelines for the treatment of ED recommend that pharmacotherapy be considered when psychotherapy is not available, or as an adjunctive treatment to psychotherapy [870]. Although there are no current evidence-based pharmacotherapies for treating co-occurring binge-eating disorder and AOD use, there is emerging evidence suggesting that pharmacotherapy may be beneficial for some people with binge eating disorder as a single disorder [1461, 1465]. RCTs examining the efficacy of SSRIs (fluoxetine, citalopram, escitalopram, fluvoxamine, and sertraline [1464]), SNRIs (duloxetine [1466]), mood stabilisers (topiramate [1467]), anticonvulsants (lamotrigine [1468]), antiobesity medications (orlistat [1464]), and psychostimulants (lisdexamfetamine [1464]), have found reductions in the frequency of binge eating episodes, BMI decreases, and overall clinical improvement.

Five RCTs to date have evaluated lisdexamfetamine for single disorder binge eating disorder, with findings demonstrating strong evidence in support of its safety and efficacy [1469–1473]. These studies found that compared to placebo, lisdexamfetamine was associated with significant improvements in binge-eating symptoms, reduced frequency of binge-eating episodes, and reduced body weight [1474]. The anticonvulsants topiramate and lamotrigine have also been evaluated for efficacy and safety for single disorder binge eating disorder in several RCTs [1467, 1468, 1475, 1476]. Although topiramate has been associated with adverse side effects (e.g., participants dropping out of trials with headache, paresthesias or pins and needles sensations), these studies found that, compared to placebo, topiramate was associated with significantly greater reductions in binge frequency, BMI, and weight loss. The antiobesity medication Orlistat has been examined for efficacy in four RCTs to date [1463, 1477–1479]. These trials found that, although weight loss was enhanced with Orlistat, the frequency of binge eating was not reduced.

There is also some evidence to support the use of pharmacotherapies which target AOD use, such as baclofen, acamprosate, and bupropion, for the treatment of binge-eating disorder as a single disorder [1480, 1481]. Two narrative reviews concluded that, while baclofen reduces the frequency of binge-eating episodes [1480, 1481], depressive symptoms may increase [1481] relative to baseline. In these reviews,

bupropion also reduced the frequency of binge-eating episodes relative to baseline, and improved weight goals relative to both a placebo and sertraline, although the findings for binge-eating episodes were somewhat mixed [1480, 1481]. In one RCT, acamprosate also reduced the frequency of binge-eating episodes, as well as related factors such as food cravings and compulsive eating, relative to before treatment, but not relative to placebo [1482].

E-health and telehealth interventions

Although there are no e-health or telehealth interventions for co-occurring ED and AOD use disorders, there has been some research conducted into the use of e-health interventions for single disorder ED. Systematic reviews of internet-based interventions for single disorder ED have found that ED symptoms, including bingeing and purging episodes, reduced significantly with the use of an internet-based therapy [1483, 1484]. In contrast, however, several studies reported poorer outcome, or no difference, for e-health interventions relative to waitlist and treatment-as-usual control groups [1485]. Notably, though, some studies that did not report significant findings are likely limited by methodological factors, such as small sample sizes.

There is no clear evidence as to which e-health intervention has the most empirical support for single disorder ED, although self-help CBT has been highlighted as an effective, accessible, time and cost effective alternative to clinician delivered CBT [1455, 1485, 1486]. The majority of studies have focused on internet-based CBT, with the online components ranging from e-mail-based therapy, adjunctive internet-based guidance, to online CBT. One review found that internet-based therapies that were bolstered by face-to-face contact via assessment and clinician support were associated with higher rates of therapeutic adherence and lower attrition from internet-based treatment [1484].

Guided self-help and self-help CBT for single disorder ED in particular have been shown to be effective in reducing the frequency of bingeing and purging, and improving ED psychopathology, but less effective than face-to-face psychotherapy in achieving abstinence [1453, 1455, 1483, 1486–1488]. These findings provide some support for the use of guided e-health interventions in the treatment of ED as an adjunct to other treatments [1487]. Unguided self-help initiatives do not appear to be effective at treating ED [1483, 1487].

A systematic review of smartphone applications for ED identified up to 20 interventions currently available for ED treatment [1487], with varying levels of empirically supported content. These apps mostly provide educational content, but some incorporate additional features such as self-assessment tools and referral infrastructure. In another systematic review, smartphone applications improved abstinence rates from bingeing and purging behaviours from baseline [1483]. Moreover, the increasing popularity and widespread use of smartphone applications suggests they could be an effective medium for delivering treatment once their clinical utility is established [1487]. However, most experts agree that the evidence for smartphone applications as treatment for ED is limited, as these applications are not necessarily founded on evidence-based principles [1487, 1489].

Physical activity

The role of exercise as adjunctive therapy for people with ED is controversial, despite the fact that physical activity can play an important role in co-occurring ED and AOD use, in terms of treatment,

recovery, and relapse prevention [990]. The benefits associated with exercise in ED include the promotion of physical activity and healthy weight control, as well as the potential prevention and/or restoration of medical conditions such as reduced bone mass, cardiovascular disease, and diabetes [1490, 1491]. However, as excessive exercise can also be an illness feature in ED, and further exercise may interfere with weight gain or reinforce the psychological/pathological symptoms of ED, it is not uncommon for ED treatment providers to limit the amount of physical activity, allowing little or no exercise [1492]. There is also the potential that physical activity may lead to compulsive 'overexercising' [1493]. As such, some current international guidelines discourage offering clients with EDs physical therapies [1428], despite evidence to suggest its effectiveness. Other guidelines recommend its use under the supervision of a skilled exercise professional with ED experience [1434, 1494, 1495].

Although physical activity has not been evaluated among people with co-occurring ED and AOD use, two reviews have examined exercise in people with single disorder ED and found moderate physical activity to be associated with reduced ED cognitions (e.g., food preoccupation), frequency of bingeing and purging episodes, and ED psychopathology [990, 1496]. One small pilot study examined a graded exercise program based on ideal body weight and percentage body fat, with exercises ranging from stretching, to strengthening and low-impact cardiovascular exercise three times per week for three months [1497]. The exercise group demonstrated improvements in weight gain as well as quality of life, which were substantially greater than the inactive control group, whose quality of life decreased over the study period.

Another study examined the effectiveness of an exercise program on weight gain among women with anorexia nervosa, bulimia nervosa, and binge eating disorder in an inpatient treatment facility and found that 60 minutes of supervised exercise conducted four times per week was associated with 40% more weight gain than the inactive control group [1498]. The exercises included stretching, yoga, Pilates, strength training, balance, exercise balls, aerobic exercise (e.g., walking or skipping), recreational games, or other enjoyable activities [1498]. It is suggested that moderate physical activity facilitates weight gain by improving emotional wellbeing, increasing appetite, and reducing body-image and appearance-related distress [1492].

Although preliminary evidence supports the positive impact of exercise for people with ED, it remains unclear as to how clinicians should approach physical activity among underweight people, or people who may be normal weight but have been treated for compulsive exercise in the past [1492]. One systematic review identified 11 therapeutic elements that appear to be essential to the success of exercise interventions within ED treatment, including the use of positive reinforcement, beginning with mild intensity exercise, using a graded program, including psychoeducation, including nutritional advice, and debriefing following exercise sessions [1494].

Despite promising research, the evidence suggests that caution should be taken when recommending exercise for people with ED, particularly anorexia nervosa, as the presence of behaviours which are indicative of problematic exercise may negatively impact on the long-term course of illness [1492, 1499], and thus, hinder potential positive outcomes.

Complementary and alternative therapies

Research into complementary and alternative therapies for co-occurring ED and AOD use disorders has examined yoga, acupuncture, therapeutic massage, hypnosis, herbal medicine, light therapy, spiritual healing, and art therapy [1500]. Despite the breadth of research, no intervention has been identified as an effective, evidence-based treatment for co-occurring ED and AOD use. While the research in this area continues to develop, there are promising preliminary findings relating to the use of yoga [1501], acupuncture [1502], hypnosis [1503–1505], relaxation [1506], brain stimulation [1507], bright light phototherapy [1506], and therapeutic massage [1502, 1508].

Summary

Despite much research, there is little evidence upon which to provide clear guidance on the treatment of co-occurring ED and AOD use disorders. Research from single disorder ED suggests that comprehensive assessments conducted by a multidisciplinary team should be followed by psychotherapy as the first line of treatment, with strongest evidence in support of CBT-based approaches [1400]. Although there is some evidence that pharmacotherapy may be a useful adjunct to the treatment of single disorder ED (particularly binge eating disorder), the evidence is not conclusive and Australian clinical guidelines do not recommend its use in the absence of psychotherapy [870]. Box 21 illustrates the continuation of Kai's case study, following their story after their ED was identified.

Box 21: Case study H: Treating co-occurring ED and AOD use: Kai's story continued

Case study H: Kai's story continued

The AOD worker consulted with an ED specialist, who arranged with Kai and their mother to attend an assessment. Kai was moderately underweight (with a BMI of 16) and the specialist arranged for a complete physical assessment, including heart rate, blood pressure, temperature, metabolic tests, assessments for any cognitive changes, and contributing factors. Kai's family were encouraged to maintain involvement with their ongoing treatment, and the specialist devised a plan with Kai that included their family's involvement, with a focus on medical stabilisation, psychoeducation with MI, reversal of the cognitive effects of starvation, and psychological treatment.

Kai continued working with the AOD service who provided ongoing support in relation to their goal of reducing their use of alcohol and non-prescribed opioids, but Kai said they were not ready to give up smoking. The AOD worker made a note of this and planned to explore it further using MI in a future appointment. During one follow-up appointment, the AOD worker asked Kai to take a urine test. Kai refused and left the appointment. Assuming Kai had used non-prescribed opioids between appointments and did not want them to show up in a urine test, Kai's AOD worker called Kai and told them that it was normal to experience lapses and they would work through the process together. The AOD worker asked Kai to please come back so they could discuss Kai's reasons for leaving, and also so she could give Kai some additional relapse prevention strategies. Kai agreed to come back.

Box 21: Case study H: Treating co-occurring ED and AOD use: Kai's story (continued)

During their next appointment, Kai told the AOD worker that they were sexually assaulted in a public toilet when they were 14, and since that time had experienced a lot of difficulty going into any public toilets, even when accompanied. The AOD worker asked Kai whether their food restriction also started around this time and thinking about it, Kai thought it may have. Kai said they had not used any opioids. The AOD worker organised a case management meeting with everyone involved in Kai's care to reassess Kai's treatment plan. The ED specialist was able to start addressing the underlying trauma which was recognised as a contributing factor to the ED. Kai also agreed to an inpatient stay at a specialised ED facility to stabilise their weight gain and was provided with ongoing support from their AOD worker, who was also involved in discharge planning and relapse prevention.

Key points:

- It can be difficult to identify ED in people with AOD use disorders.
- Once identified, it is vital that a person experiencing ED receives a comprehensive physical assessment by a medical professional. The primary focus is on stabilising the client's physical health and restoring cognitive function, and then psychotherapy can begin.
- The AOD worker should maintain client engagement, even if a referral to an ED specialist is made.

Personality disorders

Personality disorders

As described in Chapter A4, personality disorders are highly stigmatised conditions, even within mental health and healthcare more broadly. As such, it is crucial that any communication regarding clients with potential personality disorders – whether that communication involves the client directly or is with healthcare providers on behalf of the client – remains respectful, non-judgemental, compassionate, and client-centred.

Clinical presentation

People with personality disorders display patterns of thinking, behaving and emotional expression that lead to frequent and enduring problems across multiple areas of a person's life and, in particular, problems forming long-term, meaningful, and rewarding relationships with others. Symptoms can include:

- Behaviour that may be considered manipulative or deceitful.
- Impulsivity.
- Difficulties in relating to others.
- Unstable relationships.
- Difficulty showing remorse for their behaviour or empathy for other people.
- Suspiciousness.
- Difficulty accepting responsibility or accommodating others.
- Emotional instability and hypersensitivity.
- Pervasive and persistent irritation, anger, or aggression.
- Being overly self-involved.
- Excessive dependence on others.

It is important to remember however, that symptoms of personality disorders such as difficulties with emotion-regulation, self-control, and impulsivity, are often present to varying degrees in many clients and do not necessarily indicate a personality disorder.

Managing symptoms of personality disorders

Strategies for managing the symptoms of personality disorders are outlined in Table 55. The development of coping skills (e.g., breathing retraining, meditation, cognitive restructuring described in Appendix BB and Appendix CC) to regulate emotions is considered fundamental in the treatment of co-occurring personality and AOD use disorders [102]. Coping strategies have been found to mediate the relationship between personality disorder and AOD use [1509] and deficits in emotion regulation are considered core to maintaining symptoms of BPD [1510].

AOD workers may find it difficult to manage symptoms of personality disorders which are some of the most challenging conditions to treat [1511, 1512]. Establishing a positive therapeutic relationship is essential, but often difficult due to the inherent relational difficulties that are experienced by people with these conditions. These difficulties often arise from insecure attachment during childhood and frequently surface in the context of a therapeutic relationship [121]. Other challenges include strong countertransference reactions including anger, frustration or indifference; as well as often needing to manage the heightened risk that is presented with chronic suicidal thinking and AOD use [121, 162]. Some personality characteristics, impulsivity in particular, place clients at extremely high risk for suicide, and require increased levels of monitoring the risk of suicide and self-harm.

Engagement and rapport building form an intensely important part of treatment and clients with personality disorders may require more time and attention than other clients [121]. Clients with personality disorders may have trouble developing positive therapeutic relationships due to a history of poor relationships with AOD and other health professionals, a bias towards suspiciousness or paranoid interpretation of relationships, or a chaotic lifestyle, making appointment scheduling and engaging in structured work more difficult [948]. Structure and firm boundaries are very important components of the therapeutic process when managing clients with symptoms of personality disorders.

Progress may also be slow and uneven as many people with personality disorders have trouble integrating change-oriented feedback [102]. Donald and colleagues [121] note the importance of striking the right balance between validation (i.e., empathetic acceptance of the client and their difficulties), which has typically been lacking from this client group's experiences and is often responded to well, and change-oriented interventions focused on changing current behaviours (such as developing alternative coping strategies to replace self-harm or AOD use). It may also be helpful to highlight aspects of the client's personality that may be viewed as strengths, and enhance their prospects of achieving the outcomes they are working towards [162].

Table 55: Dos and don'ts of managing a client with symptoms of personality disorders

Do:
Place strong emphasis on engagement to develop a good client-worker relationship and build strong rapport.
Set clear boundaries and expectations regarding the client's role and behaviour. Some clients may seek to test these boundaries.
Establish and maintain a consistent and reliable approach to clients and reinforce boundaries.
Anticipate difficulties with adhering to treatment plans and remain patient and persistent.
Plan clear and mutual goals and stick to them; give clear and specific instructions.
Help with the current problems the client presents with rather than trying to establish causes or exploring past problems.

Table 55: Dos and don'ts of managing a client with symptoms of personality disorders (continued)

✓ Assist the client to develop skills to manage negative emotions (e.g., breathing retraining, progressive muscle relaxation, cognitive restructuring).
✓ Maintain a calm environment, as significant stress may exacerbate symptoms.
✓ Take careful notes and monitor the risk of suicide and self-harm.
✓ Avoid judgement and seek assistance for personal reactions (including frustration, anger, dislike) and poor attitudes towards the client. Remember that challenging aspects of behaviour often have survival value in the context of past experiences.
✓ Listen to and evaluate the client's concerns.
✓ Accept but do not confirm the client's beliefs.
Don't:
✗ Reward inappropriate behaviour (such as demanding, aggressive, suicidal, chaotic, or seductive behaviour).
✗ Display frustration or anger with the client. Remain firm, calm and in control.
✗ Assume a difficult client has a personality disorder; many do not, and many clients with these disorders are not difficult.

Adapted from NSW Department of Health [431], Project Air [1513], Davison [1514], and Fraser et al. [162].

Treating personality disorders

As discussed in Chapter A2, the most common personality disorders seen in AOD services are BPD and ASPD and research regarding the treatment of co-occurring personality and AOD disorders has largely focused on these two conditions [162]. Experts suggest that treating both the personality and AOD use disorder simultaneously, using a combination of psychotherapy and pharmacotherapy to support reductions in, or the cessation of, AOD use may be the best approach, although research comparing this with other approaches is lacking [162, 1515]. Donald and colleagues [121] recommend a staged approach, in which the early phases of treatment concentrate on the stabilisation of AOD use and self-harming behaviours using a transdiagnostic approach that focuses on emotion regulation and impulsivity, followed by interventions that focus on issues relating to identity and the self.

Treatment options available include psychotherapy and pharmacotherapy, which may be supplemented by other interventions including e-health and telehealth interventions, physical exercise and complementary and alternative therapies (e.g., omega-3). The evidence base surrounding each of these treatment options with regards to the treatment of BPD and ASPD is discussed below.

Borderline personality disorder (BPD)

Psychotherapy

Psychotherapy is regarded as the most effective treatment for BPD as a single disorder [1516] and is the recommended first-line of treatment for BPD in Australian and international guidelines [555, 1517–1519]. A Cochrane review of psychotherapies for BPD concluded that psychotherapy is an effective treatment for reducing BPD symptom severity, depression, and suicidality in people with BPD, but the vast majority of studies reviewed excluded people with co-occurring AOD use disorders [1516].

Although a large number of treatments have been developed for BPD, *Dialectical Behaviour Therapy (DBT)* and *Mentalisation Based Treatment (MBT)* are the most researched to date [1516]. *DBT* is a complex, skills-based, psychological intervention and has been modified for people with co-occurring BPD and AOD use disorders *(DBT-S)*. In this model, the symptoms of BPD and AOD use are viewed as attempts to regulate emotions [162]. Using some of the same principles as CBT, the client is supported with strategies to promote abstinence and is more likely to remain engaged in treatment. Although research to date is limited to a small number of studies, *DBT-S* is the preferred treatment approach to date, having demonstrated improvements in relation to both BPD symptoms and AOD use [724, 1520].

MBT is an evidence-based treatment for BPD that focuses on mentalising, rather than cognitions or behaviours [1516, 1521]. Mentalising, or mentalisation, is a general term used to describe how we make sense of ourselves and the world around us. Although difficulties with mentalisation may be associated with many mental health conditions, people with BPD in particular may be more limited in their capacity to mentalise [1521]. In targeting mentalisation, *MBT* aims to improve some of the core characteristics of BPD, such as impulsivity, emotional instability, impaired interpersonal functioning, fractured identity, and chronic emptiness [1522]. Philips and colleagues [1523] conducted a feasibility study comparing the effectiveness of *MBT* provided in combination with AOD treatment, to AOD treatment alone among people with co-occurring BPD and AOD use disorders. No significant differences were found between groups with regard to changes in BPD symptom severity or substance use, but a trend towards a reduced number of suicide attempts among those who received *MBT* was found relative to AOD treatment alone. It should be noted, however, that therapist adherence to the treatment manual in this study was low.

Another promising treatment is *Dynamic Deconstructive Psychotherapy (DDP)* [1524, 1525]. *DDP* is a modified form of psychodynamic psychotherapy, and was initially developed for particularly challenging cases of BPD, including those with co-occurring AOD disorders [1525]. In a systematic review of the literature, Lee and colleagues [724] found three studies had evaluated *DDP* among those with co-occurring BPD and AOD use. These studies found that *DDP* had a significantly greater effect on symptoms of both BPD and alcohol use disorder compared to treatment as usual (i.e., treatment in the community), which were maintained over 30 months [1524, 1526, 1527]. *DDP* also effectively reduces some secondary treatment outcomes related to personality disorders, such as suicidal behaviour [1515].

Several other treatments have also been developed and undergone preliminary examinations for co-occurring BPD and AOD use but require further research [1528, 1529]. One treatment that does not appear to be of benefit in the treatment of co-occurring BPD and AOD use is *Dual Focus Schema Therapy* (*DFST*) [704, 1530], a combination of relapse prevention and therapy focused on early maladaptive schemas (such

as continuing negative self-beliefs, negative beliefs about others or events), as well as coping styles [724, 1531]. *DFST* has only been examined in a single study to date, but appeared to be of limited benefit, and greater reductions in AOD use were found among those in the control condition (individual drug counselling) [724].

Pharmacotherapy

Although somewhat dated, current Australian and international guidelines on the management of BPD suggest pharmacotherapies only be used as an adjunct to psychotherapy [555, 1517–1519]. Pharmacotherapies that support a reduction in, or the cessation of, AOD use (e.g., naltrexone and disulfiram) in particular may be helpful in facilitating stabilisation that will allow the client to make further gains in psychotherapy [121, 1532]. Concerns have been raised with regard to the potential for dangerous interaction effects of medications and AOD use in the context of impulsivity and self-harming behaviours [1240]. As such, although disulfiram has been found to be safe and effective among people with BPD and alcohol use disorders [1532], caution is advised due to the potential risk [1515].

No pharmacotherapies have been approved for the treatment of BPD as a single disorder, and there is little evidence to support their efficacy in the context of BPD as a single disorder, and none in the context of co-occurring AOD use disorders [162]. Nonetheless, off label prescribing of antidepressants, mood stabilisers, antipsychotics and anticonvulsants to address primary or secondary symptoms of BPD is common, with medications often chosen to target specific symptoms such as affect dysregulation or impulsivity [1240, 1533]. This targeted approach to prescribing has been the subject of considerable debate and concerns have been raised regarding the use of polypharmacy. There is consensus in the literature, however, that prescribing should be kept to a minimum [1240] and polypharmacy avoided whenever possible [1515, 1533, 1534].

E-health and telehealth interventions

Several mobile phone applications have been developed for people with BPD, mostly for use as adjuncts to DBT. Research examining their acceptability, feasibility and preliminary effectiveness appear promising, but none have undergone rigorous evaluation. Only one, *DBT Coach*, has been examined among people with co-occurring AOD use disorders.

DBT Coach is a mobile phone application designed to improve the generalisation of specific skills taught in DBT. In a pilot study of the feasibility, acceptability, and effectiveness of *DBT Coach* among people with co-occurring BPD and AOD use disorders, participants found the application to be helpful and easy to use, and over the course of the study, there was a decrease in depression, emotion intensity, and urges to use AOD [1535]. A second study that evaluated *DBT Coach* among people with single disorder BPD also found reductions in subjective ratings of distress and urges to self-harm, but borderline symptoms and emotional regulation did not improve [1536].

Other mobile phone applications developed for BPD include *EMOTEO*, *mDiary* and Monsenso's *mHealth for Mental Health* module for BPD. *EMOTEO* targets emotion regulation through engagement with mindfulness or distraction exercises that are matched to the user's level of distress. An initial pilot study found that people using the app reported high levels of satisfaction, and that the application reduced aversive

tension over time [1537]. *mDiary* and Monsenso's *mHealth for Mental Health* BPD modules provide the opportunity for mood, symptom, medication, and skills monitoring, alongside changes in BPD symptoms [1538, 1539]. Although interviews with people who have used these apps found that users viewed the app as being user-friendly [1538], and helped in facilitating access to, and helping them implement, DBT strategies [1539], outcomes related to psychopathology were not assessed.

In addition to apps based on DBT, one e-health program, *Priovi*, a schema-therapy based intervention designed as an adjunct to individual psychotherapy, has been evaluated among people with single disorder BPD [1540]. Compared to baseline, using *Priovi* over 12 months was found to reduce BPD symptoms; however, some exercises provoked mild anxiety.

The use of telehealth interventions has yet to be examined among people with co-occurring BPD and AOD use specifically. However, an evaluation of the use of telehealth among people with BPD as a single disorder during the recent COVID-19 pandemic suggests that the delivery of treatments such as ACT and DBT is as effective when conducted over the phone as treatment in person [1541].

Physical activity

Physical exercise may be a useful part of a treatment approach for people with BPD, with research indicating that obesity among people with BPD increases over time, escalating the risk of obesity-related chronic medical conditions [1542, 1543]. BPD has been associated with chronic health problems later in life, such as arteriosclerosis, hypertension, heart disease, CVD, stroke, liver disease and arthritis [1544, 1545]. Although there has been no research examining the effect of physical activity on symptoms of BPD, one study recommended that initial interventions include improved sleep and scheduled exercise. It should be noted however, that this recommendation is based on theory, and lacks supportive evidence [1546]. As such, while it may be prudent for people with BPD to maintain healthy living practices, which may include physical activity, a healthy diet, and adequate sleep (see **Chapter B1**), to date there is no evidence regarding the effect of these practices on symptoms of BPD.

Complementary and alternative therapies

Although there has been some preliminary research with promising results for the use of omega-3 [1534, 1547], at present there is very little research examining the use of complementary or alternative approaches in the management or treatment of BPD, either as a single disorder or co-occurring with AOD use. However, one study found that ear acupuncture provided within the context of a modified 3-month therapeutic community for AOD use disorders that included comprehensive psychotherapy (including DBT) was positively associated with successful program completion [1548].

Antisocial personality disorder (ASPD)

There is a dearth of research regarding the psychological and pharmacological treatment of both ASPD as a single disorder, as well as co-occurring with AOD use. More research has been conducted among incarcerated populations, which may be reflective of the difficulty accessing and engaging those with ASPD in treatment within the community [1549]. Further, many studies focus on changes to symptoms and behaviour of ASPD, rather than changes to personality [1549].

Psychotherapy

A Cochrane review of psychotherapies for ASPD was unable to draw firm conclusions from the available evidence [1550]. Of the 19 studies included in the review, eight were conducted among people with co-occurring ASPD and AOD use disorders [1551–1558]. No study found significant changes to specific ASPD behaviours (e.g., offending, aggression, impulsivity); however, several found significant reductions in AOD use following treatment [1553, 1554, 1556, 1557]. The addition of contingency management and/or CBT to standard methadone maintenance was found to be superior compared to standard methadone maintenance alone [1553]. Further, contingency management plus standard methadone maintenance has been associated with significantly greater counselling session attendance and improvements in social functioning compared to standard methadone maintenance alone [1555].

A driving whilst intoxicated program plus incarceration has also been shown to produce greater improvements compared to incarceration alone [1557]. This intervention utilised principles of MI and Fraser and colleagues [162] suggest that this may be indicative of a benefit of non-confrontational approaches over confrontational approaches in enhancing outcomes for people with ASPD.

There is some evidence supporting the use of brief psychoeducation interventions and cognitive remediation among people with co-occurring ASPD and AOD use. *Impulsive Lifestyle Counselling* is a brief psychoeducation intervention which aims to foster awareness about behavioural difficulties, increase personal accountability, and support clients to develop alternative coping strategies [1559]. Several RCTs have found that, relative to treatment as usual, four sessions of *Impulsive Lifestyle Counselling* delivered over four weeks with a booster session delivered 8 weeks later [1559], significantly reduces AOD use, improves abstinence from AOD use, increases self-rated help for ASPD symptoms at 3 months post-treatment [1560] and reduces AOD treatment dropout at 10 months post-treatment [1561]. Moreover, self-rated help for ASPD symptoms has been associated with improvements in abstinence from AOD use and treatment retention [1560].

Cognitive remediation aims to improve cognitive functioning by targeting factors such as attention and memory. Four weeks of cognitive remediation provided to people with an AOD use disorder, 25-35% of whom also had a lifetime diagnosis of ASPD, was associated with improvements in impulsivity, self-control, quality of life, and AOD use cravings relative to treatment as usual [961].

Pharmacotherapy

Although several studies have examined pharmacological interventions among people with ASPD as a single disorder, a Cochrane review concluded that the limited evidence available does not provide enough support for strong recommendations [1562]. These studies have investigated the use of antiepileptics (carbamazepine, phenytoin, sodium valproate, divalproex sodium and tiagabine); antidepressants (desipramine, fluoxetine and nortriptyline); dopamine agonists (bromocriptine and amantadine); central nervous system agonists (methylphenidate); and opioid antagonists (naltrexone).

Despite the limited evidence, there has been some research conducted among people with co-occurring ASPD and AOD use. A Cochrane review examining pharmacological treatments for ASPD found that two drugs (nortriptyline and bromocriptine) were associated with improved outcomes compared to placebo control conditions among those with co-occurring conditions [1562]. Compared to placebo, those with

ASPD and AOD use disorder who were taking nortriptyline illustrated a greater reduction in alcohol use and dependence [1563]. In the same study, the use of bromocriptine was found to reduce anxiety symptoms for those with depression/anxiety and AOD use disorders [1563]. However, no changes to ASPD symptoms were observed. An additional study found that people with antisocial traits demonstrated greater reductions in alcohol use when administered naltrexone relative to people low on antisocial traits [1564].

Based on the lack of consistent evidence, the UK NICE Guidelines do not recommend treating ASPD, nor co-occurring ASPD and AOD use disorders, with pharmacological interventions. They also advise against treating underlying behavioural symptoms with pharmacotherapy [1565].

E-health and telehealth interventions

At the time of writing, there were no e-health or telehealth treatments for ASPD either as a single disorder or co-occurring with AOD use.

Physical activity

At the time of writing, no research has examined the effects of exercise interventions among people with co-occurring ASPD and AOD use or ASPD as a single disorder.

Complementary and alternative therapies

At the time of writing, there has been no research to support the use of complementary or alternative therapies among people with co-occurring ASPD and AOD use. However, limited evidence suggests that meditation may improve secondary outcomes related to the treatment of ASPD as a single disorder, such as self-control and empathy [1566].

Summary

In general, there is relatively little research to guide treatment for co-occurring personality disorders and AOD use disorders. The first line of treatment for those with co-occurring BPD and AOD use should be psychotherapy, with several interventions having been examined among people with co-occurring BPD and AOD use. Similarly, psychological interventions should be the first line of treatment for those with co-occurring ASPD and AOD use, although the available evidence is less well-developed. Without evidentiary support, pharmacological intervention is not recommended for the treatment of either co-occurring BPD and AOD use, or ASPD and AOD use, highlighting the need for further well-conducted studies to be undertaken in this area.

Box 22 illustrates the continuation of case study I, following Mira's story. As illustrated, it may be necessary to plan treatment over the long-term and coordinate between multiple services in the delivery of care to a person with co-occurring personality disorders and AOD use disorders.

Box 22: Case study I: Treating co-occurring BPD and AOD use: Mira's story continued

Case study I: Mira's story continued

The AOD worker immediately noted Mira's high risk of overdose and organised for Mira to have naloxone training, which she had never had previously, as well as several take-home naloxone kits. The AOD worker also liaised with probation and parole. As part of the new program, Mira underwent comprehensive medical and psychological assessment, where she was also diagnosed with Hepatitis C. Mira immediately began direct-acting antiviral treatment.

As Mira's medical needs were being addressed and she began to physically feel better, she told her AOD worker that she didn't want to keep going the way she has been and end up back in prison – she wanted to change. The AOD worker organised for Mira to be put on the wait list for a local DBT-S program. Mira initially didn't attend, but using MI techniques, the AOD worker helped Mira remember why attending was so important to her, and she started attending her appointments regularly. Mira's AOD worker continued to provide support along with strategies on emotion regulation and relapse prevention. While there were several setbacks, Mira remained committed to her treatment plan.

Key points:

- Both the BPD and AOD use should be addressed concurrently, and the approaches carefully coordinated.
- The need for multi-agency cooperation and information sharing is important and, in the case of co-occurring disorders, interventions need to be planned over months and years rather than weeks.

Substance-induced disorders

Substance-induced disorders

Clinical presentation

It can be difficult to distinguish substance-induced disorders from independent mental disorders at initial presentation. As described in **Chapter A4**, substance-induced disorders are those that occur as a direct physiological consequence of AOD intoxication or withdrawal, and usually abate following a period of abstinence [10]. Symptoms of mood, anxiety, psychotic, obsessive-compulsive, sleep, and neurocognitive disorders, as well as sexual dysfunction and delirium, may all be substance-induced. It is also possible that people may present to treatment with a combination of substance-induced and independent mental disorders [1567].

More information about identifying substance-induced disorders is described in **Chapter B3**. While distinguishing between substance-induced and independent mental disorders can be difficult, it is crucial that people experiencing mental health symptoms who are currently using substances, or with a history of AOD use, are not automatically assumed to have a substance-induced disorder [1568]. Such assumptions may lead to the person not being provided with appropriate and timely treatment.

Managing substance-induced symptoms

Symptoms of substance-induced disorders tend to reduce over hours to days with a period of abstinence [171]. With respect to amphetamine-induced psychosis, however, some people report experiencing symptoms of psychosis for months [170]. Substance-induced symptoms can have a dose-response relationship with AOD use, such that the heavier a person's AOD use is, the more intense their symptoms are likely to be [1569, 1570]. Heavier AOD use is associated with an increased likelihood of progressing to a substance-independent disorder [1570].

In relation to symptom-management, workers should be guided by the management strategies outlined in the earlier sections of this chapter for managing symptoms of substance-induced disorders, in relation to the predominant symptoms experienced by the client. It may also be useful to explain to clients that substance-induced symptoms will likely subside after a period of abstinence and stabilisation. Providing clients with simple strategies to manage their emotions and stress may also be useful, as psychosocial stressors can cause a recurrence of substance-induced symptoms [1571]. **Appendix CC** describes some relaxation methods which clients may find useful.

Ongoing symptom monitoring and assessment is crucial in the management of a person who is suspected of having a substance-induced disorder, both during and after discharge, as a significant proportion of people who receive a diagnosis of a substance-induced disorder are later diagnosed with independent mental disorders. It is estimated that between 25-32% of clients who receive a diagnosis of substance-induced major depressive disorder are diagnosed with major depressive disorder one year later [1078, 1572]. Similarly, a systematic review and meta-analysis examining the transition of substance-induced psychosis to schizophrenia found that 25% of those with substance-induced psychosis transitioned to schizophrenia. The risk of transitioning to schizophrenia was highest for cannabis-induced psychosis (34%), followed by hallucinogens (26%), amphetamines (22%), opioids (12%), sedatives

(10%), and alcohol (9%) [38]. Findings suggest that half of all cases who transition to a diagnosis of schizophrenia do so within two-to-three years [36, 1573]; 80% within five years [1573]. A similar proportion of people diagnosed with substance-induced psychosis are later diagnosed with bipolar disorder (24%), 50% within four years of their diagnosis of substance-induced psychosis [36].

Treating substance-induced disorders

As symptoms of substance-induced disorders are likely to reduce with abstinence, abstinence is generally recommended as a treatment approach, with careful monitoring of mental health symptoms [35]. Workers are referred to previous sections of this chapter for evidence in relation to the treatment of specific mental disorders; as, in general, evidence for the treatment of substance-induced disorders beyond abstinence is lacking.

Summary

Symptoms of substance-induced disorders will typically reduce following a period of abstinence. During this time, it is critical to monitor mental health symptoms and provide ongoing support, being mindful of the possibility of the substance-induced disorder progressing to an independent mental disorder.

Other conditions

Confusion, disorientation or delirium

On occasion a client may present with no specific symptoms but is generally confused or disorientated. The client's confusion or disorientation may be the result of intoxication, or a physical or mental health condition. In such cases, the AOD worker should [1574–1576]:

- Provide frequent reality orientation (e.g., explain where the person is, who they are, and what your role is).
- Provide reassurance.
- Attempt to involve family, friends, or carers.
- Attempt to have the client cared for by familiar healthcare workers, in familiar surroundings.
- Attempt to maintain a regular schedule for the client.
- Explain any procedures the staff are applying (e.g., physical exams, treatment).
- Encourage mobility.

The UK NICE Guidelines for the diagnosis and management of delirium [1576] recommend that, if the client is considered a risk to themselves, AOD workers should de-escalate the situation using verbal and non-verbal strategies. If these techniques are ineffective, haloperidol can be administered for up to a week. If delirium does not resolve, underlying causes, such as possible dementia, should be investigated.

Cognitive impairment

In the process of treatment, it may become clear that the client has impaired or poor functioning in one or many areas of cognition, such as verbal or non-verbal memory, information processing, problem-solving, reasoning, attention and concentration, decision-making, planning, sequencing, response inhibition and emotional regulation. Sometimes these cognitive impairments can result in behaviour that is mistakenly interpreted as the result of poor motivation or lack of effort, with impairments in executive functioning and goal-directed behaviour often the most commonly observed cognitive impairments in AOD settings [389].

Cognitive difficulties often bear no relation to mental illness and are sometimes the result of heavy AOD use or intoxication, or as a consequence of traumatic/acquired brain injury [1577]. There can, however, be a tendency for cognitive difficulties to be misattributed or minimised as being exclusively related to AOD use, leading to lack of further investigation, treatment, and subsequently further harm. While cognitive impairment is common among clients of AOD services, there are a multitude of medical, social, and neurodevelopmental factors that may contribute to its development, many of which are undiagnosed at service entry [1578]. Prescription medications and polypharmacy can also contribute to cognitive impairment. Appendix I contains information on a screening measure that AOD workers may find useful in identifying clients who may be at risk of cognitive impairment, and it is recommended that workers consult with neuropsychologists where appropriate.

AOD workers may find the recently released Turning Point guidelines on managing cognitive impairment in AOD treatment settings useful, which are available from: https://www.turningpoint.org.au/treatment/clinicians/Managing-Cognitive-Impairment-in-AOD-Treatment-Guidelines

When a client is experiencing some level of cognitive impairment, the effectiveness of therapeutic approaches can be diminished unless care is taken to adapt the approach to address these difficulties. Table 56 presents some simple techniques which can be useful in overcoming cognitive impairment [389].

Table 56: Techniques for managing cognitive impairment

General techniques to address cognitive impairment
• Integrate strategies such as repetition, writing things down, and cues to recall important information, into counselling. • Provide structure during sessions, reduce the pace of sessions, and avoid overloading clients with information. • Encourage healthy behaviours such as social and leisure activities. • Encourage or incorporate stress reduction strategies such as mindfulness. • Support motivation and realistic hope by informing clients that cognitive impairment from AOD use can improve with AOD reduction and targeted interventions.
Techniques to address attention problems
• Have a clear structure for each session. • Consider shorter but more frequent sessions. • Avoid overloading by limiting the content of each session. • Keep sessions focused on relevant topics. • Reduce session pace and provide breaks. • Conduct sessions in a quiet, non-distracting environment. • Provide written handouts of important information.
Techniques to address learning and memory problems
• Present information to be remembered both verbally and visually (e.g., draw diagrams). • Repeat and summarise key information. • Ask client to recall information from previous sessions, and suggest techniques to improve recall (e.g., writing things down, using memory aids). • Review key points from previous sessions at the start of each session to compensate for poor memory. • Remind client of appointment times and keep appointments at routine times.

Table 56: Techniques for managing cognitive impairment (continued)

Techniques to address difficulties with mental flexibility, problem-solving, planning, and organising
• Encourage routines and daily planning. • Explain step-by-step problem solving and how to break goals into smaller, more manageable tasks. • Discuss and practice responding to high-risk situations. • For impulsive clients, encourage self-monitoring and use of cue cards with strategies to use.

Adapted from Stone et al. [389].

Preliminary research suggests that psychological interventions focusing on cognitive training, such as cognitive enhancement and remediation, can improve cognitive functioning among clients in AOD treatment settings [961, 1579, 1580]. Both cognitive remediation and cognitive enhancement therapies utilise computerised games and tasks to enhance domains of cognitive functioning (e.g., attention, memory), but cognitive enhancement therapy additionally targets holistic factors such as social skills and vocational capabilities to improve overall functioning [1581].

However, training for a specific cognitive impairment may have limited transference to other cognitive domains [1582]. There is preliminary evidence to suggest that pharmacotherapies such as galantamine (an acetylcholinesterase inhibitor) and modafinil may be effective in improving working memory among people with cocaine dependence [1583, 1584].

Grief and loss

There is a multitude of different sources of grief and loss, and clients in AOD settings are often highly likely to experience these emotions for a variety of reasons. Feelings of grief or loss are often associated with traumatic experiences. It is also common for AOD clients to have lost partners, family members, or friends as a result of AOD use. Receiving treatment for AOD issues is likely to cause feelings of loss due to the heavy role AOD use plays in the client's life [389, 1585]. Other tangible losses may include the loss of relationships, employment, finances, identity, spiritual beliefs, and physical health, but a person may also experience intangible losses such as loss of hope, dignity, identity, self-worth, trust, or values [389, 1586].

Clients experiencing grief may report symptoms similar to those of major depression, such as sadness, tearfulness, difficulty sleeping, and decreased appetite. However, it is unlikely that clients experiencing feelings of grief and loss would also experience the cognitive symptoms of depression, such as feelings of guilt, hopelessness, helplessness and worthlessness [1587]. Also, while some people impacted by grief and loss may express a desire to be reunited with a lost loved one, they generally do not experience the persistent suicidal ideation that may be experienced by some people with major depression. Nevertheless, as discussed in Chapter B4, continued assessment should be undertaken, as well as a thorough risk assessment for any client who may be at increased risk of suicide, as major depression may develop following grief reactions.

Symptoms of grief and loss fall into a number of categories including [389, 1585, 1588]:

- **Emotional** – feelings of shock, numbness, disbelief, loss of control, fear, panic, confusion, anger, sadness, guilt, desire to blame, or hostility. The person is likely to fluctuate between different emotional states.
- **Psychological** – in addition to these emotions, clients may also have a preoccupation with the deceased, or a sense of the presence of the deceased. Temporary cognitive impairments are also common (e.g., concentration and memory complaints).
- **Physical** – gastro-intestinal complaints, decreased sex drive, tension, headaches, sleep/appetite disturbances, fatigue, lethargy, or depersonalisation/dissociation.
- **Behavioural/social** – inappropriate behaviour (e.g., laughter), social withdrawal, avoidance of objects or people related to grief/loss, sighing, restlessness, crying, absentminded behaviour, obsessive behaviour, or hyperactivity.

The above symptoms are all normal responses to grief that tend to dissipate as a person adjusts to the loss over time. For some people, however, these symptoms may persist for an extended period and significantly impair their ability to function. In recognition of this experience, the most recent edition of the DSM has introduced the new diagnosis of prolonged grief disorder. Prolonged grief disorder is characterised by an intense longing for the deceased person or a preoccupation with thoughts and memories of the person alongside other grief-related symptoms that occur most of the day, nearly every day. Grief-related symptoms experienced as a result of the death include identity disruption (e.g., feeling as though part of oneself has died); a marked sense of disbelief about the death; avoidance of reminders that the person is dead; intense emotional pain; difficulty reintegrating into one's relationships and activities (e.g., problems engaging with friends, pursuing interests, or planning for the future); emotional numbness; feeling that life is meaningless; and intense loneliness.

Managing grief and loss

Table 57 presents strategies for managing these symptoms. While symptoms of grief and loss may resemble each other, clients may not recognise their response as grief if it is unrelated to death [389, 1589]. The main issue in grief management is to normalise the process for the client. That is, encourage and support the grieving process, and remind the client that this process is natural [389, 1585]. Clients in AOD settings may struggle resolving their grief, as this process usually requires the ability to tolerate and express intense emotion [1586]. Everyone deals with grief and loss differently and therefore not all approaches will work for everyone. It has been suggested that treatment for grief and loss in AOD settings should target coping skills that can help clients process the emotions triggered by loss by [1586, 1590]: i) accepting the reality of the loss; ii) processing the pain associated with the loss; iii) adjusting to a world without the loss, and; iv) finding an enduring connection with the loss while moving on [389, 1588]. An information sheet for clients on grief and loss reactions is provided in the **Worksheets** section of these Guidelines.

Table 57: Dos and don'ts of managing a client with symptoms of grief or loss

Do:	
✓	Encourage the acceptance of the reality of the situation (e.g., discuss the loss, encourage client to attend gravesite), as well as the identification and experience of feelings (positive and negative) associated with loss.
✓	Normalise the client's emotional, psychological, physical, and behavioural reactions to the loss.
✓	Help the client find a suitable way to remember, but also reinvest in life.
✓	Continually monitor levels of depression and suicidal thoughts and act accordingly; risk is increased during periods of grief (e.g., the first 12 months after a death, anniversaries, holidays).
✓	Be aware and understanding of feelings associated with grief, including anger.
✓	Give both practical and emotional support.
✓	Give the client your undivided attention and unconditional positive regard.
✓	Be aware that concentration may be affected, therefore repeat instructions, write down instructions and so on.
✓	Discuss emotions and behaviours related to the loss, including AOD use.
✓	Encourage healthy avenues for the expression of grief (e.g., physical activity, relaxation, artistic expression, talking, writing) rather than AOD use.
✓	Encourage the client to seek social support. This may include bereavement services.
Don't:	
✗	Avoid the reality of the situation or the feelings associated with it (e.g., use the name of deceased).
✗	Judge or be surprised at how the client reacts – every person is different.
✗	Time-limit the client when discussing grief, it can be a slow process and the story related to grief may be retold many times.
✗	Be afraid to seek assistance.

Adapted from Marsh et al. [1585], Stone et al. [389] and Horton et al. [1591].

Aggressive, angry, or violent behaviour

Problems relating to anger and aggression are not uncommon in AOD services and should be managed appropriately [1592]. Anger and aggression may occur regardless of whether a person has a co-occurring mental health condition. In general, episodes of aggression are usually triggered by a particular event, which may involve circumstances that have led the client to feel threatened or frustrated.

The following signs may indicate that a client could potentially become aggressive or violent [431]:

- **Appearance:** intoxicated, dishevelled or dirty, bloodstained, bizarre, carrying anything that could be used as a weapon.
- **Physical activity:** restless or agitated, pacing, standing up frequently, clenching of jaw or fists, hostile facial expressions with sustained eye contact, entering 'off limit' areas uninvited.
- **Mood:** angry, irritable, anxious, tense, distressed, difficulty controlling emotions.
- **Speech:** loud, swearing or threatening, sarcastic, slurred.
- **Worker's reaction:** fear, anxiety, unease, frustration, anger.

If a client becomes aggressive, threatening or potentially violent, it is important for AOD workers to respond in accordance with the policies and procedures specific to their service. It is also important for AOD workers to have knowledge of how to respond to challenging behaviour, including physical threats or actual violence, in their work with AOD clients. Table 58 outlines some general strategies for managing aggressive clients. Beyond immediate responses that are described below, clients who have persistent issues with anger may benefit from anger management programs that promote the development of coping skills for anger regulation, problem-solving skills, and promote relaxation [1593, 1594].

Table 58: Dos and don'ts of managing a client who is angry or aggressive

Do:	
✓	Stay calm and keep your emotions in check.
✓	Adopt a passive and non-threatening body posture (e.g., hands by your side with empty palms facing forward, body at a 45-degree angle to the aggressor).
✓	Approach the client from the front.
✓	Move the client to a place without an audience if possible, and try to reduce environmental stimulation.
✓	Let the client air their feelings and acknowledge them.
✓	Ask open-ended questions to keep a dialogue going.
✓	Be flexible, within reason.
✓	Use the space for self-protection (position yourself close to the exit, don't crowd the client).

Table 58: Dos and don'ts of managing a client who is angry or aggressive (continued)

Do:	
✓	Structure the work environment to ensure safety (e.g., have safety mechanisms in place such as alarms and remove items that can be used as potential weapons).
✓	Make sure other clients are out of harm's way.
Don't:	
✗	Challenge or threaten the client by tone of voice, eyes or body language.
✗	Say things that will escalate the aggression.
✗	Yell, even if the client is yelling at you.
✗	Turn your back on the client.
✗	Rush the client.
✗	Argue with the client.
✗	Dismiss delusional thoughts. These thoughts are real for the client.
✗	Stay around if the client doesn't calm down.
✗	Ignore verbal threats or warnings of violence.
✗	Tolerate violence or aggression.
✗	Try to disarm a person with a weapon or battle it alone.

Adapted from NSW Department of Health [431] and Stone et al. [389].

Phases of aggression

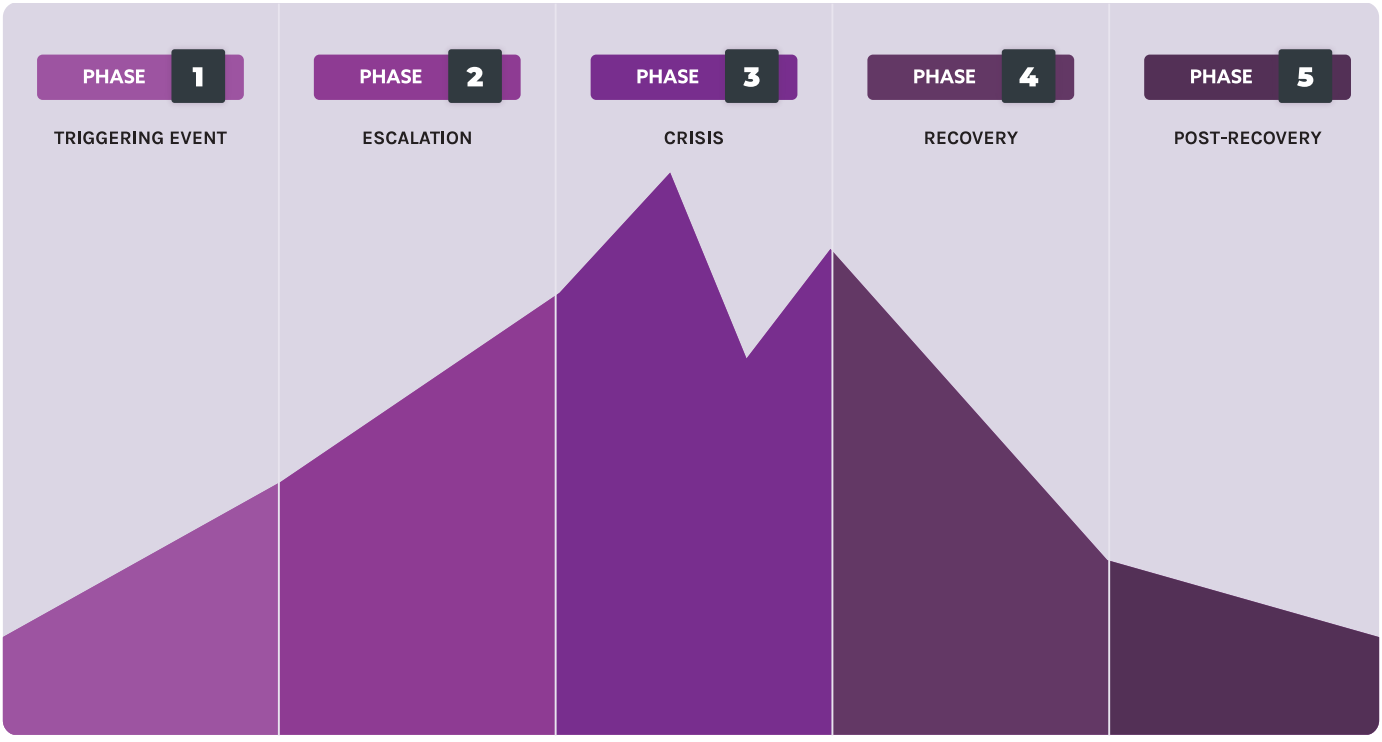
This section has been adapted from information provided by Sunshine Coast Mental Health Service [1595] and NSW Department of Health [431]. Aggressive episodes may be broken down into more detailed phases. Gaining an understanding of these phases and some of the symptom-control strategies is useful in controlling anger and aggression. Figure 18 outlines these phases of aggression.

Phase 1: Triggering event

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

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

Figure 18: Phases of aggression



Source: NSW Department of Health [431].

Phase 2: Escalation

Phase 2 is the escalation phase. It is important to recognise and address signs of distress or conflict and use appropriate techniques to try and de-escalate the situation. Common signs of escalation include pacing, voice quivering, quick breathing, flushed face, twitching, dilated pupils, tense appearance, abusive, intimidating and derogatory remarks, and clenched fists.

The LASSIE model is a useful tool for communication and de-escalation of the situation in this phase:

L	Listen actively: allow the client to run out of steam before you talk.
A	Acknowledge the problem/situation: validate the client's feelings, empathise.
S	Separate from others: to ensure the safety of others if escalation occurs.
S	Sit down: symbolises readiness to negotiate.
I	Indicate possible options: give alternatives to alleviate the situation.
E	Encourage the client to try these options: assist the client to follow through.

The following strategies may also be useful in managing escalating aggression:

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

Phase 3: Crisis

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

Phase 4: Recovery

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

Phase 5: Post-crisis depression

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

Concluding remarks

Although much of this review of treatments leaves many questions to be answered, there are some guiding principles that tend to be repeated throughout. It is clear that much more research is needed before definitive practices that will improve outcomes for both mental health and AOD use disorders can be prescribed. Despite this, it can be generally concluded that treatments that work for a single disorder will lead to some improvements in clients with co-occurring conditions, if not in both disorders. Although integrated treatments appear beneficial for some disorders, further investigation is needed [659, 666–669, 954].

For most co-occurring conditions, both psychotherapy and pharmacotherapy interventions have been found to have some benefit. Both of these require some basic knowledge or qualifications on the part of the AOD worker. In particular, psychosocial interventions tend to be based on motivational and cognitive behavioural approaches and AOD workers will benefit significantly if trained in these intervention styles. It is generally acknowledged that manual-based psychological interventions are easy to administer and are the most effective for CBT-style treatments. It is important to recognise that research demonstrating the potential of other approaches to treating co-occurring conditions, such as mindfulness, contingency management, ECT, and e-health interventions, is growing. For pharmacological interventions, an important role for AOD workers is to inform themselves of the benefits, interactions and possible side effects of the medications prescribed for their clients. Workers can assist their clients with suggestions for medication scheduling as well as providing adherence therapy.

B8: Worker self-care

B8: Worker self-care

Key points

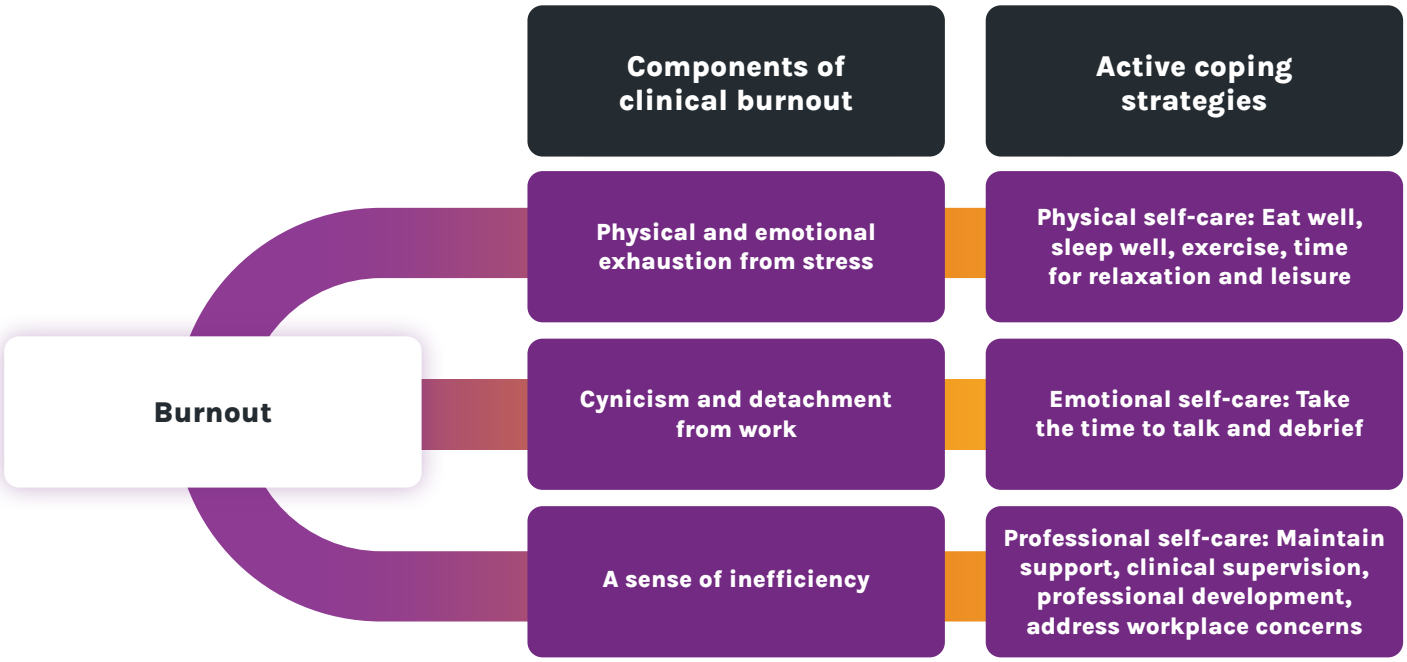
- Working directly with clients with co-occurring mental health and AOD conditions can be an incredibly rewarding and satisfying experience but is not without considerable challenges. AOD workers often experience high levels of stress and are at risk of experiencing burnout, compassion fatigue, and vicarious trauma.
- The most common workplace stress for AOD workers is the stress associated with workload and time pressures, but other stressors include concerns about whether your work is making a difference, whether you have the necessary skills and are effective in your role, whether your work is valued and adequately remunerated, workplace conflict, lack of supervisory and collegial support, and job uncertainty.
- As such, it is important that AOD workers ensure they take the time for self-care. Strategies incorporating a holistic approach to AOD worker self-care can help AOD workers in managing workplace stress and responding to workplace situations.
- Active coping strategies can help reduce the risk of clinical burnout, compassion fatigue, and vicarious trauma, and include physical, emotional, and professional self-care. Further, workplace engagement and appreciating the impact and value of your work can reduce the risk of burnout.
- Organisational factors, such as the provision of adequate clinical supervision, may also help in preventing and assisting with the management of work-related stress.

Working with clients who have co-occurring mental health and AOD conditions can be a fulfilling and satisfying experience. Having the opportunity to work directly with clients, and to observe and share the triumphs and tribulations of their personal journeys, can be extremely professionally rewarding. However, working in this area is not without considerable challenges. Although a manageable level of workplace stress is normal, and can even be motivating, AOD workers often experience high levels of stress and, in some cases, burnout. Other stress-related reactions can include compassion fatigue and vicarious trauma (also referred to as secondary traumatic stress). Stress is experienced when task demands exceed a person's available personal and social resources [1596]. As such, it is critically important that AOD workers manage and pay attention to their self-care.

Burnout

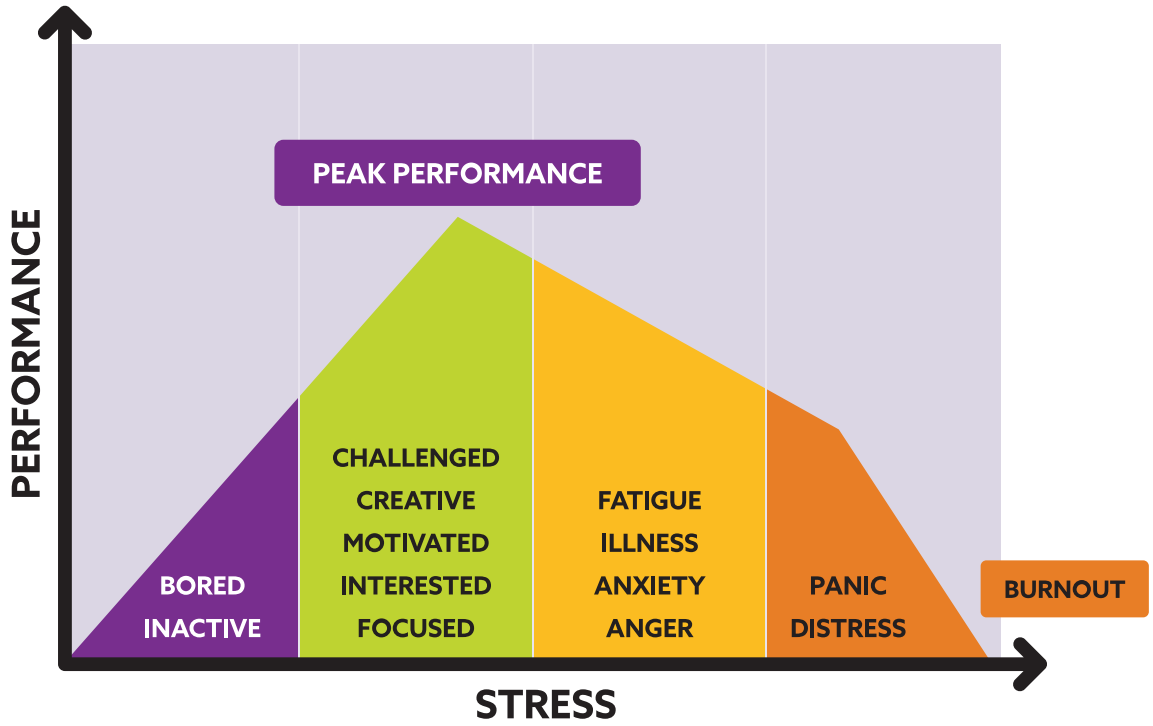
Burnout is the term used to describe the experience of long-term strain and exhaustion. It is typically a response to work overload when there is prolonged and intense stress, accompanied by ineffective coping strategies [389]. Components of burnout and active coping strategies are illustrated in Figure 19.

Figure 19: Components of clinical burnout



While some stress has been found to enhance performance, this is only up to a point. As shown in Figure 20, evidence suggests there is a 'sweet spot' of stress, which can enhance motivation and optimise creativity, where workers are challenged and engaged by their tasks. On the other hand, a lack of challenging and engaging work can result in boredom, disengagement and decreased productivity. Beyond the sweet spot, too much stress can reduce performance and lead to fatigue, illness, irritability and burnout [1597].

Figure 20: Performance stress model



Adapted from Yerkes and Dodson [1597].

Prior to the COVID-19 pandemic, more than one-third of AOD workers across Australia reported having experienced some degree of burnout [7], but this rate is likely to be an underestimate of the current situation as rates of burnout have since soared across healthcare professions [1598]. Typically these feelings are associated with the pressure to meet the clinical demands of caring for a large volume of clients, who often present with complex and challenging treatment needs and may be challenging to engage and retain in treatment, as well as frequent staff shortages [399, 1599–1603]. Other workplace stressors and risk factors include [389]:

- Excessive workload and time pressure.
- Role conflict from different job demands.
- Role ambiguity due to lack of resources and unclear goals.
- Lack of support from co-workers and supervisors.
- Lack of feedback about performance.
- Lack of control and involvement in decision-making.
- Concern about whether you are making a difference.
- Concern about whether you are doing your job effectively.
- Concern about whether you are valued and adequately remunerated.
- Distressing outcomes for clients.
- Workplace conflict.
- Lack of support for training or adequate clinical supervision.
- Job uncertainty.

Experiencing burnout can lead to reduced job satisfaction and performance, and may lead AOD workers to become exhausted, detached from clients, and feel ineffective and cynical about the profession [389, 431]. These feelings have also been found to predict whether workers will choose to continue working in the AOD sector [1604].

It is important that AOD workers who believe they may be at risk of burnout approach their supervisors and seek arrangements for support, including the use of relevant Employee Assistance Programs where available. Active coping and holistic self-care strategies, described below, have also been associated with reduced levels of stress and reduced likelihood of burnout [389, 1605].

Compassion fatigue

Compassion fatigue is a state of exhaustion resulting from prolonged exposure to another person's emotional pain whereby a person has difficulty maintaining empathy and compassion for others [1606]. It is common not only among AOD workers, but healthcare providers more broadly [1607, 1608].

Compassion fatigue can lead to declines in job performance, productivity and efficiency and may lead AOD workers to feel increasingly helpless, detached, and exhausted, with a reduced ability to empathise

with the people in their care. Cynicism, frustration, apathy, or judgemental responses may become increasingly prevalent, and workers may question their beliefs in the context of witnessing significant loss [1609]. Risk factors that have been associated with compassion fatigue include [1610, 1611]:

- Insufficient social support (at work and home).
- Insufficient staff resources, training, or supervision.
- High expectations for quality of care.
- Limited variety in work activities.
- Poor work/life balance.
- High workload or workload intensity.
- Professional isolation.
- Personal history of trauma.
- High level of empathy.
- Maladaptive coping style (e.g., self-criticism).
- Lack of emotional self-awareness.

As is the case for burnout and vicarious trauma, the use of active coping and holistic self-care strategies (described later in this chapter) are important for preventing and managing compassion fatigue.

Vicarious trauma

As detailed in **Chapter A2**, a high proportion of clients of AOD services have experienced trauma, and it is important that symptoms of trauma-related disorders such as PTSD be managed and, if appropriate, treated while the person is undergoing AOD treatment. Clinicians who work with traumatised clients describe their work as being extremely rewarding [1612, 1613]; however, hearing the details of clients' trauma can be distressing and, in some cases, lead to vicarious traumatisation or secondary traumatic stress. The majority of AOD workers are themselves trauma survivors and although this lived experience may enable them to empathise with their clients, it also places them in a position to be triggered by clients' trauma [386, 404].

Consistent with international research [1614], a survey of AOD workers from across Australia found that 20% were suffering from secondary traumatic stress [404]. The symptoms of vicarious trauma are similar to those that a person experiences with PTSD (described in **Chapter A4**). It can lead to negatively altered perceptions of both the world and oneself, and make AOD workers feel hypervigilant, isolated, frustrated, guilty, overprotective of loved ones, and desensitised or detached following repeated exposure to trauma narratives [1615]. Other signs may include [1616, 1617]:

- **Physical symptoms:** fatigue, rapid pulse, unexplained aches.
- **Emotional symptoms:** anger, hypersensitivity, helplessness.
- **Cognitive symptoms:** preoccupation with clients, self-doubt, cynicism.

- **Behavioural symptoms:** isolation, hypervigilance, changes in sleep/appetite.
- **Relational symptoms:** minimising concerns, mistrust, projecting blame.
- **Spiritual symptoms:** loss of meaning, questioning of beliefs.

Although the primary cause of vicarious trauma is secondary exposure to trauma material, vicarious trauma may be exacerbated by personal and work-related risk factors such as a personal history of trauma exposure; having experienced a greater number of trauma types; personal stressors; maladaptive coping behaviours; workload; organisational gaps; losses at work; and fewer hours of clinical supervision [404, 1618]. Importantly, findings from an Australian study indicate that secondary traumatic stress may be prevented by monitoring of workers' caseloads and the provision of adequate clinical supervision (described later in this chapter [404]). As in the case for burnout and compassion fatigue, the use of active coping and holistic self-care strategies (described below) are also important for preventing and managing vicarious trauma.

Holistic self-care: AOD workers

The importance of AOD worker self-care cannot be understated. Applying a holistic approach to self-care and the use of active coping strategies may assist AOD workers in responding to distressing events, lessen workplace stress, foster resilience, and increase their capacity to respond to workplace situations. AOD workers have described the usefulness of both self-initiated and organisational strategies which may include [389, 431, 1599, 1619–1624]:

- **Physical self-care:** Maintaining a balanced, healthy diet; sleeping well; allowing time every day for lunch and physical exercise; making time for relaxation and leisure activities; being aware of one's own AOD use.
- **Emotional self-care:** Using relaxation techniques (such as those in Appendix BB and Appendix CC); practising self-compassion; maintaining a balance between work commitments and family/personal life; scheduling regular holidays and other breaks from work (e.g., conferences, education seminars, clinical supervision); maintaining healthy supportive relationships; seeking help from medical or mental health specialists when needed.
- **Professional self-care:** Creating and contributing to a physically and psychologically safe working environment; ensuring opportunities to formally and informally debrief with co-workers; maintaining contact with peers and avoiding professional isolation; engaging in peer support, clinical supervision, and professional development activities; using time-management skills; taking the opportunity to address work-related concerns, demands, unfairness, or inequity; maintaining a feasible workload; diversifying work activities.

Clinical supervision

Clinical supervision can help reduce work-related stress by providing a mechanism of support for staff, debriefing, and managing stress. Supervision may also provide opportunities for professional development, skill enhancement, identifying new ways of working with clients, validating existing clinical

skills, and increasing job satisfaction [431]. Although definitions between workplaces differ, in general, clinical supervision means [1625, 1626]:

- Quality assurance and clinical safety.
- A method of improving clinical practice, which involves the worker learning new skills, problem solving effectively, and obtaining suggestions for improving practice (not line management).
- Professional support.
- Workforce development.

Evidence indicates that mental health and AOD workers who receive quality supervision are better able to function across multiple domains, manage their stress more effectively, and are less likely to experience burnout. Some of the demonstrated benefits of clinical supervision include greater job satisfaction [1627–1630], confidence, and self-capacity [1628–1630]; greater perceived opportunities for personal and professional growth [1631]; reduced staff turnover [1632]; improved development of complex clinical skills and delivery of evidence-based practice [1625, 1633, 1634]; reduced stress and burnout [1629, 1635–1637]; reduced work-related frustration [1638]; better communication between staff [1628, 1630, 1631]; and the transfer of newly acquired skills from training into practice [1639, 1640]. Further, less experienced AOD workers can benefit from clinical supervision by receiving feedback on their interpersonal style, counselling skills, and ongoing appraisal [1641]. Clinical supervision also enhances client care by contextualising client experiences to other healthcare professionals [1642]. As such, clinical supervision can improve the quality of client–AOD worker relationships and enhance treatment outcomes [1641]. These findings may explain why effective clinical supervision is associated with reduced burnout [1629], compassion fatigue [1643], and vicarious trauma [404, 1644, 1645].

In 2018, NSW Health reviewed their 2006 clinical supervision guidelines for AOD services, which may be useful for clinicians in other states. The guidelines are not prescriptive but make recommendations for best practice. They are intended to be applicable across disciplines, to all workers in AOD services who are responsible for providing services to clients. As such, the guidelines are designed to provide a comprehensive framework for local operations and encourage some degree of consistency [1625]. These guidelines are accessible via the NSW Health website: **https://www.health.nsw.gov.au**

Part C: Specific population groups

Part C: Specific population groups

Part C of the Guidelines aims to provide workers with an overview of the available evidence for managing and treating co-occurring AOD and mental conditions within specific population groups. Numerous cultural and contextual factors need to be considered such as the client's cultural background, gender and sexual identity, stability of accommodation, whether they live in remote locations, and whether treatment is being coerced. It is important that AOD workers are aware of specific factors that may affect the management and treatment of people from these groups so that they may tailor treatment appropriately. Although the available evidence for managing and treating co-occurring conditions is described according to different population groups, workers should be aware that it is likely that people attending AOD services will belong to more than one group.

The predominant approaches to treatment and service delivery for AOD use and co-occurring conditions have been driven by research conducted on (and by) the dominant culture of urban-dwelling Westernised adults. This is not to say that these techniques will not be effective for clients from different backgrounds with diverse needs, but rather that approaches may need to be adapted depending on the individual needs and characteristics of clients, in keeping with person-centred approaches.

Aboriginal and Torres Strait Islander people

Aboriginal and Torres Strait Islander people experience considerably poorer physical and mental health in comparison to the wider Australian community. Research shows that, although there are proportionately more Aboriginal and Torres Strait Islander people than non-Aboriginal and Torres Strait Islander people who refrain from drinking [1646], those who do drink are more likely to do so at high-risk levels [1646, 1647]. Between 2014–2018, both Aboriginal and Torres Strait Islander men and women died from alcohol-related causes at a rate four and a half times higher than their non-Aboriginal and Torres Strait Islander counterparts [1646]. As a result, it is possible that heavy drinking may be normalised within some communities, which may act as a barrier to people seeking treatment [1648].

However, alcohol is not the only substance that presents a major concern for Aboriginal and Torres Strait Islander people. In 2012-13, 46% of Aboriginal and Torres Strait Islander people over the age of 15 years reported using an illicit substance in their lifetime; in 2018-2019, 29% reported use in the previous 12-months (37% of men; 22% of women) [1649]. Substances most commonly used in 2018-19 included cannabis (25%), amphetamines (3%), and non-prescription analgesics (3%). d'Abbs and colleagues [1650, 1651] have also highlighted the devastating effects of volatile substance use and petrol-sniffing among Aboriginal and Torres Strait Islander communities in Central Australia. Of concern, in 2019 the rate of unintentional drug-related deaths (involving non-pharmaceutical opioids, stimulants, pharmaceutical opioids, benzodiazepines, and cannabinoids) was three times higher among Aboriginal and Torres Strait Islander (20 per 100,000 people) than non-Aboriginal and Torres Strait Islander (6 per 100,000 people) people [1652]. Research has also found that Aboriginal and Torres Strait Islander people aged over 18 years are three times as likely to be current daily cigarette smokers (43%) as non-Aboriginal and Torres Strait Islander people (14%) [1653].

Aboriginal and Torres Strait Islander people are also over-represented in inpatient mental health services, with almost twice as many Aboriginal and Torres Strait Islander people than non-Aboriginal and Torres Strait Islander people hospitalised for a mental illness between 2015–2017 [1654]. Across Australia, the most common mental health conditions requiring hospitalisation between 2015-2017 were substance-induced mental and behavioural disorders (40%), schizophrenia spectrum and other psychotic disorders (23%), depressive and bipolar disorders (13%), and anxiety disorders (12%) [1655]. Further, in 2018–19, Aboriginal and Torres Strait Islander people were almost three times more likely than non-Aboriginal and Torres Strait Islander people to report high or very high levels of psychological distress [1646, 1656].

In 2014–2018, the suicide rate for Aboriginal and Torres Strait Islander people across all age groups was almost double the non-Aboriginal and Torres Strait Islander rate, and highest among those aged 35-39 years [1646]. These rates are likely to underestimate actual suicide prevalence, as self-harm, suicidal ideation, and suicidal attempts are underreported among Aboriginal and Torres Strait Islander people [1657]. Aboriginal and Torres Strait Islander people were also hospitalised for self-harm at nearly three times the rate of non-Aboriginal and Torres Strait Islander people [1646].

There is limited data regarding the population prevalence of AOD and mental health disorders, or their co-occurrence, among Aboriginal and Torres Strait Islander communities; however, a landmark study examining the prevalence of mental health and AOD use disorders among 544 Aboriginal and Torres Strait Islander adults located in urban, regional and remote areas of Southern Queensland and two Aboriginal Reserves located in New South Wales was conducted between 2014-2016 [1658]. This study found that 67% of the sample had experienced a mood, anxiety, or AOD use disorder in their lifetime (73% of men and 63% of women); a rate 30% higher than that observed in the Australian general population. Among those who met diagnostic criteria for an AOD use disorder in the past 12-months, 28% of men and 71% of women also met criteria for a co-occurring mood or anxiety disorder. Table 59 presents the crude prevalence estimates for each mental disorder.

Table 59: Crude prevalence of lifetime mental health disorders among Aboriginal and Torres Strait Islander people

	Men %	Women %	Total %
Mood disorders			
Major depressive disorder	18.4	27.3	23.9
Dysthymic disorder	2.4	3.6	3.1
Bipolar disorders	0.9	3.3	2.4
Any mood disorder	31.9	38.9	36.2
Anxiety disorders			
Panic disorder	7.2	15.1	12.1
Social phobia	9.7	12.2	11.2

Table 59: Crude prevalence of lifetime mental health disorders among Aboriginal and Torres Strait Islander people (continued)

	Men %	Women %	Total %
Anxiety disorders			
Specific phobia	9.7	13.6	12.1
Generalised anxiety disorder	5.7	6.2	6.1
Post-traumatic stress disorder	13.5	25.2	20.8
Obsessive-compulsive disorder	2.4	3.3	2.9
Any anxiety disorder	32.9	49.0	42.8
Substance use disorders			
Alcohol abuse	25.6	15.4	19.3
Alcohol dependence	28.5	19.6	22.9
Substance abuse	15.9	4.2	8.6
Substance dependence	16.4	8.0	11.2
Any substance use disorder	54.6	33.5	41.5
Any mental disorder	**72.9**	**63.2**	**66.9**

Source: Nasir et al. [1658].

There is also little research regarding the prevalence of mental health conditions among Aboriginal and Torres Strait Islander people engaged in AOD treatment; however, analysis of data from a remote Aboriginal residential rehabilitation service in Western NSW revealed that 51% of clients had been diagnosed with a mental health condition [1659]. A subsequent study conducted across other Aboriginal and Torres Strait Islander residential rehabilitation services found that 78% of clients experienced moderate to very high psychological distress, and 88% were categorised as being at risk of a mental health condition [1660]. Other studies have also shown an association between depression, anxiety, suicide, and alcohol dependence in Aboriginal and Torres Strait Islander communities [1661–1663], and an association between the frequency of alcohol consumption and the experiencing of hallucinations, paranoia, self-harm, and panic [1664–1666].

Moreover, as with the general population, Aboriginal and Torres Strait Islander people who experience co-occurring disorders are more likely to experience a range of other difficulties than those with a mental health or AOD use disorder alone [1667]. Aboriginal and Torres Strait Islander women accessing treatment

for co-occurring mental health and AOD use disorders have reported that their co-occurring conditions had led to severe and wide-ranging negative outcomes, such as general poor health, diminished social networks, unemployment, and financial instability. These women also reported that their co-occurring conditions had a serious negative impact on their ability to care for themselves and others (e.g., with some women reporting children being removed from their care) [1668]. Factors that contribute to elevated rates of AOD use disorders and psychiatric morbidity in Aboriginal and Torres Strait Islander communities include the long-term effects of intergenerational trauma linked to the stolen generations and assimilation policies of the Australian Government; high rates of exposure to other traumas; the destruction of social infrastructure; rapid urbanisation and poverty; cultural, spiritual and emotional alienation; loss of identity; family dislocation; and increased AOD consumption [1669–1672]. Trauma exposure, co-occurring PTSD and AOD problems are disproportionately high among Aboriginal and Torres Strait Islander people [1668, 1673]. In a sample of people from remote Aboriginal and Torres Strait Islander communities in Western Australia, 96% reported a history of trauma exposure, 55% met diagnostic criteria for PTSD, and, of these, 91% also met diagnostic criteria for an alcohol use disorder [1673]. Aboriginal and Torres Strait Islander women accessing treatment services have reported a perceived association between negative early life events (e.g., domestic violence, physical and sexual abuse) and the onset of their AOD and mental health conditions, as well as their ability to trust and share personal information with others, including health providers [1668, 1674]. These difficulties may be a significant barrier to help-seeking.

The need for culturally appropriate tools for identifying co-occurring conditions (such as the IRIS, described in **Chapter B3**), as well as culturally appropriate integrated services that are linked with Aboriginal and Torres Strait Islander services and consultants is well recognised [1675, 1676]. Although integrated treatment is recommended, research examining the efficacy of integrated treatments for co-occurring AOD and mental health conditions among Aboriginal and Torres Strait Islander clients is limited. However, findings from preliminary research suggest that culturally adapted brief interventions may improve both wellbeing and substance dependence. In collaboration with Aboriginal medical health workers from three remote communities in the Northern Territory, Nagel and colleagues [1677] developed a brief intervention consisting of two one-hour treatment sessions delivered two to six weeks apart, which integrated problem-solving, motivational therapy, and self-management principles. Compared to treatment as usual, those randomised to the brief intervention demonstrated greater and sustained improvements in both mental health and alcohol dependence, and a trend toward greater improvements in cannabis dependence.

Existing mainstream models of practice in the AOD field have overwhelmingly been developed within Western systems of knowledge. As a result, they are not necessarily generalisable to other cultures and may ignore important Aboriginal and Torres Strait Islander perspectives and needs. Workers should also be aware of the cultural diversity within Aboriginal and Torres Strait Islander populations, which is often overlooked [1678, 1679]. Differences in cultural identity extend to different languages, accessing traditional lands, practising traditional culture, laws and governance, as well as family and kinship structures [1679, 1680]. Recognising and responding to the complexities of Aboriginal and Torres Strait Islander identity involves acknowledging the significance of diverse language and family groups, as well as the differences in gender relationships, all of which can involve complex relationships

which determine the level of interaction between family and kin [1681]. The different forms of distress experienced by Aboriginal and Torres Strait Islander people, as well as the different pathways to recovery, need to be identified, which depend on a diverse range of beliefs and experiences [1682]. It is therefore important that AOD workers try to familiarise themselves with more specific information regarding the Aboriginal and Torres Strait Islander peoples in their community. These and other issues to be aware of when working with Aboriginal and Torres Strait Islander clients are summarised in Table 60.

Recommendations for the provision of culturally appropriate services are provided in Table 61. Further detail and resources that may assist AOD workers and services in providing culturally appropriate care can be found in the Network of Alcohol and other Drugs Agencies AOD treatment guidelines for working with Aboriginal and Torres Strait Islander People in non-Indigenous settings [1675]. These Guidelines include *Yarning about Mental Health* training, which was also developed by the Australian Integrated Mental Health Initiative to strengthen AOD workforce knowledge and skills in mental health approaches, including culturally adapted strategies and tools for understanding mental health, promoting wellbeing, and delivering brief interventions. An evaluation of the training found that trainees perceived the program to be highly appropriate and helpful in their work with Aboriginal and Torres Strait Islander AOD clients, as well as significant improvement in confidence and knowledge related to Aboriginal and Torres Strait Islander mental health and wellbeing [1683].

Table 60: Considerations for AOD workers in working with Aboriginal and Torres Strait Islander clients

- The concept of **family** (including extended family and relatives) and community in Aboriginal and Torres Strait Islander culture is very important and includes immediate and extended relations. With the permission of the client, family members should be included in therapy as much as possible, and the client should be treated within the context of their community. Families are a strength that can be drawn upon to complement mental health and AOD treatment [1668]. Community and Aboriginal and Torres Strait Islander support groups may also be useful services.
- Many Aboriginal and Torres Strait Islander people have a **holistic concept of health**, which is often referred to as social and emotional wellbeing [1657]. This multifaceted concept reflects the Aboriginal and Torres Strait Islander cultural concept of health, which includes physical, psychological, social, cultural, and spiritual health and the importance of connections to land, culture, family, spirituality, ancestry, and community. These connections are maintained through generations and contribute to a person's wellbeing. As such, incorporation of these factors is essential during treatment. Integrated or coordinated services are therefore particularly important for addressing AOD and mental health conditions [108, 1668, 1684]. Nasir et al. [1658] point to the importance of land and culture as a possible explanation for lower rates of AOD and mental health disorders among Aboriginal and Torres Strait Islander people living in Reserve and remote areas relative to those living in other settings. Men accessing AOD services have also reported that they perceive traditional arts and crafts, culturally-focused talks, and connecting with the land to be the most beneficial cultural activities [1685].

Table 60: Considerations for AOD workers in working with Aboriginal and Torres Strait Islander clients (continued)

- There are high rates of **trauma, grief, and loss** in Aboriginal and Torres Strait Islander communities as Aboriginal and Torres Strait Islander people are faced with death and serious illness within their extended family more often than non-Aboriginal and Torres Strait Islander people, and at a younger age. There are also issues of unresolved grief, continued cultural loss and intergenerational trauma regarding the European colonisation and mistreatment since then (e.g., stolen generations). Approaches should address underlying issues of repeated trauma, stress, and grief [1686].
- **Stigma and victimisation** continue to exist today and are likely to impact on mental health and AOD use.
- Issues of **domestic violence, poverty, and family AOD use** are also likely to play a key role.
- When working with Aboriginal and Torres Strait Islander clients with apparent psychotic symptoms, it is important to **clarify the cultural appropriateness** of such symptoms. For example, it is not uncommon for some Aboriginal and Torres Strait Islander people to hear recently departed relatives and see spirits representing ancestors. This kind of spiritual experience is culturally valid and therefore is not a symptom of psychosis.
- Workers should be aware of the impact of intensely **distressing levels of shame** that many Aboriginal and Torres Strait Islander clients experience. This shame can be exacerbated when dealing with a non-Aboriginal worker. Involving an experienced Aboriginal worker in the client's care can help achieve the best outcomes.
- Use **appropriate language** (e.g., avoid jargon, or technical or medical terminology, use culturally appropriate terms to describe AOD) and include appropriate written materials to reinforce key verbal messages.
- Consider that you may be viewed as a member of a culture that has caused damage to Aboriginal and Torres Strait Islander culture. Anticipate and prepare a plan to deal with issues of anger, resentment and/or suspicion. **Engagement** is likely to require increased attention.
- **Enclosed spaces** may increase anxiety in Aboriginal and Torres Strait Islander clients.
- **Direct questioning** can be perceived as being threatening and intrusive and therefore should be kept to a minimum. A method of three-way talking may often be helpful, in which a client uses a third person (such as a family member) as a mediator to exchange information with the service provider.
- Watch the client's **body language** and mirror it if possible. For instance, direct eye contact is often viewed as impolite in Aboriginal and Torres Strait Islander communities and is often avoided. Speaking softly with brief answers may be a sign of shyness or good manners.

Table 60: Considerations for AOD workers in working with Aboriginal and Torres Strait Islander clients (continued)

- Be **respectful** of cultural prohibitions such as:
  - Referring to a deceased person by name.
  - Referring to certain close relatives by name (e.g., a Torres Strait Islander male may not refer to his brother-in-law by name).
  - Appearing to criticise elders or family members.
  - Confiding personal information to a member of the opposite sex – men's and women's business are usually kept separate (this may require a same sex AOD worker).
- Consultation may take longer so set aside **extra time**.
- Be aware that **levels of literacy** may be low.
- It is important to **be clear about your role** and the types of things you would like to cover in the consultation.
- Assessment of Aboriginal and Torres Strait Islander clients should occur within their own **cultural context.**
- Act as an **advocate** for the client where necessary in guiding them through the health care system.
- Understand that developing relationships with clients and communities will take time and that **establishing these relationships** is often necessary prior to engaging in treatment and learning more about how to appropriately interact with clients.
- **Be proactive** in engaging with the local community rather than waiting for them to access AOD or mental health services.

Source: [234, 776, 1686-1695].

Table 61: Considerations for AOD services providing support to Aboriginal and Torres Strait Islander clients

- Create a **welcoming environment**, including demonstrating cultural respect.
- Provide **flexible service delivery**, with consistent and reliable staff members with whom people can build trust and rapport. Consider cultural differences in service delivery, such as using cultural mapping to understand family and community dynamics.
- Include Aboriginal and Torres Strait Islander voices in AOD services by **consulting and engaging relevant communities.** Establish a consultation protocol and communicate regularly to Aboriginal and Torres Strait Islander communities about the work you are doing.

Table 61: Considerations for AOD services providing support to Aboriginal and Torres Strait Islander clients (continued)

- **Collaborate with Aboriginal and Torres Strait Islander organisations** and workers to identify and address service gaps.
- Provide opportunities to staff to **improve knowledge of Aboriginal and Torres Strait Islander issues, culture, and history,** including specific training in gender roles, communication, and trauma.
- Make efforts to **recruit and retain Aboriginal and Torres Strait Islander workers** within your organisation.
- Better integration of mental health and AOD services, and greater **collaboration** between these services and other organisations (e.g., housing, education) [108].
- Greater **promotion of available services** (e.g., active presence of mental health/AOD workers at local community events).
- Provide information and group **family support** for families and carers of people with co-occurring AOD and mental health conditions.
- Support groups to be run at local services to allow clients to share experiences with others in similar situations and to **reduce isolation** [1696].
- More **childcare options** available for clients seeking help from inpatient services.
- Greater **use of outreach services** in remote areas as a means of simplifying access to relevant services (e.g., rehabilitation, mental health, withdrawal management) and creating a less 'medicalised' environment.
- Services better addressing factors that make it difficult for people to get **appointments** (e.g., inflexible appointment times, unreliable transportation to services).

Source: Network of Alcohol and other Drugs Agencies [1675]; Lee et al. [1668]; and Liu et al. [108].

People from culturally and linguistically diverse backgrounds

Little research has been carried out in Australia on people from culturally and linguistically diverse (CALD) backgrounds in AOD services – let alone on those with co-occurring mental health conditions. As such, it is not clear whether co-occurring conditions are more common among people from CALD backgrounds than other groups. It should also be noted that there are differences between organisations in how people from CALD backgrounds are defined (e.g., country of birth, language spoken at home), which has implications in terms of the ability of some services to adequately capture and respond to behavioural patterns and trends in some CALD communities.

Findings from the most recent Australian National Drug Strategy Household Survey illustrate that compared to people from non-CALD backgrounds, people from CALD backgrounds are less likely to use alcohol, tobacco, or illicit drugs [1697]. While there is some evidence that people from CALD backgrounds may be more likely than those from non-CALD backgrounds to use harm reduction strategies with regards to their alcohol use [1698], the reverse has been observed among men from CALD backgrounds who inject performance enhancing drugs [1699]. As with other population groups, people from CALD backgrounds are not homogenous and there is variability between groups in terms of prevalence rates of mental and AOD use disorders.

Australians born overseas are underrepresented in AOD treatment services. Although 30% of Australia's population in 2020 were born overseas, the proportion of clients born overseas entering AOD treatment services in 2019-20 was only 13% [432, 1700]. This underrepresentation is likely a product of many barriers to treatment including [389, 1701–1704]:

- Strong feelings of shame and guilt.
- Fear of stigmatisation/judgement surrounding treatment and associated social disconnectedness.
- Cultural differences between client and therapist.
- Confusion and lack of education or exposure to public health campaigns.
- Different expectations of treatment and difficulty clarifying these due to language barriers.
- Lack of familiarity with what AOD treatment services are available, and how to access services.
- Lack of available culturally accessible services.
- Language difficulties which make participation in AOD treatment programs difficult.
- Fear of deportation or being placed in detention.
- Fear of authority related to previous experiences with government services.

Due to the multicultural nature of Australian society, it is imperative that AOD workers develop an awareness of issues related to working with people from CALD backgrounds. Each geographic area has its own unique cultural diversity and AOD workers should learn as much as possible about the cultures represented in their treatment populations. In particular, AOD workers should be aware of conventions of interpersonal communication (e.g., communication style, interpersonal interactions), expectations of family, understanding of healing, views of mental illness, and perceptions of substance use. However, it is fundamental not to make assumptions based on the client's culture – just because they are from a certain cultural background, that does not mean that they necessarily subscribe to the values and beliefs of that culture [102, 1705, 1706]. Reid and colleagues [1707] recommend consultation with the separate cultural communities to develop culturally relevant strategies for AOD treatment.

It has been suggested that information about three aspects of clients' lives is of crucial importance when treating CALD clients [1708]:

- **Context of migration:** If the client migrated to Australia, why they left their country of origin, how they got to Australia, their legal status, whether they have residency, any trauma experiences in the context of their country of origin or migrating to Australia (e.g., refugees of war). Helping clients to place their AOD and mental health conditions in the context of such experiences can help to reduce shame and increase self-compassion.
- **Subgroup membership:** Ethnicity, gender, sexual orientation, area in which they live, refugees or immigrants, religious affiliation.
- **Degree of acculturation:** *Traditional* (client adheres completely to beliefs, values, and behaviours of their country of origin); *bicultural* (client has a mix of new and old beliefs, values, and behaviours); *acculturated* (client has modified their old beliefs, values, and behaviours in an attempt to adjust); *assimilated* (client has completely given up their old beliefs, values and behaviours and adopted those of the new country).

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

Some people in the Australian CALD community may feel pressured to consume alcohol to adapt to the Australian culture [1709]. AOD use may also be used as a strategy to cope with trauma experienced both pre- and post-migration, such as political oppression, living in refugee camps, witnessing death of family members, and violence [1710]. These unique stressors not only increase the risk of developing a mental disorder [1711], they can also act as barriers to seeking and engaging with treatment and, as such, AOD workers should develop strategies to manage or reduce these stressors [389].

Rickwood [1712] provides a general summary of the types of problems that are specific to CALD groups in the community and makes recommendations regarding the provision of treatment services. These recommendations (such as cultural and religious awareness and the appropriate use of interpreters) would also apply to those with co-occurring mental health conditions. As with Aboriginal and Torres Strait Islander clients, screening tools should be validated for CALD groups and need to be administered and interpreted with care, although it should be noted that few validated screening tools exist.

Below is a range of useful points which may improve assessment and treatment when working with people from CALD backgrounds [431, 1705, 1713–1715]:

- Contextualise the person's ethnicity, cultural identity, and migration/settlement experience (e.g., ask about AOD use in the context of the client's culture). Respond to client issues from a cultural perspective that resonates with the client's own understanding of these issues. Notably, there is diversity between CALD communities in terms of conceptualising mental health and AOD use, as well as needs and preferences for treatment.
- Keep what you know about mental illness in mind but ensure that you try to understand the client's cultural understanding of their problems. People from different cultures often have different views on what constitutes mental illness. The DSM-5-TR [10] makes it clear that diagnoses can only be made if the person's behaviour is abnormal within their culture. While there are similarities in the

forms of illnesses across different cultures, the specific symptoms and signs vary for different societies. For example, a man in Australia with psychosis may talk of aliens controlling his thoughts, while a man in Fiji might blame black magic. It is also not uncommon for people from some cultures (particularly South-East Asian countries) to express psychological distress through somatic (physical) symptoms [431].

- Provide holistic and family-sensitive care. Where possible, and with the client's permission, involve the family in treatment. Allow the client to pick who from their family or community participates.
- Be aware that some CALD clients may come from collectivist cultures (in which greater emphasis is placed on group identity, goals, and concerns than is placed on individual ones) and may require a greater involvement of family and community for successful treatment.
- Be sure to address the client appropriately and pronounce their name correctly. Ask the client how you should address them.
- Provide language support. Try to find out before the session if the client requires an interpreter and allow the client to make decisions about if/when an interpreter is needed. Keep in mind that even clients with basic English proficiency might benefit by having an interpreter because describing symptoms, especially feelings, can be very difficult when English is a second language. Be sure the dialect is correct and be aware that some clients may have a preferred gender for the interpreter. Allow the interpreter to brief the client on the role that they will play. Even when families are involved in the client's treatment, it is inappropriate to use family members as interpreters. The client may not wish to divulge certain information to their family, or family members may not want certain information disclosed to people outside the family and may edit what is being said. Consider whether the interpreter may belong to the same community as the client, and if so, whether other options are available (e.g., telephone interpreters). When using interpreters, be aware that some meaning can be lost in translation and address issues of confidentiality.
- Address gaps in health literacy, using unambiguous language and regularly checking that you and the client understand one another. Be clear, concrete, and specific.
- Discuss and clarify the client's expectations of treatment.
- Address confidentiality and promote safety to increase engagement.
- Ensure that all treatment options are clearly explained, including rationale and processes.
- Provide flexibility in service delivery.
- Make allowances for variations in the use of personal space, including degrees of closeness. For example, people from some cultures may feel more comfortable sitting next to AOD workers, rather than being separated by a desk [1705].
- Customise the physical environment to be more culturally sensitive (e.g., hang culturally appropriate pictures).
- Be aware of gender and age. Some cultures may have specific concerns about appropriate gender and age relations, such as talking about some subjects with a member of the opposite sex or a younger person.

- Maintain a focus on healing, coping, or rehabilitation, rather than on cure.
- Set aside at least twice the usual time, especially if you need to use an interpreter.
- Be mindful of embarrassment and cultural taboos.
- Use appropriate messaging to reduce stigma/shame.
- Look for verbal and non-verbal signs of discomfort or confusion. Do not take silence as consent or agreement. Similarly, the word 'yes' may infer politeness or acknowledgment of possibility rather than assent in some languages [1716]. The client may have had negative experiences in the past when accessing services, so consider making time to discuss these experiences and learn about any discrimination they may have experienced, as doing so may help to build trust.
- Support the client and their family in accessing other relevant services. People from CALD backgrounds may not have knowledge of services that are available to them, so be aware of other services that could be helpful and offer to connect them directly by making a referral and help coordinate their care (see **Chapter B5**) [431, 1714].
- Work in partnership with CALD community leaders and bi-cultural workers.

People who identify as gender and sexual diverse

While this section has used the term 'gender and sexual diverse' to describe people who identify as lesbian, gay, bisexual, asexual, trans, non-binary, queer, or intersex, or who are attracted to same sex/genders that differ from heterosexual or cisgender norms, we acknowledge there is no all-inclusive term. Our intention in utilising this term is to describe the evidence regarding co-occurring conditions in relation to people who identify as gender and sexual diverse.

Overall, there is a lack of research examining co-occurring AOD and mental health conditions among people who identify as gender and sexual diverse in Australia [1717]. The research that does exist suggests that AOD and mental health conditions are between three and six times more prevalent among people who identify as sexual or gender diverse than the general Australian population [1653, 1718]. There is also evidence that people who identify as sexual or gender diverse are between two and nine times more likely to experience co-occurring AOD and mental disorders than those who identify as heterosexual or cisgender (i.e., a person whose gender identity corresponds to their biological sex) [1719–1724]. They are also at increased risk of experiencing suicidal ideation and suicide attempts, and multiple disorders [1718, 1720, 1723]. Although comparative research is lacking, it is important to note that there may be differences between groups who do not identify as heterosexual or cisgender [1719]. For example, women who identify as bisexual report more co-occurring conditions than other sexual diverse and heterosexual people (e.g., 38% of bisexual women compared to 12% of heterosexual women and 25% of lesbian women [1725]).

Although there is considerably less research examining co-occurring conditions among people who identify as gender diverse, one recent review found higher rates of depression, anxiety, AOD use, self-harm, and suicidal ideation among people identifying as gender diverse compared to those who identified as cisgender, and highlighted adolescence as a particularly vulnerable period [1726]. Research

has also found that medical gender reassignment may be insufficient to improve functioning and mental health outcomes among trans youth; those who experienced poorer mental health outcomes and functioning before reassignment continued to experience similar problems post-reassignment [1727]. Of note, people who identify as gender diverse may experience significant barriers to accessing and engaging in treatment due to gender segregation within many treatment facilities (e.g., housing, treatment sessions), which were designed to treat cisgender people [1728].

Fundamentally, treatment for people who identify as gender and sexual diverse is the same as for any other client group and should focus on the specific needs of the client [1729]. People who identify as gender and sexual diverse represent a diverse group of people from varying backgrounds; thus, like all other clients, a holistic view should be adopted considering all aspects of their presentation. People who identify as gender and sexual diverse often experience stigma, internal pressure, adverse childhood events, feelings of shame, isolation, guilt, being lied to, and loss of social support among other things, all increasing the risk of mental health and AOD problems [1725, 1730, 1731]. As such, co-occurring conditions among people who identify as gender and sexual diverse are likely to be a consequence of being in a minority group within the community, rather than being same sex attracted.

Key principles for inclusive service response when working with people who identify as gender and sexual diverse include [1723, 1732]:

- **Freedom from discrimination:** Ensuring there are no direct or indirect discriminatory practices (e.g., appropriate use of culturally sensitive language; auditing intake processes, including language, to ensure they are inclusive of people who identify as gender and sexual diverse).
- **Affirmation:** Encouraging and celebrating diversity, sexual and gender identity (e.g., providing an accepting and affirming approach to the client's sexual or gender identity; ensuring staff are aware of gender and sexual diverse support services; affirmation of non-traditional family networks; assisting the client develop strategies for dealing with stigma, discrimination, and stress).
- **Access and equity:** Ensuring people who identify as gender and sexual diverse can access care and incorporating organisational processes that can adapt service delivery to improve outcomes (e.g., providing a welcoming, non-judgemental, and respectful environment; providing appropriate education and training for staff; ensuring there is a high regard for confidentiality around personal information).
- **Visibility:** Regular participation in community and inclusion events, and committing to inclusive practice (e.g., presence of gender and sexual diverse staff and positive gender and sexual diverse role models; surveying your workforce to assess whether they experience inclusivity at work).
- **Co-design:** Ongoing engagement with people who identify as gender and sexual diverse as well as community stakeholders, to improve experience of services and treatment outcomes (e.g., partner with gender and sexual diverse organisations to gain expertise on content and to increase access to gender and sexual diverse communities; ensure the workforce reflects diversity and the broader society).
- **Recognition and acknowledgement of the principles of the Ottawa Charter:** In particular, that health promotion is a process of increasing a person's capacity to manage and improve their health.

AOD workers are encouraged to access additional resources provided in the ACON and NADA inclusivity guidelines: **www.nada.org.au/resources/aod-lgbtiq-inclusive-guidelines-for-treatment-providers/**.

Discussing sexuality and related issues requires a sensitive approach and, depending on the issues raised, may lead to the AOD worker assisting with safety, support, accommodation, and harm reduction. Asking people about their sexual identity is vital to informing the needs of AOD clients. People who identify as gender and sexual diverse are often missing from routinely collected data within health services – both at an individual and service level, which means sexual and gender-specific health issues may not be adequately represented or reflected in discussions regarding funding or resource allocation [1733]. While the purpose for questioning people about their sexual and gender diversity is important, it is equally important that workers consider and use professional judgement; for example [1732, 1734]:

- Ask clients open ended questions (i.e., who/what/when/where/why/how) to assist in rapport building, and practice with role play, for example:
    - How do you identify sexually (provide options as prompts, such as lesbian, gay, heterosexual, bisexual and so on)?
    - What gender do you identify with?
    - What are your pronouns (she/her, he/him, they/their, something else)?
    - When speaking with you or referring to you with others, what name would you like me to use?
- How comfortable is the person with their sexuality and with talking about it with others?
- Have they told family/friends? How have these people reacted (or how might they)?
- Is it their decision to tell someone or are they being forced?
- How much support do they have?
- Are they financially, physically, or emotionally independent?

Engagement is fundamentally important as well as confidentiality issues. AOD workers should also be aware that, for some clients (especially young clients), issues surrounding sexual and gender identity may be a principal concern and may require increased attention during treatment. Several treatments have been evaluated among people who identify as sexual or gender diverse, though none have been evaluated extensively. These include:

- *Effective Skills to Empower Effective Men (ESTEEM):* a 10-session CBT-based intervention focusing on improving coping strategies and reducing minority stress processes. An RCT conducted among young gay and bisexual men with depression or anxiety co-occurring with harmful alcohol use found that *ESTEEM* reduced depressive symptoms, alcohol use problems, and improved sexual health behaviours, relative to a wait list control [1735].
- *Empowering Queer Identities in Psychotherapy (EQuIP):* based on modules from *ESTEEM*, *EQuIP* also comprises 10 sessions focused on minority stressors such as the impact of gender norms on relationships, the intersection of sexism with other forms of oppression, and exposure to harassment. An RCT conducted among sexual diverse women with co-occurring depression or

anxiety and heavy alcohol use found that those randomised to receive *EQuIP* demonstrated greater reductions in anxiety and depression, as well as the amount of problems associated with alcohol use, compared to a wait-list control [1736].

- *Seeking Safety*: a CBT-based intervention for co-occurring PTSD and AOD use (discussed in **Chapter B7**). A single pilot study conducted among transgender women found 12 sessions of *Seeking Safety* was associated with reductions in PTSD symptoms and the severity of AOD use [1737].

Sex workers

People who engage in sex work present with unique vulnerabilities for numerous health issues. In addition to being at increased risk of experiencing sexually transmitted infections and blood borne viruses such as HIV/AIDS or hepatitis [1738–1741], sex workers are at increased risk of experiencing both AOD and mental health conditions [1742]. Previous international studies from the UK and US have estimated that among people who use AOD, a history of sex work ranges between 31 – 51% of women and 8 – 19% of men, with an estimated 41% of women and 11% of men engaging in sex work in the past year [1739, 1743]. Internationally, these rates appear to be higher among people attending AOD treatment than people who use AOD in the general population [1739, 1743]. Compared to Australians who inject drugs who have never engaged in sex work, sex workers in Australia who inject drugs also are more likely to start using AOD at a younger age, and have more AOD-related problems [1744].

There is also evidence of poor mental health among sex workers, including high rates of depression, psychosis, anxiety, suicide attempts, and mental health treatment [1739, 1745]. However, estimates vary based on whether a person is engaged in sex work that is considered legal as opposed to illegal sex work. Compared to licensed brothel workers and private operators, people who engage in illegal sex work are four times more likely to present with mental health problems in Australia, and these increased rates of mental health problems are associated with more adverse experiences prior to entering the industry [1746]. Trauma exposure is almost universal among Australian sex workers (99%) [1747] with estimates of violence against sex workers ranging between 45-75% [1748]. A higher incidence of violence has also been found among street-based sex workers compared with other types of sex workers (e.g., indoor) [1749, 1750].

Australia's approach to regulating sex work is complex, involving legalisation, criminalisation, and decriminalisation of particular aspects of sex work, which varies between Australian jurisdictions. A full review of regulatory approaches is beyond the scope of these Guidelines; however, AOD workers should be aware that Australia's policy approach has significant implications for those working in the sex work industry. For example, at the time of writing, the operation of licensed brothels and registered sex workers in Victoria are decriminalised, while other unlicensed activities remain criminalised [1751]. In contrast, Tasmania has criminalised brothels, but private sex work (excluding street-based) is legal. The legal status of a person's workplace has implications for their health and safety (e.g., reasonable shift length, breaks, use of safety equipment such as condoms), and may also impact on the likelihood of the person seeking help. Both Australian and international research demonstrates that people who engage in sex work in legalised or decriminalised environments report greater awareness of health conditions and health risk behaviours, and engage in safer sexual practices (e.g., increased condom use), in comparison with those working in criminalised environments [1738, 1752]. As such, decriminalising sex work may help

to improve the safety and representation of sex workers, though Treloar and colleagues [1753] argue that decriminalisation is not sufficient to reduce the pervasive stigma associated with sex work, which may also prevent a person accessing health services.

Several key barriers to accessing healthcare have been described, with 70% of sex workers in one study identifying one or more institutional barriers to accessing health services [1754], including stigma, discrimination, social exclusion, violence, and criminalisation of sex work [1755]. Sex workers may fear judgement from service providers, feel uncomfortable about disclosing the details of their employment, or fear the consequences of disclosing any illegal sex work. The fear of disclosing the nature of their work may also extend to families and/or friends, with the constant vigilance needed to maintain multiple identities contributing to isolation and fatigue [1753].

A study of healthcare professionals in the UK concluded that the main barriers to providing healthcare to people who engage in sex work are institutional, such as services being inflexible, under-resourced, and not trauma-informed [1756]. These barriers may explain the low rates of sex workers accessing mental health treatment. In an Australian study, only 14% of people who engaged in sex work reported accessing counselling services and 11% reported accessing mental healthcare [1742].

There is little research to guide treatment approaches for working with people who engage in sex work specifically, but given the aforementioned issues, AOD workers should be guided by the guiding principles for working with people with co-occurring conditions (see **Chapter A3**), trauma-informed care (see **Chapter B2**), assessing risk (see **Chapter B4**), and coordinating care (see **Chapter B5**).

Rural and remote populations

The term ‘rural and remote’ in this section refers to all geographic areas outside major cities in Australia, which includes both inner and outer regional, as well as remote and very remote areas [1757]. People living in rural and remote communities experience a variety of social, attitudinal, economic, geographic, and community barriers which means that they are likely to have difficulties accessing treatments and specialist care [1758, 1759]. Youth in these communities are at particularly high-risk, and alcohol-related and rural stressors are likely to play a role in the high rates of suicide among males [1760–1763].

The lack of specialists in rural and remote regions tends to result in heavy reliance on primary and AOD health care providers. Compared to major cities, rural areas have significantly less access to specialised mental health care, with per-person supply of employed medical practitioners decreasing according to remoteness [1758]. Although there is a national focus across Australia to increase the supply of health workers to rural and remote areas, it is estimated that regional areas access 42% of psychiatrists, 89% of mental health nurses, and 59% of psychologists per 100,000 people compared to major cities, with even poorer access for remote areas [1764]. Moreover, Medicare expenditure on mental health services in inner regional and remote areas is considerably lower than that in major cities [1759, 1765], which suggests lower per-person access to, and receipt of, healthcare services.

People living in rural areas have indicated that addressing treatment barriers by investing in medical infrastructure and increasing the number of healthcare providers would improve their ability to receive adequate treatment for their co-occurring conditions [1766]. This evidence aligns with experiences of

healthcare workers in rural areas, who have highlighted difficulties in providing adequate services due to personnel, resource and infrastructure shortages, such as lack of high-speed internet, or equipment for e-health/telehealth [1767, 1768]. Such disruptions impact on the continuity of care, and can result in rural patients being the least likely to receive follow-up monitoring for AOD use issues relative to people living in less remote locations [1769].

The health of rural and remote Australians is comparatively poorer than Australians living in major cities [1758], and the lack of resources and healthcare workers makes working in these settings particularly challenging. Self-harm, and suicide rates similarly increase with remoteness in Australia, and are almost three times higher in very remote areas (29.4 per 100,000 people) compared to major cities (10.9 per 100,000 people; [1759]).

Research has found that people living in remote areas are less likely than major city residents to endorse evidence-based interventions as useful for mental health treatment, and are less likely to perceive psychologists, psychiatrists, GPs, and social workers as helpful in the treatment of mental health conditions [1770, 1771]. There is also evidence that people living in remote areas are also more likely than those living in major cities to identify non-evidence-based treatments (e.g., alcohol and painkillers) as helpful interventions for mental health conditions, highlighting the need for effective communication and psychoeducation focused on best-practice treatment and management of mental health in rural and remote areas [1770, 1771].

Although accessing treatment has been identified as a particular challenge in this population group, self-guided approaches, such as bibliotherapy or e-health interventions have proven to be effective as have alternatives to face-to-face methods (e.g., telephone, email, internet) where geographical isolation and lack of specialist services are obstacles [1772]. For example, *moodgym* is a free online CBT self-help program for anxiety and depression (**http://www.moodgym.com.au**) that has been shown to be effective in treating symptoms of anxiety and depression [1131, 1773], *MindSpot* provides therapist-guided online psychological treatment for anxiety, depression, stress and low-mood (**http://www.mindspot.org.au**), and *Mental Health Online* (formerly *Anxiety Online*) comprises five e-therapy programs for GAD, SAD, panic disorder, PTSD, and OCD (**http://www.mentalhealthonline.org.au/**; [1195, 1196]). Although definitive evidence regarding the efficacy of *Mental Health Online* is lacking, two naturalistic studies found that participation in the program was associated with significant reductions in severity of all five disorders, and increased confidence in managing one's own mental health care. Significant improvements in quality of life were also consistently observed for GAD, SAD, and PTSD e-therapy programs, but not the OCD or panic disorder programs [1195, 1196]. Furthermore, in an RCT conducted among participants with co-occurring depression and AOD use, the efficacy of computerised CBT/MI among both urban and rural participants was compared to face-to-face treatment [1774]. Similar improvements were observed in depression, alcohol, and cannabis use when compared with face-to-face treatment, and the computerised delivery was acceptable to people in both urban and rural locations, even among people who indicated a preference for face-to-face therapy [1774].

In terms of feasibility and acceptability of these approaches, while there is evidence that clinicians working in rural areas are optimistic about the use of e-health interventions, until recently there has been a preference for e-health approaches to be integrated alongside existing services, and used as

an adjunct rather than alternative to more traditional face-to-face approaches [1775]. As described in Chapter B6 however, the COVID-19 pandemic has necessitated a rapid revolution to the way in which healthcare is delivered and accessed, with approximately 35% of mental health-related services delivered via telehealth between March and September 2020, following the introduction of telehealth items to the Medicare Benefits Schedule [1776]. While e-health interventions have the potential to address many limitations associated with service accessibility among people living in rural and remote areas, evidence suggests that resistance to e-health may be overcome by enhancing community education and program familiarity [1777, 1778].

A systematic review examining telehealth services in rural and remote Australia summarised six key factors associated with the successful integration of telehealth into practice [1779]:

- **Vision:** Clear, realistic, and feasible outline of the purpose of the service.
- **Ownership:** Inclusive and genuine consultative service development with stakeholders; supportive management; clinicians who are actively engaged and participating in service delivery (service champions).
- **Adaptability:** Recognition of the need to remain responsive to stakeholders; willingness to adapt the service model in response to clients, clinicians, and services.
- **Economics:** Deliver cost savings, prioritising required services for delivery of healthcare; provide value for money for clients; achieve comparable care with clinical benefits.
- **Efficiency:** Clearly defined, efficient processes for managing activity; recognition that quantity is not reflective of success; high levels of activity not necessary for sustainability.
- **Equipment:** Careful consideration of required, affordable infrastructure, with plans to manage technical support.

Patterns of AOD use and the types of stressors experienced are likely to vary across different rural and remote areas. For example, inhalants are a particular problem in some rural and remote areas, especially within Aboriginal and Torres Strait Islander populations [1650], whereas cocaine and hallucinogens are more likely to be used in major cities and inner regional areas [1780]. People living in remote and very remote areas are also more likely to use cannabis, non-prescription pharmaceuticals, and opioids compared to people living in major cities [1759, 1780]. The proportion of people drinking alcohol at risky levels increases with increasing remoteness, with certain occupational groups (in particular, farming communities) at particularly high risk, and hospitalisation and mortality associated with alcohol consumption is considerably higher for rural communities relative to urban communities [1780, 1781]. Significantly more people living in rural and remote areas smoke tobacco, although daily smoking rates have declined over the past 10 years in major cities, inner regional, remote, and very remote areas [1780]. People living in rural and remote areas may also experience unique stressors to those in urban areas. For instance, regional and remote incomes can be heavily reliant on industries affected by external factors, such as farming, forestry and mining, which can increase stress when conditions are unfavourable [1759].

AOD workers need to be aware of the particular issues related to AOD use in their communities. Professional networking with local health providers, and fostering trust, non-judgemental acceptance, and confidentiality with clients, may be particularly important in rural/remote communities. In small

rural communities, anonymity is very difficult to maintain, presenting a range of additional challenges for the AOD workers. Therefore, issues of confidentiality are particularly crucial.

Homelessness

The 2016 Australian Census estimated more than 116,000 people experiencing homelessness in Australia, which increased by 5% from 2011; Table 62 [1782]. Homelessness refers not only to sleeping rough or being without shelter. It also includes staying with friends or relatives with no other usual address (e.g., couch surfing), staying in specialist homelessness services, and living in boarding houses or caravan parks with no secure lease and no private facilities. A stable home provides safety and security as well as connections to friends, family, and a community [1783].

There tend to be higher rates of AOD use and mental health conditions among homeless people as compared to the Australian general population. A recent study examining the electronic medical records of active patients (defined as ≥3 visits within the past two years) of a multi-site specialist homelessness GP service in Perth found 68% had at least one diagnosed mental health condition, 62% at least one AOD use disorder, and 48% had been diagnosed with a co-occurring AOD and mental health condition (Figure 21) [1784]. More than one third (38%) of people had also been diagnosed with a chronic physical health condition in addition to their co-occurring AOD and mental health condition. Compared to people who are not homeless, those who are homeless are also more likely to be hospitalised for AOD and mental health issues [1785].

As described in **Chapter B5**, however, it can be extremely difficult for a person to engage in and maintain progress in relation to their AOD or mental health treatment if they do not know where they are going to live, or how they are going to feed themselves or their family. Therefore, addressing housing as part of treatment is vital, and is also in line with the approach of 'treating the person, not the illness' [9]. In addition to problems relating to housing, AOD and mental health, people experiencing homelessness present with a range of physical, financial, and social issues, and are at high risk of victimisation [1786, 1787]. High rates of exposure to other forms of trauma are also evident. In one sample of homeless adults, 88% reported having experienced adverse childhood events, and level of exposure was positively associated with negative outcomes for mental health and AOD use [1788]. For these reasons, a trauma-informed approach to treating people who experience homelessness is essential [1787]. The Trauma and Homelessness Initiative similarly emphasises the unique opportunity for homelessness agencies, as a primary contact for homeless people, to engage with homeless people to facilitate trauma recovery [1789].

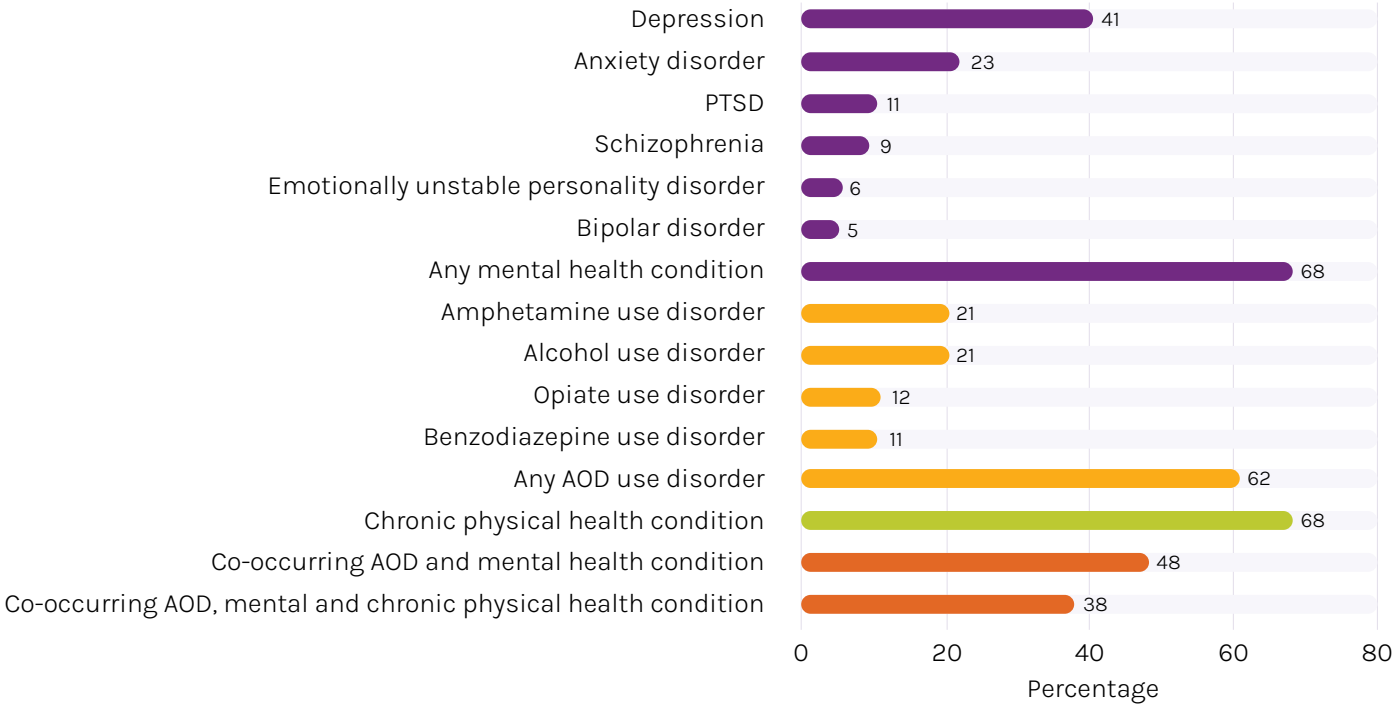
Given the range and complexity of issues faced by people who are homeless it is important to adopt a holistic and pragmatic view when identifying treatment needs (see **Chapter B5**). The complexity of problems experienced by people who are homeless is compounded by having reduced access to services and resources [1790, 1791], and it is very difficult to provide mental health or AOD treatment to those without access to stable housing [650, 1792]. Attention to immediate basic needs is often more important than diagnosing a specific condition, as successful treatment is difficult if basic needs are not met [1791]. For example, consideration of whether the client has access to primary care and from whom? Is the client likely to be able to follow through with treatment and recommendations? Will they seek help in the future? Can they afford specific treatments/medications? Thus, treatment should be guided by the client's perceived needs, as well as AOD worker judgement.

Table 62: Accommodation of homeless people in Australia, Census night 2016

Accommodation type	Number of people (%)
Severely overcrowded dwellings	51,088 (44%)
Supported accommodation for the homeless	21,235 (18%)
Temporarily staying with other households	17,725 (15%)
Boarding houses	17,503 (15%)
Sleeping rough	8,200 (7%)
Temporary lodging	678 (0.6%)

Clients and service providers have highlighted the importance of providing integrated services for people who are homeless whereby services work together and coordinate care in a cohesive approach [1793-1795]. Homeless clients from less integrated services are more likely to experience difficulties accessing help due to the lack of coordination between homelessness, AOD, and mental health services [1796]. By contrast, clients from more integrated services are more likely to have a case coordinator and report positive outcomes than those from less integrated services [1797]. Lack of integration between services can not only result in clients 'falling through the gaps' and being bounced between homelessness, AOD, and mental health services, but can also result in a need for clients to continuously retell details of distressing stories, confusion, and lack of client and service awareness [1798]. Chapter B5 contains further information about coordinating care and working with other services.

Figure 21: Prevalence of mental and AOD use disorders among homeless people in Perth



Source: Vallesi et al. [1784].

A further barrier to people who are homeless accessing care is stigma [1799]. Being homeless involves additional stigmatisation to the already marginalising attitudes directed towards people with AOD and mental health conditions. Approximately one in three homeless people report having experienced stigma related to their homelessness, with 9% having experienced homelessness-related stigma from healthcare providers [1800]. As described in **Chapter B5**, perceived and actual stigma can lead to a mistrust of healthcare providers and services. It is important to be patient and attentive, and take the time to establish trust and rapport with the client, as homeless people who mistrust practitioners may conceal their needs [1801, 1802]. The following strategies may be useful when working with homeless clients [599, 1803]:

- Become familiar with any street outreach programs or resettlement services operating in your area.
- Help the client establish skills and knowledge in obviously deficient areas, as this may provide practical living abilities. It may be necessary to read documents for the client, and assist in the filling out of forms, and other basic tasks due to low literacy levels or other difficulties.
- Be patient and flexible, and aware that homeless people are unlikely to attend all appointments or complete homework tasks. AOD workers need to remain optimistic, non-judgemental, process-oriented, and focused on long-term treatment goals.
- Where possible and beneficial, encourage clients to consider family relationships, and engage with clients' families. Be aware that this may not be easy or practicable, and ensure clients are engaged in the decision to contact their family.
- Be proactive in following up clients, and work with other services to coordinate care.

There have been several interventions developed for people who are homeless, although they have not been evaluated extensively. These include:

- *Housing First* interventions: interventions which provide stable housing and other health services without first requiring people to be 'housing ready' (i.e., attending treatment and being abstinent from AOD use [1804]), and are endorsed by the Alcohol and Drug Foundation as an effective intervention for homeless people [1805]. A systematic review of *Housing First* relative to *Treatment First* programs (i.e., programs that require people to achieve abstinence and be attending treatment before being offered access to housing [1804]) concluded that *Housing First* programs improved housing stability and reduced hospitalisation more effectively, though both programs led to similar reductions in mental health symptoms and AOD use [1804]. Evidence from interviews with homeless people attending *Housing First* programs suggest that the sense of security and dignity associated with stable housing is the most influential factor supporting changes in mental and physical health, self-esteem, and interpersonal relationships [1799].
- *Mindfulness-Oriented Recovery Enhancement (MORE):* a manualised mindfulness-based group intervention for people with co-occurring psychological distress and AOD use [1177]. An RCT conducted among homeless men with co-occurring mental health conditions and AOD use found that compared to CBT, those who received *MORE* experienced greater improvements in post-traumatic stress, negative affect, and AOD cravings from pre to post treatment [1177].

- *EQIIP SOL:* an intensive outreach intervention team for homeless people with co-occurring conditions. A prospective longitudinal study found homeless youth with co-occurring psychosis and AOD use reported reductions in the severity of psychotic symptoms and the likelihood of reaching the diagnostic threshold for an AOD disorder following 6 months of *EQIIP SOL* [956].

Women

Although rates of AOD use and related harms have historically been higher among men compared to women, the gap between men and women has narrowed in recent years, particularly among young adults [1806, 1807]. The changing rates of AOD use among women are important to consider, as the psychological, social, and physical contexts of AOD use and mental health are quite different for women as opposed to men [1807–1809]. There is increased stigma associated with female AOD use (particularly among those who are pregnant) which is likely to lead to greater guilt and shame [389, 1801, 1810]. This stigma may lead some women to delay treatment seeking so that, by the time they enter treatment, their AOD use is quite severe. Childcare considerations, family responsibilities, fear of the removal of children, factors related to relationships (e.g., family conflict, support from partner), and financial issues have also been identified as some of the barriers experienced by women seeking treatment [827, 1810, 1811]. Women presenting for AOD treatment are also more likely to show greater financial vulnerability compared to men, including a decreased likelihood of employment despite similar education levels, and an increased likelihood of being financially dependent on another person [1812].

Among women with problems related to their AOD use, rates of depression, anxiety, and personality disorders are particularly high [1813, 1814]. Poor self-esteem and self-image, high rates of suicide attempts and self-harm, psychological distress, loneliness, and co-occurring ED are also particularly common to women with AOD use issues [1811, 1815–1819]. Women, and younger women in particular, are more likely to use maladaptive coping mechanisms like AOD use [1820] to cope with negative emotional situations, manage pain, and cope with trauma [1821–1824].

Women who experience problems with AOD use are more likely than men, or women who do not experience problems with AOD use, to have experienced neglect or sexual, physical, or emotional abuse as children, as well as domestic violence [434, 1812, 1813, 1825, 1826]. Relative to men, this abuse is also more likely to be severe, occur at home, and be instigated by a current or former romantic partner [1827, 1828]. In addition, AOD use can often lead to revictimisation via dangerous or risky situations such as unsafe sex and sex work [1829]. Because of the high rates of trauma among women, often perpetrated by men, it is imperative to provide a treatment environment in which women feel safe and secure [389]. The following strategies may be helpful in creating such an environment [389, 1811]:

- Provide the client with the option of a female AOD worker.
- If attending group therapy, offer a women-only group if possible.
- If attending rehabilitation services, offer information and/or referral to women only AOD services.
- Ensure that treatment is gender-sensitive and addresses gender-specific issues and barriers to treatment.

- If appropriate, consider facilitating access to childcare, which can enable female parents and caregivers to attend treatment.
- Where appropriate, consider family inclusive practice, which incorporates the client's family and community relationships.
- Where appropriate, ensure sexual health and safety are incorporated into the treatment plan.

Men

In contrast to women, men may be less forthcoming with information concerning their mental health, which may affect their help-seeking behaviour. In general, men may be less likely than women to visit a health professional, have lengthy consultations with health professionals, or seek treatment before symptoms become advanced [1830–1834]. There are a number of barriers that may prevent men accessing mental health treatment, including [1810, 1835, 1836]:

- Feeling uncomfortable and/or finding it difficult to discuss problems and feelings.
- Not wanting to appear weak, feeling embarrassed, afraid, or ashamed of their distress.
- Feeling very aware of stigma associated with mental health difficulties and accessing services.
- Not recognising feelings of emotional distress.
- Having a preference to work things out for themselves.
- Not considering their mental health a high priority.
- Believing that no one can help them.
- Previous unsuccessful attempts at seeking help.
- Not being aware of available services, and/or not considering the services 'male friendly'.
- Having a tendency to manage emotional issues through silence or avoidance.
- Preferring 'acceptable' male outlets such as alcohol abuse or aggression to release feelings.

Although men are less likely to seek help, they make up 64% of those entering AOD treatment settings [432]. Physical, sexual, and emotional abuse are highly prevalent among men accessing AOD treatment settings, and can be accompanied by feelings of shame, guilt, and powerlessness [389]. There are also strong associations between AOD use (alcohol in particular) and the perpetration of domestic and other forms of violence, which is often exacerbated by the ways in which men are socialised, such as to display aggression and emotional restraint, rather than the use of adaptive coping strategies [389]. Difficulties regulating emotions in particular are associated with increased AOD use among men [1837] and, where appropriate, emotion management strategies should be integrated into treatment [389]. Men are also at considerably higher risk than women of death by overdose [1838] or completed suicide [1839], typically by more lethal means than women [1840], highlighting the importance of risk assessment (see **Chapter B4**; [389, 1817, 1841]).

Coerced clients

Clients may be coerced into treatment through a variety of channels, for instance, through the judicial system, via family and friends, schools or workplaces, or through child protection or other services. However, AOD workers should not assume treatment will be ineffective as a result [1842, 1843]. In fact, coercion into treatment may present an opportunity which the client may never have previously considered, and evidence suggests that some people who have been legally coerced to participate in treatment stay in treatment longer and do equally as well, or better than, people not under legal coercion [1844, 1845]. It is important for the AOD worker to present treatment as a positive opportunity from which the client may experience some benefit. A positive attitude on behalf of the AOD worker and efforts to engage coerced clients are key, as a better therapeutic alliance is associated with better mental health related treatment outcomes [1845]. Given that the motivation to engage in treatment may come largely from external sources [776], educational and motivational interventions may require more attention in treatment planning and provision.

Nevertheless, there are some special considerations that AOD workers ought to be aware of when working with coerced clients. First, confidentiality may be complicated and needs to be clarified from the outset of treatment, both with the referrer and the client. Open communication is required regarding the boundaries, rights and obligations concerning confidentiality, and these should be clarified prior to the commencement of treatment [389]. Similarly, conflicts of interest between the views of the AOD worker and the conditions under which the client accesses treatment may arise and should be addressed [776]. Treatment resistance may also be a problem, as motivation to engage in treatment among coerced clients is typically external. Harm reduction is also an important consideration when working with coerced clients [389]. Harm reduction may often be a more satisfactory goal for clients but court orders and familial requests are likely to be based on an expectation of abstinence [776, 1846]. The AOD worker, however, can play an important role in clarifying what the realistic goals are for each client.

Coerced clients may be accessing treatment services for the first time or may be accessing a different type of service. This avenue provides the opportunity for a thorough assessment which may identify previously undiagnosed co-occurring disorders and presents an opportunity for treatment. However, as clients who are coerced into treatment may present with strong emotional reactions and a reduced sense of autonomy, AOD workers may need to spend time managing these reactions [1847]. AOD workers should focus on building a therapeutic relationship, and avoid overly intrusive questions that might be perceived as judgemental [389]. Barber [1848] suggests that in cases of coercion the worker should adopt a negotiation or mediation role and follow six steps in this process:

- Clear the air with the client (present with a positive attitude and make efforts to engage).
- Identify legitimate client interests.
- Identify non-negotiable aspects of intervention.
- Identify negotiable aspects of intervention.
- Negotiate the case plan.
- Agree on criteria for progress.

When working with justice health specifically, appropriate referrals and consultation with corrective services need to take place. A client being released from custody should be reviewed to ensure that they have all medications post-release and that they are aware of services, referred to and accepted by service providers where necessary [1849, 1850].

Incarcerated clients

Working with incarcerated clients in a prison setting presents several challenges. As with people in the community, those in prison settings with co-occurring AOD and mental health conditions often experience a range of complex, long-term problems and have likely come into contact with numerous services in the past. In general, people in contact with the justice system are more likely to be socially and economically disadvantaged, experience higher rates of homelessness and unemployment, have a history of imprisonment or previous criminal involvement, and have experienced childhood neglect and/or trauma compared to those in the general community [1851–1854]. There is evidence to suggest that incarceration can exacerbate previous traumatic experiences through environmental triggers (e.g., discipline from authority figures, strip searches), institutionalised racism, lack of connection to culture for Aboriginal and Torres Strait Islander people, separation from children or family, or further exposure to trauma in prison [389, 1855–1857].

The most recent Health of Australia's Prisoners survey conducted in 2018, found high rates of AOD use and mental disorders compared to the general population [1851]. Two in five prisoners (40%) had been previously diagnosed with a mental health condition, including an AOD use disorder, and just under one in four (23%) were currently taking medication for their mental health, most commonly antidepressants. People entering prison were twice as likely to be experiencing high or very high levels of psychological distress compared to the general population (26% vs 13%), and 21% reported a history of self-harm. There is evidence that people in prison are 10 times more likely than the general population to have experienced suicidal ideation and previous attempts in the past year [1858]. Due to this elevated risk of suicide and self-harm, conducting risk assessments is especially important (see **Chapter B4**, **Chapter B5**).

Also common among people entering prison are smoking (75%) and poor physical health, with 30% reporting experiencing at least one chronic physical health condition (including arthritis, asthma, cancer, cardiovascular disease, diabetes), and 28% reporting that their physical health causes significant psychological distress [1851]. Rates of blood-borne viruses such as hepatitis B and C are higher than in the general community [1851], which is likely due to the lack of available sterile injecting equipment [1859, 1860]. Harm minimisation strategies for AOD use, such as only re-using personal injecting equipment to minimise the risk of blood borne viruses, should be encouraged [389].

As with clients who have been coerced into treatment, AOD treatment within the prison environment may present an opportunity which incarcerated clients had not previously considered. It is important for the AOD worker to positively frame the opportunity for treatment and maintain a positive attitude, hope and optimism. Many of the treatment principles for working with people who are incarcerated are similar to those for working with coerced clients. Importantly, any limits of confidentiality should be outlined clearly and early on, as they may differ to limits within community settings [389]. Due to the inherent power imbalances and structures of correctional settings, AOD workers may need to make additional

efforts to engage an incarcerated client and build a trusting, therapeutic relationship, which are key to good outcomes [117–119]. Clients may experience difficulties establishing a trusting environment and may disclose information slowly to gauge worker reactions [1861]. As with coerced clients, the role of educational and motivational interventions may require more attention.

Given the high rates of trauma exposure among incarcerated clients, a trauma-informed approach should be adopted (see **Chapter B2**; [389]), bearing in mind that clients in prison settings may not feel safe to disclose the details of their trauma history. With regard to treating PTSD, the majority of research conducted among prisoners has focused on present-/non-trauma-focused therapies [1862]. As with community samples, past-/trauma-focused therapies appear to be more effective, but implementation is challenging in a setting that does not provide a safe and consistent environment within which trauma processing can occur [1862]. With regard to treating PTSD among prisoners with a history of co-occurring AOD use disorders, research to date has been limited to pilot studies of the present-/non-trauma-focused therapy *Seeking Safety*, conducted among female prisoners in the US [1863–1865] and male prisoners in Australia [1866], all of which have positive preliminary evidence supporting its acceptability.

There are also significant challenges associated with release from prison, including transitioning from a controlled environment with routine and stability, finding accommodation and employment, managing finances on a low income, returning to the same peer groups, risk of overdose, and returning to communities with few opportunities [1867, 1868]. The 2018 Health of Australia's Prisoners survey found that one in three people were homeless in the month prior to incarceration, and less than half had stable accommodation arranged post discharge [1851]. It can also be difficult for some people who were able to access AOD and mental health care in prison to access the same care in a community setting [1851, 1868]. Linking in with post-release services and coordinating with community-based treatment, where appropriate, may help clients transition into the community. In fact, having access to effective interpersonal support, community-based resources, employment, secure housing, continuity of care throughout the release process, and enrolment in treatment programs are protective factors following release from prison [1869–1872], and many of these factors can be targeted or addressed prior to release [1873].

Young people

Adolescence and young adulthood can be a difficult, turbulent time for many people, with issues of personal change, development, identity formation, experimentation, rebellion, and uncertainty impacting upon a person's thoughts, feelings, and behaviour [389]. It is also a critical time for the development of AOD and mental health conditions. Mental and AOD use disorders are leading global causes of burden of disease in young people [1874]. The peak of this disability occurs in those aged 15-24 years and corresponds with the typical period of onset of these conditions [1875]. In Australia, at least five of the top 10 causes of disability-adjusted life-years are directly related to mental health or AOD use disorders [1876]. Added to this are concerns that we may see an increase in psychological distress and problematic AOD use among young Australians in response to the combined effects of recent national disasters (e.g., bushfires, floods), climate change anxiety, and the impacts of the COVID-19 pandemic [75, 1877], as young people are being disproportionately impacted by these events [1878, 1879]. Despite

significant government investment in health services for young Australians (e.g., the expansion of headspace services), young people are commonly undertreated and there remains significant unmet need, particularly for young people who have more complex needs such as co-occurring AOD and mental health conditions [1880]. An Australian study conducted among young people aged 16-21 years attending specialist AOD treatment services reported that co-occurring depression (39%) and anxiety (34%) were common [1881]. Early intervention when symptoms of co-occurring conditions emerge is key to preventing a long-term chronic course of illness into adulthood [55] and addressing co-occurring mental health conditions has been identified as a key component to youth AOD treatment [1882].

It should be noted that the presentation of mental illness may be different in young people compared to adults. For example, children who have experienced trauma may not have a sense of reliving the trauma, but rather they may engage in repetitive play activities that re-enact the event. AOD workers who work with children or adolescents should refer to the DSM-5-TR [10] and be aware of possible variations of symptom expression.

It is also important to recognise that AOD and mental health conditions take place in different physical, attitudinal, psychological, and social contexts for young people, and treatment needs to be tailored accordingly to meet the developmental challenges faced by young people [102, 1882, 1883]. For instance, Christie and colleagues [1882] suggest that young people may be more likely to present for treatment due to external pressures (e.g., family, school, legal issues), so a focus on engagement, building rapport, harm minimisation, and the use of motivational interviewing should be a key focus of care. Scare tactics and confrontational approaches on the other hand, should be avoided [389, 1884].

Other features of 'youth friendly' services include follow-up for missed appointments, ease of access, prompt screening and assessment, drop-in capability, flexibility, strong links to other relevant agencies to ensure holistic treatment (see **Chapter B5**), and interventions that recognise different cognitive capacities and developmental/maturational lags [776, 1882]. AOD workers may need to modify the treatment process to avoid client distraction and rebellion (e.g., creating a more active and informal environment) and place special emphasis on engagement, using appropriate language and questioning to relate to young people on their level. E-health interventions, described in **Chapter B6**, may also be particularly useful for engaging young people in treatment and overcoming some of the barriers to face-to-face engagement [109].

With regards to confidentiality, although there may be jurisdictional differences in relation to operationalisation, most young people would be considered 'mature minors' by the age of around 14 or 15 years. In this case, there is no obligation to provide information to the parents unless other legal and reporting constraints operate, and confidentiality must be respected [389]. In most circumstances, however, it is helpful to involve families (especially parents or carers) and this should be discussed with the young person at the outset of treatment and their consent for involvement sought [389, 1882]. Parents and carers may require support, education, and empowerment in order to assist with continued care and help prevent client relapse upon discharge [452, 1885].

Older people

The world's population is ageing rapidly. In Australia, it is estimated that the proportion of adults aged over 65 years will increase from approximately 15% in 2017 to 21-23% in 2066, whilst the proportion of adults aged over 85 is expected to double over the same period from around 2% to 4% [1886]. Increased life expectancy, better health care, and decreased infant mortality across Australia are contributing to the increasing proportion of older people in the Australian community, and there is a need for AOD workers to be aware of the presentation and management of co-occurring mental disorders among older people, and how these differ from younger populations [431].

Rates of AOD use among older Australians are increasing, with the highest rates of daily drinking found among people over 70 [1780]. The proportion of older Australians presenting for some AOD treatment services, such as withdrawal management and pharmacotherapy, have also increased from 2018-19 to 2019-20 [1887, 1888]. In 2019, Australians aged over 60 also accounted for one third of all drug-induced suicides, both intentional and unintentional [1652].

Internationally, more than 20% of adults aged over 60 years have a mental health or neurological condition, the most common of which are dementia and depression [1889]. One-in-four deaths from self-harm are also found among this age group [1889]; however, suicide rates overall are not elevated among older (65+) Australians compared to middle-aged (35-64) Australians [1890]. Co-occurring conditions are common, with one medical chart audit of an older adult-specific AOD treatment service within Australia reporting that 89% of clients had at least one co-occurring mental health condition, the most common of which were depression (67%) and anxiety (53%) [81]. However, mental illness is often difficult to identify due to co-occurring physical health problems, injuries, and disabilities. Older people may have many contributing risk factors for mental illness, including bereavement, loss of social roles due to ill health or retirement, loss of autonomy or independence, social isolation, financial difficulties, diminishing cognitive function, and reduced capacity to self-care and manage their affairs [431, 1891, 1892]. Depression and suicide are also easily overlooked among older adults, and people who are socially isolated without supportive networks are at particular risk [431, 1893, 1894]. National Australian data suggests that suicide rates are also elevated among people with chronic pain, which is more common among Australians aged over 60 [1895]. Similarly, AOD and mental health conditions are often overlooked or misdiagnosed among older adults, who are uniquely at risk of AOD-related harms, as well as increased vulnerability to intoxication and overdose [389]. The ageing process can enhance physiological and cognitive sensitivity to adverse effects of AOD use [389, 1896].

International research has found that older adults are significantly more likely to be prescribed medication with abuse potential, with 25-53% of older adults prescribed psychoactive medication [1897, 1898], 23.9% of older adults receiving at least one potentially inappropriate prescription (the most common of which were sedatives and hypnotics) [1899], and 9.1% receiving excessive (>10) medications [1900]. Research from Australia has similarly found that one fifth to one half of older Australians are prescribed medications for durations that exceed recommended limits [1901], and 60% of older Australians receive potentially inappropriate prescriptions (the most common of which are opiates and benzodiazepines) [1902]. These factors are particularly problematic for people with dementia or cognitive impairment, and specialised medical practitioners in mental health services for older people need to

maintain a proactive role in reviewing medications and advising appropriate prescribing practices for older people [431, 1903]. Other common co-occurring conditions and risk factors for AOD use among older adults who use AOD include anxiety, depression, sleep problems, delirium, chronic pain, and self-harm [1891, 1893, 1904–1906]. Other factors that may contribute to the increased risk of AOD use problems in older adults include [389, 1903, 1907–1910]:

- Reduced capacity to metabolise, distribute, and eliminate drugs; as such, the risk of AOD-related harm may increase if AOD use is not reduced as a person becomes older. These harms include an increased risk of falls and burns.
- An increase in disposable income, which may increase AOD consumption and associated problems.
- Life changes including new patterns of socialising, retirement, bereavement, and social isolation, which can be associated with changes in social roles and status.
- Reduced coping skills resulting from factors such as family conflict and bereavement.
- More medications available for a range of conditions, which may be a contributing factor in the increased use of psychoactive substances.
- Opioids, benzodiazepines, and hypnotic sedatives are increasingly used by older Australians, which can be harmful when used with other substances (e.g., alcohol).
- Increased use of opioid substitution programs, needle and syringe programs, and treatments for blood-borne viruses has prevented many premature AOD-related deaths, and, as a result, many long-term illicit drug users survive into older age and thus require ongoing treatment.

In general, older adults may be less likely to seek, or perceive the need for, help for mental health and AOD use disorders [1911, 1912]. Several barriers that may prevent older adults from accessing treatment include [1907, 1913]:

- Transport, mobility, language, visual, or hearing difficulties, particularly for those who are frail or housebound, in rural or remote areas.
- Social isolation, which can result in serious problems going undetected.
- Lack of time – older people may have other time commitments, including the need to care for others (e.g., spouse, friends, or grandchildren).
- The unappealing and unwelcoming nature of mixed-age clinical services, which older people may find chaotic.
- Ageism, negative stereotypes, attributing problems to the ageing process.
- A lack of awareness about mental health and AOD use problems among older people.
- Reluctance to ask older people sensitive questions that may be embarrassing.
- The perception that older people are too old to change their behaviour.
- The belief that it is wrong to ‘deprive’ older people from their final pleasures in life.
- Inability to identify symptoms of AOD and mental health conditions in older people.
- A lack of readiness to stop using AOD.

It is critical to be aware that older adults with co-occurring mental health and AOD disorders are not a homogenous group, and AOD workers and other health care providers will play a vital role in ensuring access to appropriate interventions. The following may be useful for AOD workers managing and treating older adults [389, 1906, 1907]:

- Ensure AOD programs are age-specific, supportive, non-confrontational, culturally sensitive, aim to build self-esteem and coping skills, and foster an environment of respect.
- Ensure risk assessments are conducted (see **Chapter B4**), and depression, loneliness, and loss are addressed. Assist the client to take steps to rebuild their social networks.
- Be flexible and conduct sessions at an appropriate pace.
- Where appropriate, involve families and carers.
- With the client's consent, involve staff members who are interested and experienced in working with older adults.
- Practise care coordination (see **Chapter B5**), and take care to foster links with medical, ageing, and other relevant services. Be proactive with follow-up and care coordination.
- Take a holistic approach to treatment (see **Chapter B1**), and incorporate age-specific psychological, social, and health problems.

Appendices

Appendix A: Other Australian guidelines

Below is a selection of other Australian guidelines that may be useful to those working with clients experiencing co-occurring AOD and mental health conditions. Note that some of these resources are somewhat dated, but we have retained them where more recent guidance is unavailable. Readers should nonetheless be aware that given their age, some of the information contained may not be based on the most current evidence. Although the guidelines below are Australian, there are many good sources of guidelines internationally that readers may find useful and relevant, such as the UK's National Institute for Health and Care Excellence (NICE; www.nice.org.uk/), as well as the US's Substance Abuse and Mental Health Services Administration (SAMHSA; www.samhsa.gov/).

Other Australian guidelines

ACON. 2018. *AOD LGBTIQ inclusive guidelines for treatment providers.* Sydney: ACON & NADA.

www.nada.org.au/resources/aod-lgbtiq-inclusive-guidelines-for-treatment-providers

Cash R, Philactides A. 2006. *Clinical treatment guidelines for alcohol and drug clinicians. No. 14: Co-occurring acquired brain injury/cognitive impairment and alcohol and other drug use disorders.* Fitzroy, Australia: Turning Point Alcohol and Drug Centre Inc.

www.health.vic.gov.au/publications/clinical-treatment-guidelines-for-alcohol-and-drug-clinicians-co-occurring-acquired

Crane P, Buckley J, Francis C. 2012. *Youth alcohol and drug good practice guide 1: A framework for youth alcohol and other drug practice.* Brisbane: Dovetail.

www.dovetail.org.au/media/1186/dovetail_gpg_1_framework-for-youth-aod-practice.pdf

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

www.drugsandalcohol.ie/20288/

Encompass Family and Community. 2014. *Youth alcohol and drug practice guide 4: Learning from each other: Working with Aboriginal and Torres Strait Islander young people.* Brisbane: Dovetail.

www.dovetail.org.au/media/1189/dovetail_gpg_4_learning-from-each-other_working-with-aboriginal-and-torres-strait-islander-young-people.pdf

Gordon A. 2008. *Comorbidity of mental disorders and substance use: A brief guide for the primary care clinician.* Canberra: Australian Government Department of Health and Ageing.

www.sahealth.sa.gov.au/wps/wcm/connect/68872d8041785aab92bdff67a94f09f9/Comorbidity+Mental+Disorders+Substance+Use+Guide_2008-DASSA-Oct2013+pdf.pdf?MOD=AJPERES&CACHEID=ROOTWORKSPACE-68872d8041785aab92bdff67a94f09f9-nKLdhdq

Grigg J, Manning V, Arunogiri S, Volpe I, Frei M, Phan V, Rubenis A, Dias S, Petrie M, Sharkey M, Lubman DI. 2018. *Methamphetamine treatment guidelines: Practice guidelines for health professionals (2nd edition).* Richmond: Turning Point.

www.turningpoint.org.au/sites/default/files/2019-05/Turning-Point-Methamphetamine-Treatment-Guidelines.pdf

Henderson C, Everett M, Isobel S. 2018. *Trauma-Informed Care and Practice Organisational Toolkit (TICPOT): An Organisational Change Process Resource, Stage 1 - Planning and Audit.* Mental Health Coordinating Council (MHCC).

www.mhcc.org.au/resource/ticpot-stage-1-2-3/

Henderson C, Everett M, Isobel S. 2018. *Trauma-Informed Care and Practice Organisational Toolkit (TICPOT): An Organisational Change Resource, Stage 2 - Supporting Organisational Change and Stage 3 – Implementation.* Mental Health Coordinating Council (MHCC).

www.mhcc.org.au/resource/ticpot-stage-1-2-3/

Haber PS, Riordan BC. 2021. *Guidelines for the Treatment of Alcohol Problems (4th edition).* Sydney: Speciality of Addiction Medicine, Faculty of Medicine and Health, The University of Sydney.

www.alcoholtreatmentguidelines.com.au

Jenner L, Baker A, Whyte I, Carr V. 2004. *Psychostimulants: Management of acute behavioural disturbances: Guidelines for police services.* Canberra: Australian Government Department of Health and Ageing.

Lee K, Freeburn B, Ella S, Miller W, Perry J, Conigrave K. 2012. *Handbook for Aboriginal alcohol and drug work.* Sydney: University of Sydney.

https://www.sydney.edu.au/content/dam/corporate/documents/faculty-of-medicine-and-health/disciplines/indigenous-handbook-alcohol-drug-work.pdf

Manning V, Gooden JR, Cox C, Petersen V, Whelan D, Mroz K. 2021. *Managing Cognitive Impairment in AOD Treatment: Practice Guidelines for Healthcare Professionals.* Richmond, Victoria: Turning Point.

https://www.turningpoint.org.au/treatment/clinicians/Managing-Cognitive-Impairment-in-AOD-Treatment-Guidelines

Marsh A, Towers T, O'Toole S. 2017. *Trauma-informed treatment guide for working with women with alcohol and other drug issues (3rd edition).* Perth: Improving Services for Women with Drug and Alcohol and Mental Health Issues and their Children Project.

www.whfs.org.au/resources/professional-resources

Mental Health Coordinating Council (MHCC). 2018. *Recovery oriented language guide.* Sydney: MHCC.

https://mhcc.org.au/2021/10/recovery-oriented-language-guide-quick-reference/

National Indigenous Drug and Alcohol Committee. 2014. *Alcohol and other drug treatment for Aboriginal and Torres Strait Islander peoples.* Canberra: Australian National Council on Drugs.

www.healthinfonet.ecu.edu.au/healthinfonet/getContent.php?linkid=592238&title=Alcohol+and+other+drug+treatment+for+Aboriginal+and+Torres+Strait+Islander+peoples

Network of Alcohol and other Drugs Agencies (NADA). 2017. *Aboriginal Inclusion Tool: A tool to improve Aboriginal inclusion in AOD services.* Sydney: NADA.

www.nada.org.au/resources/aboriginal-inclusion-tool-2

Network of Alcohol and other Drugs Agencies (NADA). 2021. *Access and equity: Working with diversity in the alcohol and other drugs setting (2nd edition).* Sydney: NADA.

www.nada.org.au/resources/working-with-diversity

Network of Alcohol and other Drugs Agencies (NADA). 2013. *Complex needs capable: A practice resource for drug and alcohol services.* Sydney: NADA.

www.nada.org.au/resources/complex-needs-capable

Network of Alcohol and other Drugs Agencies (NADA). 2021. *NADA practice resource: Engaging men who perpetrate domestic and family violence in the alcohol and other drugs treatment context.* Sydney: NADA.

www.nada.org.au/resources/engaging-men-who-perpetrate-domestic-and-family-violence-in-the-alcohol-and-other-drugs-treatment-context

Network of Alcohol and other Drugs Agencies (NADA). 2021. *NADA practice resource: Working with women engaged in alcohol and other drug treatment (3rd edition).* Sydney: NADA.

www.nada.org.au/resources/nada-practice-resource-working-with-women-engaged-in-alcohol-and-other-drug-treatment

Network of Alcohol and other Drugs Agencies (NADA). 2020. *Workforce Capability Framework: Core capabilities for the NSW non-government alcohol and other drugs sector.* Sydney: NADA.

www.nada.org.au/resources/workforce-capability-framework

NSW Department of Health. 2009. *NSW clinical guidelines for the care of persons with comorbid mental illness and substance use disorders in acute care settings.* Sydney: NSW Department of Health.

www.health.nsw.gov.au/aod/resources/Publications/comorbidity-report.pdf

NSW Department of Health. 2008. *NSW Health drug and alcohol psychosocial interventions.* Sydney: NSW Department of Health (last reviewed 2018, currently being updated).

www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2008_009.pdf

NSW Department of Health. 2015. *Guidelines to consumer participation in NSW drug and alcohol services.* North Sydney: NSW Department of Health (last reviewed 2020).

www1.health.nsw.gov.au/pds/ActivePDSDocuments/GL2015_006.pdf

Roche A, Trifonoff A, Ryan K. 2019. *Methamphetamine use among Aboriginal and Torres Strait Islander people: Intervention options for workers.* Adelaide: National Centre for Education and Training on Addiction (NCETA).

www.nceta.flinders.edu.au/application/files/8716/0156/0381/EN749_Roche.pdf

Stone J, Marsh A, Dale A, Willis L, O'Toole S, Helfgott S, Bennetts A, Cleary L, Ditchburn S, Jacobson H, Rea R, Aitken D, Lowery M, Oh G, Stark R, Stevens C. 2019. *Counselling Guidelines: Alcohol and other drug issues (4th edition).* Perth: Mental Health Commission.

www.mhc.wa.gov.au/media/2604/mhc_counselling-guidelines-4th-edition.pdf

Victorian Dual Diagnosis Initiative. 2012. *Our healing ways: Putting wisdom into practice: Working with co-existing mental health and drug and alcohol issues: Aboriginal way.* Melbourne: Victorian Dual Diagnosis Initiative Education and Training Unit.

www.nceta.flinders.edu.au/application/files/9915/0646/7727/Healing_Ways_Manual.pdf

Wallace R, Allan J. 2019. *Alcohol and Other Drugs Treatment Guidelines for Working with Aboriginal & Torres Strait Islander People in a Non-Aboriginal Setting.* Sydney: Network of Alcohol and other Drugs Agencies.

www.nada.org.au/wp-content/uploads/2021/01/NADA-Aboriginal-Guidelines-Web-2.pdf

Western Australian Network of Alcohol and other Drug Agencies (WANADA). 2011. *Healthy eating for wellbeing: A nutrition guide for alcohol and other drug agency workers.* Perth: Western Australian Network of Alcohol and other Drug Agencies.

www.wanada.org.au/index.php?option=com_docman&view=download&alias=45-healthyeatingfohealthy-eating-for-wellbeing-a-nutrition-guide-for-alcohol-other-drug-agency-workers&category_slug=healthy-eating-and-wellbeing-guides&Itemid=265

Winstock A, Molan J. 2007. *The patient journey: KIT2: Supporting GPs to manage comorbidity in the community.* Sydney: NSW Department of Health.

www.health.nsw.gov.au/mentalhealth//Documents/pj-kit2.pdf

Appendix B: Other useful resources

Below is a selection of other resources that may be useful for those working with clients experiencing co-occurring AOD and mental health conditions. Note that some of these resources are somewhat dated, but we have retained them where more recent resources are unavailable. Readers should nonetheless be aware that given their age, some of the information contained may not be based on the most current evidence.

Other useful resources

Australian Association of Social Workers. 2013. *National practice standards for social workers 2013.* Canberra, Australia (currently being updated).

www.aasw.asn.au/practitioner-resources/practice-standards

Australian Government Department of Health. 2012. *Mental health statement of rights and responsibilities.* Canberra, Australia.

www.health.gov.au/resources/publications/mental-health-statement-of-rights-and-responsibilities-2012

Back S, Foa E, Killeen T, Mills KL, Teesson M, Cotton BD, Carroll KM, Brady KT. 2015. *Concurrent treatment of PTSD and substance use disorders using prolonged exposure (COPE): Therapist guide.* Oxford, UK: Oxford University Press.

Baker A, Kay-Lambkin F, Lee NK, Claire M, Jenner L. 2003. *A brief cognitive behavioural intervention for regular amphetamine users.* Canberra, Australia: Australian Government Department of Health and Ageing.

www.drugsandalcohol.ie/13632/1/NTA_AMPHETAMINE_cognitive-intervention.pdf

Baker A, Velleman R. 2007. *Clinical handbook of co-existing mental health and drug and alcohol problems.* London, UK: Routledge.

Clancy R, Terry M. 2007. *Psychiatry and substance use: An interactive resource for clinicians working with clients who have mental health and substance use problems* [DVD-ROM]. Newcastle, Australia: NSW Health.

eMHPrac e-Mental Health in Practice Project. 2021. *A guide to digital mental health resources.* Brisbane, Queensland: Queensland University of Technology.

www.emhprac.org.au/wp-content/uploads/2019/12/eMHPrac-Resource-Guide-September-2021.pdf

Miller W, Rollnick S. 2013. *Motivational interviewing: Helping people change (3rd edition).* New York, NY, US: Guildford Press.

Mills KL, Marel C, Baker A, Teesson M, Dore G, Kay-Lambkin F, Manns L, Trimingham T. 2011. *Comorbidity information booklets.* Sydney, New South Wales: National Drug and Alcohol Research Centre.

- Anxiety and substance use: **https://www.sydney.edu.au/content/dam/corporate/documents/matilda-centre/resources/booklets/anxiety-substance-use.pdf**
- Mood and substance use: **https://www.sydney.edu.au/content/dam/corporate/documents/matilda-centre/resources/booklets/mood-and-substance-use.pdf**
- Trauma and substance use: **https://www.sydney.edu.au/content/dam/corporate/documents/matilda-centre/resources/booklets/trauma-and-substance-use.pdf**
- Psychosis and substance use: **https://www.sydney.edu.au/content/dam/corporate/documents/matilda-centre/resources/booklets/psychosis-and-substance-use.pdf**
- Personality and substance use: **https://www.sydney.edu.au/content/dam/corporate/documents/matilda-centre/resources/booklets/personality-and-substance-use.pdf**

Network of Alcohol and other Drugs Agencies (NADA). 2017. *Aboriginal Inclusion Tool: A tool to improve Aboriginal inclusion in AOD services.* Sydney: NADA.

https://nada.org.au/resources/aboriginal-inclusion-tool-2/

Network of Alcohol and other Drugs Agencies (NADA). 2018. *Language matters.* Sydney: NADA.

https://nada.org.au/resources/language-matters/

Reilly PM, Shopshire MS. 2019. *Anger management for substance abuse and mental health clients: A cognitive-behavioural therapy manual.* Rockville, MD, US: Substance Abuse and Mental Health Services Administration.

www.store.samhsa.gov/product/Anger-Management-for-Substance-Abuse-and-Mental-Health-Clients-A-Cognitive-Behavioral-Therapy-Manual/PEP19-02-01-001

Substance Abuse and Mental Health Services Administration. 2019. *Enhancing motivation for change in substance use disorder treatment.* Rockville, MD, US: Substance Abuse and Mental Health Services Administration.

www.samhsa.gov/resource/ebp/tip-35-enhancing-motivation-change-substance-abuse-treatment

Stapinski L, Rapee R, Haggman S, Sannibale C, Winkler C, Baillie AJ. 2021. *Combined Cognitive Behavioural Therapy for Social Phobia and Harmful Drinking: Therapist Guide, Revised Version.* Sydney, New South Wales: CASP Project. Centre for Emotional Health, Macquarie University.

www.osf.io/xuqcr/

Turning Point. 2013. *Screening and assessment tools.* Victoria.

www.turningpoint.org.au/treatment/clinicians/screening-assessment-tools

Victorian Government Department of Health. 2013. *National practice standards for the mental health workforce.* Melbourne, Victoria.

www.health.gov.au/sites/default/files/documents/2021/04/national-practice-standards-for-the-mental-health-workforce-2013.pdf

Appendix C: Sources of research, information and other resources

Below is a selection of other research and information organisations and other resources that may be useful for those working with clients experiencing co-occurring AOD and mental health conditions.

Organisation name	Contact	Service
ACON	www.acon.org.au	A health promotion organisation specialising in support for people who identify as sexual or gender diverse, or have HIV, in NSW.
Alcohol and Drug Foundation (ADF)	www.adf.org.au	A not-for-profit NGO committed to preventing and minimising AOD-related harms across Australia.
Alcohol, Tobacco, and Other Drug Association ACT (ATODA)	www.atoda.org.au	Peak body representing government and NGO alcohol and other drug sector in the Australian Capital Territory.
Alcohol, Tobacco and Other Drugs Council Tasmania (ATDC)	www.atdc.org.au	The peak body representing the NGO, not-for-profit Alcohol, Tobacco and Other Drug (ATOD) sector in Tasmania.
Alcohol and Other Drugs Knowledge Centre	www.aodknowledgecentre.ecu.edu.au	Alcohol and other drugs information resource for Aboriginal communities.
Association of Alcohol and Other Drug Agencies NT (AADANT)	www.aadant.org.au	Peak body for the alcohol and other drug sector in the Northern Territory.
Australasian Professional Society on Alcohol and Other Drugs (APSAD)	www.apsad.org.au	Professional body for individuals working in the alcohol and other drugs field.
Australasian Therapeutic Communities Association (ATCA)	www.atca.com.au	Peak body representing therapeutic communities in Australasia.

Australian Association of Social Workers (AASW)	www.aasw.asn.au	Professional body for social workers in Australia.
Australian Indigenous *HealthInfoNet*	www.healthinfonet.ecu.edu.au	Information and resources for Indigenous health.
Australian Injecting and Illicit Drug Users League	www.aivl.org.au	The peak national organisation representing peer-based AOD organisations and people with lived experience of AOD use.
Australian Institute of Criminology	www.aic.gov.au	The peak national organisation for research and knowledge on crime and justice.
Australian Institute of Health and Welfare	www.aihw.gov.au	The peak national organisation for research and knowledge on health and welfare.
Australian Psychological Society (APS)	www.psychology.org.au	Professional body for psychologists in Australia.
Beyond Blue	www.beyondblue.org.au	A national, independent, not-for-profit organisation working to address issues associated with depression, anxiety, and related substance misuse disorders in Australia.
Black Dog Institute	www.blackdoginstitute.org.au	A not-for-profit research, education, and training institute with expertise in diagnosis, treatment, and prevention of mood disorders.
Brain and Mind Centre	www.sydney.edu.au/brain-mind/	Network of researchers and clinicians who aim to develop treatments for brain and mind conditions and improve health outcomes.
Burnet Institute	www.burnet.edu.au	A research institute which aims to achieve better health for vulnerable communities in Australia and internationally.

Centre for Rural and Remote Mental Health	www.crrmh.com.au	Centre that provides leadership in rural and remote mental health research and program delivery.
Community Mental Health Drug and Alcohol Research Network	www.cmhdaresearchnetwork.com.au	Network that aims to broaden involvement of the community mental health and AOD sector in practice-based research and promote the value of research and the use of research evidence in practice.
Cracks in the Ice	www.cracksintheice.org.au	Online toolkit providing evidence-based information and resources about crystal methamphetamine ('ice') for the Australian community.
Drug and Alcohol Multicultural Education Centre (DAMEC)	www.damec.org.au	NGO providing support, education, research, and training about drug and alcohol issues for CALD groups in NSW.
Drug and Alcohol Nurses of Australasia (DANA)	www.danaonline.org	Peak body representing alcohol and other drug nursing in Australasia.
Deakin University Centre for Drug Use, Addictive and Anti-Social Behaviour Research	www.deakin.edu.au/psychology/our-research/centre-for-drug-alcohol-and-addiction-research	Research centre focusing on the psychological, biological, socio-political, and clinical aspects of AOD use, other addictive behaviours, and consequent harm.
Drug and Alcohol Services South Australia	www.sahealth.sa.gov.au/wps/wcm/connect/public+content/sa+health+internet/services/mental+health+and+drug+and+alcohol+services/drug+and+alcohol+services/drug+and+alcohol+services	A statewide South Australian health service for people with alcohol and/or other drug related problems.

Drug and Alcohol Specialist Advisory Service (DASAS)	Within Sydney Metropolitan Area: (02) 8382-1006 Regional, Rural & Remote NSW: 1800 023 687 https://www.svhs.org.au/our-services/list-of-services/alcohol-drug-service/drug-alcohol-specialist-advisory-service	Free 24/7 clinician-operated telephone service that provides general advice to NSW-based health professionals on clinical diagnosis and management of patients with AOD-related concerns.
Dual Diagnosis Australia and New Zealand	www.dualdiagnosis.org.au/home	An online community of people interested in contributing to better outcomes for persons with co-occurring substance use and mental health disorders.
eCliPSE	www.eclipse.org.au	Online portal that facilitates free 24/7 access to evidence-based online screening, eHealth treatments and resources for people experiencing co-occurring mental health and substance use problems, and the clinical services supporting them.
EveryMind	www.everymind.org.au	Institute focusing on delivering best-practice mental health and suicide prevention programs.
Family Drug Support Australia	1300 368 186 www.fds.org.au	Assists families throughout Australia to deal with drug issues and achieve positive outcomes.
Foundation for Alcohol Research and Education	www.fare.org.au	A not-for-profit organisation which develops evidence-informed policy, enables advocacy, and delivers health promotion programs designed to reduce the risk of alcohol-related harm.
GROW Mental Wellbeing Programs	1800 558 268 www.grow.org.au	A 12-step program for people experiencing mental illness. Services include meetings across Australia and a residential service in Australia.

Headspace	www.headspace.org.au	A government-funded youth mental health information site.
eheadspace	www.headspace.org.au/online-and-phone-support/	Online and telephone support service for young people experiencing mental health issues.
Hepatitis Australia and the National Hepatitis Infoline	1800 437 222 www.hepatitisaustralia.com	The peak, national NGO representing the interests of the Australian viral hepatitis community sector; provides a number of useful resources and referrals to state-based organisations.
Homelessness Australia	www.homelessnessaustralia.org.au	Peak body for homelessness in Australia.
InsideOut Institute for Eating Disorders	https://insideoutinstitute.org.au	National institute for research, translation and clinical excellence in eating disorders.
The Kirby Institute	www.kirby.unsw.edu.au	A medical research organisation dedicated to the prevention and treatment of infectious diseases and endemic response based in New South Wales.
The Matilda Centre for Research in Mental Health and Substance Use	www.sydney.edu.au/matilda-centre	A research centre that brings together world-leading researchers, clinicians, people with lived experience and community to share skills, synergise data, harness new technologies and trial innovative programs to prevent and treat mental and substance use disorders.
The Mental Health Services (TheMHS) Learning Network	www.themhs.org	Learning network aimed at improving mental health services in Australia and New Zealand.
Menzies School of Health Research	www.menzies.edu.au	A national medical research organisation dedicated to improving the health and wellbeing of Aboriginal and Torres Strait Islander people, as well as tropical health.

Mental Health Australia	www.mhaustralia.org	The peak, national NGO representing and promoting the interests of the Australian mental health sector.
Mental Health Coalition of South Australia	www.mhcsa.org.au	The peak body promoting the interests of NGOs supporting people with a psychiatric disability in SA.
Mental Health Community Coalition ACT (MHCC ACT)	www.mhccact.org.au	The peak body representing the non-profit community mental health sector in the ACT.
Mental Health Coordinating Council (MHCC)	www.mhcc.org.au	The peak body for community mental health organisations in NSW.
Mental Health Council of Tasmania (MHCT)	www.mhct.org	The peak body representing the interests of non-government mental health consumer organisations, carer organisations and service provider organisations in Tasmania.
Mental Health First Aid Australia	www.mhfa.com.au	Provides evidence-based mental health first aid education to all.
Mental Health Victoria	www.mhvic.org.au	The peak body for mental health in Victoria.
Mission Australia	www.missionaustralia.com.au	A national organisation that provides community services throughout Australia.
MindSpot Clinic	www.mindspot.org.au	An online mental health clinic that provides free, anonymous assessment and treatment for adults experiencing stress, anxiety, depression, OCD, PTSD and chronic pain.
moodgym	www.moodgym.com.au	A CBT self-help training program for depression and anxiety.
National Centre for Education and Training on Addiction	www.nceta.flinders.edu.au	Research centre that specialises in AOD workforce development.

National Centre for Youth Substance Use Research	www.ncysur.centre.uq.edu.au	Centre that aims to promote the health and wellbeing of young people by increasing Australia's capacity to respond effectively to the harm associated with alcohol, tobacco, and other drug misuse.
National Drug and Alcohol Research Centre	www.ndarc.med.unsw.edu.au	Centre that conducts research that can be put into practice in order to develop and improve approaches to both prevention and treatment of addiction related problems.
National Drug Research Institute	www.ndri.curtin.edu.au	Institute that conducts and disseminates research that contributes to effective policy, strategies and practice to prevent and reduce harmful AOD use.
National Eating Disorders Collaboration	www.nedc.com.au	Collaboration dedicated to developing and implementing a nationally consistent, evidence-based system of care for the prevention and treatment of eating disorders.
National Health and Medical Research Council	www.nhmrc.gov.au	Australian national council that creates pathways to a healthier future through research funding, health guidelines and ethical standards.
The National Institute for Health and Care Excellence (UK)	www.nice.org.uk	Institute that develops guidance, advice, quality standards and information services for health, public health and social care in the UK.
Network of Alcohol and Other Drugs Agencies (NADA)	www.nada.org.au	The peak organisation for NGO AOD services in New South Wales.
Northern Territory Council of Social Service (NTCOSS)	www.ntcoss.org.au	The peak body for the social and community sector in the Northern Territory.

Northern Territory Mental Health Coalition	www.ntmhc.org.au	The peak body representing the community-based mental health sector in the NT.
ORYGEN Youth Mental Health Australia	www.orygen.org.au	A national not-for-profit organisation and research centre for young people with mental health issues.
Phoenix Australia: Centre for Posttraumatic Mental Health	www.phoenixaustralia.org	A national non-for-profit organisation for people experiencing trauma and posttraumatic stress.
Positive Choices	www.positivechoices.org.au	An online portal with AOD-related resources for schools, parents, and communities.
Project Air	www.uow.edu.au/project-air	Organisation that conducts research, education and treatment into personality disorders.
Queensland Alliance for Mental Health (QAMH)	www.qamh.org.au	The peak body for community mental health organisations in Queensland.
Queensland Network of Alcohol and other Drug Agencies (QNADA)	www.qnada.org.au	The peak organisation for NGO AOD agencies throughout Queensland.
ReachOut	www.au.reachout.com	An online service providing information and referrals to young people with a variety of problems including AOD and mental health.
ReachOut Schools	https://schools.au.reachout.com/	An organisation that provides online wellbeing resources for parents, teachers, and carers of young people.
Royal Australian and New Zealand College of Psychiatrists	www.ranzcp.org	The body responsible for training, educating and representing psychiatrists in Australia and New Zealand.

Sax Institute	www.saxinstitute.org.au	Institute that develops, tests and delivers best-practice approaches to working at the interface of research and health decision-making.
SMART Recovery Australia	www.smartrecoveryaustralia.com.au	A peer-managed self-help group that assists recovery from AOD use.
SMART Family and Friends	https://smartrecoveryaustralia.com.au/family-friends/	Support program designed to assist anyone affected by the addictive behaviour of someone close to them.
Society for Mental Health Research (SMHR)	www.smhr.org.au	National body for individuals engaged in research relating to mental health.
South Australian Network of Drug and Alcohol Services (SANDAS)	www.sandas.org.au	The peak body for NGOs working in the AOD field in South Australia.
Substance Abuse and Mental Health Services Administration (US)	www.samhsa.gov	US-based agency that aims to reduce the impact of substance abuse and mental illness on communities.
Telethon Kids Institute	www.telethonkids.org.au	Medical research institute that aims to improve the health and wellbeing of children through excellence in research.
Turning Point Alcohol and Drug Centre	www.turningpoint.org.au	National addiction treatment, education and research centre.
Victorian Alcohol and Drug Association (VAADA)	www.vaada.org.au	The peak body representing AOD services in Victoria.
Western Australian Association for Mental Health (WAAMH)	www.waamh.org.au	The peak mental health representative body in Western Australia for NGO non-profit agencies.
Western Australian Network of Alcohol and Other Drug Agencies (WANADA)	www.wanada.org.au	The peak body for the non-profit AOD sector in Western Australia.
Youth Support and Advocacy Service	www.ysas.org.au	Victorian-based youth-specific community service organisation.

Appendix D: DSM-5-TR and ICD-11 classification cross-reference

Below is a cross-reference of the DSM-5-TR disorders described in Chapter A4 with the corresponding ICD-11 codes.

DSM-5-TR disorder classification	ICD-11 classification	ICD-11 coding
Attention-deficit/hyperactivity disorder (ADHD)	Attention deficit hyperactivity disorder	6A05
Schizophrenia	Schizophrenia	6A20
Schizoaffective disorder	Schizoaffective disorder	6A21
Brief psychotic disorder	Acute and transient psychotic disorder	6A23
Delusional disorder	Delusional disorder	6A24
Bipolar I disorder	Bipolar type I disorder	6A60
Bipolar II disorder	Bipolar type II disorder	6A61
Cyclothymic disorder	Cyclothymic disorder	6A62
Major depressive disorder	Single depressive disorder Recurrent depressive disorder	6A70 6A71
Persistent depressive disorder	Dysthymic disorder	6A72
Generalised anxiety disorder (GAD)	Generalised anxiety disorder	6B00
Panic disorder	Panic disorder	6B01
Agoraphobia	Agoraphobia	6B02
Social anxiety disorder (SAD)	Social anxiety disorder	6B04
Specific phobia	Specific phobia	6B03
Obsessive-compulsive disorder	Obsessive-compulsive disorder	6B20

Post traumatic stress disorder (PTSD)	Post traumatic stress disorder Complex post traumatic stress disorder	6B40 6B41
Anorexia nervosa	Anorexia nervosa	6B80
Bulimia nervosa	Bulimia nervosa	6B81
Binge eating disorder	Binge eating disorder	6B82
Antisocial personality disorder (ASPD) **Borderline personality disorder (BPD)**	Personality disorder (mild, moderate, severe); trait domain qualifier: • negative affectivity • detachment • dissociality • disinhibition • anankastia • borderline	6D10.0, 6D10.1, 6D10.2 6D11.0 6D11.1 6D11.2 6D11.3 6D11.4 6D11.5

Appendix E: Motivational interviewing

A useful tool in AOD client management is motivational interviewing (MI), irrespective of whether the client is experiencing co-occurring mental health conditions. MI can be beneficial for clients with co-occurring conditions by increasing treatment motivation, adherence, and readiness to change [762, 947, 1090, 1914, 1915], although it may not prove effective in all cases [762, 947]. A number of useful resources for MI are given in Appendix B, including Miller and Rollnick [758], the Substance Abuse and Mental Health Services Administration [1847], Baker and Velleman [122], and Clancy and Terry [448], from which this section draws upon.

MI is a directive, non-confrontational, client-centred counselling strategy aimed at increasing a person's motivation to change. This strategy assumes equity in the client-AOD worker relationship and emphasises a client's right to define their problems and choose their own solutions. It is, in this sense, a counselling style based on collaboration rather than confrontation, evocation rather than education and autonomy instead of authority, as opposed to a set of techniques [1916].

Principles of MI include:

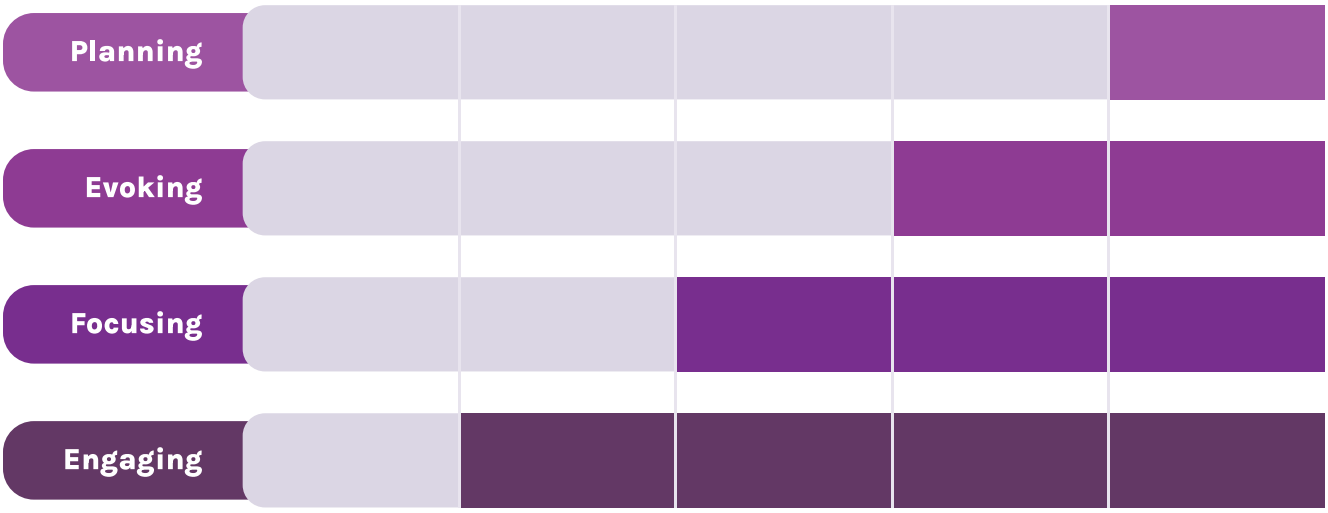
- **Avoid argumentation.** Confrontation is unhelpful to change and is likely to increase resistance.
- **Express empathy, warmth, and genuineness** in order to facilitate engagement and build rapport.
- **Support self-efficacy.** Build confidence that change is possible.
- **Roll with resistance.**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

Thus, MI aims to rouse feelings of ambivalence and discomfort surrounding current behaviour in order to motivate change. Key to facilitating change are the concepts of 'change talk' (a process whereby a person becomes more committed to a position by arguing for that position) and 'sustain talk' (the more argument against change is evoked, the less likely a person is to change).

MI involves four overlapping processes (Figure 22, Table 63) [758]:

- **Engaging:** the establishment of a meaningful connection and therapeutic relationship between the client and AOD worker and is a prerequisite for everything that follows.
- **Focusing:** the development and maintenance of a specific direction in conversation about change.
- **Evoking:** the elicitation of the client's own motivations for change, which has always been at the heart of MI. It can be achieved when there is a focus on a particular change and the client's own ideas and feelings about how to achieve it are harnessed (i.e., the client talks themselves into changing).
- **Planning:** involves developing commitment to change and formulating a specific plan of action. It is often the point where a client begins to talk about when and how to change, as opposed to whether and why.

Figure 22: Four processes of MI



Source: Miller and Rollnick [758].

Table 63: Questions regarding each MI process

Engaging
• How comfortable is the client talking with you?
• How supportive/helpful are you being?
• Does this feel like a supportive/collaborative partnership?
Focusing
• What goals for change does the client really have?
• Are you working together with a common purpose?
• Does it feel like you're moving together or in opposing directions?
Evoking
• What are the client's own reasons for change?
• Is the reluctance about confidence or importance of change?
• Are you pushing the client too far or too quickly in a particular direction?
Planning
• What would be a reasonable next step towards change?
• Are you remembering to evoke rather than prescribe a plan?
• Are you offering advice or information with permission?

Source: Miller and Rollnick [758].

Core skills of MI

Miller and Rollnick [758] identify five core skills that are used throughout the different processes of MI, which can be remembered with the OARS + I&A acronym:

- Asking **O**pen questions.
- **A**ffirming.
- **R**eflective listening.
- **S**ummarising.
- **I**nforming and **A**dvising (with permission, elicit-provide-elicit).

Asking open questions

Asking open questions refers to a questioning method that does not invite short answers, which increases information flow and trust, and invites the client to reflect and elaborate. While there are times when asking closed questions may be necessary (e.g., gathering information for screening or assessment), in the engaging and focusing processes of MI, open questions help the AOD worker understand the client's frame of mind, find a clear direction for change, and strengthen the relationship between the client and AOD worker [758]. Certain kinds of open questions are particularly suited to the different processes involved in MI (e.g., engaging, evoking). Some examples of closed and open questions are provided in Table 64. AOD workers may also find the range of open questions provided in Table 66 useful [776], which have been grouped according to the stages of change model [446, 1917]. The goal of open-ended questions is to elicit self-motivational statements from the client [776]. There should be a balance between asking open questions and reflective listening [1847]. Among clients who may be experiencing symptoms of co-occurring mental health conditions, these questions should be simplified. Compound questioning (two questions in one sentence) should be avoided [1847].

Table 64: Examples of closed and open questions

Closed questions	Open questions
You've come in today because you're worried about how much alcohol you've been drinking lately, is that right?	What brings you in today?
Do you have any children?	Tell me about your family.
How old were you when you drank alcohol for the first time?	Tell me about the first time you drank alcohol.
On a typical day, how much cannabis do you use?	Tell me about your cannabis use on a typical day.
Do you think it would be a good idea for you to go into detoxification?	What do you think about the possibility of going through detoxification?

Adapted from SAMHSA [1847].

Affirming

Affirming is a way of enhancing the confidence of clients to take action, by the AOD worker showing their genuine appreciation and positive regard for the client [758]. It is the client, rather than the AOD worker, who produces change in MI, and as such, the process of MI relies on the client's own personal strengths, efforts and resources. Affirming therefore focuses on the positive with direct compliments and statements of appreciation and understanding rather than attempting to produce change by making the client feel bad [758]. The technique of affirming helps build rapport, self-efficacy and reinforces open exploration.

Among clients who may be experiencing symptoms of co-occurring mental health conditions, affirming can be inspiring and build rapport [1918]. Affirming can be general (the AOD worker respects the client as a person of worth, who has the capacity for growth, change, and the choice about whether to do so), and specific (recognition of the client's strengths, abilities, intentions, and efforts) [758]. AOD workers may find the following strategies helpful to consider when affirming [1847]:

- Focus on the client's strengths, previous successes and efforts, however small, to achieve their change goals.
- Take care not to confuse affirming with praise. Praise implies the worker is approving the client, expresses judgement (of praise or blame), and is more likely to begin with an 'I'.
- Use phrases that begin with 'you' rather than 'I', to maintain focus on the client. For example, rather than '*I am proud you came in today*', which shifts the focus to the AOD worker, try '*You worked really hard and persisted in being here today*', which illustrates appreciation and maintains focus on the client.

Some other examples of affirming statements that AOD workers may find useful include [758, 1847]:

- 'You took a big step in coming here today.'
- 'That is a great suggestion for how you might avoid situations where you might be tempted to use.'
- 'Your intention was really good, even though it may not have turned out as you would have liked.'
- 'You were discouraged this week, but you still came back. You are persistent.'
- 'Welcome back! It's good to see you.'

Reflective listening

Reflective listening is a key component of showing empathy and a core skill of person-centred therapy. It involves listening to what the client is saying, forming an understanding of what they are talking about and then giving voice (reflecting) to that understanding. Reflecting shows respect and acceptance to clients, establishes trust and helps with the exploration of perceptions and values, enables the building of a collaborative and non-judgemental relationship, and allows the AOD worker to show their support without necessarily agreeing with the client's ideas or statements [758].

Good reflective listening keeps the client talking, exploring, and considering. It is also specific in the sense that the AOD worker selects specific information on which to reflect. Reflecting can range from simple (i.e., repeating or rephrasing the client's words) to complex (i.e., reflecting the underlying meaning

or feelings with the use of different words). The depth of reflection increases with the level of the AOD worker's experience and expertise. Importantly, reflective listening is not making assumptions about the underlying meaning of clients' statements, but rather forming hypotheses about the meaning or feeling and listening carefully to the client's response after the hypothesis is tested. Simple reflections are useful for client engagement and obtaining their perspective but can sometimes lead to slower progress if the AOD worker is not able to add complexity and depth by interpreting the spoken and unspoken content, anticipating what may come next. More complex reflections can expand a client's self-exploration [758, 1847]. Some examples of simple and complex reflections are provided in Table 65.

Table 65: Examples of reflective listening responses

Type	Client statement	AOD worker response	Purpose	Considerations
Simple				
Repeat	My girlfriend is hassling me about how much I smoke.	Your girlfriend is hassling you about how much you smoke.	Shows empathy. Builds rapport.	Avoid mimicking.
Rephrase	My girlfriend is hassling me about how much I smoke.	Your girlfriend is pestering you about how much you smoke.	Shows empathy. Emphasises selected meaning or feeling.	Moves the conversation along but slower than with complex reflections.
Feeling	I'd like to give up smoking pot so I don't make my girlfriend's asthma worse.	You're afraid that your girlfriend's asthma will get worse if you keep smoking pot.	Emphasises selected feeling. Emphasises discrepancy between values and behaviour.	Reinforce change talk, avoid reinforcing sustain talk.
Meaning	I'd like to stop smoking pot because my girlfriend has asthma and I heard that second-hand smoke can make asthma worse, and I don't want that to happen to her.	You want to protect your girlfriend from the possibility that her asthma will get worse if you continue to smoke pot.	Emphasises selected meaning. Emphasises discrepancy between values and behaviour.	Reinforce change talk, avoid reinforcing sustain talk.

Table 65: Examples of reflective listening responses (continued)

Type	Client statement	AOD worker response	Purpose	Considerations
Complex				
Double-sided	I know I should quit smoking pot but it's the only time I have for myself.	Giving up smoking pot would be hard and you recognise that it's time to stop.	Resolves ambivalence. Acknowledges sustain talk and emphasises change talk.	Use 'and' to join reflections. Start with sustain talk reflection and end with change talk reflection.
Amplified	I think my pot smoking is just not a problem for me.	There are absolutely no negative consequences of smoking pot.	Amplifies sustain talk to evoke change talk.	Use sparingly. Avoid being caught in sustain talk.

Adapted from SAMHSA [1847].

Among clients experiencing symptoms of co-occurring mental health conditions, these statements should be simple, concise, and frequent. Avoid repeated reflecting of the client's negative statements and allow them time to consider these reflections [1919].

Summarising

Summarising is a type of reflective listening that links together the core components of several important client statements and reflects them back to the client. Summaries are useful in collating, linking, and reinforcing information discussed during the interviewing process, and offer a 'what else' opportunity for the client to add any information that may be missing. Summarising should be conducted often to promote meaningful relationships and contrasts between statements to enhance motivation to change [1918]. Some examples of summarising techniques include:

- Linking summary: making associations between two parts of the discussion.
- Collecting summary: gathering a few themes from what the client has said.
- Ambivalence summary: gathering a few client statements about change and sustain talk, to acknowledge sustain talk but reinforce and highlight change talk.
- Transitional summary: shifting focus from one area to another.
- Recapitulation summary: gathering change talk from many conversations.

Table 66: Examples of open questions to elicit self-motivational statements

Stage of change	Self-motivational statement	Open question examples
Pre-contemplation	Problem recognition (e.g., 'I guess there might be more of a problem than I thought')	• What things make you think that this is a problem? • What difficulties have you had in relation to your AOD use? • What difficulties have you had in relation to your mood? • In what ways has this been a problem for you? • How has your use of AOD stopped you from doing what you want to do?
Contemplation	Expression of concern (e.g., 'I'm worried about this')	• What worries do you have about your AOD use? • What can you imagine happening to you? • Tell me more about preventing a relapse to using… Why is that so important to you… What is it like when you are ill?… And how about your family – what effect did it have on them? How important are these issues to you? • Can you tell me some reasons why drinking or using may be a health risk? Would you be interested in knowing more about the effects of drinking/using? How important are these issues to you? • What would your best friend/mum say were your best qualities? Tell me, how would you describe the things you like about yourself?… And how would you describe you the user?… How do these two things fit together?… How important are these issues to you?
Action	Intention to change (e.g., 'This isn't how I want to be')	• You seem a bit stuck at the moment. What would have to change to fix this? • What would have to happen for it to become much more important for you to change? • If you were 100% successful and things worked out exactly as you would like, what would be different? • The fact that you are here indicates that at least a part of you thinks it is time to do something. What are the reasons you see for making a change? What would be the advantages of making a change? • What things make you think that you don't need to worry about changing your AOD use? • And what about the other side… What makes you think that it's time to do things a bit differently? • If you were to decide to change what might your options be?

Table 66: Examples of open questions to elicit self-motivational statements (continued)

Stage of change	Self-motivational statement	Open question examples
Maintenance	Optimism (e.g., 'I think I can do this')	• What would make you more confident about making these changes? • Are there ways you know about that have worked for others? Is there anything you found helpful in any previous attempts to change? • What are some of the practical things you would need to do to achieve this goal? Do they sound achievable? • What encourages you that you can change if you want to? • What makes you think that if you did decide to make a change, you could do it?

Adapted from NSW Department of Health [776].

Informing and advising

Informing and advising refers to the offering of information or advice. Although MI adopts a client centred approach, this does not mean that offering advice or information to clients is always inappropriate. There are some circumstances where it is certainly appropriate (e.g., if the client requests information). However, MI does not involve dispensing unsolicited information in a directive style. Instead, MI involves [758]:

- Offering information or advice with permission.
- When advice is provided, the perspective of the client is explored, particularly in terms of the relevance of the information to them and helping them to reach their own conclusions.

Miller and Rollnick [758] recommend using the 'elicit-provide-elicit' approach when exchanging information with a client.

Elicit

- Ask permission to give information or advice: 'May I...?'
- Clarify the client's information needs and gaps: 'What do you know about...?', 'Is there any information I can help you with?'

Provide

- Prioritise: what does the client most want/need to know?
- Be clear: avoid jargon.

- Support autonomy: do not offer too much information at once; allow the client time to reflect.
- Do not prescribe the client's response: acknowledge their freedom to disagree or ignore, present what you know without interpreting its meaning for the client.

Elicit

- Ask for the client's interpretation, understanding, or response: ask open questions, use reflection, allow the client time to process and respond to the information.

Additional strategies

In addition to these five core communication skills, some key strategies have been developed to build intrinsic motivation for change and resolve ambivalence. This is achieved by assisting the client to present their own arguments for change in order to [758]:

- Recognise the disadvantages of current behaviour.
- Recognise the advantages of change.
- Express optimism about change.
- Express intent to change.

These strategies include:

- Typical day.
- Decisional balance.
- Elaboration.
- Querying extremes.
- Asking about lifestyle and stresses.
- Looking back.
- Looking forward.
- Exploring goals and values.
- Strengthening commitment.

Typical day

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

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

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

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

Summarise these problem areas briefly, using those issues raised by the client in the 'typical day' discussion (e.g., quality of life, health, mood, AOD use). When the client is providing information about their typical day, it gives the AOD worker opportunities to ask more detail about behaviour patterns, feelings, and mood changes. Areas of concern often emerge naturally from such discussions [758].

Decisional balance (good and not so good aspects)

This technique involves a conscious weighing up of the pros and cons of certain behaviours (e.g., AOD use). Considering the pros and cons can be used as a way of neutral counselling, where the worker is not trying to steer the client into making one choice over another, but instead allowing the client to make their own choice about personal change [758]. Clients are often aware of the negative aspects involved in certain behaviours but have never consciously assessed them. The decisional balance is a frequently used motivational strategy, particularly when clients are displaying ambivalence regarding their substance use, and as a useful way of determining their stage of change in regard to their substance use.

Begin by asking questions such as:

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

For clients who have difficulty articulating things they like about using, it may be useful to offer a menu of options for them to choose from, although this should be done sparingly. Remember the focus should be on finding out what the client enjoys about using, not making assumptions about why they like it! Encourage the client to write down good things they have identified (a useful template is included at the end of this MI summary).

Briefly summarise the good aspects of AOD use that the client has identified. Next, ask the client about the not-so-good things about their AOD use. Try to avoid using negative words such as the 'bad things' or 'problems'. Questions that may be useful in obtaining this information include:

- 'So, we have talked about some of the good things about AOD use. Now could you tell me some of the less good things?'
- 'What are some of the things that you don't like about your AOD/substance use?'
- 'Tell me what some of the not-so-good things about using are'.

Again, it may be useful to provide some options or ask questions (based on collateral information), such as, 'How does your family feel about your using?' but avoid suggesting that an issue should be of concern, and do not put any value judgement on the beliefs of the client by saying something like 'Don't you think that getting arrested twice is a bit of a problem?' The success of MI rests on the client's personal exploration of their AOD use, and the good and not-so-good effects that it has on them. Explore each element in full with appropriate use of the core communication skills, such as the use of open questions and reflection.

Unlike the good things, the less good things need to be explored in detail. If the client claims AOD use reduces their mental health symptoms, explore this in particular detail: for instance, enquire about longer-term effects [1920]. It is important to maintain focus on the client's perspective of the less good things. It can be useful to ask follow up questions such as:

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

Or ask for more detail:

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

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

It is then useful to assess, through the use of a scale from 1-10, the client's perspective of how important an issue is. Beside each pro and con the client should rate the importance it holds for them. This exercise ascertains to what extent cons are a concern for the client. Many workers make the mistake of assuming that just because the client acknowledges a not-so-good thing about their AOD use, this automatically presents a direct concern for them.

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

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

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

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

If ambivalence is evident, attempt to explore the reasons that underlie this imbalance and re-establish the initial reasons for wishing to quit/cut down. Incorporate information on health and psychological effects of continued use. Guide the client through a rational discussion of issues involved, and carefully challenge faulty logic or irrational beliefs about the process of quitting. Positive reinforcement and encouragement are crucial, but if you encounter resistance from the client, do not push them.

NOTE: Use this strategy with caution for clients with high levels of anxiety or those who are not ready to deal with the pressure of increased ambivalence. In addition, do not leave a depressed client in psychological distress for too long after using the decisional balance strategy [1920]. Avoid using this strategy with a client who is currently tempted to use. Distraction is a better strategy to use with someone who is currently tempted rather than to discuss the things they like about using [448].

Elaboration

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

Querying extremes

Clients can also be asked to describe the extremes of their concerns, to imagine worst consequences. This activity can sometimes help when a client is expressing little desire for change. For instance, you may ask:

- 'What concerns you the most?'
- 'What are your worst fears about what might happen if you don't make a change?'
- 'What do you suppose are the worst things that may happen if you keep on the way you've been going?'

It can also be useful to ask the client the best possible consequences that might happen after pursuing a change (e.g., exploring the opposite extreme), such as:

- 'What could be the best results if you did make the change?'
- 'If you were completely successful in making the changes you want, how would things be different?'

Ask about lifestyle and stresses

Asking about lifestyle and stresses involves discussing routines and day-to-day stresses. Examples of some questions might be:

- 'How does your AOD use affect your:
  - Mental health?
  - Physical health?
  - Relationships?
  - Finances?'

Looking back

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

- 'Do you remember a time when things were going well for you? What has changed and how?'
- 'What were things like before you started using?'
- 'What were you like back then? What were your plans? What has changed and why?'
- 'How has your use of alcohol/drugs influenced things?'

The goal is for the client to obtain some perspective from the immediacy of their circumstances and to observe how things have changed over time. If the client has positive views on how things were before the problem emerged, highlighting the discrepancy between how things are currently, and the possibility of life being better again can help motivate them.

NOTE: Among clients experiencing symptoms of a co-occurring depressive condition, this strategy should be avoided or used with caution [1920].

Looking forward

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

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

As with querying extremes, you could also ask the client to anticipate the future if no changes are made (e.g., 'Suppose things continue as they are now and you don't make any changes, what will your life be like in five years from now?'). The difference between looking forward and querying extremes is that in this looking forward method, the AOD worker is asking for the client's most realistic assessment of the future rather than their imagined 'extreme' outcome.

NOTE: Among clients experiencing symptoms of a co-occurring depressive condition, this strategy should be avoided or used with caution [1920].

Exploring goals and values

It can be useful to ask clients about their goals and what is most important to them, comparing their goals to the current situation. Rather than perceiving a person as unmotivated, it may be more useful to understand their different goals and priorities [758]. Explore the ways in which the problem behaviour is inconsistent with, or undermines important values and goals for them. When the highest or most central values and goals have been defined, you can ask how the problem you are discussing (e.g., AOD use) fits into this picture.

For example:

- 'Where do you think your AOD use fits in?'
- 'What effect is your current behaviour likely to have on your goals and values?'

Exploring what matters most to a person can also help build rapport, and as such, this strategy can be used in the engaging process. Exploring goals and values need not be limited to benefits that could result from a particular change; the process can also be used to learn about the client's priorities and life values.

Strengthening commitment

Although some people experience a specific moment in which their desire to change suddenly crystalises, for most people this is a gradual process. As such, it is common for clients' commitment to taking action to fluctuate over time [758]. MI is a method of facilitating the natural growth of commitment. The AOD worker will consolidate all issues raised by the client and help them build their commitment to change while also planning a concrete action plan. Ambivalence will still possibly be present, and if encountered, continue the use of the strategies and micro skills outlined above. It can be useful to encourage the client to confront the idea and process of change. For example:

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

Although abstinence is one possible goal, some people may not be ready to stop completely and may opt for reduced or controlled use. In MI, the client has the ultimate responsibility for change and total freedom of choice to determine their goal for treatment. The AOD worker's role is to assist the client to determine treatment goals and guide the realisation of those goals. Goals may often change during the course of treatment, and an initial goal of cutting down may become a goal of abstinence as the client's confidence increases.

In clients with co-occurring mental health conditions, abstinence is favoured [131, 1921] as mental health symptoms may be exacerbated by AOD use. In particular, those with more severe mental disorders (or

cognitive impairment) may have adverse experiences even with low levels of substance use [795]. Those taking medications for mental health conditions (e.g., antipsychotics, antidepressants) may also find that they become intoxicated even with low levels of AOD use due to the interaction between substances. Although abstinence is favoured, many people with co-occurring conditions prefer a goal of moderation, and that goal should be respected. It is possible to accept a client's decision to use and provide harm reduction information without condoning use.

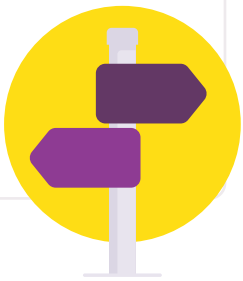
Explore any fears or obstacles that are identified in the change process and assist the client with problem solving for each of these. Explore any concerns with the management of withdrawal symptoms (e.g., irritability, insomnia, mood disturbances, lethargy, and cravings to use) if this is raised. Education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

Finally, when the client begins behaviour change, try manipulating the environment to exaggerate positive outcomes (e.g., involve family, increase social interaction, use encouragers and compliments), particularly in clients with co-occurring mental health conditions in order to strengthen resolve [1920].

Good things & not-so-good things worksheet

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

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



Appendix F: Case formulation table

Presenting issues: Initial signs, symptoms, challenges or difficulties that are clinically relevant:

	Biological *(e.g., genetic factors, medications, environment)*	**Psychological** *(e.g., resilience, personality, thoughts, feelings, behaviours)*	**Social** *(e.g., socioeconomic background, relationships, family, school, work, cultural factors, spirituality, community, social supports and connectedness)*
Predisposing factors *Factors over a person's lifetime that may have contributed to problem*			
Precipitating factors *Any triggers or events that have initiated or exacerbated problem*			
Perpetuating factors *Factors that may maintain problem or make it worse if not addressed*			
Protective factors *Internal and external supports*			

Adapted from PsychDB (2022). *Biopsychosocial model and case formulation.* Retrieved from https://www.psychdb.com/teaching/biopsychosocial-case-formulation#biopsychosocial-model-and-case-formulation

Appendix G: Mental state examination

Name: D.O.B. Date:

Appearance

Physical appearance? (*Posture, grooming, clothing, signs of AOD use, nutritional status*)

Behaviour

General behaviour? Behaviour to situation and to examiner? (*Angry/hostile, uncooperative, withdrawn, inappropriate, fearful, hypervigilant*)

Speech

Rate, volume, tone, quality and quantity of speech?

Language (form of thought)

Incoherence/illogical/irrelevant thinking? Amount? Rate?

Mood and affect

How does the client describe their emotional state (mood)? What do you observe about the person's emotional state (affect)? Are these two consistent and appropriate?

Thought content

Delusions, suicidality, paranoia, homicidality, depressed/anxious thoughts?

Perception

Hallucinations? Depersonalisation? Derealisation?

Cognition

Level of consciousness? Attention? Memory? Orientation? Abstract thoughts? Concentration?

Insight and judgement

Awareness? Decision making?

Appendix H: Integrated Motivational Assessment Tool (IMAT)

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

Source: Clancy R, Terry M. (2007). *Psychiatry and substance use: An interactive resource for clinicians working with clients who have mental health and substance use problems [DVD-ROM].* Newcastle: NSW Department of Health.

Appendix I: Additional screening tools

The **General Health Questionnaire (GHQ)** is a self-report screening instrument which detects the presence of psychological symptoms [1922]. It has demonstrated adequate reliability and validity in both the 12- and 28-item forms, on which a client rates each statement on a four-point scale [1922, 1923]. The GHQ is easy to administer and score and can be used by a range of health professionals; however, this instrument must be purchased. Generally, a score of 10 or more on the GHQ is considered indicative of significant psychological distress and the presence of an underlying psychological disorder. However, it has been suggested that approximately 75% of people who use drugs could be expected to obtain scores of 10 or more upon entering treatment; therefore, clients need to be reassessed after entering treatment [1585]. If the client continues to score 10 or more, a more in-depth psychological assessment should be conducted. The GHQ has demonstrated good validity among people attending treatment for AOD use [1924].

The **Symptom Checklist-90-Revised (SCL-90-R)** is a 90-item self-report questionnaire measuring symptoms of somatisation, obsessive compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid thoughts, and psychoticism [1925]. It has been used among people with AOD-related conditions and has been found to perform better than other general measures of psychological functioning [1926]. It has also demonstrated good reliability and validity in clinical and non-clinical populations [1927, 1928]. The scale provides scores for severity, intensity and extensiveness of symptoms and has been shown to have superior sensitivity to competing scales [1929].

Shorter forms of the SCL-90-R have been developed, including the **Brief Symptom Inventory** with 53 items and the **Symptom Assessment**, each of which show adequate reliability and validity [1930]. However, the long and short forms of the SCL-90-R are copyrighted and must be purchased by registered psychologists [1925]. There are both a pen and paper and computerised versions of the SCL-90-R. The former takes 12-15 minutes to complete, is designed for adolescents over the age of 13 years and for adults. A Year 8 reading age is required.

The **Brief Psychiatric Rating Scale** is an 18-item clinician-administered scale measuring a broad range of psychiatric symptoms. It has been shown to be effective in various populations of people who use AOD [1931, 1932]. However, the reliability and validity of the scale is dependent upon clinical expertise and specific training [1926]. It was initially devised as an instrument to assess the symptoms of schizophrenia on five sub-scales of thought disorder, withdrawal, anxiety/depression, hostility and activity [1933, 1934].

The **Psychiatric Diagnostic Screening Questionnaire** consists of 132-items designed to screen for over 13 different DSM-IV-TR [29] Axis I disorders, including AOD use disorders [1935]. Reports have found the questionnaire to have good validity and reliability along with strong sensitivity and high negative predictive value indicating most cases are detected and most non-cases are indeed non-cases [1935–1937]. These psychometric properties are fundamentally important in a screening instrument and suggest the measure might have broad applicability in numerous health care settings including AOD [1938].

The **Beck Depression Inventory (BDI or BDI-II)** is a 21-item self-report instrument intended to assess the existence and severity of symptoms of depression [1939, 1940]. Each item is ranked on a four-point scale. The BDI-II has been shown to be a reliable and valid measure of depression particularly in substance misusing populations [1941, 1942]. The **Beck Hopelessness Scale** is a 20-item scale designed to detect negative feelings about the future and has been found to be a good predictor of suicide attempts [1943]. It has been shown to have high internal consistency and test-retest reliability. It also shows good discriminant validity when distinguishing between low and high suicide risk among people with mental health disorders [1944]. Instruments such as this can be helpful in ongoing treatment where particular thoughts can continue to be monitored through this and other suicidal thoughts instruments. The **Beck Scale for Suicidal Ideation** is a 21-item scale assessing suicidal ideation [1945]. It has been found to be a valid predictor of admission to hospital for suicidal intention and has high internal consistency and test-retest reliability [1926]. This scale has been found to have similar psychometric properties to other reliable and valid measures of suicide risk assessment [1946]. The **Beck Anxiety Inventory** [1947] consists of 21 items, each describing a common symptom of anxiety. The respondent is asked to rate how much they have been bothered by each symptom over the past week on a four-point scale. The items are summed to obtain a total score that can range from 0 to 63. The Beck Anxiety Inventory has similarly shown good reliability and validity for the measurement of anxiety symptoms [1947–1950]. The Beck scales are quite simple to administer but scoring and interpretation must be supervised by a registered psychologist and the cost is high.

The **General Anxiety Disorder Screener (GAD-7)** also measures anxiety, and was developed as an anxiety-specific version of the Patient Health Questionnaire [1951]. This self-report measure consists of seven symptoms of anxiety that correspond to those for GAD in the DSM-IV [29], and clients rate the frequency with which they have experienced these symptoms in the last fortnight on a four-point scale. These items are summed to obtain a total score, and an additional item assesses the extent to which anxiety symptoms have affected overall functioning. The GAD-7 demonstrates good reliability and validity among people with both single mental and AOD use disorders [1952–1955], as well as the general population [1956]. A brief two-item version demonstrates similar diagnostic accuracy to the seven-item version [1952]. This measure can be downloaded from: www.phqscreeners.com/select-screener.

The **Montreal Cognitive Assessment (MoCA)** is a 30-item clinician-administered questionnaire which assesses for cognitive impairment and takes around 10 minutes to complete [1957]. This screening tool assesses several cognitive domains including memory, orientation, and attention. Before being able to administer and score the MoCA, clinicians must first complete official MoCA training and be certified. The MoCA should be interpreted in the wider context of a person's presentation and history [1958], particularly among people with co-occurring conditions due to the complex presentation of this population. As the MoCA is a screening rather than a diagnostic instrument, a low score would indicate the need for referral to a neurocognitive specialist for assessment and/or treatment [1959]. The MoCA has been shown to be valid and accurate among people with single mental and AOD use disorders [1960–1963]. One study which evaluated screening tools for cognitive impairment additionally concluded that the MoCA demonstrates the most consistent adequate diagnostic accuracy among adults with AOD use disorders [1964]. This measure, and the related training and certification, are available from: www.mocatest.org.

The **Patient Health Questionnaire (PHQ-9)** is a nine-item self-report questionnaire which assesses the presence and frequency of depression symptoms corresponding to those for major depressive disorder in the DSM-IV [29, 1965, 1966]. Clients rate the frequency with which they have experienced these symptoms in the last fortnight on a four-point scale. These items are summed to obtain a total score, and an additional item assesses the extent to which these symptoms have affected overall functioning. The PHQ-9 demonstrates good reliability and validity among people with both single mental and AOD use disorders [1952, 1967–1969]. Among people with AOD use disorders, the PHQ-9 similarly predicts an increased risk of suicidal behaviour [1970], and an evaluation of different measures for screening depression concluded the PHQ-9 has the highest diagnostic accuracy [1971]. As the PHQ was originally developed to screen for five disorders, there have been several versions of the PHQ developed, including a 15-item scale for somatic symptoms, a seven-item scale for generalised anxiety (the GAD-7; described above), and brief two-item versions of both the depression and anxiety scales [1972]. Although the evidence described in this section refers to the nine-item version, the two-item version demonstrates similar diagnostic accuracy [1952]. The PHQ-9 is available to download from: **www.phqscreeners.com/select-screener**.

Appendix J: CANSAS-P

Name: _____

Other identifying information (e.g., date of birth): _____

Date of completion: _____

Instructions: please tick one box in each row (22 in total)

☐ No need = this area is not a serious problem for me at all

☐ Met need = this area is not a serious problem for me because of help I am given

☐ Unmet need = this area remains a serious problem for me despite any help I am given

		No need	Met need	Unmet need	Do not want to answer
1	**Accommodation** *What kind of place do you live in?*	☐	☐	☐	○
2	**Food** *Do you get enough to eat?*	☐	☐	☐	○
3	**Looking after the home** *Are you able to look after your home?*	☐	☐	☐	○
4	**Self-care** *Do you have problems keeping clean and tidy?*	☐	☐	☐	○
5	**Daytime activities** *How do you spend your day?*	☐	☐	☐	○
6	**Physical health** *How well do you feel physically?*	☐	☐	☐	○
7	**Psychotic symptoms** *Do you ever hear voices or have problems with your thoughts?*	☐	☐	☐	○
8	**Information on condition and treatment** *Have you been given clear information about your medication?*	☐	☐	☐	○

		No need	Met need	Unmet need	Do not want to answer
9	**Psychological distress** *Have you recently felt very sad or low?*	☐	☐	☐	○
10	**Safety to self** *Do you ever have thoughts of harming yourself?*	☐	☐	☐	○
11	**Safety to others** *Do you think you could be a danger to other people's safety?*	☐	☐	☐	○
12	**Alcohol** *Does drinking cause you any problems?*	☐	☐	☐	○
13	**Drugs** *Do you take any drugs that aren't prescribed?*	☐	☐	☐	○
14	**Company** *Are you happy with your social life?*	☐	☐	☐	○
15	**Intimate relationships** *Do you have a partner?*	☐	☐	☐	○
16	**Sexual expression** *How is your sex life?*	☐	☐	☐	○
17	**Dependents** *Do you have any dependents, e.g., children under 18?*	☐	☐	☐	○
18	**Basic education** *Do you have any difficulty in reading, writing or understanding English?*	☐	☐	☐	○
19	**Digital communication** *Do you have a phone and access to the internet?*	☐	☐	☐	○
20	**Transport** *How do you find using the bus, tram or train?*	☐	☐	☐	○
21	**Money** *How do you find budgeting your money?*	☐	☐	☐	○
22	**Benefits** *Are you getting all the money you are entitled to?*	☐	☐	☐	○

Source: Slade M, & Thornicroft G. (2020). *Camberwell Assessment of Need (2nd Ed.).* Cambridge, UK: Cambridge University Press. www.researchintorecovery.com/measures/can

Appendix K: Depression Anxiety Stress Scale (DASS 21)

Name: _____ Date: _____

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0. Did not apply to me at all
1. Applied to me to some degree, or some of the time
2. Applied to me to a considerable degree, or a good part of the time
3. Applied to me very much, or most of the time

						Office use D	A	S
1.	I found it hard to wind down	0	1	2	3			
2.	I was aware of dryness of my mouth	0	1	2	3			
3.	I couldn't seem to experience any positive feeling at all	0	1	2	3			
4.	I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3			
5.	I found it difficult to work up the initiative to do things	0	1	2	3			
6.	I tended to overreact to situations	0	1	2	3			
7.	I experienced trembling (e.g., in the hands)	0	1	2	3			
8.	I felt that I was using a lot of nervous energy	0	1	2	3			
9.	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3			
10.	I felt that I had nothing to look forward to	0	1	2	3			
11.	I found myself getting agitated	0	1	2	3			
12.	I found it difficult to relax	0	1	2	3			
13.	I felt downhearted and blue	0	1	2	3			
14.	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3			
15.	I felt I was close to panic	0	1	2	3			
16.	I was unable to become enthusiastic about anything	0	1	2	3			
17.	I felt I wasn't worth much as a person	0	1	2	3			

						Office use D	A	S
18.	I felt that I was rather touchy	0	1	2	3			
19.	I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)	0	1	2	3			
20.	I felt scared without any good reason	0	1	2	3			
21.	I felt that life was meaningless	0	1	2	3			
				Totals				

Source: Lovibond SH, & Lovibond PF. (1995). *Manual for the Depression Anxiety Stress Scales* (2nd. ed). Sydney, Australia: Psychology Foundation.

DASS-21 Scoring template and interpretation

The **Depression Anxiety Stress Scale (DASS)** [467] has been shown to be a valid and reliable measure of the dimensions of depression, anxiety, and stress separately but also taps into a more general dimension of psychological distress [468, 469]. The DASS is available in two forms: the DASS-21 and the DASS-42. The use of either test is sufficient in the screening process (i.e., the use of both is unnecessary). The two forms have 21 and 42 items respectively and are each rated on a 4-point scale of how much each particular statement applies to the person. The DASS is a self-report instrument, and no special skills are required to administer or score it. However, decisions based on particular score profiles should be made only by experienced clinicians who have carried out an appropriate clinical examination [467]. Nevertheless, it is a useful tool for screening and assessment.

For all questions, the client circles the answer truest to them in the past week. Scores are summed for each scale (D = Depression, A = Anxiety, S = Stress), and the total for each scale multiplied by 2. A guide to interpreting DASS scores is provided in Table 67.

Currently, no studies have been conducted to validate the DASS as a measure of anxiety among people with AOD use disorders. However, one study has shown that the DASS can reliably screen for depression symptoms among people seeking treatment for AOD use [470]. Similarly, another study has shown that the DASS can be used as a reliable screen for symptoms of PTSD among people with AOD use disorders [471].

Table 67: Interpreting DASS scores

	Depression	Anxiety	Stress
Normal	0-9	0-7	0-14
Mild	10-13	8-9	15-18
Moderate	14-20	10-14	19-25
Severe	21-27	15-19	26-33
Extremely severe	28+	20+	34+

Adapted from: Lovibond SH, & Lovibond PF. (1995). *Manual for the Depression Anxiety Stress Scales* (2nd. ed). Sydney, Australia: Psychology Foundation.

Appendix L: Indigenous Risk Impact Screener (IRIS)

Name: _____ Date: _____

1. In the last 6 months have you needed to drink or use more to get the effects you want?

1. No | 2. Yes, a bit more | 3. Yes, a lot more

2. When you have cut down or stopped drinking or using drugs in the past, have you experienced any symptoms, such as sweating, shaking, feeling sick in the tummy/vomiting, diarrhoea/runny gonna, feeling really down or worried, problems sleeping, aches and pains?

1. Never | 2. Sometimes when I stop | 3. Yes, every time

3. How often do you feel that you end up drinking or using drugs much more than you expected?

1. Never/Hardly ever | 2. Once a month | 3. Once a fortnight

4. Once a week | 5. More than once a week | 6. Most days/Every day

4. Do you ever feel out of control with your drinking or drug use?

1. Never/Hardly ever | 2. Sometimes | 3. Often | 4. Most days/Every day

5. How difficult would it be to stop or cut down on your drinking or drug use?

1. Not difficult at all | 2. Fairly easy | 3. Difficult | 4. I couldn't stop or cut down

6. What time of the day do you usually start drinking or using drugs?

1. At night | 2. In the afternoon | 3. Sometimes in the morning | 4. As soon as I wake up

7. How often do you find that your whole day has involved drinking or using drugs?

1. Never/Hardly ever | 2. Sometimes | 3. Often | 4. Most days/Every day

8. How often do you feel down in the dumps, sad or slack?

1. Never/Hardly ever | 2. Sometimes | 3. Most days/Every day

9. How often have you felt that life is hopeless?

1. Never/Hardly ever | 2. Sometimes | 3. Most days/Every day

10. How often do you feel nervous or scared?

1. Never/Hardly ever | 2. Sometimes | 3. Most days/Every day

11. Do you worry much?

1. Never/Hardly ever | 2. Sometimes | 3. Most days/Every day

12. How often do you feel restless and that you can't sit still?

1. Never/Hardly ever | 2. Sometimes | 3. Most days/Every day

13. Do past events in your family still affect your wellbeing today (such as being taken away from family)?

1. Never/Hardly ever | 2. Sometimes | 3. Most days/Every day

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

IRIS interpretation

The **Indigenous Risk Impact Screen (IRIS)** [472] was developed by an expert group of Indigenous and non-Indigenous researchers in Queensland to assist with the early identification of AOD problems and mental health risks. This screen has been shown to be reliable, simple, and effective [473]. It has also been validated for use in Indigenous prison populations [474, 475]. The IRIS consists of 13 items which are asked by the AOD worker. The IRIS is made up of two sets of questions, with items 1–7 forming the 'AOD risk' component and items 8– 13 forming the 'mental health and emotional wellbeing risk' component. The items assessing mental health and emotional wellbeing focus on symptoms of anxiety and depression. The client chooses the answer from a list of response options which best describes their current situation. After tallying up the corresponding numbers, a score of 10 or greater on the AOD component indicates problematic use of AOD is likely, while a score of 11 or greater indicates the need for further assessment or brief intervention regarding mental health and emotional wellbeing [473].

Appendix M: Kessler psychological distress scale (K10)

Name: _____ Date: _____

For all questions, please circle the answer *most* commonly related to you. Questions 3 and 6 automatically receive a score of one if the previous question was 'none of the time'.

In the past four weeks:	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1. About how often did you feel tired out for no good reason?	1	2	3	4	5
2. About how often did you feel nervous?	1	2	3	4	5
3. About how often did you feel so nervous that nothing could calm you down?	1	2	3	4	5
4. About how often did you feel hopeless?	1	2	3	4	5
5. About how often did you feel restless or fidgety?	1	2	3	4	5
6. About how often did you feel so restless you could not sit still?	1	2	3	4	5
7. About how often did you feel depressed?	1	2	3	4	5
8. About how often did you feel that everything is an effort?	1	2	3	4	5
9. About how often did you feel so sad that nothing could cheer you up?	1	2	3	4	5
10. About how often did you feel worthless?	1	2	3	4	5
Total:					

Test: Kessler, RC. (1996). *Kessler's 10 Psychological Distress Scale.* Boston, MA: Harvard Medical School.

Normative data: Australian Bureau of Statistics. (1997). *National Survey of Mental Health and Well-being.* Canberra, Australia.

K10 scoring and interpretation

The **Kessler psychological distress scale (K10)** [476] is a widely used, simple self-report measure of psychological distress which can be used to identify those in need of further assessment for anxiety and depression. This measure was designed for use in the general population; however, it may also serve as a useful clinical tool. The K10 comprises 10 questions that are answered using a five-point scale (where 5 = all of the time, and 1 = none of the time). For all questions, the client circles the answer truest for them in the past four weeks. Scores are then summed with the maximum score of 50 indicating severe distress, and the minimum score of 10 indicating no distress. A guide to interpreting K10 scores is provided in Table 68.

A number of studies have been conducted to test the reliability and validity of the K10, and its brief version, the K6. Good reliability and validity have been found when these measures have been used with individuals with AOD use disorders [479, 1973, 1974].

Table 68: Severity of psychological distress according to K10 score

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

Source: Andrews G, & Slade T. (2001). Interpreting scores on the Kessler Psychological Distress Scale (K10). *Australian and New Zealand Journal of Psychiatry, 25,* 494-497.

Appendix N: The PsyCheck screening tool

Client's name: _____ DOB: _____

Service: _____ UR: _____

Mental health services assessment required? No ☐ Yes ☐

Suicide/self-harm risk (please circle): High Moderate Low

Date: _____ Screen completed by: _____

Clinician use only

Complete this section when all components of the *PsyCheck* have been administered.

Summary

Section 1	Past history of mental health problems	No ☐	Yes ☐	
Section 2	Suicide risk completed and action taken	No ☐	Yes ☐	
Section 3	SRQ score	0 ☐	1-4 ☐	5+ ☐

Interpretation/score – Self-Reporting Questionnaire (SRQ)

Score of 0* on the SRQ	No symptoms of depression, anxiety and/or somatic complaints indicated at this time. **Action:** Re-screen using the *PsyCheck* Screening Tool after four weeks if indicated by past mental health questions or other information. Otherwise monitor as required.
Score of 1-4* on the SRQ	Some symptoms of depression, anxiety and/or somatic complaints indicated at this time. **Action:** Give the first session of the *PsyCheck* Intervention and screen again in four weeks.
Score of 5+* on the SRQ	Considerable symptoms of depression, anxiety and/or somatic complaints indicated at this time. **Action:** Offer sessions 1–4 of the *PsyCheck* Intervention.

Re-screen using the *PsyCheck* Screening Tool at the conclusion of four sessions.

If no improvement in scores evident after re-screening, consider referral.

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

PsyCheck general screen

Clinician to administer this section

The following questions are about your emotional wellbeing. Your answers will help me get a clearer idea of what has been happening in your life and suggest possible ways that we might work together to relieve any distress you may be experiencing. We ask these questions of everybody, and they include questions about mental, physical and emotional health.

1. Have you ever seen a doctor or psychiatrist for emotional problems or problems with your 'nerves'/anxieties/worries? ☐ No ☐ Yes

Details:

2. Have you ever been given medication for emotional problems or problems with your 'nerves'/anxieties/worries?

☐ No, never

☐ Yes, in the past but not currently Medication(s):

☐ Yes, currently Medication(s):

3. Have you ever been hospitalised for emotional problems or problems with your 'nerves'/anxieties/worries? ☐ No ☐ Yes

Details:

4. Do you have a current mental health worker, psychiatrist, psychologist, general practitioner or other health provider? **If 'No', go to Question 5**.

☐ **Psychiatrist**		☐ **Psychologist**	
Name:		Name:	
Contact details:		Contact details:	
Role:		Role:	
☐ **Mental health worker**		☐ **General practitioner**	
Name:		Name:	
Contact details:		Contact details:	
Role:		Role:	
☐ **Other - specify**		☐ **Other - specify**	
Name:		Name:	
Contact details:		Contact details:	
Role:		Role:	

5. Has the thought of ending your life ever been on your mind? ☐ No ☐ Yes **If 'No', go to Section 3**

Has that happened recently? ☐ No ☐ Yes **If 'Yes', go to Section 2**

PsyCheck risk assessment

Name: _____ Date: _____

Clinician to administer this section

If the person says 'Yes' to recently thinking about ending their life (Question 5), complete the suicide/ self-harm risk assessment below. Specific questions and prompts and further guidance can be found in the *PsyCheck* User's Guide.

1. Previous attempts: Consider lethality and recency of attempts. Very recent attempt(s) with moderate lethality and previous attempts at high lethality both represent high risk. Recent and lethal attempts of family or friends represent higher risk.

Risk factor	Low risk	Moderate risk	High risk
History of harm to self	☐ Previous low lethality	☐ Moderate lethality	☐ High lethality, frequent
History of harm in family members or close friends	☐ Previous low lethality	☐ Moderate lethality	☐ High lethality, frequent

2. Suicidal ideation: Consider how the suicidal ideation has been communicated; non-disclosure may not indicate low risk. Communication of plans and intentions are indicative of high risk.

   Consider non-direct and non-verbal expressions of suicidal ideation here such as drawing up of wills, depressive body language, 'goodbyes', unexpected termination of therapy and relationships etc. Also consider homicidal ideation or murder/suicide ideation.

Risk factor	Low risk	Moderate risk	High risk
Intent	☐ No intent	☐ No immediate intent	☐ Immediate intent
Plans	☐ Vague plan	☐ Viable plan	☐ Detailed plan
Means	☐ No means	☐ Means available	☐ Means already obtained
Lethality	☐ Minor self-harm behaviours, intervention unlikely	☐ Planned overdose, serious cutting, intervention impossible	☐ Firearms, hanging, jumping, intervention unlikely

3. Mental health factors: Assess for history and current mental health symptoms, including depression and psychosis.

Risk factor	Low risk	Moderate risk	High risk
History of current depression	☐ Lowered or unchanged mood	☐ Enduring lowered mood	☐ Depression diagnosis
Mental health disorder	☐ Few or no symptoms or well-managed significant illness	☐ Pronounced clinical signs	☐ Multiple symptoms with no management

4. Protective factors: These include social support, ability or decision to use support, family involvement, stable lifestyle, adaptability and flexibility in personality style etc.

Risk factor	Low risk	Moderate risk	High risk
Coping skills and resources	☐ Many	☐ Some	☐ Few
Family/friendships/ networks	☐ Many	☐ Some	☐ Few
Stable lifestyle	☐ Many	☐ Some	☐ Few
Ability to use supports	☐ Many	☐ Some	☐ Few

Self-reporting questionnaire (SRQ)

Name: _____ Date: _____

Client or clinician to complete this section

First: Please tick the **'Yes'** box if you have had this symptom in the **last 30 days.**

Second: Look back over the questions you have ticked. For every one you answered **'Yes'**, please put a tick in the circle if you had that problem at a time when you were NOT using alcohol or other drugs.

1.	Do you often have headaches?	☐ No	☐ Yes	○
2.	Is your appetite poor?	☐ No	☐ Yes	○
3.	Do you sleep badly?	☐ No	☐ Yes	○
4.	Are you easily frightened?	☐ No	☐ Yes	○
5.	Do your hands shake?	☐ No	☐ Yes	○
6.	Do you feel nervous?	☐ No	☐ Yes	○
7.	Is your digestion poor?	☐ No	☐ Yes	○
8.	Do you have trouble thinking clearly?	☐ No	☐ Yes	○
9.	Do you feel unhappy?	☐ No	☐ Yes	○
10.	Do you cry more than usual?	☐ No	☐ Yes	○
11.	Do you find it difficult to enjoy your daily activities?	☐ No	☐ Yes	○
12.	Do you find it difficult to make decisions?	☐ No	☐ Yes	○
13.	Is your daily work suffering?	☐ No	☐ Yes	○
14.	Are you unable to play a useful part in life?	☐ No	☐ Yes	○
15.	Have you lost interest in things?	☐ No	☐ Yes	○
16.	Do you feel that you are a worthless person?	☐ No	☐ Yes	○
17.	Has the thought of ending your life been on your mind?	☐ No	☐ Yes	○
18.	Do you feel tired all the time?	☐ No	☐ Yes	○
19.	Do you have uncomfortable feelings in the stomach?	☐ No	☐ Yes	○
20.	Are you easily tired?	☐ No	☐ Yes	○

Total score (add circles):

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

Appendix O: Adult ADHD Self-Report Scale (ASRS)

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist Instructions

The questions on the back page are designed to stimulate dialogue between you and your patients and to help confirm if they may be suffering from the symptoms of attention-deficit/hyperactivity disorder (ADHD).

Description: The Symptom Checklist is an instrument consisting of the eighteen DSM-IV-TR criteria. Six of the eighteen questions were found to be the most predictive of symptoms consistent with ADHD. These six questions are the basis for the ASRS v1.1 Screener and are also Part A of the Symptom Checklist. Part B of the Symptom Checklist contains the remaining twelve questions.

Instructions:

Symptoms

1. Ask the patient to complete both Part A and Part B of the Symptom Checklist by marking an X in the box that most closely represents the frequency of occurrence of each of the symptoms.
2. Score Part A. If four or more marks appear in the darkly shaded boxes within Part A then the patient has symptoms highly consistent with ADHD in adults and further investigation is warranted.
3. The frequency scores on Part B provide additional cues and can serve as further probes into the patient's symptoms. Pay particular attention to marks appearing in the dark shaded boxes. The frequency-based response is more sensitive with certain questions. No total score or diagnostic likelihood is utilised for the twelve questions. It has been found that the six questions in Part A are the most predictive of the disorder and are best for use as a screening instrument.

Impairments

1. Review the entire Symptom Checklist with your patients and evaluate the level of impairment associated with the symptom.
2. Consider work/school, social and family settings.
3. Symptom frequency is often associated with symptom severity, therefore the Symptom Checklist may also aid in the assessment of impairments. If your patients have frequent symptoms, you may want to ask them to describe how these problems have affected the ability to work, take care of things at home, or get along with other people such as their spouse/significant other.

History

1. Assess the presence of these symptoms or similar symptoms in childhood. Adults who have ADHD need not have been formally diagnosed in childhood. In evaluating a patient's history, look for evidence of early-appearing and long-standing problems with attention or self-control. Some significant symptoms should have been present in childhood, but full symptomology is not necessary.

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name: **Today's Date:**

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.	Never	Rarely	Sometimes	Often	Very often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organisation?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
Part A					
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					

	Never	Rarely	Sometimes	Often	Very often
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					
Part B					

The Value of Screening for Adults With ADHD

Research suggests that the symptoms of ADHD can persist into adulthood, having a significant impact on the relationships, careers, and even the personal safety of your patients who may suffer from it (Schweitzer, et al. 2001; Barkley 1998; Biederman, et al. 1993; AMA 2000). Because this disorder is often misunderstood, many people who have it do not receive appropriate treatment and, as a result, may never reach their full potential. Part of the problem is that it can be difficult to diagnose, particularly in adults.

The Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist was developed in conjunction with the World Health Organisation (WHO), and the Workgroup on Adult ADHD that included the following team of psychiatrists and researchers:

Lenard Adler, MD

Associate Professor of Psychiatry and Neurology

New York University Medical School

Ronald C. Kessler, PhD

Professor, Department of Health Care Policy

Harvard Medical School

Thomas Spencer, MD

Associate Professor of Psychiatry

Harvard Medical School

As a healthcare professional, you can use the ASRS v1.1 as a tool to help screen for ADHD in adult patients. Insights gained through this screening may suggest the need for a more in-depth clinician interview. The questions in the ASRS v1.1 are consistent with DSM-IV criteria and address the manifestations of ADHD symptoms in adults. Content of the questionnaire also reflects the importance that DSM-IV places on symptoms, impairments, and history for a correct diagnosis (Schweitzer, et al. 2001).

The checklist takes about 5 minutes to complete and can provide information that is critical to supplement the diagnostic process.

References:

Schweitzer JB, et al. Med Clin North Am. 2001;85(3):10-11, 757-777.

Barkley RA. Attention Deficit Hyperactivity Disorder: A Handbook for Diagnosis and Treatment. 2nd ed. 1998.

Biederman J, et al. Am J Psychiatry. 1993;150:1792-1798.

American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC, American Psychiatric Association. 2000: 85-93.

Source: Kessler, R.C., Adler, L., Ames, M., Demler, O., Faraone, S., Hiripi, E., ... Walters, E.E. (2005). The World Health Organisation Adult ADHD Self-Report Scale (ASRS). *Psychological Medicine, 35*, 245-256.

Appendix P: The International Trauma Questionnaire (ITQ)

Instructions: Please identify the experience that troubles you most and answer the questions in relation to this experience.

Brief description of the experience: _____

When did the experience occur? (circle one)

a. Less than 6 months ago
b. 6 to 12 months ago
c. 1 to 5 years ago
d. 5 to 10 years ago
e. 10 to 20 years ago
f. More than 20 years ago

Below are a number of problems that people sometimes report in response to traumatic or stressful life events. Please read each item carefully, then circle one of the numbers to the right to indicate how much you have been bothered by that problem **in the past month.**

		Not at all	A little bit	Moderately	Quite a bit	Extremely
P1.	Having upsetting dreams that replay part of the experience or are clearly related to the experience?	0	1	2	3	4
P2.	Having powerful images or memories that sometimes come into your mind in which you feel the experience is happening again in the here and now?	0	1	2	3	4
P3.	Avoiding internal reminders of the experience (for example, thoughts, feelings, or physical sensations)?	0	1	2	3	4
P4.	Avoiding external reminders of the experience (for example, people, places, conversations, objects, activities, or situations)?	0	1	2	3	4

		Not at all	A little bit	Moderately	Quite a bit	Extremely
P5.	Being 'super-alert', watchful, or on guard?	0	1	2	3	4
P6.	Feeling jumpy or easily startled?	0	1	2	3	4

In the past month have the above problems:		Not at all	A little bit	Moderately	Quite a bit	Extremely
P7.	Affected your relationships or social life?	0	1	2	3	4
P8.	Affected your work or ability to work?	0	1	2	3	4
P9.	Affected any other important part of your life such as parenting, or school or college work, or other important activities?	0	1	2	3	4

Below are problems that people who have had stressful or traumatic events sometimes experience. The questions refer to ways you **typically** feel, ways you **typically** think about yourself and ways you **typically** relate to others. Answer the following thinking about how true each statement is of you.

How true is this of you?		Not at all	A little bit	Moderately	Quite a bit	Extremely
C1.	When I am upset, it takes me a long time to calm down.	0	1	2	3	4
C2.	I feel numb or emotionally shut down.	0	1	2	3	4
C3.	I feel like a failure.	0	1	2	3	4
C4.	I feel worthless.	0	1	2	3	4
C5.	I feel distant or cut off from people.	0	1	2	3	4
C6.	I find it hard to stay emotionally close to people.	0	1	2	3	4

In the past month, have the above problems in emotions, in beliefs about yourself and in relationships:		Not at all	A little bit	Moderately	Quite a bit	Extremely
C7.	Created concern or distress about your relationships or social life?	0	1	2	3	4
C8.	Affected your work or ability to work?	0	1	2	3	4
C9.	Affected any other important parts of your life such as parenting, or school or college work, or other important activities?	0	1	2	3	4

Source: Cloitre, M., Shevlin M., Brewin, C.R., Bisson, J.I., Roberts, N.P., Maercker, A., Karatzias, T., & Hyland, P. (2018). The International Trauma Questionnaire: Development of a self-report measure of ICD-11 PTSD and Complex PTSD. *Acta Psychiatrica Scandinavica, 139*, 536-546.

ITQ: Scoring and interpretation

PTSD. A diagnosis of PTSD requires the endorsement of at least one of the two symptoms from each of the symptom clusters of (1) re-experiencing in the here and now (P1 or P2), (2) avoidance (P3 or P4), and (3) sense of current threat (P5 or P6); plus endorsement of at least one indicator of the three types of functional impairment associated with these symptoms (P7, P8 or P9).

Endorsement of a symptom or functional impairment item is defined as a score ≥ 2.

CPTSD. A diagnosis of CPTSD requires the endorsement of at least one of the two symptoms from each of the three PTSD symptom clusters described above (i.e., re-experiencing in the here and now, avoidance, and sense of current threat) and at least one of the two symptoms from each of the three Disturbances in Self-Organisation (DSO) clusters: (1) affective dysregulation (C1 or C2), (2) negative self-concept (C3 or C4), and (3) disturbances in relationships (C5 or C6). Functional impairment must also be identified where at least one indicator of the three types of functional impairment is endorsed related to the PTSD symptoms (as described above), and one indicator of the three types of functional impairment is endorsed related to the DSO symptoms (C7, C8, or C9).

Endorsement of a symptom or functional impairment item is defined as a score ≥ 2.

An individual can receive either a diagnosis of PTSD or CPTSD, but not both. If a person meets the criteria for CPTSD, that person does not also receive a PTSD diagnosis.

Appendix Q: Life Events Checklist for DSM-5 (LEC-5)

Instructions: Listed below are a number of difficult or stressful things that sometimes happen to people. For each event, check one or more of the boxes to the right to indicate that: (a) it **happened to you** personally; (b) **you witnessed it** happen to someone else; (c) you **learned about it** happening to a close family member or close friend; (d) you were exposed to it as **part of your job** (for example, paramedic, police, military, or other first responder); (e) you're **not sure** if it fits; or (f) it **doesn't apply** to you.

Be sure to consider your ***entire life*** (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)	☐	☐	☐	☐	☐	☐
2. Fire or explosion	☐	☐	☐	☐	☐	☐
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)	☐	☐	☐	☐	☐	☐
4. Serious accident at work, home, or during recreational activity	☐	☐	☐	☐	☐	☐
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)	☐	☐	☐	☐	☐	☐
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)	☐	☐	☐	☐	☐	☐

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not sure	Doesn't apply
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)	☐	☐	☐	☐	☐	☐
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)	☐	☐	☐	☐	☐	☐
9. Other unwanted or uncomfortable sexual experience	☐	☐	☐	☐	☐	☐
10. Combat or exposure to a war-zone (in the military or as a civilian)	☐	☐	☐	☐	☐	☐
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)	☐	☐	☐	☐	☐	☐
12. Life-threatening illness or injury	☐	☐	☐	☐	☐	☐
13. Severe human suffering	☐	☐	☐	☐	☐	☐
14. Sudden violent death (for example, homicide, suicide)	☐	☐	☐	☐	☐	☐
15. Sudden accidental death	☐	☐	☐	☐	☐	☐

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not sure	Doesn't apply
16. Serious injury, harm, or death you caused to someone else	☐	☐	☐	☐	☐	☐
17. Any other very stressful event or experience	☐	☐	☐	☐	☐	☐

Source: Weathers, F. W., Blake, D. D., Schnurr, P. P., Kaloupek, D. G., Marx, B. P., & Keane, T. M. (2013). *The Life Events Checklist for DSM-5 (LEC-5) – Standard.* [Measurement instrument]. Available from www.ptsd.va.gov.

Appendix R: Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- a serious accident or fire
- a physical or sexual assault or abuse
- an earthquake or flood
- a war
- seeing someone be killed or seriously injured
- having a loved one die through homicide or suicide.

Have you ever experienced this kind of event?

YES NO

If no, screen total = 0. Please stop here.

If yes, please answer the questions below.

In the past month have you:	Yes	No
1. Had nightmares about the event(s) or thought about the event(s) when you did not want to?	1	0
2. Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?	1	0
3. Been constantly on guard, watchful, or easily startled?	1	0
4. Felt numb or detached from people, activities, or your surroundings?	1	0
5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?	1	0

Source: Prins, A., Bovin, M. J., Kimerling, R., Kaloupek, D. G., Marx, B. P., Pless Kaiser, A., & Schnurr, P. P. (2016). *Primary Care PTSD Screen for DSM-5 (PC-PTSD-5)* [Measurement instrument]. Available from www.ptsd.va.gov.

PC-PTSD-5: Scoring and interpretation

The measure begins with an item designed to assess whether the respondent has had any exposure to traumatic events. If a respondent denies exposure, the PC-PTSD-5 is complete with a score of 0.

If a respondent indicates a trauma history – experiencing a traumatic event over the course of their life – the respondent is instructed to answer five additional yes/no questions about how that trauma has affected them over the past month.

Preliminary results from validation studies suggest that a cut-point of 3 on the PC-PTSD-5 (e.g., respondent answers 'yes' to any 3 of 5 questions about how the traumatic event(s) have affected them over the past month) is optimally sensitive to probable PTSD. Optimising sensitivity minimises false negative screen results. Using a cut-point of 4 is considered optimally efficient. Optimising efficiency balances false positive and false negative results.

Total score is sum of 'YES' responses in items 1 to 5.

Appendix S: PTSD Checklist for DSM-5 (PCL-5)

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem and then select one of the options to indicate how much you have been bothered by that problem **in the past month**. The options include not at all, a little bit, moderately, quite a bit, and extremely.

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0	1	2	3	4
2. Repeated, disturbing dreams of the stressful experience?	0	1	2	3	4
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0	1	2	3	4
4. Feeling very upset when something reminded you of the stressful experience?	0	1	2	3	4
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0	1	2	3	4
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0	1	2	3	4
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0	1	2	3	4
8. Trouble remembering important parts of the stressful experience?	0	1	2	3	4

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0	1	2	3	4
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0	1	2	3	4
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0	1	2	3	4
12. Loss of interest in activities that you used to enjoy?	0	1	2	3	4
13. Feeling distant or cut off from other people?	0	1	2	3	4
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0	1	2	3	4
15. Irritable behavior, angry outbursts, or acting aggressively?	0	1	2	3	4
16. Taking too many risks or doing things that could cause you harm?	0	1	2	3	4
17. Being 'super alert' or watchful or on guard?	0	1	2	3	4
18. Feeling jumpy or easily startled?	0	1	2	3	4
19. Having difficulty concentrating?	0	1	2	3	4
20. Trouble falling or staying asleep?	0	1	2	3	4

Source: Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). *The PTSD Checklist for DSM-5 (PCL-5) – Standard* [Measurement instrument]. Available from www.ptsd.va.gov.

PCL-5: Scoring and interpretation

Respondents are asked to rate how bothered they have been by each of 20 items in the past month on a 5-point Likert scale ranging from 0-4 (0 = Not at all, 1 = A little bit, 2 = Moderately, 3 = Quite a bit, 4 = Extremely). Items are summed to provide a total severity score (range 0-80).

The PCL-5 can determine a **provisional** diagnosis in two ways:

- Summing all 20 items (range 0-80) and using a cut-point score of 31-33 which appears to be reasonable based upon current psychometric work. However, when choosing a cut-off score, it is essential to consider the goals of the assessment and the population being assessed. The lower the cut-off score, the more lenient the criteria for inclusion, increasing the possible number of false-positives. The higher the cut-off score, the more stringent the inclusion criteria and the more potential for false-negatives.
- Treating each item rated as 2 = 'Moderately' or higher as a symptom endorsed, then following the DSM-5 diagnostic rules which requires at least: 1 Criterion B item (questions 1-5), 1 Criterion C item (questions 6-7), 2 Criterion D items (questions 8-14), 2 Criterion E items (questions 15-20). In general, use of a cut-off score tends to produce more reliable results than the DSM-5 diagnostic rule.

If a patient meets a provisional diagnosis using either of the methods above, they need further assessment (e.g., Clinical Administered PTSD Scale for DSM-5: CAPS-5) to confirm a diagnosis of PTSD.

There are currently no empirically derived severity ranges for the PCL-5.

Appendix T: Psychosis Screener (PS)

1. In the past 12 months, have you felt that your thoughts were being directly interfered with or controlled by another person?	☐ No	☐ Yes
a. Did it come about in a way that many people would find hard to believe, for instance, through telepathy?	☐ No	☐ Yes
2. In the past 12 months, have you had a feeling that people were too interested in you?	☐ No	☐ Yes
a. In the past 12 months, have you had a feeling that things were arranged so as to have a special meaning for you, or even that harm might come to you?	☐ No	☐ Yes
3. Do you have any special powers that most people lack?	☐ No	☐ Yes
a. Do you belong to a group of people who also have these special powers?	☐ No	☐ Yes
4. Has a doctor ever told you that you may have schizophrenia?	☐ No	☐ Yes

Source: Degenhardt, L., Hall, W., Korten, A., & Jablensky, A. (2005). *Use of brief screening instrument for psychosis: Results of a ROC analysis. Technical report no. 210.* Sydney, Australia: National Drug and Alcohol Research Centre.

Appendix U: Alcohol Use Disorders Identification Test (AUDIT)

The Alcohol Use Disorders Identification Test: Self-Report Version

PATIENT: Because alcohol use can affect your health and can interfere with certain medications and treatments, it is important that we ask some questions about your use of alcohol. Your answers will remain confidential so please be honest. Circle one box that best describes your answer to each question.

	0	1	2	3	4	
1. How often do you have a drink containing alcohol?	Never	Monthly	2-3 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	

	0	1	2	3	4	
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year	
					Total:	

Source: Babor, TF, Higgins-Biddle, JC, Saunders, JB, & Monteiro, MG. (2001). *The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care, Second Edition.* Geneva, Switzerland: World Health Organisation, Department of Mental Health and Substance Dependence.

AUDIT Scoring: Clinician use only

The number in the column of each response circled by the client should be entered by the scorer in the extreme right-hand column. All responses should be added and recorded in the Total box.

Risk level	AUDIT score*	Intervention
Zone I: Low risk	0 to 7	Alcohol education
Zone II: Hazardous	8 to 15	Simple advice and patient education materials
Zone III: Harmful	16 to 19	Simple advice plus brief counselling and ongoing monitoring
Zone IV: Dependent	20 to 40	Referred to a specialist for diagnostic evaluation and possible treatment

*The cut-off score may vary slightly depending on the country's drinking patterns, the alcohol content of standard drinks, and the nature of the screening program. Clinical judgement should be exercised in cases where the patient's score is not consistent with other evidence, or if the patient has a prior history of alcohol dependence. It may also be instructive to review the patient's responses to individual questions dealing with dependence symptoms (Questions 4, 5 and 6) and alcohol-related problems (Questions 9 and 10). Provide the next highest level of intervention to patients who score 2 or more on Questions 4, 5 and 6, or 4 on Questions 9 or 10.

Source: Babor, TF, Higgins-Biddle, JC, Saunders, JB, & Monteiro, MG. (2001). *The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care, Second Edition.* Geneva, Switzerland: World Health Organisation, Department of Mental Health and Substance Dependence.

Appendix V: CAGE Substance Abuse Screening Tool

	Yes	No
1. Have you ever felt you should cut down on your drinking?	1	0
2. Have people annoyed you by criticising your drinking?	1	0
3. Have you ever felt bad or guilty about your drinking?	1	0
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)?	1	0

Source: Ewing, J. A. (1984). Detecting alcoholism. The CAGE questionnaire. *JAMA, 252*(14), 1905–1907.

CAGE: Scoring and interpretation

Directions

Ask your patients these four questions and use the scoring method described below to determine if substance abuse exists and needs to be addressed.

Scoring

Item responses on the CAGE questions are scored 0 for 'no' and 1 for 'yes' answers, with a higher score being an indication of alcohol problems. A total score of two or greater is considered clinically significant.

The normal cut-off for the CAGE is two positive answers, however, it is recommended that primary care clinicians lower the threshold to one positive answer to cast a wider net and identify more patients who may have substance abuse disorders.

Appendix W: Drug Abuse Screening Test (DAST-10)

Instructions:

'Drug use' refers to (1) the use of prescribed or over-the-counter drugs in excess of the directions, and (2) any nonmedical use of drugs.

The various classes of drugs may include cannabis, solvents (e.g., paint thinner), benzodiazepines (e.g., Valium), cocaine, stimulants (e.g., speed), hallucinogens (e.g., LSD) or opioids (e.g., heroin). The questions do not include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

These questions refer to drug use in the past 12 months. Please answer No or Yes.

	No	Yes
1. Have you used drugs other than those required for medical reasons?	☐	☐
2. Do you use more than one drug at a time?	☐	☐
3. Are you always able to stop using drugs when you want to?	☐	☐
4. Have you had 'blackouts' or 'flashbacks' as a result of drug use?	☐	☐
5. Do you ever feel bad or guilty about your drug use?	☐	☐
6. Does your spouse (or parents) ever complain about your involvement with drugs?	☐	☐
7. Have you neglected your family because of your use of drugs?	☐	☐
8. Have you engaged in illegal activities in order to obtain drugs?	☐	☐
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	☐	☐
10. Have you had medical problems as a result of your drug use (e.g., memory loss, hepatitis, convulsions, bleeding, etc.)?	☐	☐

Source: Skinner, H. A. (1982). The Drug Abuse Screening Test. *Addictive Behavior*, 7(4), 363-371.

DAST-10: Scoring and interpretation

Scoring

Score 1 point for each question answered 'Yes', except for question 3 for which a 'No' receives 1 point. A guide to interpreting scores is provided in Table 69.

Total score: _____

Table 69: Interpreting DAST-10 score

Score	Degree of problems related to drug abuse	Suggested action
0	No problems reported	None at this time
1-2	Low level	Monitor, reassess at a later date
3-5	Moderate level	Further investigation
6-8	Substantial level	Intensive assessment
9-10	Severe level	Intensive assessment

Appendix X: Drug Use Disorders Identification Test (DUDIT)

Here are a few questions about drugs. Please answer as correctly and honestly as possible by indicating which answer is right for you.

1. How often do you use drugs other than alcohol?

Never	Once a month or less often	2-4 times a month	2-3 times a week	4 times a week or more often
☐	☐	☐	☐	☐

2. Do you use more than one type of drug on the same occasion?

Never	Once a month or less often	2-4 times a month	2-3 times a week	4 times a week or more often
☐	☐	☐	☐	☐

3. How many times do you take drugs on a typical day when you use drugs?

0	1-2	3-4	5-6	7 or more
☐	☐	☐	☐	☐

4. How often are you influenced heavily by drugs?

Never	Less often than once a month	Every month	Every week	Daily or almost every day
☐	☐	☐	☐	☐

5. Over the past year, have you felt that your longing for drugs was so strong that you could not resist it?

Never	Less often than once a month	Every month	Every week	Daily or almost every day
☐	☐	☐	☐	☐

6. Has it happened, over the past year, that you have not been able to stop taking drugs once you started?

Never	Less often than once a month	Every month	Every week	Daily or almost every day
☐	☐	☐	☐	☐

7. How often over the past year have you taken drugs and then neglected to do something you should have done?

Never	Less often than once a month	Every month	Every week	Daily or almost every day
☐	☐	☐	☐	☐

8. How often over the past year have you needed to take a drug the morning after heavy drug use the day before?

Never	Less often than once a month	Every month	Every week	Daily or almost every day
☐	☐	☐	☐	☐

9. How often over the past year have you had guilt feelings or a bad conscience because you used drugs?

Never	Less often than once a month	Every month	Every week	Daily or almost every day
☐	☐	☐	☐	☐

10. Have you or anyone else been hurt (mentally or physically) because you used drugs?

No	Yes, but not over the past year	Yes, over the past year
☐	☐	☐

11. Has a relative or a friend, a doctor or a nurse, or anyone else, been worried about your drug use or said to you that you should stop using drugs?

No	Yes, but not over the past year	Yes, over the past year
☐	☐	☐

Source: Berman, A. H., Bergman, H., Palmstierna, T., & Schlyter, F. (2003). *DUDIT. The Drug Use Disorders Identification Test Manual.* Stockholm, Sweden: Karolinska Institutet.

DUDIT: Scoring and interpretation

The **Drug Use Disorders Identification Test (DUDIT)** is an 11-item tool, which can be self or clinician administered, developed as a parallel to the AUDIT to identify problematic past year AOD use [522]. As with the AUDIT, items 1 to 9 are scored on a 0 to 4 scale, with the final two questions scored 0, 2, 4 (Table 70). The maximum score is 44. Scoring guidelines suggest that a score of 6 or more among men, and 2 or more among women, may be indicative of drug-use-related problems. A score of 25 points or more, regardless of sex, is strongly indicative of dependence [522].

Table 70: Scoring each DUDIT item

Item	Scoring
1-9	0, 1, 2, 3, 4
10-11	0, 2, 4

Appendix Y: The Michigan Alcohol Screening Test (MAST)

The MAST is a simple, self-scoring test that helps assess if you have a drinking problem. Answer 'yes' or 'no' to the following questions:

	Yes	No
1. *Do you feel you are a normal drinker? (by normal, we mean you drink less than or as much as most other people)	☐	☐
2. Have you ever awakened the morning after drinking the night before and found that you could not remember a part of the evening?	☐	☐
3. Does your partner, a parent, or other near relative ever worry or complain about your drinking?	☐	☐
4. *Can you stop drinking without a struggle after one or two drinks?	☐	☐
5. Do you ever feel guilty about your drinking?	☐	☐
6. *Do friends or relatives think you are a normal drinker?	☐	☐
7. *Are you able to stop drinking when you want to?	☐	☐
8. Have you ever attended a meeting of Alcoholics Anonymous (AA) because of your own drinking?	☐	☐
9. Have you ever gotten into physical fights when drinking?	☐	☐
10. Has drinking ever created problems between you and your partner, a parent, or other near relative?	☐	☐
11. Has your partner, a parent, or other near relative ever gone to anyone for help about your drinking?	☐	☐
12. Have you ever lost friends or partners because of your drinking?	☐	☐
13. Have you ever gotten into trouble at work or school because of drinking?	☐	☐
14. Have you ever lost a job because of your drinking?	☐	☐
15. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?	☐	☐
16. Do you drink before noon fairly often?	☐	☐
17. Have you ever been told you have liver trouble, such as cirrhosis?	☐	☐
18. After heavy drinking, have you ever had delirium tremens (DTs), severe shaking, or heard voices or seen things that weren't really there?	☐	☐
19. Have you ever gone to anyone for help about your drinking?	☐	☐
20. Have you ever been in a hospital because of drinking?	☐	☐
21. Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where your drinking was part of the problem that resulted in hospitalisation?	☐	☐

	Yes	No
22. Have you ever been seen at a psychiatric or mental health clinic or gone to any doctor, social worker, or clergy member for help with any emotional problem where your drinking was part of the problem?	☐	☐
23. Have you ever been arrested for drunken driving, driving while intoxicated, or driving under the influence of alcohol?	☐	☐
24. Have you ever been arrested, even for a few hours, because of other drunken behaviour?	☐	☐

Source: Selzer, M. (1971). The Michigan Alcoholism Screening Test: The quest for a new diagnostic instrument. *American Journal of Psychiatry, 127*, 1653–1658.

MAST: Scoring and interpretation

The **Michigan Alcohol Screening Test (MAST)** is a 24-item self-report tool designed to identify lifetime problems with alcohol use [523]. Several modified versions of the MAST have been developed, varying in length (e.g., the Short MAST or SMAST, containing 13-items; the Brief MAST or bMAST, containing 10-items), and for use in different population groups (e.g., MAST-Geriatric version, MAST-Adolescent version).

The MAST can either be scored using a weighted scoring system or by assigning one point per item. Raw unweighted scores are calculated by summing the points assigned to each question (yes = 1, no = 0). Questions 1, 4, 6 and 7 are reverse scored (yes = 0, no = 1). Raw scores range from 0 to 24 with higher scores indicative of more problematic alcohol use. Weighted scores are calculated by summing the weighted points assigned to each question (see Table 71). Weighted scores range from 0 to 53, with higher scores indicative of more problematic alcohol use. While there is little evidence for one scoring method over another and weighted and unit scoring systems are highly correlated [524], treatment recommendations are based on weighted scores (see Table 72).

Table 71: Calculating MAST scores

Questions	Points for raw (unweighted) score	Points for weighted score
1, 4, 6, 7	Yes = 0, No = 1	Yes = 0, No = 2
2, 10 – 15, 17, 18, 21 – 24	Yes = 1, No = 0	Yes = 2, No = 0
3, 5, 9, 16	Yes = 1, No = 0	Yes = 1, No = 0
8, 19, 20	Yes = 1, No = 0	Yes = 5, No = 0

Table 72: Interpreting MAST weighted scores

Weighted score	Interpretation	Suggested action
0 – 4	No alcohol use disorder indicated	No need for further action
5 – 6	Further evaluation by a healthcare professional indicated	Possible alcohol use disorder
7 – 53	Comprehensive AOD use evaluation by a healthcare professional indicated	Indicates alcohol use disorder

Source: PAR Staff. (2021). *Administration and Scoring of the Michigan Alcoholism Screening Test (MAST) [technical supplement].* Florida, US: PAR Inc.

Appendix Z: Suicide risk screener scorer and interpretation

Client: _____

Screen completed by: _____

Date: _____

I need to ask you a few questions on how you have been feeling, is that ok?

1. In the past 4 weeks, did you feel so sad that nothing could cheer you up?

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

2. In the past 4 weeks, how often did you feel no hope for the future?

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

3. In the past 4 weeks, how often did you feel intense shame or guilt?

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

4. In the past 4 weeks, how often did you feel worthless?

☐ All of the time ☐ Most of the time ☐ Some of the time ☐ A little of the time ☐ None of the time

5. Have you ever tried to kill yourself? ☐ **Yes*** ☐ No

If **Yes**:

a. How many times have you tried to kill yourself? ☐ Once ☐ Twice ☐ 3+

b. How long ago was the last attempt (mark below)? Have things changed since? _____

☐ In the last 2 months ☐ 2-6 months ago ☐ 6-12 months ago ☐ 1-2 years ago ☐ More than 2 years ago

6. Have you gone through any upsetting events recently? (tick all that apply) ☐ Yes ☐ No

☐ Family breakdown ☐ Conflict relating to sexual identity ☐ Child custody issues ☐ Chronic pain/illness ☐ Impending legal prosecution

☐ Loss of loved one ☐ Relationship problem ☐ Trauma ☐ Other (specify) _____

7. Have things been so bad lately that you have thought about killing yourself? ☐ **Yes*** ☐ No

If **Yes**:

a. How often do you have thoughts of suicide? _____

b. How long have you been having these thoughts? _____

c. How intense are these thoughts when they are most severe?

☐ Very intense ☐ Intense ☐ Somewhat intense ☐ Not at all intense

d. How intense have these thoughts been in the last week?

☐ Very intense ☐ Intense ☐ Somewhat intense ☐ Not at all intense

If **No: *Skip to 10***

8. Do you have a current plan for how you would attempt suicide? ☐ **Yes*** ☐ No

If **Yes:**

a. What method would you use? _____ (Access to means? ☐ Yes ☐ No)

b. Where would this occur? _____

(Have all necessary preparations been made? ☐ Yes ☐ No)

c. How likely are you to act on this plan in the near future?

☐ Very likely ☐ Likely ☐ Unlikely ☐ Very unlikely

9. What has stopped you acting on these suicidal thoughts? _____

10. Do you have any friends/family members you can confide in if you have a serious problem? ☐ Yes ☐ No

a. Who is/are this/these person/people? _____

b. How often are you in contact with this/these person/people? _____

☐ Daily ☐ A few days a week ☐ Weekly ☐ Monthly ☐ Less than once a month

11. What has helped you through difficult times in the past? _____

☐* indicates a high or moderate risk answer

Client: _____

Date: _____ Screen completed by: _____

Client presentation/statements (tick all that apply)

☐ Agitated	☐ Intoxicated
☐ Disorientated/confused	☐ Self-harm
☐ Delusional/hallucinating	☐ Other: _____

Note: If client presents as any of the above and is expressing thoughts of suicide, risk level is automatically **HIGH**

Worker rated risk level: ☐ **Low** ☐ **Moderate** ☐ **High**

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

Source: Deady, M., Ross, J., & Darke, S. (2015). *Suicide Assessment Kit (SAK): A comprehensive assessment and policy development package.* Sydney, Australia: National Drug and Alcohol Research Centre.

Appendix AA: Referral pro forma

Patient identified with possible mental health condition

Date: _____

Referral from: _____

Patient details:

Name: _____ Year of birth: _____

Address: _____ Postcode: _____

Aboriginal or Torres Strait Islander: ☐ Yes ☐ No

Gender identity:

Patient lives: ☐ Alone ☐ With carer/family

Patient contact details:

Phone: _____

Patient may be contacted at this number ☐ Yes ☐ No

Patient can be contacted at home during B/H ☐ Yes ☐ No

Leave message with household member ☐ Yes ☐ No

Reason for referral

Multiple responses permitted

☐ Diagnostic assessment

☐ Psychoeducation

☐ Other: _____

Presenting problem

Multiple responses permitted

☐ Alcohol and/or other drug use/disorder

☐ Attention-deficit/hyperactivity disorder (ADHD)

☐ Psychotic disorder

☐ Bipolar disorder

☐ Depression

- [ ] Anxiety
- [ ] Obsessive compulsive disorder (OCD)
- [ ] Post traumatic stress disorder (PTSD)
- [ ] Eating disorder: _____
- [ ] Borderline personality disorder (BPD)
- [ ] Antisocial personality disorder (ASPD)
- [ ] Substance-induced disorder
- [ ] Cognitive impairment
- [ ] Unexplained somatic disorder
- [ ] Unknown
- [ ] Other: _____

Provide relevant clinical information

Current medications

Risk assessment

- [ ] Within 2 weeks
- [ ] Within 1 month

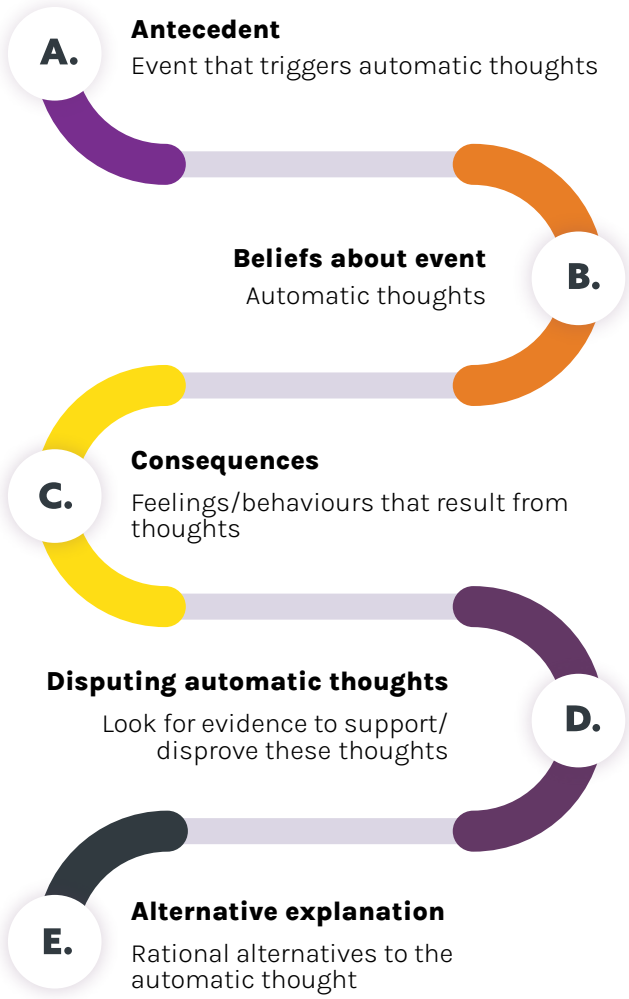
Appendix BB: Cognitive behavioural techniques

Cognitive behavioural therapy (CBT) has been identified as one of the most effective ways of treating co-occurring depression and substance use difficulties [1090, 1978, 1979]. A number of simple CBT-based strategies are useful in managing clients with these symptoms, including:

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

Cognitive restructuring

Cognitive restructuring is a useful method for controlling symptoms of depression (and anxiety) and is based on the premise that what causes these feelings is not the situation itself but, rather, the interpretation of the situation [1980]. The idea is that our behaviours and feelings are the result of automatic thoughts which are related to our core (deeply held) beliefs. Therefore, feelings and behaviours of anxiety, depression, relapse etc. are the result of negative thoughts and beliefs that can be modified. A simple process of recognition and modification of these thoughts and beliefs can be conducted with clients using the A–E model depicted to the right.



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

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

All or none (black and white or dichotomous) thinking

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

Mental filter

Interpreting events based on what has happened in the past.

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

Overgeneralisation

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

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

Catastrophising

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

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

Mistaking feelings for facts

People are often confused between feelings and facts.

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

Should statements

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

'I must always be on time.'

Personalising

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

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

Discounting positive experiences

People often discount positive things that happen.

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

(Adapted from Leahy [1981], Josefowitz and Myran [1982] and Kuru et al. [1983]).

Client information sheets on common negative thoughts and cognitive restructuring are included in the Worksheets section of these Guidelines.

Structured problem solving

Structured problem solving is also a useful means to manage the symptoms of anxiety/depression as these symptoms are often the result of an inability (or perceived inability) to deal effectively with problems [1984, 1985]. Some simple steps suggested by Renn et al. [1986] and Nezu et al. [1987] can be a useful guide in assisting the client:

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

A problem-solving worksheet for clients is included in the **Worksheets** section of these Guidelines.

Goal setting

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

Goal setting can keep therapy on track and also enables progress to be measured over time. It allows the client to experience feelings of control and success, which may counter common feelings of hopelessness and worthlessness. Goal setting also ensures that therapy remains client-focused which increases motivation and helps the therapist ascertain what the client's central concerns are. However, it is important that the focus is on the process of goal pursuit rather than outcome and expectations of achievement; it is important that happiness is not conditional upon goal achievement or else failure may exacerbate depressive symptoms [1988, 1989].

According to Stone and colleagues [389], goals should be:

- Geared towards the client's level of motivation and concern (client's stage of change – see **Chapter B2** of these Guidelines).
- Negotiated between client and AOD worker.
- Specific and achievable – it is important that the client begins to gain a sense of mastery by achieving their goals.
- Based on process rather than outcome.

- Short term – break down overall goals into shorter-term ones in order to increase motivation and feelings of success.
- Described in positive rather than negative terms – for example, the goal to 'decrease feelings of apprehension and worry at parties' is expressed in negative terms. The same goal, expressed in positive terms is, 'I will try to relax and enjoy myself at parties'.
- Not necessarily limited to AOD use (e.g., improving social adjustment and functioning, reducing criminal behaviour).

A goal setting worksheet is provided in the **Worksheets** section of these Guidelines.

Pleasure and mastery events scheduling

Individuals with depressive symptoms often stop engaging in behaviours that give them a sense of pleasure and achievement. This disengagement can lead to a cycle in which they become very inactive, leading to more negative feelings and lower mood and energy, which then leads to even less engagement in activities, and so on [389, 1990].

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

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

Appendix CC: Anxiety management techniques

Relaxation techniques are also a common means to manage the distressing and distracting symptoms of anxiety [1991]. Some useful relaxation methods include:

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

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

Progressive muscle relaxation

Progressive muscle relaxation involves tensing and relaxing of different muscle groups in succession. It is particularly useful for clients with intrusive thoughts. Before starting, make sure the client is sitting in a quiet and comfortable place. Ask the client that when they tense a particular muscle group, they do so strongly and hold the tension for 10 seconds. Encourage the client to concentrate on the feelings of tension and release in their body. Tell the client when relaxing muscles to feel the tension draining out of their body and enjoy the sensation of relaxation for 15 seconds. Isolate each muscle group at a time, allowing the other muscle groups to remain relaxed. The following instructions are based on Bourne [1992]. A client copy is also available in the **Worksheets** section of these Guidelines.

1. Take two to three deep abdominal breaths, exhaling slowly each time, imagining the tension draining out of your body.
2. Clench your fists. Hold for seven to 10 seconds (AOD workers may want to count to 10 slowly), before releasing and feeling the tension drain out of your body (for 15-20 seconds).
3. Tighten your biceps by drawing your forearms up toward your shoulders and make a muscle with both arms. Hold, then relax.
4. Tighten your triceps (the muscles underneath your upper arms) by holding out your arms in front of you and locking your elbows. Hold, then relax.
5. Tense the muscles in your forehead by raising your eyebrows as high as you can. Hold, then relax.
6. Tense the muscles around your eyes by clenching your eyelids shut. Hold, then relax. Imagine sensations of deep relaxation spreading all over your eyes.
7. Tighten your jaws by opening your mouth so widely that you stretch the muscles around the hinges of your jaw. Hold, then relax.

8. Tighten the muscles in the back of your neck by pulling your head way back, as if you were going to touch your head to your back. Hold, then relax.
9. Take deep breaths and focus on the weight of your head sinking into whatever surface it is resting on.
10. Tighten your shoulders as if you are going to touch your ears. Hold, then relax.
11. Tighten the muscles in your shoulder blades by pushing your shoulder blades back. Hold, then relax. This area is often especially tense, so this step can be repeated twice.
12. Tighten the muscles of your chest by taking in a deep breath. Hold, then relax.
13. Tighten your stomach muscles by sucking your stomach in. Hold, then relax.
14. Tighten your lower back by arching it up (don't do this if you have back pain). Hold, then relax.
15. Tighten your buttocks by pulling them together. Hold, then relax.
16. Squeeze the muscles in your thighs. Hold, then relax.
17. Tighten your calf muscles by pulling your toes towards you. Hold, then relax.
18. Tighten your feet by curling them downwards. Hold, then relax.
19. Mentally scan your body for any leftover tension. If any muscle group remains tense, repeat the exercise for those muscle groups.
20. Now imagine a wave of relaxation spreading over your body.

Controlled or abdominal breathing

When tense, a person's breathing is rapid and shallow, which can lead to hyperventilation or panic attacks. Hyperventilation is a process where shallow breathing gets rid of too much carbon dioxide which can lead to light-headedness, breathlessness, feeling of suffocation, blurred vision, and numbness or tingling in hands or feet as well as a hot, flustered feeling. Mild hyperventilation can lead to increased perpetual anxiety and apprehension [1992].

When teaching clients breathing retraining, it is important they understand and feel the difference between shallow, chest-level breathing and controlled, abdominal breathing. A good way to do this is to ask clients to practice each type of breathing. However, it is important to inform clients who are extremely anxious that they may experience trouble breathing deeply and may need to try this when feeling less anxious (some clients may always have trouble with this). Encourage clients to increase their breathing speed. Ask them to place their hand gently on their abdomen and feel how shallow and rapid their breathing is, only the chest moves up and down. Compare this technique with abdominal breathing based on the following instructions for the client provided by Bourne and Garano [1993]:

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

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

Meditation

This technique builds on the benefits of breathing exercises by incorporating deliberate attention or awareness to the present moment. There are many types of meditation, though non-judgemental awareness, acceptance of the present moment, and detachment from thoughts and emotions are common components [1992].

The following 10-30 minute meditation exercise was adapted from Bourne [1992]:

1. Start by focusing on your breathing, and expand your attention to include an awareness of your whole body. Focus on your arms and legs, along with your breath cycle. You can extend your attention to your hands and feet.
2. Don't judge yourself if your mind wanders. Each time you find yourself distracted, gently bring your attention back to your arms, legs, and breath cycle. With practice, your concentration should improve. Start by practicing for 10 minutes a day, working your way gradually up to 30 minutes.

A list of additional meditation exercises compiled by headspace is available from **www.headspace.com/meditation/exercises**.

Calming response

This quick skill was developed by Montgomery and Morris [1994] to reduce the discomfort of unwanted feelings. The basic steps involve the client mentally detaching from the situation and thinking 'clear head, calm body' as they take one slow deep breath. As they exhale, they relax.

Visualisation and imagery

This relaxation technique might be only useful for a select few clients and should not be used where a client finds the process difficult or has unpleasant effects as a result [1992].

1. Sit comfortably in a chair, close your eyes and breathe deeply. Clear your mind of all thoughts and images.
2. Imagine a place where you feel safe and relaxed; this could be a real or imaginary place. Think in as much detail as possible: What are the sounds? What are the smells? What do you feel? What do you see? What time of day is it? Are you alone or with somebody else?
3. Think about how your body feels in this place (e.g., Are your muscles relaxed? Is it warm? Is your breathing and heart rate slow or fast?).
4. Stay in this relaxed state for a moment and remember how it feels so you can return to it when you need to.
5. Slowly clear your mind again and return to the 'here and now' and the sounds around you. Stretch your arms and legs and when you are ready, open your eyes.

A client worksheet for visualisation in provided in the **Worksheets** section of these Guidelines.

Grounding

For most clients suffering anxiety symptoms, most breathing and relaxation techniques are effective; however, for sufferers of panic or trauma, some relaxation and breathing strategies can occasionally trigger flashbacks, intrusive memories, panic, fear, and dissociation. AOD workers can assist these clients and reduce traumatic and panic reactions by focusing the attention of these clients on the outside world rather than the internal trauma. This process is known as 'grounding' (or distraction, centering, or healthy detachment) [1995].

There are different forms of grounding outlined below; different strategies work best for different clients, and it is important to use a strategy appropriate to the individual. The examples of grounding techniques provided below are adapted from Najavits and Peckham [702, 1995].

Examples of mental grounding:

- Describe objects in your environment in detail using all your senses.
- Describe an everyday activity, such as eating or driving to work, in detail.
- Use a grounding statement. 'I am Jo, I am 23 years old, I am safe here, today is…'.

- Say the alphabet slowly.
- Counting backwards from 20.

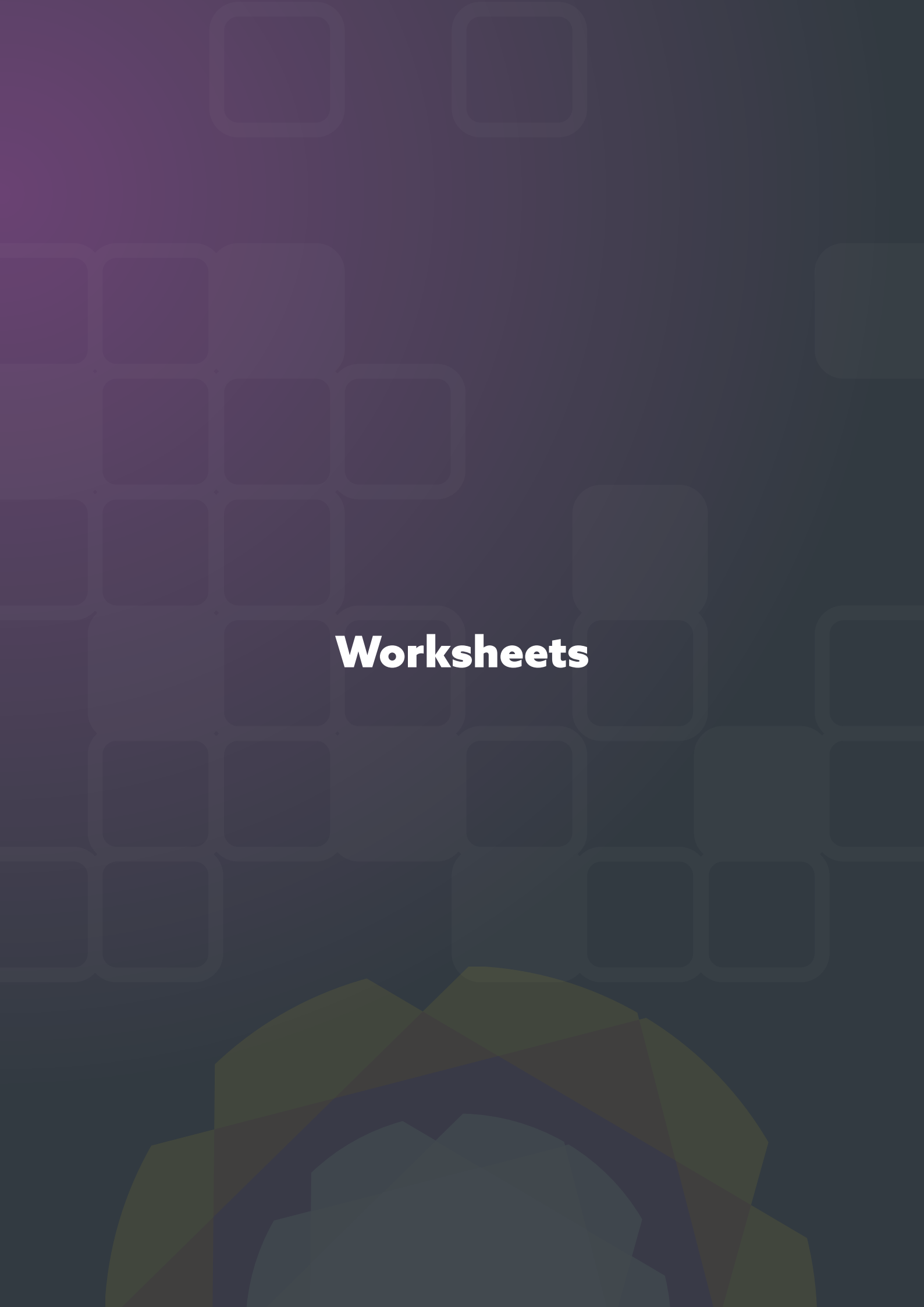
Examples of physical grounding:

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

Examples of soothing grounding:

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

Worksheets



Identifying negative thoughts

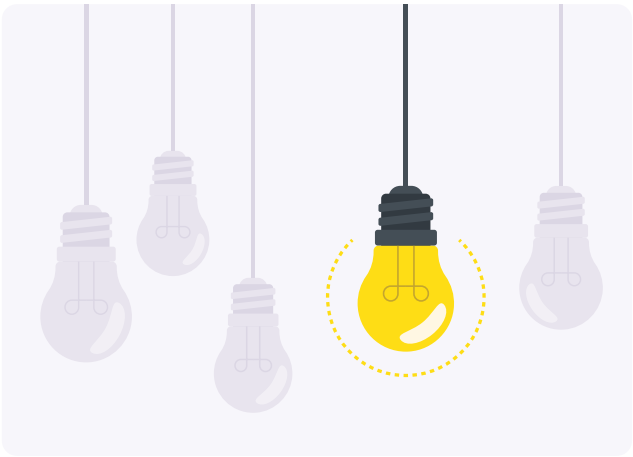
It can be useful to categorise your negative thoughts in order to identify the process that is occurring. Some common negative automatic thoughts and beliefs which can be challenged by using cognitive restructuring exercises include:

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

Sources: Leahy, R. L. (2017). *Cognitive therapy techniques: A practitioner's guide.* New York: Guildford Press; Josefowitz, N., & Myran, D. (2021). *CBT made simple.* Oakland, CA: New Harbinger Publications.

Cognitive restructuring

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



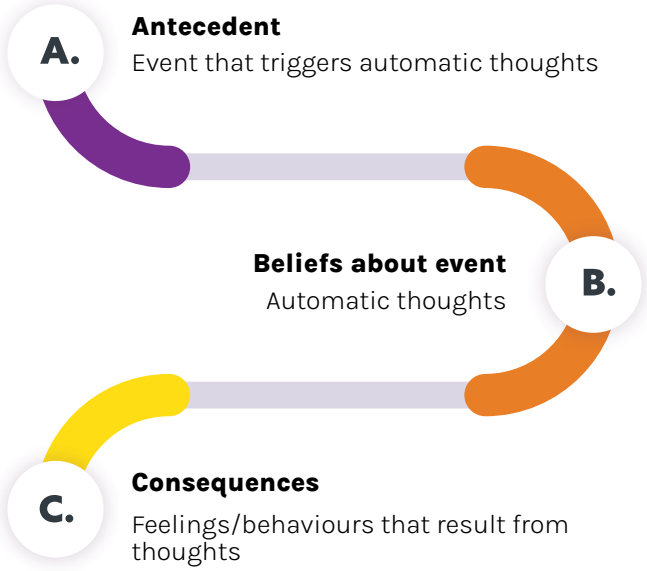
Step 1: Identification of negative/ inaccurate thoughts

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

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

Step 2: Notice how thoughts cause feelings and motivate behaviour

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



Step 3: Challenging and replacing negative thoughts

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

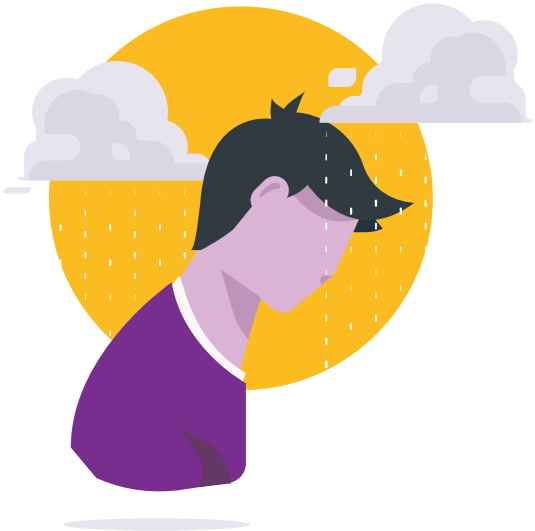
Reality testing:

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

Alternative explanations:

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

Putting it into perspective:



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

Goal-directed thinking:

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

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

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

Cognitive restructuring worksheet

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

Structured problem-solving worksheet

1. What is the problem?
   (Break it down into manageable smaller problems)

   _____

   _____

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

3. What can I do?
   (Brainstorm a list of possible solutions, good and bad, real and unreal)

Solution	Pros	Cons

4. Cross out any silly or impossible options. With those that remain, write down the short-term and long-term consequences and the pros and cons.
5. Write down your favourite three.
   1. _____
   2. _____
   3. _____
6. Put it into action!
   (What do you need to do to implement it? Did it work? Why/why not? Would another solution work better?)

Goal setting worksheet

I want to...

(e.g., stop smoking)

For these reasons...

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

The obstacles stopping me are...

(e.g., routine)

I can overcome these by...

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

These people can help...

(e.g., family)

By...

(e.g., providing support)

I will start working towards this goal...

(e.g., today)

I know I will have achieved this goal because...

(e.g., I no longer crave)

Pleasure and mastery worksheet

Create a list of activities you do for pleasure or you get a sense of achievement from.

Try to think of more each day and add to the list.

Make note of how each activity makes you feel.

Find time to complete some of these tasks every day.

A list of examples is included on the next page to help start you off.

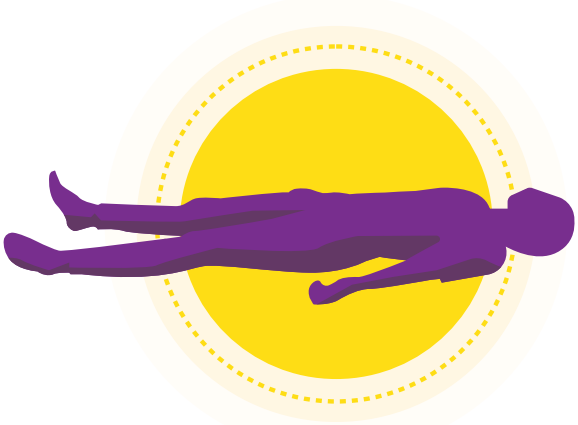
Task	How I feel

Examples of fun activities

- Listening to music
- Playing soccer
- Playing golf
- Having a bath
- Going for a swim
- Watching a movie
- Watching favourite TV show
- Going shopping
- Going bowling
- Working on car/bike
- Sex
- Reading poetry
- Cooking
- Surfing
- Playing video games
- Have coffee at a café
- Riding bike
- Playing pool/billiards
- Looking at photos
- Bushwalks
- Playing volleyball
- Picnics
- Playing cards
- Discussing politics
- Playing with pets
- Woodworking
- Getting a massage
- Watching a sporting event
- Hobbies (e.g., collecting things)
- Going horse riding
- Lying in the sun
- Talking to others
- Camping
- Going on holiday
- Going to the beach
- Going fishing
- Having a relaxed evening
- Debating
- Going to the zoo/aquarium
- Eating
- Going to the gym
- Playing cricket
- Playing hockey
- Driving
- Doing jigsaws
- Buying things
- Playing basketball
- Doing martial arts
- Playing netball
- Yoga
- Playing squash
- Playing tennis
- Going to church/ synagogue/temple/ mosque
- Photography
- Surfing the net
- Getting hair done
- Going to museums and galleries
- Doing crosswords/word games
- Throwing parties
- Going to parties
- Exercise
- Having a meal with friends
- Singing
- Going sailing
- Praying
- Going to concerts or plays
- Sewing
- Working
- Reading books
- Playing board games
- Volunteering
- Having a BBQ
- Eating out
- Acting
- Cleaning
- Meditating
- Playing with children
- Sleeping
- Gardening
- Going canoeing
- Painting/drawing
- Skating
- Skiing
- Writing
- Reading newspaper
- Dancing
- Rock climbing

Progressive muscle relaxation

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



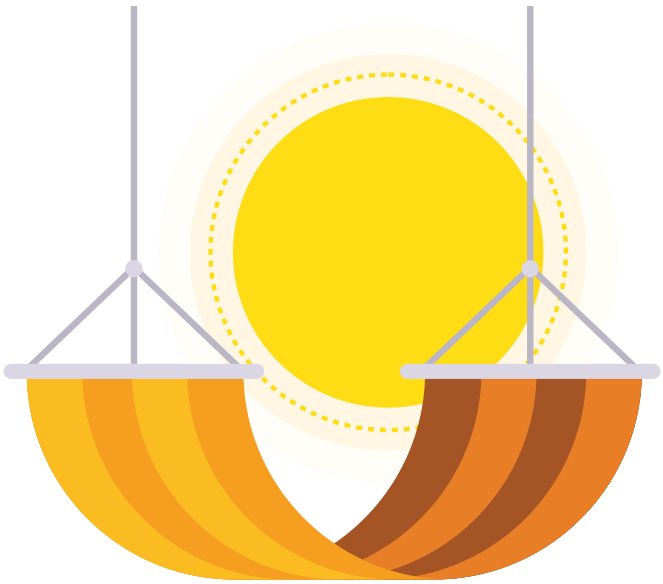
Source: Bourne, E. J. (2020). *The anxiety and phobia workbook.* Oakland, CA: New Harbinger Publications.

Controlled abdominal breathing

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

Visualisation and imagery

1. Sit comfortably in a chair, close your eyes and breathe deeply. Clear your mind of all thoughts and images, like a blank page.
2. Imagine a place where you feel safe and relaxed – this could be a real or imaginary place. Think in as much detail as possible:
   - What are the sounds?
   - What are the smells?
   - What do you feel?
   - What do you see?
3. Think about how your body feels in this place:
   - Are your muscles relaxed?
   - Is it warm?
   - Is your breathing and heart rate slow or fast?
4. Stay in this relaxed state for a moment and remember how it feels so you can return to it when you need to.
5. Slowly clear your mind again and return to the 'here and now' and the sounds around you. Stretch your arms and legs and when you are ready open your eyes.



Food and activity diary

Date	Time of day	Food eaten	Physical activity	Mood

Adapted from: Western Australian Network of Alcohol and other Drug Agencies (2016). *Healthy eating for wellbeing: A nutrition guide for alcohol and other drug consumers*. Perth, Australia: WANADA.

Common reactions to trauma

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

Feelings of sadness/depression

It is common to:

- Experience feelings of hopelessness and despair.
- Have thoughts of suicide.
- Have an altered perception of yourself (e.g., I am a bad person).
- Lose interest in once pleasurable activities.

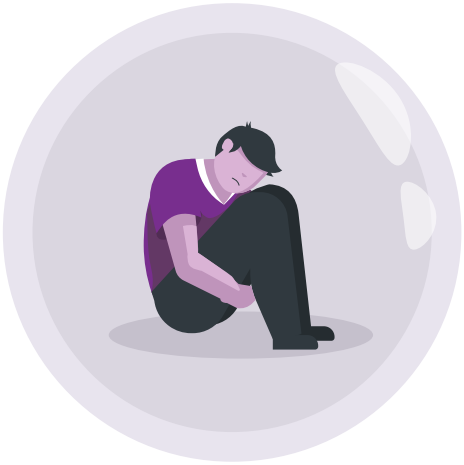
Feeling a loss of control or trust

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

Feelings of anger

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

Feelings of guilt and shame



These feelings are a common reaction to trauma survival.

You might find yourself second-guessing your reactions or blaming yourself.

Re-experiencing the event

This includes:

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

Physical arousal

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

Avoidance reactions

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

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

Common reactions to grief and loss

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

Changed behaviours:

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

Sleep and energy disturbances:

- Feeling fatigued, restless, lethargic.
- Sleep difficulties.

Other physical symptoms:

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

A range of troubling emotions:

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

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

Spiritual emptiness and pessimism.

Constant thought about the deceased or a feeling of their presence.

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

Wellbeing plan

Name: _____ Date: _____

Step	Description/Examples	Plan
Things that are important to me	List some of the things that you enjoy and value, such as hobbies, leisure and social activities, spending time with family, going to the gym:	How will you fit in the things you need to do and the things that are important to you? Are there any resources you need to help you do these things (what and from who)?
Triggers	List some of the things that cause you stress, such as not asking for support when you need it, significant events, times or situations:	What can you can do to lessen the impact?
Warning signs	List some of your warning signs that suggest you may need to take action, such as feeling unusually tired, irritable or overly sensitive, negative self-talk, difficulty sleeping:	What actions can you take? What has helped in the past?

Step	Description/Examples	Plan
Strategies	List some strategies below that you can use to help manage difficult situations, such as talking to someone you trust, remembering how you have gotten through difficulties in the past, identifying your strengths:	Are there things other people could do to help you?
Trusted people I can talk to	List some of your main, trusted support people, such as your partner, family member, workmate, neighbour, best friend:	Are there any other people in your life who support you?
Professional support	List some of the main names and numbers/locations of AOD/ mental health professionals, crisis teams, hospitals and support services you can contact. **In an emergency, always call 000**.	

Sources: Heads up. (2020). *Personal wellbeing plan*. Available from **https://www.headsup.org.au/your-mental-health/taking-care-of-yourself-and-staying-well**; Repper, J., Perkins, R., & Meddings, S. (2013). *A personal health and wellbeing plan for family, friends and carers*. Central and North West London NHS Foundation Trust. (2019). *Health and Wellbeing Plan*. Available from **https://www.cnwl.nhs.uk/services/recovery-and-wellbeing-college/resources**

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