

Mental Health and Addiction Screening and Assessment



*Ko te manu kai i te miro,
nōna te ngahere.
Ko te manu kai i te mātauranga,
nōna te ao.*

*The bird that consumes the miro berry,
owns the forest.
The bird that consumes knowledge,
owns the world.*



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Introduction

The aim of this resource is to promote the use of standardised and consistent high quality mental health and addiction screening and comprehensive assessment processes in mental health and addiction services. The recommended screening processes are also relevant and appropriate to utilise in related services such as primary care and results can be used to inform the appropriate stage of intervention on a stepped care pathway. It is hoped that people, families and whānau needing addiction and mental health support receive care appropriate to their wants and needs based on appropriate screening and, where specialist care is required, a thorough comprehensive assessment and holistic understanding of the person and their whānau.

- » Screening aims to identify who may have an issue from those who may not.
- » Comprehensive assessment formally explores the nature, the relationships between and the extent of any presenting problem(s) as part of identifying potential pathways to improve the wellbeing and mauri of people and their whānau.

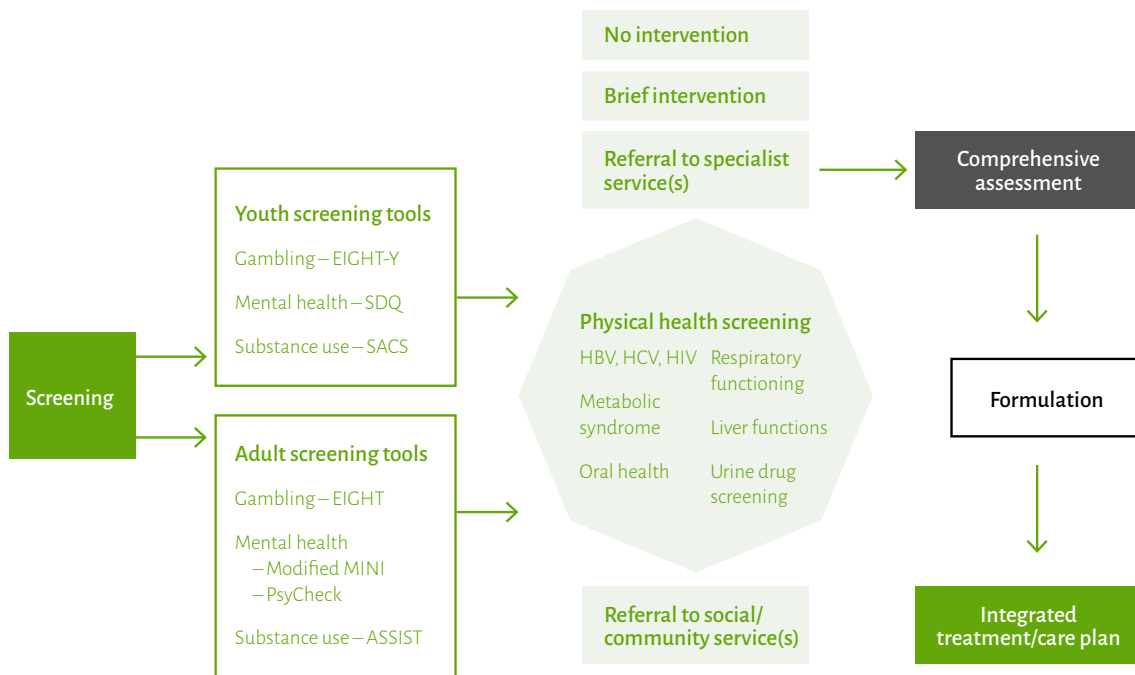
The screening tools selected for inclusion in the guideline have been chosen for ease of use, thoroughness and applicability across a wide range of settings and they are freely available. In recognition of the demands on the person and the worker of carrying out multiple screening processes substance specific and mental health disorder specific screening tools have not been included. It is hoped that recommending a limited number of validated screening tools that are appropriate for use in a wide range of contexts will make them more likely to be used by both the mental health and addiction workforce and the wider health provider workforce. Most of the screening tools chosen for inclusion have been done so on the basis that they have been developed and/or formally validated for use with New Zealand populations, including Māori and Pacific people¹. Where tools have not been validated for use in New Zealand they have been included because of their specific utility and relevance. For this reason some of the recommendations and language of those tools may require adaptation and/or explanation for local use. The description of each screening tool includes at least one key reference; information about any validation studies undertaken with New Zealand populations and an outline of the tool's use (administration and scoring).

While this resource promotes the use of specific mental health and addiction screening tools it is important to recognise that people present to services with a wide range of complex health and social issues that also need to be recognised as contributing to wellbeing. Screening for physical health, parenting, caregiving, employment, accommodation and wairua issues should be routine and used to inform integrated person and whānau centred care provided collaboratively with appropriate community service providers.

The purpose of a comprehensive assessment is to gather information that allows clinicians/practitioners to develop an understanding of the social and cultural context of a person and their family and whānau, their strengths and why they are presenting in order to present a range of intervention options that suit that person's needs and goals for wellbeing.

The comprehensive assessment template described in this resource draws heavily on the comprehensive assessment for co-existing mental health and substance use problems developed by Dr Fraser Todd (2010). Emerging priorities for health providers have also been highlighted as specific parts of the comprehensive assessment template, recognizing the growing awareness of the impact of and need to respond to the social and cultural determinants of health and wellbeing. A thorough person and whānau centred comprehensive assessment may require input from multiple practitioners and clinicians from a range of disciplines and services.

1) Validation with Māori and Pacific people has generally been limited to broad definitions of ethnicity rather than validation with specific Pacific cultures, hapu and iwi. Differences in interpretation of and responses to screening questions may exist across different Pacific cultures and different hapu and iwi and this may need to be explored with the person and their whānau before interpreting screening results.



Engagement

Any screening and comprehensive assessment processes should be an adjunct to good practice and should be secondary to engagement as evidence indicates that therapeutic engagement is the strongest indicator of better recovery outcomes for people who access mental health and addiction services (Dixon, Holoschitz and Nossel, 2016). An important aspect of engagement is to make a person and their family and whānau feel welcome when they first approach a service and before any screening and assessment is carried out the purpose of this needs to be clearly stated.

It is also important that any questions asked are understood by those being screened and assessed. In addition to potential language and cultural barriers to communication and understanding; intoxication, cognitive impairment, psychosis, hallucinations, paranoia, coercion and withdrawal states can all affect the quality and veracity of information gathered in screening and assessment.

Cultural considerations

The concept of culture encompasses both the culture of origin and the culture(s) and groups that people identify with. Effective engagement, assessment and goal setting with a person and their family and whānau may be affected by their 'cultural identity' and that of the clinician/practitioner. The way people identify themselves and 'see the world' will impact on; the way they express and react to distress; the way in which they perceive problems or solutions and/or their communication styles. Throughout the process of screening or assessment clinicians/practitioners are encouraged to remain aware of and integrate knowledge of their own social and cultural context and that of the people, families and whānau they are working with.

Clinicians/practitioners have a responsibility to ensure that the people they are working with understand health information well enough to be able to make informed choices and decisions. New Zealanders in general have poor health literacy, particularly Māori and Pacific people and their whānau.² This means that clinicians/practitioners need to communicate screening and assessment information to a person and their family and whānau using oral and written language, metaphors and images that are appropriate to and in a context relevant to that person and their family and whānau.

2) 'the degree to which individuals have the capacity to obtain, process and understand basic health information and services needed to make appropriate health decisions': Ministry of Health. 2010. *Kōrero Mārama: Health Literacy and Māori*. Wellington: Ministry of Health.

Screening

The purpose of screening is to determine whether particular problems may or may not be present, and to some extent indicate the possible degree of severity. Routine screening for various conditions is important for early detection and may help to prevent problems escalating. Screening can also help identify issues the person (and/or their whānau and family) is not aware of or does not acknowledge as problematic but which impact, or are likely to impact, on their wellbeing. Screening is not comprehensive assessment and does not generate diagnoses. Screening tools should be brief, easy to interpret, valid and appropriate to the purpose and the social and cultural context of the community they are being used in.

It is important to introduce a screening tool in a non-threatening way and to clearly state that it is the person's choice to complete the screen or not. Letting people and their family and whānau know the purpose and limitations of screening, reassuring them of confidentiality and letting them know how the information will be used and how long it will take, will all help to reduce anxiety. It is important to offer people a choice of responding to a screening tool either in written form on a standard response sheet or verbally in response to asking the screening questions. This can help with both literacy and language problems and also where there may be potential confusion about terms and phrases used in a screening tool.

After using any screening tool it is important to give individualised and tailored feedback about the results. A screening result indicating potential issues must be followed up. Responses can include:

- » further investigation
- » a brief intervention
- » referral, with the consent of the person, to a specialist service for a comprehensive assessment.

Brief intervention

Many people do not need treatment from specialists to change behaviour or to improve their wellbeing. Brief interventions are generally provided as opportunities arise but they can also be more structured and extend over more than one occasion. They are appropriate for people who may not have sought help for a particular issue and may not need specialist care or who may not be willing to go to a specialist service. The goal of a brief intervention is to provide people, and their family and whānau, with feedback, information and strategies that can help them to reflect on and address behaviours and lifestyle factors that may contribute to their and their family and whānau wellbeing.

A brief intervention can include:

- » giving people and their family and whānau accurate feedback
- » advice and information (including providing self-help material and online resources)
- » encouraging lifestyle changes that support wellbeing and whānau ora
- » problem solving, goal setting and/or relapse prevention
- » assessment of motivation
- » negotiating further assessment, treatment, referral or follow-up sessions.

For more information about Brief Interventions see:

- » Brief Intervention Guide (Matua Raki 2012) <http://www.matuaraki.org.nz/>
- » <http://www.tepou.co.nz/initiatives/talking-therapies/54>

Mental health and addiction screening tools for use with young people/rangatahi

The following screening tools have been specifically developed and validated for use with people under the age of 18 years old.

1. Gambling: Early Intervention Gambling Health Test– Youth (EIGHT-Y)
2. Mental Health: Strengths and Difficulties Questionnaire (SDQ)
3. Substance use: Substances and Choices Scale (SACS)

Depending on a young person's level of maturity and/or life experience the appropriate age to use these screening tools with may range up to 24 years old. Conversely some young people as young as 15/16 years old may be appropriately screened using adult screening tools. However the tools are not validated for use outside the age range with whom they were developed so results should be interpreted with caution when used outside of these conditions.

Early Intervention Gambling Health Test– Youth (EIGHT-Y)

Principal Reference

Sullivan, S. (2005). A hidden curriculum: gambling and problem gambling among high school students in Auckland. *Health Promotion Journal of Australia*, 16 (3): 201 – 206.

The EIGHT-Y is the youth version of the EIGHT screen and was developed and validated in New Zealand, including with Māori and Pacific populations.

Use

The EIGHT-Y is a behavioural health screening tool developed with the help of youth focus groups. It is based on the adult EIGHT screen and helps identify whether gambling has become a problem for the young person, and whether a longer conversation about current impacts of gambling is necessary.

The EIGHT-Y may be used by any clinician / practitioner who needs a reliable screening instrument to identify gambling-related problems.

Administration and Scoring

EIGHT-Y screen is preferably self-completed, but can be administered by another person if literacy or language barriers exist.

A score of three 'yes' responses can indicate hazardous gambling that may develop into problem gambling. If four 'yes' responses are made, this suggests that a young person might be experiencing gambling-related problems.

If positive, enquire if the responses reflect their current situation.

Training

No specific training is required

Availability

EIGHT-Y is open source and therefore free to use – with due acknowledgement to the source.

Copies of the screen and further information can be obtained from www.acts.co.nz

Early Intervention Gambling Health Test – Youth (EIGHT-Y)

Gambling is an entertainment that most adults enjoy, whether it's Lotto, playing the horses, gambling machines, or even going to a casino. Young people can often access gambling and, as with some adults, it can become increasingly important in our lives.

Sometimes it can also start to affect our health.

To help us check your well-being please answer the questions below as truthfully as you are able from your own experience:

	Yes, sometimes	No, never
1. Sometimes I've felt down or stressed out after a session of gambling.	<input type="checkbox"/>	<input type="checkbox"/>
2. Sometimes I've felt bad about the way I gamble.	<input type="checkbox"/>	<input type="checkbox"/>
3. When I think about it, gambling has sometimes caused me grief.	<input type="checkbox"/>	<input type="checkbox"/>
4. Sometimes I've found it better not to tell people, especially my friends, about the amount of time or money I spend gambling.	<input type="checkbox"/>	<input type="checkbox"/>
5. I often find that when I stop gambling I've run out of money.	<input type="checkbox"/>	<input type="checkbox"/>
6. I often feel like going gambling again to win back losses.	<input type="checkbox"/>	<input type="checkbox"/>
7. Some people have put me down about my gambling in the past.	<input type="checkbox"/>	<input type="checkbox"/>
8. I have tried to win the money that I owe others.	<input type="checkbox"/>	<input type="checkbox"/>

Strengths and Difficulties Questionnaire (SDQ)

Principal Reference

Goodman, R. (1997). The Strengths and Difficulties Questionnaire: A Research Note. *Journal of Child Psychology and Psychiatry*, 38: 581–586.

SDQ is in wide use in New Zealand, especially in Infant Child and Adolescent Mental Health and Alcohol and Other Drug (ICAMH/AOD) Services. While it has not been validated with New Zealand populations, it has been well validated in Australia and described as having “sound psychometric” properties.

Use

The SDQ is a twenty-five-item questionnaire concerning child and adolescent behaviour. The SDQ is designed to screen for conduct problems, hyperactivity, emotional symptoms, peer problems, and pro-social behaviour. The SDQ can be paired with the SACS as a package to provide a more holistic screening process to assist development of appropriate treatment plans for adolescents.

Administration and Scoring

The SDQ can be self-administered or administered by a clinician/practitioner. Different versions are also available for parents or teachers to administer depending on the age of the child or adolescent.

Training

Formal training to use and interpret the SDQ is not available. It appears that a background in the health or education sectors would be helpful to make best use of the results.

Availability

While the SDQ is copyrighted, it is free to download and use without modification. Full scoring instructions and guidelines for use can be obtained from: www.sdqinfo.org/ao.html

SDQ was developed in 1997 and has been translated into numerous languages over the intervening years. Translations are available at the above website.

Strengths and Difficulties Questionnaire (SDQ)

For each item, please mark the box for Not True, Somewhat True or Certainly True. It would help us if you answered all items as best you can even if you are not absolutely certain. Please give your answers on the basis of how things have been for you over the last six months.

Name _____ Date of birth _____ Male / Female

	Not True	Somewhat True	Certainly True
I try to be nice to other people. I care about their feelings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am restless, I cannot stay still for long	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get a lot of headaches, stomach-aches or sickness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I usually share with others, for example CD's, games, food	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get very angry and often lose my temper	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I would rather be alone than with people of my age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I usually do as I am told	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I worry a lot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am helpful if someone is hurt, upset or feeling ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am constantly fidgeting or squirming	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have one good friend or more	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I fight a lot. I can make other people do what I want	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am often unhappy, depressed or tearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other people my age generally like me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am easily distracted, I find it difficult to concentrate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am nervous in new situations. I easily lose confidence	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

I am kind to younger children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I am often accused of lying or cheating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other children or young people pick on me or bully me	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I often offer to help others (parents, teachers, children)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I think before I do things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I take things that are not mine from home, school or elsewhere	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I get along better with adults than with people my own age	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I have many fears, I am easily scared	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I finish the work I'm doing. My attention is good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

© Robert Goodman, 2005

Substances and Choices Scale (SACS)

Principal Reference

Christie, G., Marsh, R., Sheridan, J., Wheeler, A., Suaalii-Sauni, T., Black, S. and Butler, R. (2007). The Substances and Choices Scale (SACS) - the development and testing of a new alcohol and other drug screening and outcome measurement instrument for young people. *Addiction*, 102 (9): 1390–1398.

SACS was developed and validated in New Zealand populations, and has good specificity and reliability.

Use

SACS can be used by professionals working with young people in schools, primary care, youth services and and Infant Child and Adolescent Mental Health and Alcohol and Other Drug (ICAMH/AOD) Services.

SACS is a twenty-three-question problematic substance use screening instrument that captures the past month's substance use and is also useful for measuring changes in patterns of use over time. It has been specifically designed for use with adolescents.

The SACS has the potential to both complement and monitor the effectiveness of interventions with adolescents. It is recommended that it be used in conjunction with the SDQ (Strengths and Difficulties Questionnaire) to monitor changes in wellbeing.

Administration and Scoring

The screen is a self-report instrument.

Training

Training in the use of the SACS is available through The Werry Centre (www.werrycentre.org.nz)

Availability

The SACS is copyrighted but free to use by non-profit health organisations. Guidelines for its use and scoring can be obtained from sacsinfo.com

Substances and choices scale (SACS)

The questions in part A) and B) are about your use of alcohol and drugs over the last month. This does not include tobacco or prescribed medicines. Please answer every question as best you can, even if you are not certain. Tick only one box on each row.

Name _____ Date of birth _____

A) On how many times did you use each of the following in the last month?	Never	Once a week or less	More than once a week	Most days or more
1. Alcoholic drinks (e.g. beer, wine, spirits etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Cannabis (e.g. weed, marijuana, pot, skunk etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Cocaine (e.g. coke, crack, blow etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Amphetamines (e.g. speed, 'P', ice, whiz, goee etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Ecstasy and other party drugs (e.g. 'E', GHB etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Inhalants (e.g. nitrous, glue, petrol, solvents, paint etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Sedatives (e.g. sleeping pills, benzos, downers, valium)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Hallucinogens (e.g. LSD, acid, mushrooms, ketamine etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Opiates (e.g. heroin, morphine, methadone, codeine etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. BZP (e.g. 'herbal highs', energy pills etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Other drug. Name.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Other drug. Name.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

B) Mark one box (on each row), on the basis of how things have been for you over the last month.	Not True	Somewhat True	Certainly True
1. I took alcohol or drugs when I was alone.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. I've thought I might be hooked or addicted to alcohol or drugs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Most of my free time has been spent getting hold of, taking, or recovering from alcohol or drugs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I've wanted to cut down on the amount of alcohol and drugs that I am using.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. My alcohol and drug use has stopped me getting important things done.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. My alcohol or drug use has led to arguments with the people I live with (family, flatmates or caregivers etc.).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. I've had unsafe sex or an unwanted sexual experience when taking alcohol or drugs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. My performance or attendance at school (or at work) has been affected by my alcohol or drug use.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. I did things that could have got me into serious trouble (stealing, vandalism, violence etc.) when using alcohol or drugs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. I've driven a car while under the influence of alcohol or drugs (or have been driven by someone under the influence).	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SACS difficulties score	Never	Once a week or less	More than once a week	Most days or more
C) Finally, how often have you used tobacco (e.g. cigarettes, cigars) over the last month?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Date completed _____ Clinician _____

Mental health and addiction screening tools for use with adults

The following screening tools have been specifically developed and validated for use with people over the age of 18 years old.

- » Substance use: Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)
- » Gambling: Early Intervention Gambling Health Test (EIGHT)
- » Mental health: Modified Mini International Neuropsychiatric Interview (MINI)
- » Common mental health disorders and risk: PsyCheck

Alcohol, Smoking and Substance Involvement Screening Test (ASSIST)

Principal Reference

Humeniuk, R. (2006). Validation of the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) and pilot brief intervention: A technical report of phase II findings of the WHO ASSIST Project. The WHO ASSIST Phase II Study Group. WHO, Geneva.

Use

The ASSIST is an eight-domain questionnaire developed by an international group of substance use researchers for the World Health Organisation. It has been developed for use in primary health care settings however is being increasingly used in specialist mental health services as well. Its purpose is to detect problematic substance use. A modified version of the ASSIST has recently been validated with a New Zealand Pacific population (Newcombe et al., 2016).

The ASSIST is an interviewer-administered pen and paper questionnaire that screens for all levels of problem or hazardous substance use. It provides information about the substances ever used over a person's lifetime and in the past three months. The ASSIST also elicits information about problems related to substance use, risk of harm (current and future) and possible dependence, as well as injecting drug use.

A risk score is generated for each substance used (substances addressed include: tobacco, alcohol, amphetamine type stimulants, cannabis, cocaine, hallucinogens, inhalants, opioids, sedatives, and other drugs). The risk score helps determine the level of intervention needed e.g. brief intervention, referral.

Administration and Scoring

The ASSIST is an interviewer-administered screening tool which it is estimated takes around 7–10 minutes to administer. The resulting scores are recorded on the ASSIST Feedback Report card and are used to provide feedback to clients about their substance use and associated risks as part of linked Brief Intervention. The linked Brief Intervention adds another 10–15 minutes to the administration time.

Training

Training on how to administer the ASSIST and the linked brief intervention can be obtained through reading the Self-Training Manuals.

Availability

The ASSIST is open source and copies of the screen and guidelines for use can be obtained from:
www.who.int/substance_abuse/activities/assist_v3_english.pdf

Early Intervention Gambling Health Test (EIGHT)

Principal Reference

Sullivan, S. (2007). Don't let an opportunity go by: Validation of the EIGHT gambling screen. *International Journal of Mental Health and Addiction*, 5 (4): 381–389.

Used in a number of jurisdictions EIGHT has been validated in New Zealand, including with Māori and Pacific populations.

Use

The EIGHT is a screening tool developed in New Zealand. It is a series of eight questions originally developed for use in primary health settings, but it is now used in many other health and social service settings as well. It is brief and helps identify whether gambling has become a problem and whether a longer conversation about current impacts of gambling, including safety, depression and anxiety problems (which commonly co-exist), is necessary. The EIGHT may be used by any clinician/practitioner who needs a reliable screening instrument to identify gambling-related problems.

Administration and Scoring

The EIGHT is preferably a self-completed screen, but can be administered by another person if literacy or language barriers exist.

Guidelines for Scoring:

- 0 controlled gambling
- 1–2 low harm
- 3 low harm but at risk for moderate harm
- 4–5 harm is occurring from gambling
- 6–8 serious harm is occurring from gambling (and may meet criteria for Gambling Disorder)

Training

No specific training is required.

Availability

The EIGHT is open source and therefore free to use – with due acknowledgement to the source. Copies of the screen and guidelines for use can be obtained from www.bpac.org.nz/BP/2010/June/docs/addiction_eight_gambling_screen.pdf

Further information can be obtained at: www.acts.co.nz

Early Intervention Gambling Health Test (EIGHT)

Most people in New Zealand enjoy gambling, whether it's Lotto, track racing, the pokies, or at the casino. Sometimes, however, it can affect our health. To help us check your well-being, please answer the questions below as truthfully as you are able from your own experience.

	Yes, that's true	No, never
1. Sometimes I've felt depressed or anxious after a session of gambling.	<input type="checkbox"/>	<input type="checkbox"/>
2. Sometimes I've felt guilty about the way I gamble.	<input type="checkbox"/>	<input type="checkbox"/>
3. When I think about it, gambling has sometimes caused me problems.	<input type="checkbox"/>	<input type="checkbox"/>
4. Sometimes I've found it better not to tell others, especially my family, about the amount of time or money I spend gambling.	<input type="checkbox"/>	<input type="checkbox"/>
5. I often find that when I stop gambling I've run out of money.	<input type="checkbox"/>	<input type="checkbox"/>
6. Often I get the urge to return to gambling to win back losses from a past session.	<input type="checkbox"/>	<input type="checkbox"/>
7. Yes, I have received criticism about my gambling in the past.	<input type="checkbox"/>	<input type="checkbox"/>
8. Yes, I have tried to win money to pay debts.	<input type="checkbox"/>	<input type="checkbox"/>

Modified Mini International Neuropsychiatric Interview Screen (MINI)

Principle reference

Alexander, M.J., Haugland, G., Lin, S.P., Bertollo, D.N., and McCorry, F.A. (2008). Mental Health Screening in Addiction, Corrections and Social Service Settings: Validating the MMS. *International Journal on the Addictions*, 6 (1): 105–119.

Sheehan, D.V., Lecrubier, Y., Sheehan, K.H., Amorim, P., Janavs, J., Weiller, E., Hergueta, T., Baker, R., and Dunbar, G.C. (1998). The mini-international neuropsychiatric interview (M.I.N.I.): the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *Journal of Clinical Psychiatry*, 59 (suppl. 20).

Use

The Modified Mini Screen is a generic screening measure for mood, anxiety, and psychotic spectrum disorders. There are twenty-two questions with yes/no responses.

Administration and scoring

The Modified Mini can be self-completed or completed by a clinician/practitioner if literacy or language barriers exist. It takes about fifteen minutes to complete.

To score the MMS, total the number of yes answers.

A score of 6 or greater indicates the likely presence of a mental health disorder.

A person who answers yes to question 4 should be monitored for suicidality.

A person who answers yes to questions 14 and 15 should be assessed for trauma.

Availability

The Modified Mini Screen is in the public domain and is available from: www.bhevolution.org/public/screening_tools.page

SECTION A	YES	NO
1. Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks?	<input type="checkbox"/>	<input type="checkbox"/>
2. In the past two weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time?	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you felt sad, low or depressed most of the time for the last two years?	<input type="checkbox"/>	<input type="checkbox"/>
4. In the past month did you think that you would be better off dead or wish you were dead?	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you ever had a period of time when you were feeling 'up', hyper or so full of energy or full of yourself that you got into trouble, or that other people thought you were not your usual self? (Do not consider times when you were intoxicated on drugs or alcohol).	<input type="checkbox"/>	<input type="checkbox"/>
6. Have you ever been so irritable, grouchy or annoyed for several days, that you had arguments, verbal or physical fights, or shouted at people outside your family? Have you or others noticed that you have been more irritable or overreacted, compared to other people, even when you thought you were right to act this way?	<input type="checkbox"/>	<input type="checkbox"/>

SECTION B	YES	NO
7. Have you had one or more occasions when you felt intensely anxious, frightened, uncomfortable or uneasy even when most people would not feel that way? Did these intense feelings get to be their worst within 10 minutes? (If "yes" to both questions, answer "yes", otherwise check "no")	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you feel anxious, frightened, uncomfortable or uneasy in situations where help might not be available or escape might be difficult? Examples include: <ul style="list-style-type: none"> » Being in a crowd » Standing in a line » Being alone away from home or alone at home » Crossing a bridge » Traveling in a bus, train or car 	<input type="checkbox"/>	<input type="checkbox"/>
9. Have you worried excessively or been anxious about several things over the past 6 months?	<input type="checkbox"/>	<input type="checkbox"/>
10. Are these worries present most days?	<input type="checkbox"/>	<input type="checkbox"/>
11. In the past month, were you afraid or embarrassed when others were watching you or when you were the focus of attention? Were you afraid of being humiliated? Examples include: <ul style="list-style-type: none"> » Speaking in public » Eating in public or with others » Writing while someone watches » Being in social situations 	<input type="checkbox"/>	<input type="checkbox"/>
12. In the past month, have you been bothered by thoughts, impulses, or images that you couldn't get rid of that were unwanted, distasteful, inappropriate, intrusive or distressing? Examples include: <ul style="list-style-type: none"> » Were you afraid that you would act on some impulse that would be really shocking? » Did you worry a lot about being dirty, contaminated or having germs? » Did you worry a lot about contaminating others, or that you would harm someone even though you didn't want to? » Did you have any fears or superstitions that you would be responsible for things going wrong? » Were you obsessed with sexual thoughts, images or impulses? » Did you hoard or collect lots of things? » Did you have religious obsessions? 	<input type="checkbox"/>	<input type="checkbox"/>
13. In the past month, did you do something repeatedly without being able to resist doing it? Examples include: <ul style="list-style-type: none"> » Washing or cleaning excessively » Counting or checking things over and over » Repeating, collecting, or arranging things » Other superstitious rituals 	<input type="checkbox"/>	<input type="checkbox"/>

<p>14. Have you ever experienced or witnessed or had to deal with an extremely traumatic event that included actual or threatened death or serious injury to you or someone else? Examples include:</p> <ul style="list-style-type: none"> » Serious accidents » Sexual or physical assault » Terrorist attack » Being held hostage » Kidnapping » Fire » Discovering a body » Sudden death of someone close to you » War » Natural disaster 	<input type="checkbox"/> <input type="checkbox"/>
<p>15. Have you re-experienced the awful event in a distressing way in the past month? Examples include:</p> <ul style="list-style-type: none"> » Dreams » Intense recollections » Flashbacks » Physical reactions 	<input type="checkbox"/> <input type="checkbox"/>

SECTION C	YES	NO
<p>16. Have you ever believed that people were spying on you, or that someone was plotting against you, or trying to hurt you?</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>17. Have you ever believed that someone was reading your mind or could hear your thoughts, or that you could actually read someone's mind or hear what another person was thinking?</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>18. Have you ever believed that someone or some force outside of yourself put thoughts in your mind that were not your own, or made you act in a way that was not your usual self? Or, have you ever felt that you were possessed?</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>19. Have you ever believed that you were being sent special messages through the TV, radio, or newspaper? Did you believe that someone you did not personally know was particularly interested in you?</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>20. Have your relatives or friends ever considered any of your beliefs strange or unusual?</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>21. Have you ever heard things other people couldn't hear, such as voices?</p>	<input type="checkbox"/>	<input type="checkbox"/>
<p>22. Have you ever had visions when you were awake or have you ever seen things other people couldn't see?</p>	<input type="checkbox"/>	<input type="checkbox"/>

PsyCheck

Principal Reference:

Lee, N.K. and Jenner, L. (2010). Development of the PsyCheck screening tool: An instrument for detecting common mental health conditions among substance use treatment clients. *Mental Health and Substance Use: Dual Diagnosis*, 3(1): 56-65.

The PsyCheck was developed by Turning Point, Alcohol & Drug Centre, Australia. It has been validated for use with people accessing AOD treatment. It has not been designed or tested for indigenous or culturally and linguistically diverse people. The PsyCheck has not been validated with New Zealand populations.

Use

The PsyCheck Screening Tool has been developed as part of a brief intervention package and is designed for routine screening of mental health problems in people accessing addiction treatment services by non-mental health specialists.

PsyCheck has 29 items with three sections that focus on different aspects of mental health experiences:

1. General Mental Health Screen (5 items)
2. Suicide/Self Harm Risk Assessment (4 items)
3. Self-reporting Questionnaire of Symptoms (20 items)

Administration and Scoring

The first two sections of the PsyCheck are administered by the practitioner, the third section can be administered by the practitioner with the person or self-administered by the person.

Sections 1 and 2 collect information regarding people's history of mental health issues and treatment. Section 3 (the self-report questionnaire) is scored. If any symptoms are identified, the practitioner provides the level of PsyCheck intervention appropriate for their severity and then re-screens after four (4) sessions/weeks. If after the re-screen there is no improvement in the score, referral to a specialist service should be considered.

Availability

The PsyCheck is open source. An orientation package is available on the PsyCheck website www.psycheck.org.au as is a Screening Tool User's Guide.

The *PsyCheck* Screening Tool

Client's Name:	DOB:
Service:	UR:
Mental health services assessment required?	No <input type="checkbox"/> Yes <input type="checkbox"/>
Suicide/self-harm risk (please circle):	High Moderate Low
Date:	Screen completed by:

Clinician use only			
Complete this section when all components of the <i>PsyCheck</i> have been administered.			
Summary			
Section 1	Past history of mental health problems	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Section 2	Suicide risk completed and action taken	<input type="checkbox"/> No	<input type="checkbox"/> Yes
Section 3	SRQ score	<input type="checkbox"/> 0	<input type="checkbox"/> 1–4 <input type="checkbox"/> 5+
Interpretation/score – 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 <i>PsyCheck</i> Screening Tool after 4 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 <i>PsyCheck</i> Intervention and screen again in 4 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 <i>PsyCheck</i> Intervention.		
Re-screen using the <i>PsyCheck</i> 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.

SECTION 1: 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

SECTION 2: Risk Assessment

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

SECTION 3: Self Reporting Questionnaire

Client or clinician to complete this section

First: Please tick the 'Yes' box if you have had this symptom in the **last 30 days**.

Second: Look back over the questions you have ticked. For every one you answered 'Yes', please put a tick in the circle if you had that problem at a time when you were NOT using alcohol or other drugs.

- | | | | | |
|--|-----------------------------|------------------------------|---|-----------------------|
| 1. Do you often have headaches? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | → | <input type="radio"/> |
| 2. Is your appetite poor? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | → | <input type="radio"/> |
| 3. Do you sleep badly? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | → | <input type="radio"/> |
| 4. Are you easily frightened? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | → | <input type="radio"/> |
| 5. Do your hands shake? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | → | <input type="radio"/> |
| 6. Do you feel nervous? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | → | <input type="radio"/> |
| 7. Is your digestion poor? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | → | <input type="radio"/> |
| 8. Do you have trouble thinking clearly? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | → | <input type="radio"/> |
| 9. Do you feel unhappy? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | → | <input type="radio"/> |
| 10. Do you cry more than usual? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | → | <input type="radio"/> |
| 11. Do you find it difficult to enjoy your daily activities? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | → | <input type="radio"/> |
| 12. Do you find it difficult to make decisions? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | → | <input type="radio"/> |
| 13. Is your daily work suffering? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | → | <input type="radio"/> |
| 14. Are you unable to play a useful part in life? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | → | <input type="radio"/> |
| 15. Have you lost interest in things? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | → | <input type="radio"/> |
| 16. Do you feel that you are a worthless person? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | → | <input type="radio"/> |
| 17. Has the thought of ending your life been on your mind? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | → | <input type="radio"/> |
| 18. Do you feel tired all the time? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | → | <input type="radio"/> |
| 19. Do you have uncomfortable feelings in the stomach? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | → | <input type="radio"/> |
| 20. Are you easily tired? | <input type="checkbox"/> No | <input type="checkbox"/> Yes | → | <input type="radio"/> |

Total score (add circles):

Physical health screening

Evidence from across the world, including New Zealand, indicates people who have mental health and/or addiction problems are more likely to die prematurely than their peers without mental health and addiction problems (Te Pou, 2014). For this reason physical health screening should be a routine part of any interaction with people accessing services for assistance with mental health and/or addiction problems. At times the medication to treat mental health and addiction problems can have physical health consequences and screening for these should be a routine part of ongoing treatment. One aspect of screening for physical health problems associated with mental health and addiction problems is the use of biochemical testing, including blood and urine testing. Self-report is often inadequate as many of the physical consequences of having long standing mental health and addiction problems are not obvious to the person and may be symptomless.

A routine screening instrument for general physical health can be useful. The Physical Health Check tool (Rethink Mental Illness 2014, available from www.ucl.ac.uk/core-resource-pack/documents/RethinkPHchecklist) is a quick screening instrument for people with mental health problems. It is also useful for people with addiction problems given that the majority of people with addiction problems also have other co-existing mental health problems.

Hepatitis B and C and HIV screening

Lifestyle factors and behaviours associated with mental health and addiction problems can increase the risk of the person being exposed to and contracting Hepatitis B Virus (HBV), Hepatitis C Virus (HCV) and Human Immunodeficiency Virus (HIV) infection.

Notable amongst these is HCV with an estimated prevalence in New Zealand of approximately 50,000 people of whom a disproportionate proportion come from the intravenous drug using community (www.hepatitisfoundation.org.nz). When people indicate that they have used any substance (e.g. opioids, methamphetamine and/or steroids) intravenously in the course of their life they should be offered screening, via a blood test, for the presence of HCV and discuss the impact of possible positive results. Harm reduction advice should also be offered to reduce the risk of contracting HCV if not already present and reduce the risk of passing HCV on to others, especially partners. Other risk factors include having had blood transfusions in New Zealand prior to 1992, amateur tattoos and any exposure to blood products, especially in countries with a high prevalence. While people may be unaware that they have HCV, having hepatitis C is associated with debilitating side effects including: lethargy, aches and fatigue. Long term outcomes can include cirrhosis and liver cancer. With effective and subsidised treatment options for HCV now available it is important that people at risk are screened and if HCV positive have rapid access to treatment to help improve their wellbeing and reduce the risk of premature mortality.

Hepatitis B is more prevalent in the wider community than HCV, especially in Māori and Pacific peoples, with approximately 100,000 people in New Zealand having chronic hepatitis B (www.hepatitisfoundation.org.nz). HIV is less prevalent but screening should also be considered especially for intravenous drug users, people who have been exposed to blood products and other bodily fluids, people living with or who have previously lived with someone who has hepatitis B or HIV and/or from countries with high prevalence of either, people who have engaged in unprotected sex and sex workers. Counselling about the possible implications and consequences of having either HBV or HIV infection should be provided before proceeding with screening. Where people have not been exposed to HBV they should be offered access to the HBV vaccine to reduce the risk of contracting it in the future, especially if they have either HCV or HIV. Harm reduction advice regarding safe sex, sharing of bodily fluids and safer injecting practices should also be provided to reduce the risk of future exposure to either virus and reduce the risk of passing on the virus to others if present.

Metabolic screening

Medication used to treat some mental health conditions can contribute to weight gain and obesity, changes in cholesterol levels, high blood pressure and elevated blood sugars. These changes all increase the risk of developing a range of disorders including diabetes, heart disease and stroke, collectively described as 'metabolic syndrome', and the risk of premature mortality. These risk factors may be exacerbated by the impact of mental health problems on lifestyle factors such as diet, exercise and substance use. The prevalence of metabolic syndrome in people with serious mental health problems may be two to three times the prevalence in the general population (Te Pou, 2014). Metabolic screening should be carried out at first contact with people accessing mental health and addiction services to establish a baseline of physical health and routine screening for changes should be part of ongoing support for all people receiving any psychotropic medication.

Specific tests include:

- » Body mass index (BMI)
- » Blood pressure
- » Cholesterol levels
- » Blood sugars
- » HBA1C levels (a measure of glucose levels over the past 2-4 months)

Oral health

Oral health can be an issue for people with a history of mental health and addiction problems (Te Pou, 2014). Medications and substances can both have a direct impact on saliva production which in turn exposes people to the risk of tooth decay. These risks are compounded by the impact of poverty, poor nutrition and a high sugar content diet for many people with mental health and addiction problems. Screening for oral health problems can highlight the need for access to subsidised and/or specialist dental care. Improvements in pain and self-image associated with poor oral health can contribute significantly to peoples' wellbeing

Respiratory problems

Respiratory problems are more common in people with mental health and addiction problems (Te Pou, 2014), and screening for respiratory functioning can increase the likelihood of early treatment for respiratory diseases including asthma, bronchitis, chronic obstructive pulmonary disease and emphysema. This is particularly important if people have a tobacco use disorder or have used substances intravenously.

Screening for substances and the impact of substance use

Alcohol specific

Laboratory tests can detect abnormalities in the body chemistry that may be a result of heavy alcohol consumption. Unfortunately there are no biomarkers which combine high sensitivity with high specificity and ready availability for clinical use. The following biomarkers are useful to note for the purposes of this resource; while others exist, they tend to be used in specialised settings.

Test	Window of assessment	Sensitivity	Specificity	Utility
Breath/blood/urinary alcohol level	Hours	High	High	With clinical correlation can indicate high tolerance and by inference extended high level consumption
AST* Aspartase aminotransferase	2–3 weeks	Less than GGT	Many sources false positives	Chronic heavy drinking, cheap, widely available
ALT* Alanine transaminase	2–3 weeks	Less than GGT	Many sources false positives	Chronic heavy drinking, cheap, widely available
AST/ALT	2–3 weeks	Similar to either alone	Less false positives	
CDT Carbohydrate deficient transferrin	2–3 weeks	Similar to GGT	Less false positives	Expensive, availability varies, in some regions requires specific funding
GGT* Gamma glutamyl transpeptidase	2–3 weeks	Moderate	Many sources false positives	Chronic heavy drinking, cheap, widely available
GGT + CDT	2–3 weeks	Similar to either alone	Less false positives	
MCV Mean cell volumes of erythrocytes	months	Less than GGT	Several conditions cause false positives	Several conditions causing false positives (liver disease, B12 deficiency, folate deficiency, hypothyroidism) are known and can readily be excluded

* These measures of liver functioning may be elevated when people have chronic hepatitis B or C.

Blood alcohol concentration (BAC) refers to the concentration of alcohol in the blood and is measured in milligrams of alcohol per 100 ml of blood (mg/100ml). Blood alcohol concentrations can be reliably measured using breath alcohol testing equipment, a noninvasive procedure in which the concentration of alcohol in end-expiratory breath is measured. The advantages of using BAC include ease of administration, immediacy of feedback, affordability and portability. BAC, however, cannot distinguish between acute and chronic alcohol use, as BAC detects recent alcohol consumption only. It is also insensitive to episodic heavy-drinking patterns and long-term heavy alcohol use.

In most situations self-report remains the most reliable, sensitive and specific, measure of alcohol consumption. The exception is when an individual faces significant sanction as a result of detection of alcohol use (e.g. drinking driving or work-based drug testing) in which case laboratory tests can be used to confirm use.

Urine drug analysis

Urine drug testing aims to detect the presence or absence of specific substances, including alcohol, and/or drug metabolites in urine. A toxicologist can roughly determine, using metabolite concentrations, the approximate time, dose and therefore (within reasonable doubt) extent of use. However this latter procedure can be costly and so is rarely used to determine dosage, time of drug administration or the extent of any drug effect.

To differentiate between recent substance use and continued excretion of the drug from previous (heavy and prolonged) use, it is possible to perform a semi-quantitative analysis in which the concentration of the drug in urine is monitored over time. If the person has ceased to use the drug, then the concentration of drug in urine would be expected to decrease each time a urine sample is assayed. Increases or no change in the concentration of the drug in urine is consistent with continued use.

There are a number of factors that influence whether a urine drug screen is positive or negative. Firstly, the higher the dose, the more likely it is that the drug will be detected. For example, while a dose of 30 mg of codeine might be detected for 1–6 hours after use, a 60 mg dose may be detected for 1–10 hours. Frequency and heaviness of use is also an important factor influencing detection. As a general rule, with regular use, most drugs tend to accumulate in the body. The more frequently and the heavier a drug is consumed the more likely it is that it will be detected in a drug screen (Dawe et al., 2002). For example cannabis can be detected for several weeks after cessation of use if it has been used on a daily basis over an extended period.

Accurate interpretation of urinalysis results requires an understanding of the type of laboratory assay ordered, major and minor drug metabolic pathways, expected drug detection times and potential causes of false-positive and false-negative results. Misinterpretation of results can harm therapeutic alliance or perceptions of wellbeing, especially if it contributes to misdiagnosis or the discontinuation of any medications etc. It is recommended that clinicians/practitioners using, or investigating, urine drug testing have an understanding of its use and limitations. They should also regularly consult the laboratory toxicologist regarding which test(s) to order and how to interpret results.

Triage

The concept of triage is based on the aim that people and families and whānau with the greatest need and/or at the greatest risk of adverse outcomes receive treatment the soonest. When people and families and whānau seek or are referred to treatment for mental health and addiction problems triage, sometimes known as an 'intake assessment' or, in services utilizing the choice and partnership (CAPA) approach, the 'choice' appointment, can help to prioritise their needs, providing an indication of what needs to be addressed first and what can wait. Triage can also help to identify the setting that would be most appropriate to provide care for the most urgent issues. For instance a person presenting in acute alcohol withdrawal or with paranoid delusions needs immediate care, probably within an inpatient setting, while someone presenting with social anxiety or moderate cannabis use is more likely to be able to safely wait for a brief period before needing care in a community setting.

Clinicians/practitioners who carry out a triage or intake assessment need to be highly competent and knowledgeable about holistic comprehensive assessment with the ability to rapidly engage with tāngata whai ora and their family and whānau. They also need to have knowledge of and close relationships with the health and social service providers in their community in order to recommend appropriate care pathways.

At the least a triage assessment should cover:

- » name
- » age
- » gender
- » ethnicity (including hapu and iwi if Māori)
- » current family and whānau responsibilities
- » presenting problem (stated reason for being at service)
- » current substance use (including stated and apparent withdrawal symptoms)
- » current gambling
- » current mental health (including stated and apparent symptoms)
- » current suicidal risk
- » current homicidal risk and/or risk of violence to others, especially children and partners

- » current physical health issues
- » current prescribed and over the counter (OTC) medications
- » the persons expectations/goals

Appropriate screening tools, as recommended above, can support the triage process. It is particularly helpful if screening is carried out prior to triage and the results are available to the clinician/practitioner to discuss with the person and their family and whānau.

Comprehensive assessment

A personalised and individualised 'comprehensive assessment' is the foundation for the development of an appropriate treatment plan that is developed in collaboration with the person, and their family and whānau, being assessed.

A comprehensive assessment gathers information that allows clinicians/practitioners to develop an understanding of the social and cultural context of a person and their family and whānau, their strengths and why they are presenting. As mentioned earlier a comprehensive assessment may require input from multiple sources and clinicians/practitioners from a range of disciplines. From this information clinicians/practitioners develop a formulation that is a combination of clinical judgement and objective criteria, such as outlined in the Diagnostic and Statistical Manual of Mental Disorders (DSM5) or the International Classification of Diseases (ICD 10).

The assessment process is often the first opportunity to engage and build rapport with the person, and any family or whānau present, not just a structured interview or a tick box process. Comprehensive assessment is also an intervention in its own right as asking appropriate questions at the right time can help people and their family and whānau make connections between events in their lives and their behaviours and wellbeing. Cultural perspectives and, where available, practice frameworks need to be integrated throughout the engagement and assessment process to ensure that the assessment is comprehensive.

The feedback of a formulation based on the comprehensive assessment can contribute to significant change in motivation. Sharing the formulation and providing accurate non-judgemental feedback can help to increase a person's and their family and whānau knowledge about lifestyle factors that contribute to issues such as anxiety and depression and the harms associated with substance use and gambling. This can also reassure people and their family and whānau that their reactions to life events and trauma are 'normal' and help to address the stigma that many people, families and whānau internalise about their thoughts and behaviors.

Feedback should be should be delivered in plain language, appropriate to the person and their family and whānau, in an empathic, collaborative, non-judgemental and non-threatening manner so that the person and their family and whānau can understand what is being said, and the range of options available to them to develop or negotiate their own treatment goals.

A comprehensive assessment will include a statement of:

- » the person's strengths, including the strengths of their family and whānau
- » a problem list
- » case formulation
- » prognosis
- » integrated care/treatment plan.

It is expected that clinicians/practitioners completing comprehensive assessments have experience and training in the assessment and management of mental health and addiction-related conditions and have a person and whānau centred recovery focused approach. An experienced clinician/practitioner may be able to carry out most of a comprehensive assessment in a single session though it is likely that information will continue to be gathered over time from multiple sources including cultural and clinical specialists.

It is important to note that the comprehensive assessment section in this resource should be considered a minimum standard for a 'comprehensive assessment'.

Comprehensive assessment template³

It is not necessary to carry out a comprehensive assessment in the order presented in this template. Clinicians/practitioners will need to develop their own process for gathering the information under these headings depending on personal preferences, approach and discipline. Engagement with the person is the priority.

History

1. Introduction (demographics)

What is the name, age, ethnicity, occupation, and marital/relationship status of the person? Do they have children, whāngai and/or other dependants (eg. parents, disabled siblings, whānau living with them), and what are their current social circumstances and key relationships? What is their personal definition of wellbeing and vision of purpose/meaning in life?

2. Presentation

What is the nature of referral? Is it a self-referral, directly or through another health provider or community agency, voluntary or mandated? Is it supported by family and whānau? What are the person's view of their presenting issue(s) and expectations of help? What are the family and whānau views of their presenting issue(s) and expectations of help?

3. Presenting problem(s)

What is the most important issue to the person? What is the most important issue to the family and whānau? Note: If the person is not self-referred this may differ from the issue identified by the referrer. Where people are mandated to attend an assessment, meeting the needs of the referrer may be identified as the most important issue.

4. Addiction history

Information about a person's history of substance use and gambling needs to be detailed and specific in order to identify patterns of behaviour and triggers, consequences and associated risks. Questions about specific substances and gambling behavior will elicit a broader picture of a person's addiction history. This information will inform the formulation and treatment plan.

A. Alcohol and other drug

- i) Substances used in life, including nicotine:
 - » ever used (the substances listed below are indicative not exhaustive)
 - » alcohol
 - » cannabis: leaf, buds/heads, hash, hash oil
 - » synthetic cannabinoids
 - » tobacco: e-cigarettes, snuff
 - » stimulants: amphetamine (speed), methamphetamine (P, ice, crystal meth), methylphenidate (rits), cocaine, MDMA (ecstasy), mephedrone, BZP, caffeine
 - » opioids: opium, morphine, heroin, oxycodone, codeine, methadone, buprenorphine, tramadol

- 3) Matua Raki appreciates the permission of Dr Fraser Todd to use and adapt the template for comprehensive assessment outlined in Te Ariari o te Oranga: The assessment and management of people with coexisting mental health and substance use problems (Todd, 2010).

- » hallucinogens: psilocybin (mushrooms), mescaline (cactus), LSD (acid), NBOMe, datura, benztropine, ketamine
- » sedatives: benzodiazepines, zopicone, antihistamines, barbiturates
- » other: steroids, OTC medications, inhalants (glue, butane, petrol, aerosols), nitrous oxide, GHB, gabapentin, kava kava, salvia, khat
- » regularly used
- » recently used or currently using
- » quantity and frequency of use
- » ever used intravenously
- ii) Pattern of substance use for each regularly used substance:
 - » current or most recent use
 - » age of first use
 - » age of first regular heavy use
 - » first problems observed from use
 - » heaviest three- to six-month period of use
 - » DSM symptoms during heaviest period of use
 - » current patterns of use
 - » current DSM symptoms
 - » longest periods of abstinence
- iii) Person's stated or implied reasons for using
- iv) Consequences of alcohol and drug use
- v) Severity (i.e. DSM symptoms)
- vi) Treatment history (including use of self-help groups).

Gambling:

- » current gambling
 - » poker machines
 - » TAB
 - » online sports betting
 - » online poker
 - » scratch and wins
 - » casinos
- » exploration of beginning and patterns of gambling behaviour
- » attempts to control or reduce gambling
- » consequences of gambling on: finances, employment, relationships, parenting, offending
- » DSM criteria for a gambling disorder
- » previous treatment

DSM5	Gambling	Alcohol	Cannabis	Nicotine	Sedatives	Stimulants	Opioids	Poly
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

5. Mental health history

A longitudinal record of mental health issues, not simply disorders, identified by the person over the course of their life can assist with the identification of precipitating and maintaining factors that may be amenable to treatment. Untreated mental health issues can contribute to poor wellbeing and a thorough assessment will explore more than the conditions most prevalent in the general population.

A. Mental health issues in life:

- » Low mood
- » Anxiety
- » Trauma
- » Cyclic moods
- » Psychosis/hallucinations/delusions
- » Suicidal ideation/behavior
- » Other

Specific questions to ask include:

- i) Have you ever worried a lot about terrible things that might happen, even when it was unrealistic to worry as much as you did? (Generalised anxiety)
- ii) Is there anything that you were ever afraid to do or felt uncomfortable doing in front of other people, like speaking, eating or writing? What were you afraid could happen when doing this? (Social anxiety)
- iii) Were you ever afraid of going out of the house alone, being in crowds, standing in a line or travelling on buses or trains? What were you afraid could happen? (Agoraphobia)
- iv) Have you ever had a panic attack, when you suddenly felt frightened, anxious or extremely uncomfortable? Have you ever had one when you did not expect to at all? (Panic)
- v) Have you ever experienced or witnessed an event in which you were or thought you were going to be seriously injured or your life was in danger? Have you ever been physically, emotionally and/or sexually abused? (Post-traumatic stress disorder)
- vi) Have you ever had a time when you weighed much less than other people thought you ought to weigh but you continued to feel overweight? Have you ever had eating binges during which you ate a considerable amount of food in a short period of time and during which your eating was out of control? (Anorexia nervosa)
- vii) Have you ever been bothered by thoughts that did not make any sense and kept coming back to you even when you tried not to have them? Was there ever anything that you had to do over and over again and could not resist doing, like washing your hands again and again or checking something several times to make sure you had done it right? (Obsessive compulsive disorder)
- viii) Have you ever been bothered by, or experienced, depressed mood most of the day, more days than not, for a period of several years? (Persistent depressive disorder - Dysthymia)
- ix) Has there ever been a period of time when you were feeling depressed or down most of the day, nearly every day, for at least two weeks? (Major depressive disorder - Bipolar disorder)
- x) What about ever having the opposite of depression, when you were feeling so good or high that other people thought you were not your normal self, or you were so high that you got in trouble? (Mania - Bipolar disorder)
- xi) Did it ever seem that people were talking about you or taking special notice of you? What about receiving special messages from the TV, radio or newspaper, or from the way things were arranged around you? What about anyone going out of their way to give you a hard time, or trying to hurt you? (Delusions – of reference and persecutory - Schizophrenia)
- xii) Did you ever hear things that other people could not hear, such as noises, or the voices of people whispering or talking? Did you ever have visions or see things that other people could not see? (Hallucinations -auditory and visual - Schizophrenia)

What are the pattern of symptoms for each issue?

- » current or most recent symptoms
- » age of first symptoms and any vulnerability factors or prodromal symptoms (e.g. history of shyness and separation problems with current anxiety problems)
- » age of first intrusive symptoms causing distress
- » first problems observed/evident from issue
- » longest period that symptoms lasted
- » DSM symptoms during this period
- » current problems and symptoms
- » current problems/DSM symptoms
- » longest periods symptom free

Explore

- i) Person's and their family and whānau stated or implied understanding/explanation of problem(s)
- ii) Consequences of issues/impact of mental health symptoms on functioning
- iii) Severity (i.e. number of DSM symptoms)
- iv) Treatment history and/or diagnoses (including use of self-help strategies and alternative treatments).

DSM5	Mood	Anxiety	PTSD	Schizophrenia	BiPolar	Eating	Suicidality
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								

B. Personality disorders

Identifying personality disorders requires a longitudinal exploration of the ways people think and feel about others, and their behaviours and social relationships over the course of their life. This information can help to identify pervasive patterns of behaviour that contribute to poor functioning in society and/or exacerbation of mental health, substance use and/or gambling problems. Use of a screening tool specifically for personality disorders can indicate the need or not for a more structured clinical interview. One of the briefest tools available with good sensitivity and specificity (Furnham et al., 2014) is the SAPAS (Standardised Assessment of Personality – Abbreviated Scale). The SAPAS is available here www.nhshighland.scot.nhs.uk (enter SAPAS into the Search on the webpage).

In particular explore for the presence of antisocial, borderline, schizoaffective and schizotypal personality disorders.

6. Interactions between mental health, substance use and gambling

It can be helpful to construct a timeline of the course of mental health symptoms, substance use and gambling relative to each other.

Use the timeline to identify mental health symptoms likely to be secondary to substance use or gambling or vice versa as suggested by:

- » amelioration of symptoms during abstinence
- » exacerbation of symptoms during abstinence
- » absence of whānau, or family history of the mental health problem
- » absence of whānau, or family history of addiction

- » onset of mental health symptoms after onset of substance use or gambling and possibly during a period of heavy use
- » onset of problematic substance use and/or gambling during manic episode or period of low mood or anxiety
- » onset of problematic substance use during periods of heavier gambling
- » onset of problematic use following trauma

Use the timeline to identify the relationship between substance use, gambling and mental health symptoms, including:

- » the course or intrusiveness of mental health symptoms during abstinence
- » mental health symptoms during periods of heavy substance use or gambling
- » the effects on intoxication on symptoms
- » the effects of withdrawal on mental health symptoms

This should be informed by current research on interactions.

Note: It is important not to expect that certain interactions should occur. While there is good evidence that depressive symptoms may be secondary to alcohol use for some people and psychotic symptoms secondary to stimulant and hallucinogen use for some people, the evidence for many other interactions, e.g. cannabis causing psychosis, is equivocal, despite 'clinical lore'.

7. Physical health and medical history

There are many physical risks and consequences related to long term substance use and mental health disorders and there are specific vulnerabilities to the effects of substances for people with some physical health disorders and/or taking many common medications. A thorough physical and medical history can highlight some of the risks and consequences and inform harm reduction advice and treatment options.

- i) current prescribed medications
- ii) past diagnoses/treatment, including BBV, history of overdoses and head injuries
- iii) current symptoms/problems in systematic review:
 - » nervous, e.g. epilepsy
 - » endocrine, e.g. thyroid function and diabetes
 - » cardiovascular, e.g. blood pressure
 - » respiratory, e.g. CORD
 - » gastrointestinal, e.g. hiatus hernia, HCV
 - » genitourinary, e.g. urinary tract infection
 - » musculoskeletal, e.g., scoliosis
- iv) iv. familial disorders, e.g. Huntington's disease
- v) v. estimated risk of infection, especially Hep B, Hep C, HIV
- vi) vi. results of biochemical testing including CBC, LFTs, blood sugars, thyroid functions, HCV and HBV screening, etc.
- vii) vii. physical examination
 - » track marks
 - » bruising
 - » acne/scabs
 - » spider nevi
 - » tremor
 - » tardive dyskinesia
 - » pulse
 - » blood pressure
 - » weight

8. Legal/forensic history

People with mental health and addiction issues are over represented in offending statistics and it is important to clarify how these issues are, or have previously been, related to their offending. Patterns and types of offending may be related to particular issues. Appropriate treatment may reduce the nature and/or extent of offending if the offending is secondary to their issues.

- » convictions
- » illegal activities not convicted of
- » terms of imprisonment and/or supervision
- » charges pending and current legal status
- » relationship between substance use, gambling, mental health symptoms and offending

9. Cultural history

Culture has a significant impact on how mental health and addiction issues are interpreted and expressed and also on what treatment options may or may not be considered appropriate. Culture is a broad term that includes more than ethnicity, language and appearance and it is unwise to assume someone's cultural background from their name and/or appearance.

- » cultural identity
- » cultural practices
- » relevant cultural and spiritual beliefs
- » cultural issues likely to affect substance use, gambling and/or mental health and treatment and vice versa

It is helpful to have access to and/or know how to use assessment tools that are appropriate for different cultures. For example, when working with Māori knowing how to speak te reo Māori, having knowledge of tikanga and knowing how to use Māori frameworks, such as, Te Pae Mahutonga (Durie, 2001) or Meihana Model (Pitama et al., 2007).

10. Whānau and family history

Collecting information about a person's family and whānau history and their developmental history is important to identify the aetiology and maintenance of any mental health and addiction issues. Knowledge about how the combination of historical, genetic and environmental influences has contributed to the development of mental health and addiction issues helps to identify what and where appropriate therapeutic strategies can be best utilised.

- » structure of whānau and family of origin if known or of adoptive family and whānau: a genogram can help both elicit and represent this information
- » role within whānau and family
- » whānau and family problems and disorders in first and second-degree relatives:
 - » alcohol and other drug use
 - » maternal substance use during pregnancy
 - » gambling
 - » mental health
 - » wairua
 - » physical health
 - » legal
- » living in the whānau and family while growing up
- » general whānau and family functioning
- » adequacy of specific relationships within whānau and family
- » occurrence and awareness of emotional/physical/wairua/sexual abuse

- » other behavioural and emotional disturbances
- » historical involvement with social agencies (e.g. Child, Young Persons and Families Service)
- » current relationships within whānau and family of origin
- » ability of whānau and family to fulfill key functions

11. Personal/developmental history

This may include:

- » whakapapa
- » birth problems, early developmental milestones
- » attachments
- » significant life events in infancy, including separations from parents
- » nature and personality in infancy, early childhood
- » significant early health problems
- » schooling:
 - » primary, intermediate, secondary and tertiary
 - » number of schools attended/shifts during schooling
 - » academic ability and performance, including periods of success and reduced performance
 - » learning difficulties, estimate of baseline intellectual ability
 - » socialisation – ability to make and sustain friendships, nature of peer affiliation
 - » discipline and behavioural problems at school, attention problems
- » other behavioural disturbances, including conduct disorder
- » adult relationships
 - » ability to establish and maintain friendships
 - » psychosexual development and intimate relationships
 - » enduring friendships
 - » nature of peer relationships
 - » quality of family, whānau and social support networks
 - » sexual orientation
 - » parenting
- » occupational history
- » personality:
 - » including description by tangata whai ora and whānau and family if available
 - » personality strengths
 - » other issues (e.g. anger control problems, impulsivity, low harm avoidance)
- » areas of personal and character strengths
- » leisure skills:
 - » interests, hobbies, physical activity

12. Spiritual history

People's experience of spirituality and/or involvement with specific religious movements can contribute positively and negatively to their wellbeing. Exploring their spiritual history and current perceptions and expression of spirituality can help to identify specific areas of strength and vulnerability that can inform and enhance treatment options.

- » spiritual or religious beliefs
- » spiritual experiences
- » spiritual practices
- » impact of spirituality or religion on substance use, gambling and/or mental health issues
- » impact of substance use, gambling and/or mental health issues on spirituality

Current psychosocial functioning

Information about a person's current psychosocial functioning helps to establish their strengths and factors in their lives that are being effected by their mental health and addiction problems and vice versa. This information is critical to the development of realistic treatment options that can be discussed with the person.

- » work: full time, part time and voluntary work
- » relationships
- » parenting and/or caregiver responsibilities and impact of substance use and mental health problems on quality of care: include names and age of children and/or person(s) receiving care
- » accommodation
- » finances
- » family, whānau and social networks
- » on-going stresses
- » coping skills
- » problem-solving skills

Motivation

People and their family and whānau are likely to have differing levels of insight and motivation to address issues and problems. It is important to gauge their motivation and readiness to engage in any change process related to each and all of their major problems, whether they identify them as problems or not.

Current mental state examination

The current mental state examination observes the mental state of tangata whai ora as they present currently i.e. during the current interview. For example, if delusional thinking is evident during the interview it is included, but if there is a recent history of delusional thinking over preceding days but not observable during the interview, it would be entered in the history section.

Appearance and behaviour:

- » physical appearance
- » clothing
- » movements
- » state of intoxication
- » state of consciousness

Speech:

- » speed
- » articulation
- » volume
- » relevance

Affect and mood:

- » depressed mood
- » elation
- » anxiety
- » congruence with content

Thought process:

- » specific thought disorder
 - » thought insertion
 - » thought transfer

Thought content:

- » preoccupations
- » overvalued ideas
- » delusions
- » poverty of thought
- » tangential
- » flight of ideas

Perception:

- » illusions
- » hallucinations
 - » visual
 - » auditory
 - » tactile
 - » olfactory

Insight:

- » degree of awareness/acceptance and ability to co-operate with treatment for each issue

Cognitive screening

Brain injuries (traumatic, FASD and/or acquired), and possible resulting cognitive impairment, are very common in people who access mental health and addiction services and can have a significant impact on their wellbeing and their ability to hear, process and act on treatment recommendations. It is not wise to assume that someone with good fluency skills and/or no obvious history of brain injury is likely to not have cognitive impairment. Carrying out a formal cognitive impairment screening process (e.g. using the Montreal Cognitive Assessment (MoCA): www.mocatest.org/paper-tests/moca-test-full) can add valuable information to a comprehensive assessment and inform appropriate treatment planning and/or further neuropsychological assessment. Understanding and using the results of a cognitive screening requires a level of familiarity and knowledge in order for the process to be effective.

In general cognitive screening involves investigating:

- » Attention and concentration: e.g.
 - » repeating a sentence
 - » serial 7 subtraction (100 – 7, 93 – 7, etc)
- » Executive functions: e.g.
 - » drawing a clock face at a particular time
 - » naming animals beginning with any letter
- » Memory: e.g.
 - » short-term recall of four unrelated objects
 - » general knowledge: naming the Prime Minister of New Zealand, capital city of Australia, closest planet to the sun
- » Language: e.g.
 - » naming objects - smart phone, wallet, pen, book
 - » repeating sentences
- » Visuospatial/constructional skills: e.g.
 - » drawing a clock face at a particular time
 - » drawing a 3-d cube/cylinder
- » Conceptual thinking: e.g.
 - » how are items alike
 - » interpretation of a proverb
- » Calculations: e.g. serial 7 subtraction (100 – 7, 93 – 7, etc)
- » Orientation: e.g. knowing
 - » time/place/person
 - » year, season, month, day, date, time

The person's responses to any of these items can indicate specific cognitive deficits or sites of damage. This knowledge can be used to develop specific approaches to the provision of interventions, e.g. using a smart phone and/or notebook to remind the person with an impaired working memory of daily tasks. Screening results can also indicate when more specialist neuropsychological assessment would be helpful.

Opinion

1. Diagnosis

What are the potential and/or provisional mental health and addiction 'diagnosis/diagnoses'?

2. Problem list

What are the person's current problems:

- » physical health, include cognitive impairment
- » mental health
- » substance use
- » gambling
- » work
- » whānau and family
- » relationship
- » parenting/caregiving
- » wairua
- » accommodation
- » financial
- » legal
- » any other

3. Formulation

The aetiological, or causal, formulation is a statement that links individual characteristics and issues (past and present) to problems/diagnoses in a way that generates treatment goals and management plans.

The formulation attempts to answer a key clinical question:

'Why is this person presenting in this way at this time?'

The 4x4 grid (Todd 2010) may help in organising ideas)

	Vulnerability (Predisposing)	Triggers (Precipitating)	Maintaining (Perpetuating)	Strengths (Protecting)
Biological				
Psychological				
Social				
Spiritual				

Sharing the formulation with the person and developing a shared understanding forms the basis for negotiation of a care/management plan.

4. Risk assessment

Risk assessment is the assessor's opinion of imminent and medium to long term risk. The risk assessment identifies key risk factors, protective factors and future potential risk factors to inform clinical judgement about risk in specific contexts and about what needs to be done to manage that risk in a broad sense.

Risk assessment is by its nature subjective and reliant on a combination of thorough assessment of static and dynamic risk and protective factors and clinical judgement. Static factors include aspects of a person that are generally considered to be unchangeable and include gender, age, upbringing, historical mental health and substance use issues including trauma, cognitive impairment and ethnicity/culture. Also explore their history of self-harm, suicidality, homicidality, aggression, violence, criminal offending, exploitation by others, exploitation of others, parenting and caregiving, and impaired driving (past and current). Dynamic factors are those current factors that can change from moment to moment and include acute physical health, mental health and substance use problems - including intoxication and withdrawal, relationship problems, impulsivity, employment, accommodation, pain, debt, grief and sleep problems.

Specific questions to answer include:

- » Are there any children, young people, dependent relatives or others (disabled and/or aged) who may be effected by current mental health or addiction issues? If so gather names and ages of children and others at possible risk.
- » Within the past year has the person been scared or threatened by a partner or close family or whānau member? (If so who and when?)
- » Within the past year has the person felt that someone has tried to control them and/or their finances and/or make them feel bad about themselves? (If so who and when?)
- » Within the past year has the person been hit, pushed, shoved, slapped, kicked, choked or physically hurt? (If so who and when?)
- » Within the past year has anyone forced them to have sex or other sexual activity against their wishes? (If so who and when?)
- » Is the person currently having thoughts of suicide or thinking they would be better off dead? (If so do they have plan and/or easy access to lethal means?)
- » Does the person have a history of violence, especially within their relationships and/or family and whānau? (If so who and when?)
- » Does the person have a history of substance impaired driving? (If so what substances and when?)
- » Is the person having violent fantasies?
- » Is the person hearing voices commanding them to do things?
- » Has the person ever self-harmed? (If so how and when?)
- » Does the person have access to weapons and/or means of self-harm? (If so what specifically?)

Document static factors: history of substance use, trauma, offending, mental health problems, etc as above.

Document dynamic factors: current substance use, stress, unemployment, homelessness, mental health problems, suicidal ideation, relationship problems etc as above.

Document protective factors: close relationships with family and whānau, spiritual/religious beliefs, employment and social supports.

On the basis of this information develop a 'risk assessment' that takes account of historical risk factors, current risk factors, possible and predictable future risk factors and protective factors. A risk assessment should also include strategies to manage current dynamic risk factors, eg. withdrawal management and/or mood disorder management, and recommendations for enhancing protective factors to reduce impact of future negative events and triggers.

Note: short term risk factors for suicide are usually those that have been identified in studies over 12 month or longer. The term 'imminent' is therefore used for shorter periods such as the next few days, weeks or months. Care needs to be taken over the use of these terms given clinicians/practitioners are often asked to make assessments of imminent risk, and identified imminent risk factors for suicide differ from risk factors for suicide over the next 12 months or longer.

Management

1. Management Goals

The key goals of management are drawn from the opinion.

2. Management Plan

Eleven key areas to address are:

1. setting
2. further information required
3. risk to self and others
4. treatment of physical health problems
5. psychopharmacology/medication assisted treatment
6. psychological/talking therapy interventions
7. whānau and family, relationship, parenting and social interventions (navigator)
8. spiritual/wairua interventions
9. education/work/occupation
10. psycho-education of tangata whai ora, significant others and family and whānau
11. self-help groups/peer worker

Note: see Todd 2010 for a discussion about management planning for the phases of treatment.

Prognosis

This includes:

- a) the natural course of the disorder(s) if unresolved
- b) positive factors that modify the course in this person/tangata whai ora
- c) negative factors that modify the course in this person/tangata whai ora
- d) synthesis and prediction (symptoms and general functioning)

Reports to external agencies

Reports prepared for external agencies need to be based on a comprehensive assessment in order to ensure their utility, consistency and credibility, though the format, language and layout may differ for different purposes.

In order to make informed decisions agencies such as Courts, Child Youth and Family Service and professional bodies must obtain the best possible assessment and appropriate treatment recommendations. The time frames for completing assessments may on occasion be short and assessments are likely to have been requested by someone other than the person being assessed, such as:

- » The Court asks for an assessment to assist disposition – including sentencing
- » The Probation Service asks for an assessment to assist them to make recommendations to Courts and/or the Parole Board
- » The person (or a member of their whānau or family) before the Court asks for an assessment
- » The Parole Board requests an assessment to assist decision-making prior to release
- » Child Youth and Family Service requests an assessment to assist with decision making about caregiver suitability or a 'health assessment' when concerned for a young person's wellbeing
- » Civil Aviation Authority, or other safety sensitive workplace, requests an assessment of a pilot/worker
- » Section 65a assessments for NZTA

Assessments to prepare a report intended for external agencies should be conducted by clinicians/practitioners with experience and training in the comprehensive assessment of mental health and addiction problems/disorders. Assessors should also have a sound knowledge of available interventions and a working experience of New Zealand's criminal justice processes and other statutory agencies.

When a comprehensive assessment is carried out for the purposes of preparing a report for an external agency it needs to be explicitly explained to the person being assessed that the information they share is not confidential. The person being assessed needs to know this so that they can decide for themselves what they wish to disclose. It is also important to discuss if the assessor is able to have access to pre-existing assessments, case notes or reports. When practicable it is important to review a draft copy of the report with the person before final preparation in order to correct factual errors and add relevant information. Where the person disagrees with the assessment or recommendations this can be noted in the report.

The assessor (or any agency the assessor might work for) may end up not be involved in ongoing treatment or case management that might be recommended. For this reason the assessment and report may only provide an indicator of the type and level of intervention/care appropriate to the person's needs and their motivation. This also includes identifying primary healthcare and social services that may be appropriate to the person's needs, matching people with the services that are available.

The comprehensive assessment should be carried out as usual with the following additions:

- » Motivation, if this is extrinsic or intrinsic, and stated readiness to change behaviours and/or actions taken
- » The person's explanation, and any contributing circumstances, about what contributed to the need for an assessment, e.g.
 - » drinking alcohol with work mates and ending up in a fight
 - » feeling anxious about going to town and shoplifting after taking too much medication
 - » being unemployed for a year and cultivating cannabis to make a living
 - » burning down a building to exorcise it
 - » driving over legal alcohol levels to get partner from work
 - » hearing abusive voices and attacking a nearby person
 - » using cannabis to manage low mood after birth of second child
- » Offending history and person's explanation of offending patterns and the relationship between mental health and addiction problems and offending

The report developed from the comprehensive assessment should be in narrative form based on self-report by the person (and any corroboration from others), biochemical testing (if appropriate), documentation provided by the referring agency or previous assessments and clearly articulated and evidence based clinical opinion. When writing a report for a statutory agency it is important to provide information that is relevant to the context and needs of that agency. It is however important to highlight and reinforce that a mental health and addiction assessment has a health focus and that this is the expertise of the assessor.

If a report is paid for by the Court, the Department of Corrections or any other external agency then the report belongs to them.

The report must be signed and dated by the clinician/practitioner who carried out the assessment and prepared the report (including their registration number if a member of a professional body).

Introduction

The introduction to the report should at the least include:

- » Name
- » Date of birth
- » Relationship status and any caregiving responsibilities
- » Current social circumstances
- » Ethnicity and cultural identity
- » Nature of the referral and where the interview occurred
- » What the person perceived to be their main problem and what their expectations were
- » What other sources of information were used to prepare the report

Example

John Smith (30-08-92)

This report is based on self-report by John on the 1st of April 2016 and biochemical testing. John was referred by the Court for assessment at CADS after his third charge of driving with excess breath alcohol. He indicated that he does not think he has an alcohol problem and that he had been under stress at the time of the offending.

John is a single 24-year-old New Zealand born male of Tongan descent. He currently lives in a central city flat with two other men and is in receipt of a jobseeker benefit. He reported that he has been out of work for several months, having lost his job as a driver after losing his licence following his second EBA. This has been stressful as he is expected to contribute to his family finances in Tonga.

Addiction, mental health and offending history (when preparing a report for the Court)

The purpose of this section is to explore if there is a relationship between mental health problems, substance use or gambling and any offending. The assessor is looking for any patterns and listening for any cognitive distortions or justifications related to a person's offending, mental health and/or addiction.

Care should be taken that any explanation of the factors that are likely to have contributed to an offence(s) should not be written as mitigation - the purpose is to look for and report patterns.

Example

Aaron first used alcohol at the age of 14 and by 15 was drinking to intoxication at least once a week. When he started work at 17 his drinking increased in frequency and for the past 8 years he has been drinking at least 24 'stubbies' of beer two times a week. Once a month he will also consume a litre bottle of bourbon on a Saturday night. Aaron first used cannabis at 12 but did not use again till he was 15 when he rapidly developed a pattern on at least once a day consumption. When he started working Aaron increased his use of cannabis over weekend days and nights and he currently smokes about half an ounce of cannabis most weeks. Aaron first smoked tobacco at 10 and was smoking daily by 12 years old. His level of use escalated when he began working and he currently smokes 50 gms of tobacco a week. Aaron has tried LSD, psilocybin mushrooms, synthetic cannabinoids and methamphetamine once or twice each in the past three years.

Aaron described several periods of low mood in his life from the age of 13 when his parents separated. He has never actively tried to harm himself but has on occasion thought of taking his own life. Aaron also believes that people, especially those in authority, are out to get him and that sometimes people he knows conspire with the authorities to do him harm. He finds that cannabis use helps him to relax and not think about this too much. Aaron has never talked about this with any family member or health worker.

Aaron stated that he had two drink driving convictions, four driving while disqualified convictions and two assault convictions. Aaron indicated that the majority of his offending has happened soon after he has consumed alcohol and cannabis together or has done so in the previous 24 hours.

Aaron did not believe his convictions for drink driving and disqualified driving were 'fair' as he said he always 'felt he was in control and safe to drive and the police were out to get him'. When asked about convictions for assault he said "sometimes people would be talking about him behind his back and they just needed to be sorted out."

Motivation

A key component of a report for any external agency must be an assessment of insight and motivation and readiness to change behaviours that are considered to contribute to offending, the risks or the issue that necessitated the report. Motivation in this context is the likelihood that someone will enter into, continue with, and adhere to a specific agreed strategy of behaviour change. There is a need to be cautious when assessing the reliability of a person's stated motivation especially if there are external pressures. During an assessment interview the assessor will be listening for:

- » inconsistencies in relation to stated motivation
- » cognitive distortions such as minimisations
- » justifications for substance use, gambling and offending
- » not seeking or complying with treatment
- » ambivalence about change.

Motivation and readiness to change needs to be identified and commented on for each issue or problem identified.

Low motivation or readiness for change identified through an assessment process does not mean that someone will not engage in treatment. Extrinsic motivation due to external agency demands may be an opportunity for change, even if that change is increased awareness and/or motivation.

Example

Mary has indicated that she believes she needs to take her anti-depressant medication more regularly and reduce the amount of alcohol she consumes. She is not sure how to achieve this but is unwilling to attend any local service. A major motivating factor is her desire to avoid imprisonment if she is caught driving with excess alcohol again.

Summary

This section should include:

- » Assessment of criteria of disorders within the DSM/ICD diagnostic system including:
 - » Current substance use disorders and/or gambling disorder
 - » Current mental health disorders
 - » Personality disorders
- » Individualised problem list
- » A brief formulation pulling together the information contained in the assessment in a logical narrative
- » Physical health condition
- » Assessment of motivation and readiness to change for each issue

Example

From his self-report Paul currently meets DSM5 criteria for a moderate alcohol use disorder, severe cannabis use disorder, severe tobacco use disorder, major depressive disorder and anti-social personality disorder.

Paul has a family history of substance use disorders as both his father and grandfather have alcohol and tobacco use disorders, and he appears to have a genetic vulnerability to develop substance use disorders. Compounding this he was physically abused as a young child and has some indicators of post-traumatic stress without meeting the criteria for post-traumatic stress disorder. As a child low mood and anxiety appear to have been expressed through aggression and fighting and as a consequence he was regularly in trouble at school, attending six different schools before finally leaving at 17. Since that time he has continued to act aggressively at times, especially when very intoxicated on alcohol or in cannabis withdrawal, and he is currently facing charges of aggravated assault.

Paul has a history of having had two significant head injuries received in assaults but generally is in good physical health. It is likely that the compounded impact of the head injuries contribute to his impulsivity and inability to manage his aggression.

While Paul continues to use substances regularly and heavily he will be highly likely to act aggressively at times. It is possible that if his major depressive disorder was treated with medication and therapy, that the source of some of his irritability would be reduced. However until his substance use is addressed his cycle of cannabis use and alcohol use will continue to contribute to his impulsivity and poor self-control. Paul cannot imagine life without using alcohol or cannabis or even a reduction in his level of use but also does not wish to return to prison in the future and has indicated a willingness to attend residential addiction treatment.

Treatment options and prognosis

Possible treatment options and a treatment plan that have been discussed with the person should be outlined. Depending on the nature of the referral the assessor might also be expected to make general recommendations for treatment, e.g. outpatient, inpatient/residential, and where these are available, further assessment and/or medication. These may or may not have been negotiated but would be appropriate. This section should also comment on issues that could affect the ability of the person to participate in treatment (e.g. transportation problems, homelessness, child care needs, cultural or language preference, cognitive impairment, disability).

Example

Mark would benefit from a period of outpatient/community based support focused on relapse prevention to monitor his mood state, support him with continuing to take antidepressant medication and help strengthen his motivation to maintain changes. Ongoing contact would help to raise his awareness of his potential to return to previous patterns of alcohol use which could potentially lead to further offending (especially related to drink driving) and mental health and relationship problems. It would also provide an opportunity to discuss his tobacco use disorder which has long term physical health consequences.

Without formal support and monitoring the prognosis for Mark is poor.

Specialist Reports

Some professional groups have developed standards and examples of report writing that include profession specific guidance. Of particular relevance are the 'Guidelines for mental health nursing assessment and reports' available from: www.nzcmhn.org.nz

Report writing guidelines have also been developed by the Ministry of Health for clinicians/practitioners who assess 'fitness to drive' following a person receiving a Section 65 Land Transport Act conviction. People who receive multiple convictions for substance impaired driving can be sentenced to indefinite disqualification from driving a motor vehicle. After the mandatory minimum disqualification period of a year and one day people who want to have their driving licence disqualification removed (section 100 of the Act) are able to apply to sit their drivers licence. This can only occur following comprehensive assessment and the completion of a report to the New Zealand Transport Agency (NZTA) by an approved assessment centre. The approved processes and forms to be used for the assessment and the report to NZTA are available through the Ministry of Health.

Section 65 Land Transport Act: assessment and report to NZTA

The road safety risks of alcohol and other drug use include:

- » Impairment due to sedation effects
- » Impaired motor function
- » Risk taking
- » Exacerbation of other risk factors such as mental health problems, impulsivity and cognitive impairment.

The assessment processes were developed to minimise these road safety risks by assessing the 'fitness to drive' of repeat substance impaired drivers. The Act and the associated assessment process and report to NZTA provide an opportunity to promote and support a change in behaviour.

Section 65 assessment

A comprehensive assessment of fitness to drive will take into account other factors related to driving offending such as impulsivity, risk taking and decision making skills, and, along with supporting medical evidence, forms the basis of making a judgement call about 'fitness to drive'. The Director- General of Health and the Director of New Zealand Transport Agency (NZTA) have approved the assessment components as:

- » The identification of current alcohol and other drug use
- » Other issues related to fitness to drive and factors contributing to substance impaired driving
- » Relevant historical information relating to substance use (including previous episodes of treatment)
- » Medical assessment and advice (including results of liver function tests and physical examination)
- » An assessment of motivation and readiness to change substance use and/or driving behaviour.

An assessment for the purposes of the Act is carried out to determine whether a person meets the criteria for a substance use disorder and/or to indicate the likelihood they will drive under the influence of alcohol and/or other drugs in the future. If a person is assessed with a substance use disorder they have a greater risk of accidents if they drive. This risk is particularly escalated if they have a history of driving after or during substance use.

However many people who have Section 65 disqualifications do not meet the criteria for a substance use disorder apart from:

- » 'recurrent use in situations in which it is physically hazardous' and
- » 'persistent problems caused or exacerbated by the effects of a substance' (DSM5, 2013).

Both of these can be associated with repeated substance impaired driving and the legal consequences, but only meet the criteria for a disorder if they occur within the previous 12 month period.

A person's ability to make decisions about driving a vehicle following use of a substance may be impaired for a variety of reasons other than having a substance use disorder. These risk factors need to be identified in the comprehensive assessment process. Possible reasons include:

- » Impulsivity
- » Risk taking
- » Poor forward planning, thinking through consequences
- » Cognitive impairment
- » Attitude to authority

Assessing these factors requires a thorough history of impulsivity, offending and other life choices as this information can provide some insight into the person's patterns of behaviour. Once identified it may be possible to support a person to devise strategies to help them to potentially avoid future substance impaired driving. It may also require the assessor to decline to sign off the person as being 'fit to drive'.

Section 65 report

The report to the New Zealand Transport Agency must be completed on the prescribed form. It is a summary of the assessment process, justifying any recommendation about the person's suitability for having their driver licence disqualification removed. The full assessment needs to be kept on file by the assessment centre in case of appeal.

It is not mandatory for people to undergo any intervention in order to be able to re-sit their licence. For people who undertake education or intervention the report would take this into account as evidence (i.e. more than self-reported information) of a commitment to change. When the assessor prepares the report to NZTA some of the key elements for recommending if the person is suitable to re-sit their licence include:

- » Mental health and substance use assessment (current diagnoses using DSM/ICD criteria)
- » Results of the liver function tests (including GGT) and other tests
- » Motivation and readiness to change their substance use and/or driving behaviour
- » Previous substance impaired driving
- » Treatment/intervention completion/outcome
- » A person's attitude towards driving and the situations they consider driving is necessary
- » Cognitive impairment, risk taking, other personality factors and/or impulsivity
- » Other factors (e.g. changes in job, relationship and support systems).

The guidelines are available on the Ministry of Health's website: www.moh.govt.nz

Glossary

Addiction: used in this resource as a comprehensive term to cover the range of problems potentially related to use of alcohol and other drugs, tobacco and gambling.

Co-existing problems (CEP): initially used as a term to describe the presence of addiction and mental health-related problems in the same person at the same time, it is now recognised that co-existing problems that also impact on wellbeing and recovery include coexisting physical health, cognitive and social problems. Other terms used interchangeably include dual diagnosis, co-occurring disorders, co-existing disorders and comorbidity.

Cognitive impairment: is used as a term to describe the range of conditions that can impact on a person's ability to learn and process information. This includes traumatic brain injury, intellectual or learning disability and acquired brain injuries such as alcohol related brain injury.

Diagnosis: A diagnosis is a short hand way of describing a cluster of mental health or addiction symptoms and potential treatment pathways appropriate to address those symptoms to improve wellbeing. The criteria for a wide range of mental health and addiction diagnoses can be found in DSM5 and ICD-10.

Domains: category; a group of related behaviours.

DSM5: Diagnostic and Statistical Manual of Mental Disorders (American Psychiatric Association, 2013).

False negatives: occur when test scores suggest the absence of problems which are in fact there.

False positives: occur when test scores suggest the presence of problems, which are not in fact there.

Gambling Disorder: an impaired control over gambling which has had negative consequences, including behavioural change and subjective psychological impact with gambling becoming more central to the person's thoughts, life and behaviour.

ICD-10: International Classification of Diseases (World Health Organisation, 2016).

Mental Health Disorder: a condition that effects how a person thinks, feels and behaves. Common mental health disorders include depression, anxiety, bipolar disorder, schizophrenia and eating disorders.

Personality Disorder: an established pattern of behaviour that causes long term difficulties in personal relationships or functioning in society. Common personality disorders include antisocial personality disorder, borderline personality disorder and schizotypal personality disorder.

Practitioner: Within the addiction sector, the term 'practitioner' is preferred by many, while within mental health services 'clinician' is often the preferred term.

Prevalence: the number of instances of a given condition, e.g. the number, or percentage, of people with an alcohol use disorder or depression in a given population at a particular time.

Primary Care: settings where the core business of the clinicians/practitioners is not addiction and mental health specific but who may well work with addiction and mental health related problems – the presentation of low mood, sleep problems, risky substance use or the consequences of someone else's gambling e.g. Corrections, primary health organisations (PHO) or food banks.

Psychometric: the validity and reliability of the measurement or assessment of individual differences in abilities, aptitudes, attitudes, behaviour, intelligence and/or other attributes.

Reliability: consistency; the extent to which a test or measuring procedure yields the same results on repeated trials.

Self-efficacy: describes a person's belief in their capability to do things or to have influence over things in their life.

Sensitivity: refers to the proportion of people with the problem screened who score positive on the screen.

Specificity: refers to the proportion of people without the problem screened who score negative on the screen.

Substance use disorder: an impaired control over substance use which has had negative consequences, including behavioural change, subjective psychological impact, or adverse physical implications; may include tolerance, withdrawal and substance use becoming more central to the person's thoughts, life and behaviour.

Tangata whai ora: used to describe a person who accesses mental health and addiction services, encompassing the terms 'client', 'patient', 'service user' and 'consumer'.

Validity: the extent to which a test measures accurately what it is intended to measure.

References and resources

Alberta Alcohol and Drug Abuse Commission. (2004). Review of Addiction-Related Screening and Assessment Instruments. Alberta Health Service.

Alexander, M.J., Haugland, G., Lin, S.P., Bertollo, D.N., & McCorry, F.A. (2008). Mental Health Screening in Addiction, Corrections and Social Service Settings: Validating the MMS. *International Journal on the Addictions*, 6 (1): 105-119.

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders*. (5th ed). Washington DC: American Psychiatric Association.

Christie, G., Marsh, R., Sheridan, J., Wheeler, A., Suaalii-Sauni, T., Black, S., & Butler, R. (2007). The Substances and Choices Scale (SACS) - the development and testing of a new alcohol and other drug screening and outcome measurement instrument for young people. *Addiction*, 102 (9): 1390–1398.

Dawe, S., Loxton, N., Hides, L., Kavanagh, D., & Mattick, R. (2002). Review of diagnostic screening instruments for alcohol and other drug use and other psychiatric disorders (2 ed). Commonwealth Department of Health and Aging.

Deady, M. (2009). A Review of Screening, Assessment and Outcome Measures for Drug and Alcohol Settings. Network of alcohol & other Drug Agencies. New South Wales.

Dixon, L.B., Holoshitz, Y., & Nossel, I. (2016). Treatment engagement of individuals experiencing mental illness: review and update. *World Psychiatry*, 15(1), 13–20.

Durie, M. (2001). *Mauri ora: The dynamics of Māori health*. Auckland: Oxford University Press.

Furnham, A., Milner, R., Akhtar, R., & De Fruyt, F. (2014). A Review of the Measures Designed to Assess DSM-5 Personality Disorders. *Psychology*, 5, 1646-1686.

Goodman, R. (1997). The Strengths and Difficulties Questionnaire: A Research Note. *Journal of Child Psychology and Psychiatry*, 38: 581–586.

Hepatitis Foundation: www.hepatitisfoundation.org.nz

Hulse, G., White, J., & Cape, G. (eds.) (2002). *Management of Alcohol and Drug Problems*. New York. Oxford University Press.

Humeniuk, R. (2006). Validation of the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) and pilot brief intervention: A technical report of phase II findings of the WHO ASSIST Project. The WHO ASSIST Phase II Study Group. WHO, Geneva.

Knapp, M., McDaid, D., & Parsonage, M. (2011). *Mental Health Promotion and Mental Illness Prevention: The Economic Case*, London School of Economics.

- Lee, N.K., & Jenner, L. (2010). Development of the PsyCheck screening tool: An instrument for detecting common mental health conditions among substance use treatment clients. *Mental Health and Substance Use: Dual Diagnosis*, 3(1): 56-65.
- Pitama, S., Robertson, P., Cram, F., Matea, G., Huria, T., & Dallas-Katoa, W. (2007). Meihana model: A clinical assessment framework. *New Zealand Journal of Psychology*, 36, 118-125.
- Matua Raki. (2012). Brief Intervention Guide: Addressing risk and harm from alcohol, other drugs and gambling. Matua Raki, Wellington.
- Ministry of Health. (2010). Kōrero Mārama: Health Literacy and Māori. Wellington: Ministry of Health.
- National Health Committee. (1999). Guidelines for Recognising, Assessing and Treating Alcohol and Cannabis Abuse in Primary Care. Wellington: National Health Committee on Health and Disability.
- Newcombe, D., Tanielu-Stowers, H., McDermott, R., Stephen, J., & Nosa, V. (2016). The validation of the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) amongst Pacific People in New Zealand. *New Zealand Journal of Psychology*, 45 (1), 30-39.
- Pulford, J., Adams, P., & Sheridan, J. (2009). Developing a clinical assessment model suited to use in an agency providing shortterm substance use treatment: findings from a delphi survey of expert opinion. *Administration and Policy in Mental Health*; 36 (5): 322 – 330.
- Rethink Mental Illness: www.rethink.org/home
- Sheehan, D.V., Lecrubier, Y., Sheehan, K.H., Amorim, P., Janavs, J., Weiller, E., Hergueta, T., Baker, R., & Dunbar, G.C. (1998). The miniinternational neuropsychiatric interview (M.I.N.I.): the development and validation of a structured diagnostic psychiatric interview for DSM-IV and ICD-10. *Journal of Clinical Psychiatry*, 59 (suppl. 20).
- Sullivan, S. (2005). A hidden curriculum: gambling and problem gambling among high school students in Auckland. *Health Promotion Journal of Australia*, 16 (3): 201 – 206.
- Sullivan, S. (2007). Don't let an opportunity go by: Validation of the EIGHT gambling screen. *International Journal of Mental Health and Addiction*, 5 (4): 381-389.
- Te Pou o te Whakaaro Nui. (2014). The physical health of people with serious mental illness and/or addiction: An evidence review. Te Pou o te Whakaaro Nui, Auckland.
- Todd, F.C. (2010). Te Ariari o te Oranga: the Assessment and Management of People with co-existing Mental Health and Substance Use Problems. Ministry of Health, Wellington.
- World Health Organization. (2016). International Classification of Disorders (ICD-10 Version: 2016). [Online] apps.who.int/classifications/icd10/browse/2016/en
- Zimmerman, M. (1994). Interview Guide for Evaluating DSM-IV Psychiatric Disorders and Mental Status Examination. Philadelphia, PA: Psych Products Press.



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