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AUSTRALIA**

Clinical Guidelines for the Physical Care of Mental Health Consumers

Psychosocial Assessment

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Government of Western Australia
Mental Health Commission



SUMMARY OF CLINICAL GUIDELINES ASSESSMENT PACKAGE

The poor physical health of mental health consumers has long been highlighted (Lawrence, Holman & Jablensky, 2001 – Duty to Care report).

Medication effects and lifestyle are known to cause metabolic disturbances, cardiovascular disease and type 2 diabetes, and the monitoring of these and other common conditions is paramount to improving both the mental and physical health of consumers.

Based upon an extensive review of the literature and best practice guidelines, an overall Clinical Guidelines assessment package has been developed to assist in the examination and ongoing monitoring of mental health consumers' physical health.

Five dimensions that impact upon a mental health consumer's physical health have been identified. Each dimension has a number of components, and an evaluation tool has been either sourced or developed for each; Medication effects, Lifestyle factors, Physical conditions (pre-existing or developing), Alcohol & Illicit drug use, and Psychosocial factors.

The Clinical Guidelines for the Physical Care of Mental Health Consumers' assessment package includes:

Wall Chart – Metabolic Syndrome Algorithm

This algorithm represents the basic physical health screening that must be conducted when assessing metabolic syndrome - waist circumference, blood pressure, fasting lipids, and fasting blood glucose. Designed as a wall chart, clinicians can easily access information they need to conduct required tests.

Clinical Handbook

The handbook outlines information specifically dealing with medications and medical investigation, along with an overview of the other major health dimensions that need to be monitored. Designed for use by psychiatrists and general practitioners, the handbook represents an easily accessible knowledge source, and all results of specific tests are to be placed on the general screening forms provided.

Lifestyle and Psychosocial Assessment

This booklet is a compilation of tools designed to give a deeper understanding of each consumer's health-related behaviours and social situation – Culture / religion / spirituality, exercise, diet, smoking, oral / dental, sexual activity, alcohol and other drug use, psychosocial supports.

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It is structured to be user-friendly as most people working within the health field can administer it.

General Screening Forms

There are three results forms. A general screening form has been provided listing the recommended tests for each medication / medication category. A second screening form outlines additional tests recommended for specific medications (e.g. lithium carbonate), and a third screening form has been provided for clozapine. These forms are to be used as a summary of each consumer's results, are to sit in front of the consumer's medical file, and are colour-coded to match the lifestyle and psychosocial assessment booklet.

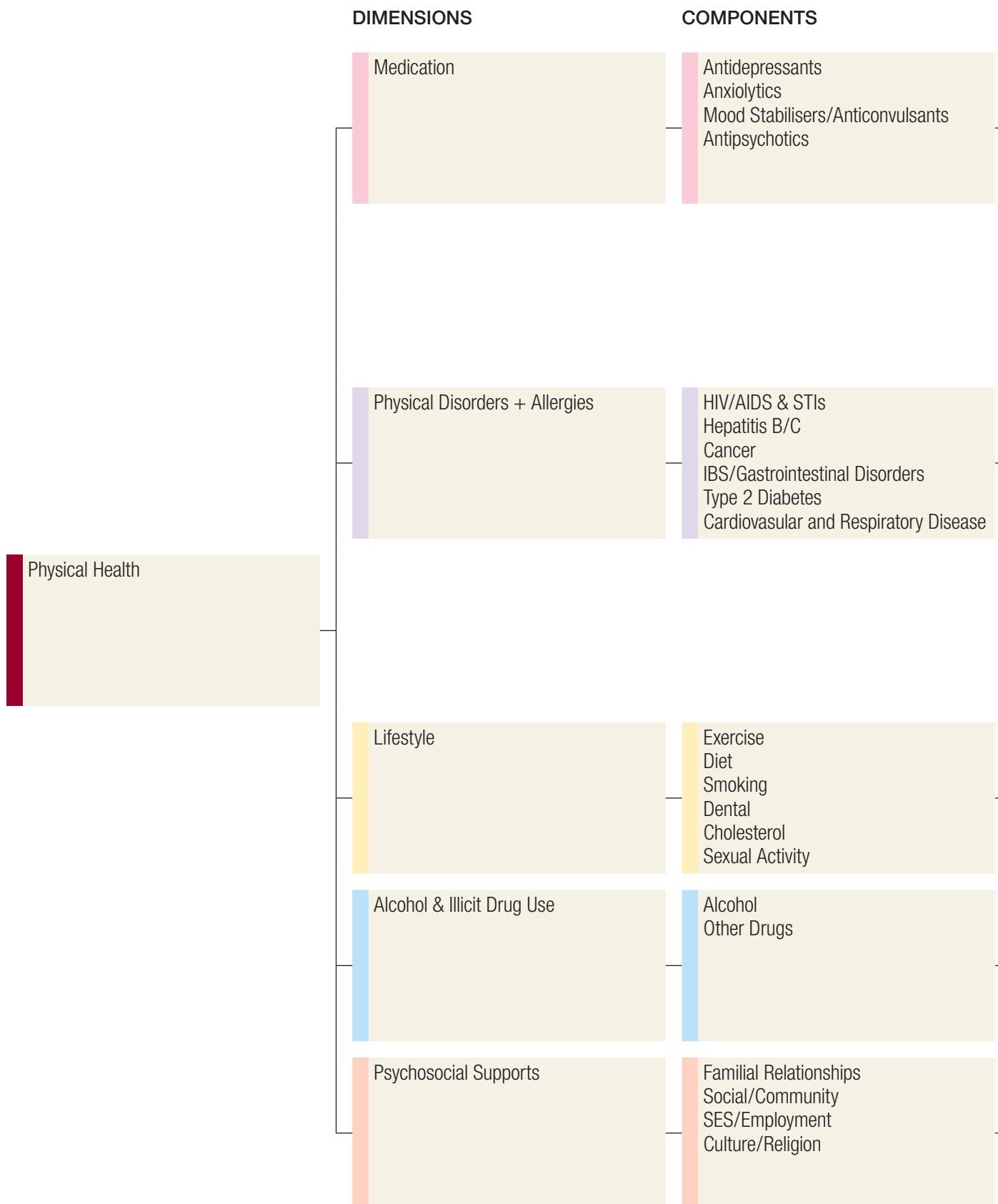
This assessment package provides an overall evaluation of each consumer's physical health status, with information on the general screening form covering a time span of two years. This allows for recognition of patterns occurring over time, and places relevant information on physical health in the one spot.

The Clinical Guidelines for the Physical Care of Mental Health Consumers' package has been developed for adults. Further information on distinct populations can be found in the Clinical Guidelines for the Physical Care of Mental Health Consumers Report – people over 65 years of age, children/adolescents, Aboriginal and Torres Strait Islanders, pregnant women, people with intellectual impairments, people from culturally and linguistically diverse backgrounds.

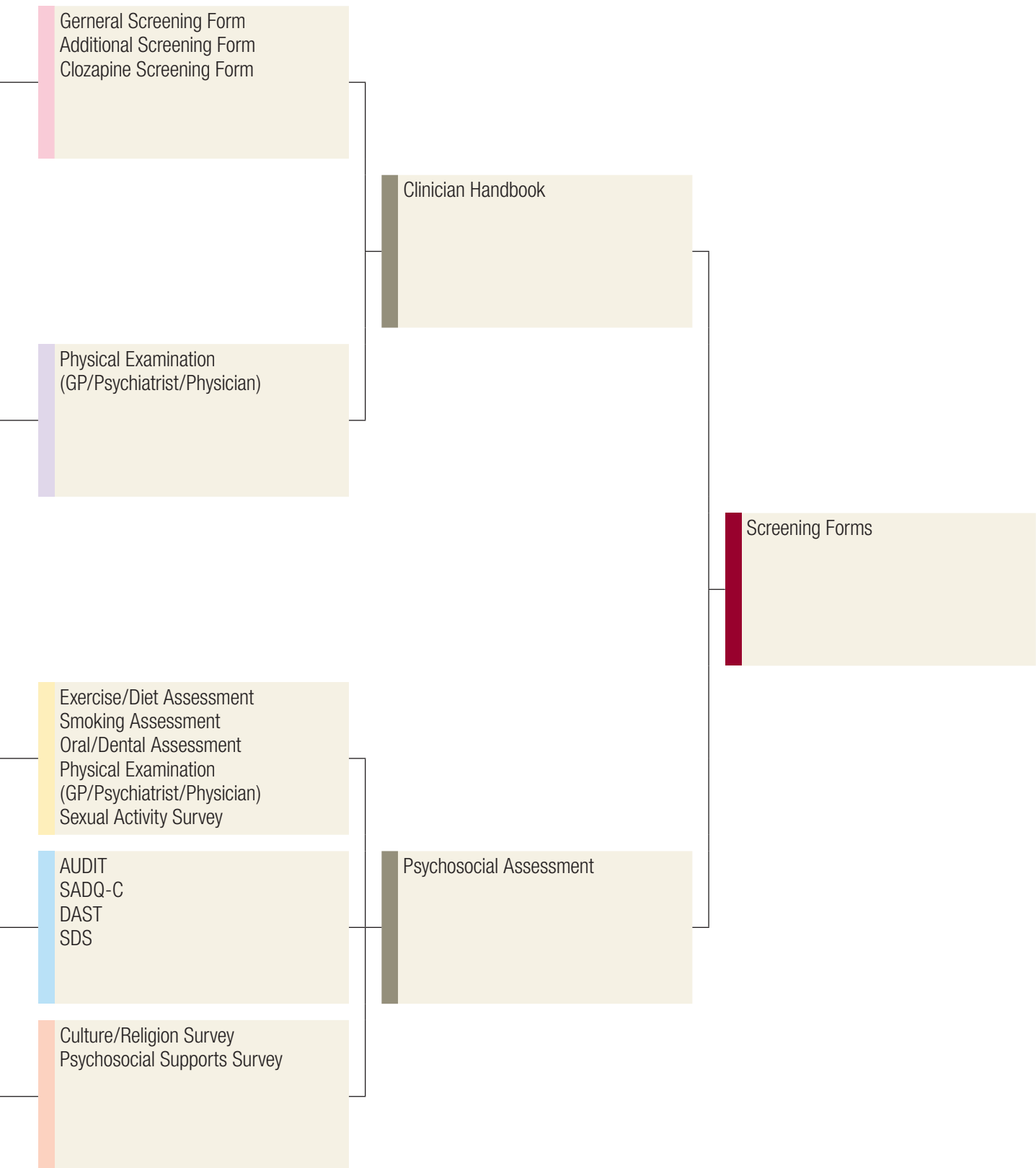
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 and Clinical Neurosciences, The University of Western Australia.
 Perth: The University of Western Australia.

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MENTAL HEALTH CONSUMERS: DIMENSIONS OF PHYSICAL HEALTH



MONITORING PROTOCOLS



CULTURE, RELIGION AND SPIRITUALITY

1. Language spoken at home?

Does the client have a sound grasp of comprehending and speaking English or is an interpreter needed?

2. Client's personal values of autonomy and relatedness:

When you think about relationships, what do you value most – self-reliance and independence or feeling connected and relating to others? (Please tick)

Autonomy
(Self-Reliance)

Both

Relatedness
(Connection to Others)

1 2 3 4 5 6 7

Are you currently able to achieve this in your most important relationship? (Please tick)

Very Much

Sometimes

Not at All

1 2 3 4 5 6 7

3. Do you follow a particular religion/faith and how does this impact on your life?

4. What is your understanding of physical health?

5. What is your understanding of mental health?

6. What is your understanding of your particular problem?

7. What do you think would help in treating your problem?

EXERCISE AND DIET

PHYSICAL ACTIVITY

Please circle the answer that is correct for you/consumer

1. How many times a week do you usually do 20 minutes or more of vigorous-intensity physical activity that makes you sweat or puff and pant? (e.g. heavy lifting, digging, jogging, aerobics or fast bicycling)

0 1 2 3 4 5 6 7+ Score

2. How many times a week do you usually do 30 minutes or more of walking? (e.g. walking from place to place for exercise or recreation)

0 1 2 3 4 5 6 7+ Score

3. How many times a week do you usually do 30 minutes or more of other moderate-intensity physical activity that increases your heart rate or makes you breathe harder than normal? (e.g. carrying light loads, bicycling at a regular pace or doubles tennis)

0 1 2 3 4 5 6 7+ Score

TOTAL

Scoring:

The number circled is the score for each question.
Add up the three scores to obtain a total score.

- | | | |
|-----|--------------|--|
| 0-1 | Low | Assess what might be preventing activity, goal setting |
| 2-4 | Nearly There | Assess willingness to increase activity, practical suggestions |
| 5-7 | Active | Healthy levels - at least 2.5hrs of moderate intensity activity per week |

NOTE: Important to check for contraindications to moderate intensity exercise: Unstable angina, chest discomfort or shortness of breath on low intensity activity, uncontrolled heart failure, severe aortic stenosis, uncontrolled hypertension, acute infection or fever, resting tachycardia (>100 beats per minute), recent complicated acute myocardial infarction (< 3 months), uncontrolled diabetes.

Adapted from Lifescripts – Department of Health & Ageing (2008)

Action:

WEIGHT AND BODY MASS INDEX

BMI classification

Body Mass Index (BMI) is a simple index of weight-for-height that is commonly used to classify underweight, overweight and obesity in adults. It is defined as the weight in kilograms divided by the square of the height in metres (kg/m²).

For example, an adult who weighs 70kg and whose height is 1.75m will have a BMI of 22.9.

Work out and write down the consumer's **BMI**.

e.g. BMI = 70 kg / (1.75 m²) = 70 / 3,0625 = 22.9

Height	<input type="text"/>	Weight	<input type="text"/>	BMI	<input type="text"/>
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Table 1: The International Classification of adult underweight, overweight and obesity according to BMI

Classification	BMI(kg/m ²)	
	Principal cut-off points	Action
Severe thinness	<16.00	Refer to Dietician - High Risk
Moderate thinness	16.00 - 16.99	
Mild thinness	17.00 - 18.49	Note to watch weight
Underweight	<18.50	
Normal range	18.50 - 24.99	Normal
Overweight	≥25.00	Note to watch weight or refer to Dietician
Pre-obese	25.00 - 29.99	
Obese	≥30.00	Refer to Dietician - High Risk
Obese class I	30.00 - 34.99	
Obese class II	35.00 - 39.99	Refer to Dietician - High Risk
Obese class III	≥40.00	

Adapted from World Health Organisation (2004).

ABDOMINAL GIRTH

Increased abdominal fat is associated with an increased risk for type 2 diabetes, hypertension, cardiovascular disease, and dyslipidemia. Waist circumference can be useful for people who fall into the 'normal' range of the BMI index, but who may carry excess weight around their waist.

To determine a person's abdominal girth measurement:

- Measure directly against the skin.
- Tell the person to breathe out normally.
- Make sure the tape is snug, without compressing the skin.
- Measure halfway between the lowest rib and the top of the hipbone, roughly in line with the belly button.

<94cm (male)	<80cm (female)	Europid	Repeat monitoring - 3 monthly
<90cm (male)	<80cm (female)	Asian	
≥94cm (male)	≥80cm (female)	Europid	Review medication Treat / advise weight problem / consider referral to physiotherapy or group programme (Healthy Lifestyle groups)
≥90cm (male)	≥80cm (female)	Asian	

Write down the consumer's Abdominal Girth measurement

Based on Waterreus, A. & Laugharne, J.D.E. Screening for the metabolic syndrome in patients receiving antipsychotic treatment: a proposed algorithm. MJA, 190 (4), 185-189, 2009.

NUTRITION / DIET

Use BMI Classification and Waist Circumference to decide whether the consumer needs to be referred to a dietician or receive a healthy eating guide.

Action:

ORAL / DENTAL

1.	Does the consumer have natural teeth?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
2.	Does the consumer have dentures?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Upper	<input type="checkbox"/> Lower
	If yes, are dentures labelled	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
	If yes, how old are dentures?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
3.	Does the consumer have any problems? e.g. pain, difficulty eating, decayed teeth, denture problems, dry mouth, ulcers, halitosis, other etc.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
		<input type="checkbox"/> Teeth	<input type="checkbox"/> Gums	<input type="checkbox"/> Denture	<input type="checkbox"/> Other
	<hr/> <hr/> <hr/> <hr/>				
4.	Has the consumer ever smoked?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
5.	Is the consumer on medication with oral side-effects?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
6.	Does the consumer need urgent dental treatment?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Don't Know	
7.	When did the consumer last see a dentist?	<input type="checkbox"/> < 1 yr	<input type="checkbox"/> > 1 yr	<input type="checkbox"/> Don't Know	
8.	Is the consumer registered with a dentist?	<input type="checkbox"/> < 1 yr	<input type="checkbox"/> > 1 yr	<input type="checkbox"/> Don't Know	
	If yes, record name and address of dentist:	<hr/> <hr/> <hr/>			

Adapted from Griffiths et al. (2000) - Oral health care for people with mental health problems: Guidelines and recommendations.

Action:

SMOKING

1. Do you smoke?

Yes

No, but I used to smoke

No, never smoked

When did you quit?

Month

Year

2. When you wake up each day, how soon do you smoke your first cigarette?

Tick one box

More than 60 minutes

31-60 minutes

5-30 minutes

Less than 5 minutes

Score

3. How many cigarettes do you smoke on a typical day?

10 or less

11-20

21-30

More than 30

Score

4. How keen are you to stop smoking?

Tick the number that best matches your current attitude, from 0 (not at all keen) to 7 (keen)

0

1

2

3

4

5

6

7

Score

5. If you decided to stop smoking right now, how confident of success would you be?

Tick the number that best matches your current attitude, from 0 (not confident) to 7 (very confident)

0

1

2

3

4

5

6

7

Score

TOTAL

SMOKING - SCORING

Questions 2-3 (combined score). Probability of nicotine addiction or dependence

0-3 Very low or low – advise good chance of success if attempt to quit.
Assess psychological dependence.

4-6 Moderate to very high – recommend Nicotine Replacement Therapy (if considering nicotine patches ask about the nicotine strength of the cigarettes the consumer smokes), or see clinician for prescription of bupropion / varenicline (care must be taken as these drugs are linked to depression / suicide).

SEXUAL ACTIVITY SURVEY

Sexual Behaviour

1. Are you currently sexually active? Yes No
2. Do you have a spouse or partner? Yes No
3. In the past 12 months, how many people have you had sex with? _____
4. Do you have sex with: Males Females Both

Sexual Difficulties

How much of a problem was each of the following over the past four weeks:

5. Lack of sexual interest? None S/time Often Always
6. Difficulty in becoming sexually aroused? None S/time Often Always
7. Difficulty in having/maintaining an erection? None S/time Often Always N/A
8. Difficulty in having an orgasm? None S/time Often Always

Contraception / HIV and STI's

9. Are you currently using some form of contraception? Yes No
If yes, please indicate which type: _____
If taking the pill, when was the last time you took it? _____
10. The last time you had sex did you or your partner use contraception? Yes No
11. Have you ever had a Sexually Transmitted Infection (STI)?
e.g. Chlamydia, Gonorrhoea (also called clap or GC), Syphilis, Genital Herpes, Warts (HPV), Hepatitis B or C, HIV/AIDS. Yes No
If yes, which infection? _____ How long ago? _____
12. When was the last time you were tested for:
HIV/AIDS _____
Hepatitis C _____
Hepatitis B _____
STIs _____
13. When was the last time you had a pap smear? _____

ALCOHOL AND DRUGS

AUDIT - ALCOHOL USE DISORDERS IDENTIFICATION TEST SCREENING INSTRUMENT

Please tick the answer that is correct for you:

1. How often do you have a drink containing alcohol?

Never ≤ Monthly 2-4 times/mth 2-3 times/wk 4+ times/wk

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

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

3. How often do you have six or more drinks on one occasion?

Never ≤ Monthly Monthly Weekly Daily/almost daily

4. How often during the last year have you found that you were not able to stop drinking once you had started?

Never ≤ Monthly Monthly Weekly Daily/almost daily

5. How often during the last year have you failed to do what was normally expected from you because of drinking?

Never ≤ Monthly Monthly Weekly Daily/almost daily

6. How often during the last year have you needed a drink in the morning to get going after a heavy drinking session?

Never ≤ Monthly Monthly Weekly Daily/almost daily

7. How often during the last year have you had a feeling of guilt or remorse after drinking?

Never ≤ Monthly Monthly Weekly Daily/almost daily

8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?

Never ≤ Monthly Monthly Weekly Daily/almost daily

9. Have you or someone else been injured as a result of your drinking?

Never ≤ Monthly Monthly Weekly Daily/almost daily

10. Has a relative or friend or a doctor or other health worker, been concerned about your drinking or suggested you cut down?

Never Yes, but not in the last year Yes, during the last year

TOTAL

SCORING THE AUDIT

The AUDIT is designed as a self-report measure that you can score and interpret yourself. Alternatively, it can also be administered by an assessor.

Questions 1-9:

Never	0
Less than monthly	1
Monthly	2
Weekly	3
Daily / almost daily	4

For question 10:

No	0
Yes, but not in the last year	2
Yes, during the last year	4

Now add the score for each question to give a grand total for the AUDIT questionnaire.

Interpretation

If your total score is less than 4:

It is unlikely that you have a problem with alcohol, provided that you have been completely honest and that your answers represent your 'normal' consumption behaviour.

If your score is between 4 and 8 and you are under 18 years old or female:

This test suggests that your drinking patterns may be hazardous or harmful. That is your drinking may be currently causing you some problems, or may cause you problems in the future should you continue to drink in this way. If you are in this category you should seek the advice of a doctor or alcohol specialist.

If you are male and scored 8 or more:

This suggests that your drinking may be hazardous or harmful. If you are in this category you should seek the advice of a doctor or alcohol specialist.

If you scored 13 or above:

This suggests that your drinking shows signs of dependency. If you are in this category you should seek the advice of a doctor or alcohol specialist as a matter of urgency.

You should also complete the SADQ-C questionnaire on the next page and take both the completed AUDIT and SADQ-C to your doctor.

These tools will help your doctor with any diagnosis and/or treatment planning.

SADQ-C – SEVERITY OF ALCOHOL DEPENDENCE QUESTIONNAIRE

Please answer all the following questions by ticking the most appropriate response:

1. The day after drinking alcohol, I woke up feeling sweaty.

Never / almost never Sometimes Often Nearly always

2. The day after drinking alcohol, my hands shook first thing in the morning.

Never / almost never Sometimes Often Nearly always

3. The day after drinking alcohol, I woke up absolutely drenched in sweat.

Never / almost never Sometimes Often Nearly always

4. The day after drinking alcohol, my whole body shook violently first thing in the morning if I don't have a drink.

Never / almost never Sometimes Often Nearly always

5. The day after drinking alcohol, I dread waking up in the morning.

Never / almost never Sometimes Often Nearly always

6. The day after drinking alcohol, I was frightened of meeting people first thing in the morning.

Never / almost never Sometimes Often Nearly always

7. The day after drinking alcohol, I felt at the edge of despair when I awoke.

Never / almost never Sometimes Often Nearly always

8. The day after drinking alcohol, I felt very frightened when I awoke.

Never / almost never Sometimes Often Nearly always

9. The day after drinking alcohol, I liked to have a morning drink.

Never / almost never Sometimes Often Nearly always

10. The day after drinking alcohol, in the morning, I always gulped down my first few alcoholic drinks as quickly as possible.

Never / almost never Sometimes Often Nearly always

11. The day after drinking alcohol, I drank more alcohol in the morning to get rid of the shakes.

Never / almost never Sometimes Often Nearly always

12. The day after drinking alcohol, I had a very strong craving for an alcoholic drink when I awoke.

Never / almost never Sometimes Often Nearly always

13. I drank more than a quarter of a bottle of spirits in a day (or one bottle of wine, or seven beers)

Never / almost never Sometimes Often Nearly always

14. I drank more than half a bottle of spirits in a day (or two bottles of wine, or 15 beers)

Never / almost never Sometimes Often Nearly always

15. I drank more than one bottle of spirits in a day (or four bottles of wine, or 30 beers)

Never / almost never Sometimes Often Nearly always

16. I drank more than two bottles of spirits in a day (or eight bottles of wine, or 30 beers)

Never / almost never Sometimes Often Nearly always

Imagine the following situation:

You have hardly drunk any alcohol for a few weeks. You then drink very heavily for two days. How would you feel the morning after those two days of heavy drinking?

17. I would start to sweat.

Not at all Slightly Moderately Quite a lot

18. My hands would shake.

Not at all Slightly Moderately Quite a lot

19. My body would shake.

Not at all Slightly Moderately Quite a lot

20. I would be craving for a drink.

Not at all Slightly Moderately Quite a lot

TOTAL

Stockwell, Sitharan, McGrath & Lang (1994).

SCORING THE SADQ-C:

The SADQ-C does not require specialised training and takes between 5-10 minutes to complete.

All items of the SADQ are all scored as follows:

0 = never or almost never

1 = sometimes

2 = often

3 = nearly always

Now add your scores for all the questions to give a total score for the SADQ-C.

INTERPRETING THE SADQ-C SCORES:

The SADQ-C questions cover the following aspects of dependency syndrome:

- physical withdrawal symptoms
- affective withdrawal symptoms
- relief drinking
- frequency of alcohol consumption
- speed of onset of withdrawal symptoms

Score	Interpretation
< 16	Mild dependence
16 – 30	Moderate dependence
≥ 31	Severe alcohol dependence

DAST – DRUG ABUSE SCREENING TEST

The following questions concern information about your possible involvement with drugs not including alcoholic beverages during the past 12 months. Carefully read each statement and decide if your answer is 'Yes' or 'No'. Then, tick the appropriate response beside the question.

In the statements 'drug abuse' refers to (1) the use of prescribed or over the counter drugs in excess of the directions and (2) any non-medical use of drugs.

The various classes of drugs may include: cannabis (e.g. marijuana, hash), solvents, tranquillisers (e.g. Valium), barbiturates, cocaine, stimulants (e.g. speed), hallucinogens (e.g. LSD), or narcotics (e.g. heroin). Remember that the questions **do not** include alcoholic beverages.

Please answer every question. If you have difficulty with a statement, then choose the response that is mostly right.

These questions refer to the past 12 months.

1. Have you used drugs other than those required for medical reasons?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
2. Do you abuse more than one drug at a time?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
3. Are you always able to stop using drugs when you want to?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
4. Have you had 'blackouts' or 'flashbacks' as a result of drug use?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
5. Do you ever feel bad or guilty about your drug use?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
6. Does your spouse (or parents) ever complain about your involvement with drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
7. Have you neglected your family because of your use of drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
8. Have you engaged in illegal activities in order to obtain drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
9. Have you ever experienced withdrawal symptoms (felt sick) when you stopped taking drugs?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
10. Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
		TOTAL <input type="checkbox"/>

Skinner (1982)

SCORING THE DAST-10:

The DAST total score is computed by summing all items.

Yes = 1

No = 0

Items 4 and 5 are reverse scored:

Yes = 0

No = 1

Interpretation:

	SCORE	ACTION
None	0	Monitor
Low	1-2	Brief counselling
Intermediate (likely meets DSM criteria)	3-5	Outpatient (Intensive)
Substantial	6-8	Intensive
Severe	9-10	Intensive

A low score doesn't necessarily mean that the consumer is free of drug related problems. One must consider the length of time the consumer has been using drugs, the consumer's age, level of consumption and other data collected in the assessment in order to interpret the DAST score.

Drugs identified:

Action:

SDS - SEVERITY OF DEPENDENCE SCALES

This questionnaire will assist your GP to identify ways of meeting your needs about a drug which may be causing some concern.

Tick the answer that best applies to how you have felt about your use of _____ over the last twelve months.

1. Did you ever think your use of _____ (drug) was out of control?	<input type="checkbox"/> Never/almost never (0)	<input type="checkbox"/> Sometimes (1)	<input type="checkbox"/> Often (2)	<input type="checkbox"/> Always (3)	<input type="checkbox"/>
2. Did the prospect of missing a shot/snort make you very anxious or worried?	<input type="checkbox"/> Never/almost never (0)	<input type="checkbox"/> Sometimes (1)	<input type="checkbox"/> Often (2)	<input type="checkbox"/> Always (3)	<input type="checkbox"/>
3. How much did you worry about your use of the drug?	<input type="checkbox"/> Never/almost never (0)	<input type="checkbox"/> Sometimes (1)	<input type="checkbox"/> Often (2)	<input type="checkbox"/> Always (3)	<input type="checkbox"/>
4. Did you wish you could stop?	<input type="checkbox"/> Never/almost never (0)	<input type="checkbox"/> Sometimes (1)	<input type="checkbox"/> Often (2)	<input type="checkbox"/> Always (3)	<input type="checkbox"/>
5. How difficult would you find it to stop or go without _____ (drug)?	<input type="checkbox"/> Never/almost never (0)	<input type="checkbox"/> Sometimes (1)	<input type="checkbox"/> Often (2)	<input type="checkbox"/> Always (3)	<input type="checkbox"/>
TOTAL					<input type="checkbox"/>

Gossop, Darke, Griffiths, Hando, Powis, Hall & Strang (1995).

Scoring and Interpretation:

Sum all individual scores to obtain a total score. Below are the cut-offs for measuring dependence on various illicit drugs.

> 4	> 5	> 6	> 7
Amphetamines	Heroin		Cannabis & Benzodiazepines

PYSCHOSOCIAL SUPPORTS

Social supports may need to be investigated and support structures implemented if they are absent or not available when the person needs them.

Emotional support

Empathy and care from family and friends for a person in crisis allows for the expression of feelings e.g. fear, anxiety, emotional distress.

Cognitive support

Knowledge and information, and developing coping skills assists with decision making and personal direction.

Material support

Rent assistance and hostel accommodation assists people experiencing a deficiency in personal resources e.g. housing and homelessness.

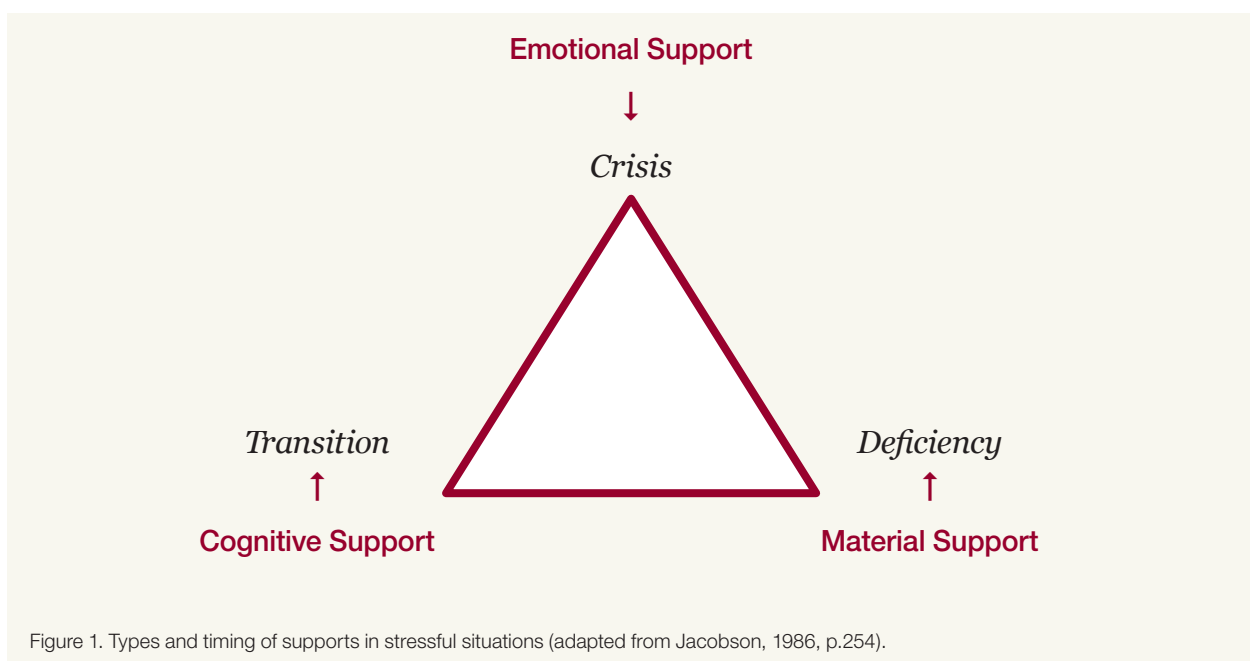


Figure 1. Types and timing of supports in stressful situations (adapted from Jacobson, 1986, p.254).

SCORING:

Each of the three domains should be evaluated separately:

Score	Support Level	Action Required
5 - 9	Very low	Support structures need to be implemented
10 - 14	Low	Support structures need to be implemented
15 - 19	Medium	Ongoing monitoring
20 +	High	Ongoing monitoring

Questions 5, 10 and 15 indicate the timing of each of the domains of social supports:

Providing support

Do you currently provide emotional/cognitive/material support for someone (e.g. children, family members, friends)?

Employment Status:

Full-time Part-time Casual Volunteer Unemployed



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