Management of alcohol misuse and wellbeing concerns of injured patients

December 2012
Produced by the Prevention of Alcohol related Crime and Trauma (PACT) Pathways to Care Project conducted within the Wellbeing and Preventable Chronic Diseases Division of Menzies School of Health in collaboration with the Maxillofacial Surgical Unit at Royal Darwin Hospital.

This manual has been developed by the Menzies Aboriginal and Islander Mental Health Initiative.
FOREWORD

This protocol manual is designed to help provide care for people with wellbeing concerns who have been admitted to hospital with injury.

PURPOSE

This resource will guide hospital staff in:

• identification of injured patients with substance use problems and/or wellbeing concerns

• provision of information and brief interventions that can assist patients and minimise the impact of substance use problems and/or wellbeing concerns on their physical and/or mental health

• recognition of patients in need of further treatment for substance use problems and/or wellbeing concerns

• appropriate referral of patients who wish to stop or reduce their substance use and/or seek external psychological support

CONTACT INFORMATION

For more information about the project:
w: AIMhi website www.menzies.edu.au/AIMHI
e: info@menzies.edu.au

Or contact
Associate Professor Tricia Nagel, Menzies School of Health Research
p: (08 89228196)

Or contact
The Tobacco Alcohol and Other Drugs Service
e: tads.ths@nt.gov.au

design:
Yvonne Coleman
LayedOut
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**Research team**
- **Associate Professor Tricia Nagel**
  Principal Investigator, Menzies School of Health Research
- **Dr. Rama Jayaraj**
  Project Manager and Investigator, Menzies School of Health Research
- **Dr. Mahiban Thomas**
  Head Maxillofacial Surgical Unit, RDH
- **Professor David Kavanagh**
  Queensland University of Technology
- **Professor Peter d’Abbs**
  Substance Misuse Studies, Menzies School of Health Research
- **Dr. Didier Palmer**
  Director of Emergency Department, RDH
- **Caroline Griffin**
  Senior Indigenous Research Officer, Menzies School of Health Research
- **Valerie Thompson**
  Indigenous Research Officer, Menzies School of Health Research
- **Luke Mayo**
  Indigenous Research Officer, Menzies School of Health Research
- **Megan Whitty**
  Postgraduate Research Student, Menzies School of Health Research

**Indigenous reference group**
- **Regina Bennett**
  Coordinator, Darwin Aboriginal & Islander Womens Shelter
- **John Boneham**
  Chief Executive Officer, FORWAARD Aboriginal Corporation
- **Charlie Dhammarndj**
  Aboriginal Mental Health Worker, Miwatj Aboriginal Corporation
- **Edward Mulholland**
  Chief Executive Officer, Miwatj Aboriginal Corporation
- **Gwen Paterson-Walley**
  Aboriginal Employment and Career Development Officer, Department of Health (DOH)
- **Allan Randall**
  VET Lecturer / Workplace Assessor, CDU (Alice Campus)
- **Charles Hodgson**
  Remote Health Coordinator
- **Patricia Taylor**
  Alcohol and Other Drug Worker
- **Charles Hodgson**
  Aboriginal Mental Health Worker, Miwatj Health

**Expert reference group**
- **Didier Palmer**
  Director, RDH, Emergency Department
- **Dee Robinson**
  AOD Clinical Nurse Consultant, RDH
- **Sara Gobbert**
  Acting Manager, Alcohol and Other Drug Services
- **Len Notaras**
  Executive Director, National Critical Care & Trauma Response Centre
- **Jenn Frendin**
  Coordinator, Remote Alcohol and Other Drugs Workforce, NT
- **Kath Harradine**
  Mental Health Program Manager - General Practice Network NT
- **Steven Skov**
  Public Health Physician, Centre for Disease Control, Department of Health
- **Jan Gibbet**
  Clinical Nurse Manager, (Specialist Clinics)
- **Leandra Codana**
  Aboriginal Liaison Officer Head, RDH
- **Jane Alley**
  Senior Director Licensing, Regulation & Alcohol Strategy Department of Justice
- **Kim Woosnam**
  Discharge Officer, RDH
- **Tracy Espi**
  RAPU Clinical Nurse Manager
- **Sally Weir**
  Service Integration Manager, Headspace NT
- **Susan Mansfield**
  TADS Social Worker, RDH
INTRODUCTION

Prevention of Alcohol related Crime And Trauma Project

How this manual was developed

Project background:
This manual is one of the products of an 18 month project conducted by the Menzies School of Health Research in partnership with the Northern Territory Department of Health and funded by the Australian Government through the Attorney-General’s Department under the Proceeds of Crime Act.

Objective:
To introduce screening and brief interventions for high risk drinkers admitted to hospital with facial trauma and evaluate the implementation of a best practice pathway to care.

Development of a best practice pathway:
A treatment pathway suited to the setting of the maxillofacial unit was developed through consultation with staff. It included clear guidelines for screening, assessment, intervention and referral and plain English pictorial information about alcohol-related risks. The brief intervention is based on resources developed through the Aboriginal and Islander Mental health initiative (AIMhi) in the NT (Nagel et al., 2009).

Implementation of best practice pathway:
A series of six one hour training workshops introduced the new resources to the hospital staff.

Evaluation of project activities:
Post workshop questionnaires assessed participant’s knowledge and confidence. File audits over 6 months at baseline (2010, n=76) and 9 months (2012, n=77) assessed changes to service provider practice.

Key informant interviews explored experience of the practice best practice pathway.

Findings
• Strong links exist between risky drinking and assault related injuries
• The project increased awareness of and screening for alcohol and wellbeing concerns
• AOD screening rates were 9% at base line and 71.4% at follow up
• Wellbeing screening rates were 6.6% at base line and 15 % at follow up
• Staff reported positive responses to the training and newly developed resources
• 90% of workshop attendees indicated that the training would change their practice
• Brief interventions within the hospital were still a challenge – few delivered
• There were limited referrals to services inside and outside of the hospital
• Staff reported that sustainability is linked with ongoing availability of training and resources
There are four important actions which can uncover wellbeing concerns of people who have been admitted to hospital with injury.

1. Screening
2. Information
3. Intervention
4. Referral

Four ways to help uncover wellbeing concerns are: through checking for common problems like alcohol and other drug use, depression, or post traumatic stress disorder (screening), through giving more information, through talking about changes a person wants to make (a brief intervention) and through organising a referral to other services.

Four opportunities to act:

1. Admission
2. Ward
3. Discharge
4. Outpatient review

Four opportunities during the hospital journey for uncovering wellbeing concerns are at admission, during ward care, at discharge or at outpatient review.

### BEST PRACTICE PATHWAY ACTIVITIES

<table>
<thead>
<tr>
<th>Admission</th>
<th>Nurse/Doctor/AOD Worker/Allied health</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital</td>
<td>Nurse/Doctor/AOD Worker/Allied health</td>
</tr>
<tr>
<td>Discharge</td>
<td>Nurse/Doctor/AOD Worker/Allied health</td>
</tr>
<tr>
<td>Review</td>
<td>Nurse/Doctor/AOD Worker/Allied health</td>
</tr>
</tbody>
</table>

**WHEN AND WHO?**

- At time of admission
- Within 48 hours of admission
- At time of discharge
- At appointment
STEP 1: SCREENING FOR ALCOHOL AND WELLBEING

The first step toward uncovering wellbeing concerns and offering help is to have a conversation. Gaining trust is an important way of learning more about people.

**TIPS**

for good engagement – especially with Indigenous people:

- Talk about yourself, what you do and where you are from
- Link yourself with the client through place, relationship, activities, hobbies, preferences
- Give choices about where you will talk, avoid face to face
- Use plain English, pictorial tools, local language, slow clear speech
- Talk about how family can link with our wellbeing
- Avoid direct questions
- Explore detail using ‘tell me about it’ or other open questions
- Explore strengths and worries using a metaphor to discuss wellbeing and what we can do to maintain wellbeing

It can be useful to use a formal screening tool to check for alcohol or other drug use

Examples of formal screening tools are:

- **MAD tool** The RDH admission assessment form
- **AUDIT–C** Alcohol use Disorder Identification Tool (Appendix 1)
- **SDS** Severity of Dependence Scale (Appendix 2)

Checking for mental health concerns

It can be useful to use a formal screening tool to check for alcohol or other drug use

Examples of formal screening tools are:

- **Kessler 6 or K10** Screen for emotional distress (Appendix 3)
- **PHQ 2+ or PHQ-9** Patient Health Questionnaire (Appendix 4)
- **TSQ** Trauma Screening Questionnaire (Appendix 5)

Ask simple questions such as:

- It looks like drinking or other substance use might be causing you problems is that right?
- Do you worry about your use of alcohol (other substance)?
- Have you ever thought about cutting down or stopping?

OR

Ask simple questions such as:

- Sounds like worries or stress might be getting you down and causing your problems – is that right?
- Is that something you would like help with?
STEP 2 INFORMATION

It can be helpful to share information about risks linked with drinking such as:

Safe drinking:
Safe drinking is no more than 2 standard drinks per day or 4 standard drinks in one session (a full strength can of beer is 1.3 standard drinks)

General problems with drinking are:
- Trouble concentrating/feeling on edge
- Missing work because of hangovers
- Problems with your relationships
- Disturbing thoughts and paranoia
- Aggression and violence
- Increased risk of having an accident/causing injury

Other health concerns are:
- Brain damage
- Chest infection
- Liver troubles
- Poor control of diabetes
- Heart troubles
- Stomach troubles
- Pancreatitis

Mental illnesses linked with drinking are:
- Depression
- Anxiety
- Post traumatic stress disorder
- Self harm and suicide

Different types of treatment available are:
- Counselling
- Alcoholics Anonymous (12 step programs)
- Medicated withdrawal
- Community based rehabilitation
- Pharmacotherapies

TIP

Examples of opportunities for information or brief interventions

Any time you are alone with a patient might offer an opportunity for an intervention such as:
- Changing a dressing
- Changing IV fluids
- Filling out routine paperwork
STEP 3 INTERVENTION

If you think that a person is ready to consider making changes you can talk to them about what they might do.

Use a resource such as
- Yarning about Alcohol
- Brief Yarning about Wellbeing pamphlet
- AIMhi stay strong plan
(click on links above to open)

TIP
Ask simple questions such as:
- It looks like alcohol (other substance) might be causing you problems. Thinking about your strengths and worries and how your substance use impacts on these, is there something you want to do about your substance abuse?
- What would be the most important thing to change first?

Promoting motivation
- Explore current worries: use a metaphor to explain how worries link with our wellbeing and confirm that although substance use can appear to help it becomes a part of the problem not the solution
- Build confidence in goal setting through review of the person’s own changes from the past, (or use other resources to prompt ideas and confidence)
- Review family strengths and worries and reasons for change

Goal setting
- Aim to choose a goal for change they can work on right now.
- Sample questions:
  - Thinking about your strengths and worries and how your substance use impacts on these, is there something you want to do about your substance use?
  - What would be the most important thing to change first?
  - What is the very first thing that needs to be done to make that change?
  - How might you go about it? When? Who might help?
  - Now that you’ve got some plans for change who would you like to see to follow up with those plans and let’s put in an appointment time before you go (GP/AOD service/myself)

TIP
Goal setting
- Aim to set the simplest goal possible
- Allow the person to choose their own goals and steps to change
- Help the person to choose practical goals and steps that use resources and support that they already have.
- Have reasonable time frames that do not expect too much too soon
STEP 4  REFERRAL

There are a range of services in the hospital and outside of hospital that may meet the needs of these clients such as:

- AOD services in the hospital (TADS – 89228399, tads.ths@nt.gov.au)
- General Practitioner or local health centre
- Youth – Headspace 89315999
- Mental health Crisis Assessment 1800 682 288
- Domestic Violence Worker
- Aboriginal Liaison Officer

Treatment services available (see services pamphlet)
- Aboriginal and Torres Strait Islander Social and Emotional Well Being
- Community living support
- Psychological Support Services
- Crisis contacts/telephone help lines
- Drug and Alcohol, Family or Mental Illness
- Support Groups
- Withdrawal services
- Sobering up Shelters
- Residential rehabilitation
- Trauma treatment and counselling
- Young People’s Social and Emotional Well Being

TIP

Referral
- Make the appointment with the client before they leave
- Allow the person to choose when and where they will have follow up
- Remember your priority may not be theirs
RESOURCES

APPENDIX ONE: AUDIT- C

How often do you have a drink containing alcohol?

- Never (0)
- Monthly (1)
- Weekly (2)
- Some days each week (3)
- Most days each week (4)

How many drinks of alcohol do you have on a typical day when you are drinking?

- 1 or 2
- 3 or 4
- 5 or 6
- 7 - 9
- More than 10

How often do you have six (6) or more drinks on one occasion

- Never (0)
- Monthly (1)
- Weekly (2)
- Some days each week (3)
- Most days each week (4)

AUDIT – C
Maximum score is 12

In men a score of 4 or more (and women a score of 3 or more) indicates hazardous drinking
APPENDIX TWO: SEVERITY OF DEPENDENCE SCALE (SDS)

A screen for identifying individuals with symptoms of substance use dependence

During the past year...

1. Did you think your use of (substance) was out of control?

| never/almost never (0) | sometimes (1) | often (2) | always/nearly always (3) |

2. Did the prospect of missing a dose of (substance) make you anxious or worried?

| never/almost never (0) | sometimes (1) | often (2) | always/nearly always (3) |

3. Did you worry about your use of (substance)?

| never/almost never (0) | sometimes (1) | often (2) | always/nearly always (3) |

4. Did you wish you could stop the use of (substance)?

| never/almost never (0) | sometimes (1) | often (2) | always/nearly always (3) |

5. How difficult did you find it to stop, or go without (substance)?

| not difficult (0) | quite difficult (1) | very difficult (2) | impossible (3) |

The cut-off point varies between 2 and 4 across different studies

APPENDIX THREE: KESSLER 10 (SCREEN FOR EMOTIONAL DISTRESS)

Source: Kessler R. Professor of Health Care Policy, Harvard Medical School, Boston, USA.

This is a 10-item questionnaire intended to yield a global measure of distress based on questions about anxiety and depressive symptoms that a person has experienced in the most recent 4 week period.

Why use the K10
The use of a consumer self-report measure is a desirable method of assessment because it is a genuine attempt on the part of the clinician to collect information on the patient’s current condition and to establish a productive dialogue. When completing the K10 the consumer should be provided with privacy.

How to administer the questionnaire
As a general rule, patients who rate most commonly “Some of the time” or “All of the time” categories are in need of a more detailed assessment. Referral information should be provided to these individuals. Patients who rate most commonly “A little of the time” or “None of the time” may also benefit from early intervention and promotional information to assist raising awareness of the conditions of depression and anxiety as well as strategies to prevent future mental health issues.

(Information sourced from the NSW Mental Health Outcomes and Assessment Training (MH-OAT) Facilitator’s Manual, NSW Health Department 2001)

K10 Test
The following questions concern how you have been feeling over the past 30 days. Tick a box below each question that best represents how you have been.

| 1. During the last 30 days, about how often did you feel tired out for no good reason? |
|---|---|---|---|---|---|
| 1. None of the time | 2. A little of the time | 3. Some of the time | 4. Most of the time | 5. All of the time |
| 1 | 2 | 3 | 4 | 5 |

| 2. During the last 30 days, about how often did you feel nervous? |
|---|---|---|---|---|---|
| 1. None of the time | 2. A little of the time | 3. Some of the time | 4. Most of the time | 5. All of the time |
| 1 | 2 | 3 | 4 | 5 |

| 3. During the last 30 days, about how often did you feel so nervous that nothing could calm you down? |
|---|---|---|---|---|---|
| 1. None of the time | 2. A little of the time | 3. Some of the time | 4. Most of the time | 5. All of the time |
| 1 | 2 | 3 | 4 | 5 |
### APPENDIX THREE

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<tr>
<td><strong>4. During the last 30 days, about how often did you feel hopeless?</strong></td>
<td>1. None of the time</td>
<td>2. A little of the time</td>
<td>3. Some of the time</td>
<td>4. Most of the time</td>
<td>5. All of the time</td>
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<td><strong>5. During the last 30 days, about how often did you feel restless or fidgety?</strong></td>
<td>1. None of the time</td>
<td>2. A little of the time</td>
<td>3. Some of the time</td>
<td>4. Most of the time</td>
<td>5. All of the time</td>
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<td><strong>6. During the last 30 days, about how often did you feel so restless you could not sit still?</strong></td>
<td>1. None of the time</td>
<td>2. A little of the time</td>
<td>3. Some of the time</td>
<td>4. Most of the time</td>
<td>5. All of the time</td>
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<td><strong>7. During the last 30 days, about how often did you feel depressed?</strong></td>
<td>1. None of the time</td>
<td>2. A little of the time</td>
<td>3. Some of the time</td>
<td>4. Most of the time</td>
<td>5. All of the time</td>
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<td><strong>8. During the last 30 days, about how often did you feel that everything was an effort?</strong></td>
<td>1. None of the time</td>
<td>2. A little of the time</td>
<td>3. Some of the time</td>
<td>4. Most of the time</td>
<td>5. All of the time</td>
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<td><strong>9. During the last 30 days, about how often did you feel so sad that nothing could cheer you up?</strong></td>
<td>1. None of the time</td>
<td>2. A little of the time</td>
<td>3. Some of the time</td>
<td>4. Most of the time</td>
<td>5. All of the time</td>
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<td><strong>10. During the last 30 days, about how often did you feel worthless?</strong></td>
<td>1. None of the time</td>
<td>2. A little of the time</td>
<td>3. Some of the time</td>
<td>4. Most of the time</td>
<td>5. All of the time</td>
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APPENDIX THREE

SCORING
FOR DOCTOR'S EYES ONLY

This is a questionnaire for patients to complete. It is a measure of psychological distress. The numbers attached to the patients' responses are added up and the total score is the score on the Kessler Psychological Distress Scale (K10). Scores will range from 10 to 50. People seen in primary care who

* score under 20 are likely to be well
* score 20-24 are likely to have a mild mental disorder
* score 25-29 are likely to have moderate mental disorder
* score 30 and over are likely to have a severe mental disorder

13% of the adult population will score 20 and over and about 1 in 4 patients seen in primary care will score 20 and over. This is a screening instrument and practitioners should make a clinical judgement as to whether a person needs treatment. Scores usually decline with effective treatment. Patients whose scores remain above 24 after treatment should be reviewed and specialist referral considered.

REFERENCES:

### APPENDIX FOUR: PHQ - 9 PATIENT HEALTH QUESTIONNAIRE

#### PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Use “✓” to indicate your answer)

<table>
<thead>
<tr>
<th>Problem</th>
<th>Not at all</th>
<th>Several days</th>
<th>More than half the days</th>
<th>Nearly every day</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Little interest or pleasure in doing things</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2. Feeling down, depressed, or hopeless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3. Trouble falling or staying asleep, or sleeping too much</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4. Feeling tired or having little energy</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5. Poor appetite or overeating</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7. Trouble concentrating on things, such as reading the newspaper or watching television</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9. Thoughts that you would be better off dead or of hurting yourself in some way</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**PHQ - 9 SCORING**

**Depression Severity**

- **0-4** none
- **5-9** mild Depression
- **10-14** moderate depression
- **15-19** moderately severe depression
- **20-27** severe depression

For Office Coding: $0 + ____ + ____ + ____ = Total Score: ____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐

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APPENDIX FIVE: TRAUMA SCREENING - QUESTIONNAIRE

TRAVISA SCREENING – QUESTIONNAIRE

NAME: _______________________________________________     DATE:  ________________

TRAUMATIC EVENT:____________________________________________________________

DATE OF EVENT:_______________________________________________________________

INSTRUCTIONS: Please consider the following reactions that sometimes occur after a traumatic event. This questionnaire is concerned with your personal reactions to the traumatic event. Please indicate whether or not you have experienced any of the following AT LEAST TWICE IN THE PAST WEEK:

<table>
<thead>
<tr>
<th>ITEM</th>
<th>Yes, at least twice in the past week</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Upsetting thoughts or memories about the event that have come into your mind against your will.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Upsetting dreams about the event.</td>
<td></td>
<td></td>
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<tr>
<td>3. Acting or feeling as though the event were happening again.</td>
<td></td>
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<tr>
<td>4. Feeling upset by reminders of the event.</td>
<td></td>
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<tr>
<td>5. Bodily reactions (such as fast heartbeat, stomach churning, sweatiness, dizziness) when reminded of the event.</td>
<td></td>
<td></td>
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<tr>
<td>6. Difficulty falling or staying asleep.</td>
<td></td>
<td></td>
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<tr>
<td>7. Irritability or outbursts of anger.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Difficulty concentrating.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Heightened awareness of potential dangers to yourself and others.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. Being jumpy or being startled at something unexpected.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Brewin et al. (2002) considered the screen “positive” when at least 6 items were endorsed. The authors recommended that screening be conducted 3-4 weeks post-trauma to allow for normal recovery processes to take place. Those screening positive should then be assessed with a structured interview for PTSD.

APPENDIX SIX: YARNING ABOUT ALCOHOL

Click on this link to download brochure from the AIMhi website

Tips for making change
- Make healthy choices
- Keep busy
- Spend time with family
- Play sport
- Get involved in cultural activities
- Go hunting
- Talk to someone you respect and trust
- Drink more slowly
- Drink more water

Who will help?
What will they do to help?
- Check with

What keeps us STRONG?
Doing more of what keeps us strong helps us make change

www.healthynt.nt.gov.au

Name: ...............................................................................................................................................................................................................................
Health Centre: ......................................................................................................................................................................................................
Contact Person: .................................................................................................................................................................................................
Contact Number: ..............................................................................................................................................................................................
Next Visit: ............................................................................................................... Time: ................................................................................

Who to see

What do you need to do to take your first steps?

This pamphlet has been developed in collaboration with the Menzies Aboriginal and Islander Mental Health Initiative. Images supplied by ICT Team NT Department of Health.

Plan for change
What is the most important thing for you to work on changing right now?

Goal:
What would be your first step for making that change?

Step 1:
What else could you do to make that change?

Step 2:
Goal:
Step 1:
Step 2:

Helping you change

PHYSICAL
- Familie, Social and Work
- Mental and Emotional
- Spiritual and Cultural

Support
- Family
- Think positive
- Know about illness
- Hunting
- Teach kids
- Music
- Work
- Health Centre
- Other
- Good tucker
- Go to country
- Dance
- Spiritual belief
- Art and craft
- Exercise
- EUROA?

How often do you have a drink containing alcohol?
Never (0)...... Monthly (1) ....... Weekly (2)  ...... Some days each week (3) ......Most days each week (4)

How many alcoholic drinks do you typically have when you are drinking?
1or 2 (0) .........3 or 4 (1) ....................5 or 6 (2)  ..........................7-9  (3) more than 10 (4)

How often do you have (6) or more standard drinks on one occasion?
Never (0)... Less than monthly (1) ...Monthly (2) ...Some days a week  (3) ....  Most days each week (4)

Thinking about drinking alcohol
High risk = Score more than 6 in total

8-12 points
6-7 points
3-5 points
females
4-5 points
males
1-2 points
females
1-3 points
males

TOTAL SCORE:

Add the number for each question to get your total score

SCORE:

Too much alcohol causes trouble

Is it a problem?

Do you think you have a problem?
Do you think you drink too much alcohol?
Are you worried about your drinking?
Does your family worry about your drinking?
Do you feel stressed out without alcohol?
Do you wish you could stop?

I trust:............................... and .....................................    to give advice about my treatment.

YOU

WHO keeps us STRONG?

Who are the family and friends that help to keep you strong?

TOGETHER WE CAN STAY STRONG

19. Resources: Appendix Six
Click on this link to download brochure from the ALMhi website.
APPENDIX 8: BRIEF YARNING ABOUT WELLBEING

Click on this link to download brochure from the AIMhi website

Brief Yarning about Wellbeing

1. It looks like drinking (or other substance use) might be causing you problems - is that right?
2. Are you worried about it?
3. Have you ever thought about drinking/using less?
4. What would be a good reason for drinking/using less?

High Risk Drinking

- Is more than four standard drinks on one occasion and/or drinking most days each week
- (Three full strength beers is more than four standard drinks)

Tips for Change

- Delay/set later in the day
- Avoid triggers such as people and places and ‘gear’
- Do other things/hang out with other people
- Get help from friends and family
- Do other things: sport, exercise, going out, bush
- Hang out with other people, go different places

Reasons other people have given are:

- Less family worry
- Better health
- Better concentration
- Less anger and fighting
- More money for food
- More better steadier life
- And feel happier

Brief Yarning about Information

4. Referral

Referral in the Hospital

AGS services:
P: (08) 8322 8399 P: (08) 8322 8403
E: tads@nt.gov.au

Domestic Violence
P: (08) 8324 8344

Aboriginal Liaison Officer
P: (08) 8322 8888 (via switch)

For more information see these pamphlets or visit www.mhfa.com.au/cms/ or www.menzies.edu.au/AIMHI

Brief Yarning about Motivation

3. Motivation

- Less family worry
- Better health
- Better concentration
- Less anger and fighting
- More money for food
- More better steadier life
- And feel happier

Resources:
Appendix Eight

21. Resources: Appendix Eight
APPENDIX 9: AIMHI STAY STRONG PLAN

Click on this link to download brochure from the AIMhi website

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**STEP 1** Family and friends

I trust ______ and ________ to give advice about my treatment.

---

**STEP 2** What keeps us strong?

---

**STAY STRONG PLAN**

Name: ____________________________

DATE: __________/

Client No: ____________________________
There are four things to do to treat depression and get back in balance again:

- Talk to someone - family or friends
- Do more things that keep you strong
- Do less of the things that take your strength away… and if that’s not working
- Try talking with a health professional

There can be many treatments to help people to grow their spirit back to strength

- Education can help change how a person feels and help them make good choices that make their spirit stronger.
- Knowing early warning signs of stress can help us be prepared

Mental and emotional health is like a tree with four branches which needs to be looked after. When the tree is well balanced a person’s mental health is strong. What’s around us, what we do, what we think and what we feel helps to keep us strong.

Click on this link to download brochure from the AIMhi website

APPENDIX 10: YARNING ABOUT SADNESS

Click on this link to download brochure from the AIMhi website
USEFUL LINKS

Standard Drinks Guide

Stay Strong Plan And Other Resources
w: www.menzies.edu.au/AIMHI

Information About Alcohol-Related Health Issues

Drug And Alcohol Clinical Advisory Service (DACAS)
w: http://www.dacas.org.au
t: 1800 111 092

Alcohol And Drug Information Service (ADIS)
24/7 Counselling and Referral service
w: http://www.yourroom.com.au
t: 1800 131 350

Top End Mental Health Services
w: http://www.teamhealth.asn.au
t: (08) 8999 4988

For bulk billing options see:

Darwin Directory Of Psychological Services

Remote Central Australian Health Services Directory (GPNNT)