Comorbidity Guidelines Training Program

Session Three Handouts

Assessment of Mental State

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

Behaviour *(How is the client behaving?)*
- Motor activity – immobile, pacing, restless, hyperventilating.
- Abnormal movements – tremor, jerky or slow movements, abnormal walk.
- Bizarre/odd/unpredictable actions.

Attitude *(How is the client reacting to the current situation and worker?)*
- Angry/hostile towards interviewer/others.
- Unco-operative.
- Withdrawn.
- Over familiar/inappropriate/seductive.
- Fearful, guarded, hypervigilant.

Speech *(How is the client talking?)*
- Rate – rapid, uninterruptible, slow, mute.
- Tone/volume – loud, angry, quiet, whispering.
- Quality – clear, slurred.
- Anything unusual about the client's speech?

Language *(How does the client express himself/herself?)*
- Incoherent/illogical thinking (word salad: communication is disorganised and senseless and the main ideas cannot be understood).
- Derailment (unrelated, unconnected or loosely connected ideas, shifting from one subject to another).
- Tangentiality/loosening of associations (replies to questions are irrelevant or may refer to the appropriate topic but fail to give a complete answer).
- Absence/retardation of, or excessive thought and rate of production.
- Thought blocking (abrupt interruption to flow of thinking so that thoughts are completely absent for a few seconds or irretrievable).

Mood *(How does the client describe his/her emotional state?)*
- Down/depressed; angry/irritable; anxious/fearful; high/elevated.

Affect *(What do you observe about the client's emotional state?)*
- Depressed – flat, restricted, tearful, downcast.
- Anxious – agitated, distressed, fearful.
- Irritable, hostile.

– Labile – rapidly changing.
– Inappropriate – inconsistent with content
– High/elevated – excessively happy or animated.

Thought Content *(What is the client thinking about?)*
– Delusional thoughts (e.g., bizarre, grandiose, persecutory, self-referential).
– Preoccupations: paranoid/depressive/anxious/obsessional thoughts; overvalued ideas.
– Thoughts of harm to the self or others.
– Does the client believe that his/her thoughts are being broadcast to others or that someone/thing is disrupting or inserting his/her own thoughts?

Perception *(Is the client experiencing any misinterpretations of sensory stimuli?)*
– Does the client report auditory, visual, olfactory or somatic hallucinations? Illusions?
– Are they likely to act on these hallucinations?
– Do you observe the client responding to unheard sounds/voices/unseen people/ objects?
– Any other perceptual disturbances (e.g., derealisation, depersonalisation, heightened/ dulled perception)?

Cognition:
Level of consciousness
– Is the client alert and oriented?
– Is the client attentive during the interview (drowsy, stupor, distracted)?
– Does the client's attention fluctuate during the interview?
– Does the client present as confused?
– Is the client's concentration impaired? (can he/she count from 100 or say the months of the year backwards?)

Orientation
– Does the client know:
- Who he/she is?
- Who you are?
- Where he/she is?
- Why he/she is with you now?
- The day of the week, the date, the month and the year?

Memory
– Can the client remember:
- Why he/she is with you? (Immediate)
- What he/she had for breakfast? (Recent)
- What he/she was doing around this time last year? (Remote)
– Are they able to recall recent events (memory and simple tasks e.g., calculation)?

Insight and Judgment
– How aware is the client of what others consider to be his/her current difficulty?
– Is the client aware of any symptoms that appear weird/bizarre or strange?
– Is the client able to make judgments about his/her situation?

MENTAL STATE EXAMINATION REPORT

Name_____ D.O.B._____
Date_____

Appearance

Physical appearance? (posture, grooming, clothing, signs of AOD use, nutritional status)

Behaviour

General behaviour? Behaviour to situation and to examiner? (angry/hostile, unco-operative, withdrawn, inappropriate, fearful, hypervigilant)

Speech

Rate, volume, tone, quality and quantity of speech?

Language (form of thought)

Incoherence/illogical/irrelevant thinking? Amount? Rate?

Mood and affect

How does the client describe his/her emotional state (mood)? What do you observe about the person's emotional state (affect)? Are these two consistent and appropriate?

Thought content

Delusions, suicidality, paranoia, homicidality, depressed/anxious thoughts?

Perception

Hallucinations? Depersonalisation? Derealisation?

Cognition

Level of consciousness? Attention? Memory? Orientation? Abstract thoughts? Concentration?

Insight and judgement

Awareness? Decision making?

SAMPLE MENTAL STATE EXAMINATION REPORT

Name: ADAM JONES (fictional person) D.O.B. 1/1/89 Date: 22/1/10

Appearance

21 year old Adam Jones presented to the service in the company of his mother. Adam sat slumped in a chair. He appeared unshaven with unkempt hair. His clothes were clean and ironed. Adam appeared to be underweight for his height. (Adam's mother reported that he has recently lost weight).

Behaviour

Adam made very little eye-contact during the assessment interview. He appeared quite withdrawn and gave minimal or no responses to the questions asked. He remained slumped in the chair throughout the interview.

Speech

Adam said very little during the interview. When he did speak it was barely audible. The rate of his speech was slow.

Language (form of thought)

Although Adam said very little during the interview, he did at times respond appropriately to some questions. For example, when asked about what he liked about smoking cannabis, Adam responded with "It makes me feel relaxed, it helps me to sleep". Later in the interview Adam appeared to be crying and stated "I feel like I've made a mess of things".

Mood and affect

When asked how he was feeling, Adam shrugged his shoulders and stated "I dunno. Sort of nothing". His affect was flat and congruent with his mood.

Thought content

Adam did not appear to be paranoid or delusional. When assessed for suicidal thoughts, Adam stated "I just want to go to sleep and not wake up". He denies having a plan to commit suicide or to self-harm. Adam also has no thoughts of harming others. He stated towards the end of the interview "I know mum's worried about me. I don't want to hurt her.".

Perception

Adam denied hearing voices or any other perceptual disturbance.

Cognition

Adam remained conscious throughout the interview. Adam had difficulty answering questions at times. Twice he asked the interviewer to repeat the question. He appeared to be oriented to time, place and person.

Insight and judgement

Adam showed some insight into his situation when he stated “I just want to feel better”. His concern about worrying his mother was also noted. Adam did agree to return in the near future to talk further about his use of cannabis and the possibility of making a change. He wants to return to his TAFE course at some time.

TRAUMA SCREENING QUESTIONNAIRE (TSQ)

Please consider the following reactions which sometimes occur after a traumatic event. This questionnaire is concerned with your personal reactions to the traumatic event which happened to you. Please indicate (Yes/No) whether or not you have experienced any of the following at least twice in the past week.

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

Source: Brewin, C. R., Rose, S., Andrews, B., Green, J., Tata, P., McEvedy, C., Turner, S. & Foa, E. B. (2002) Brief screening instrument for post-traumatic stress disorder. *British Journal of Psychiatry, 181*, 158-162.

SUICIDE RISK ASSESSMENT CHECKLIST

Name_____ D.O.B._____ Date_____

Questions used to complete this assessment might include:

- Have things been so bad lately that you have thought you would rather not be here?
- Because of the high rates of suicide, I ask all my clients about whether they have ever had any suicidal thoughts. I am wondering if you have ever been feeling so awful that you have begun thinking about suicide?
- Have you had any thoughts of harming yourself?
- Are you thinking of suicide?
- How often do you have these thoughts of killing yourself?
- Have you made any current plans?
- What has happened that makes life not worth living?
- Have you ever tried to harm yourself?
- Do you have access to firearms or any other lethal means?
- Is there anyone you rely upon for support?
- Is there anything that is preventing you from acting on your thoughts?
- Do you think that the treatment offered is going to help you get better?

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1. ***Previous history of suicidal behaviour***
   (Self-harm, previous attempts)

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2. ***Risk factors***
   (Social isolation, recent loss/death, family/relationship problems, incarceration, unemployment/lack of skills, lack of problem-solving skills, impulse control problems, hopelessness, physical/mental illness, does motivation exist for treatment?)

3. ***Current suicidal thoughts***

   (Presence of thoughts, frequency, duration, intensity, intent)

4. ***Plans***

   (How? When? Where? Access to chosen method)

5. ***Protective factors***

   (Actively in treatment, good physical health, good problem-solving abilities, social/spiritual support, employment/financial/educational stability, reasons for living, plans for future)

Assessment of Suicide Risk Level

Level of risk	Suggested response
Non-existent: No identifiable suicidal thoughts, plans or intent	• Monitor risk periodically or when indicated
Mild/Low: Suicidal thoughts of limited frequency, intensity and duration. No plans or intent, mild dysphoria, no prior attempts, good self-control (i.e., subjective or objective), few risk factors, identifiable protective factors	• Review frequently • Identify potential supports/contacts and provide contact details • Contract with client to seek immediate assistance if fleeting thoughts become more serious or depression deepens
Moderate: Frequent suicidal thoughts with limited intensity and duration, some plans but no intent (or some intent but no plans), limited dysphoria, some risk factors present, but also some protective factors	• Request permission to organise a specialist MHS assessment as soon as possible • Continue contract as above • Review daily
Severe/High: Frequent, intense and enduring suicidal thoughts. Specific plans, some intent, method is available/accessible, some limited preparatory behaviour, evidence of impaired self-control, severe dysphoria, multiple risk factors present, few if any protective factors, previous attempts	• If risk is high and the client has an immediate intention to act, contact the mental health crisis team immediately and ensure that the client is not left alone • Call an ambulance/police if the client will not accept a specialist assessment, or the crisis team is not available • Consult with a colleague or supervisor for guidance and support
Extreme/Very high: Frequent, intense, enduring suicidal thoughts and clear intent, specific/well thought out plans, access/available method, denies social support and sees no hope for future, impaired self-control, severe dysphoria, previous attempts, many risk factors, and no protective factors	

Adapted from: Lee N, Jenner L, Kay-Lambkin F, Hall K, Dann F, Roeg S, et al. PsyCheck: Responding to mental health issues within alcohol and drug treatment. Canberra: Commonwealth of Australia; 2007;
Rudd MD, Joiner T, Rajab MH. Treating Suicidal Behaviour: An effective, time-limited approach. New York: Guilford Press; 2001.
Schwartz RC, Rogers JR. Suicide assessment and evaluation strategies: A primer for counselling psychologists. Counselling Psychology Quarterly. 2004; 17(1):89-97.

Standardised Screening Tools

Kessler – 10 (K-10)

Name.....Date.....

For all questions, please circle the answer *most* commonly related to you. Questions 3 and 6 automatically receive a score of one if the proceeding question was "none of the time".

In the past four weeks:	None of the time	A little of the time	Some of the time	Most of the time	All of the time
1. About how often did you feel tired out for no good reason?	1	2	3	4	5
2. About how often did you feel nervous?	1	2	3	4	5
3. About how often did you feel so nervous that nothing could calm you down?	1	2	3	4	5
4. About how often did you feel hopeless?	1	2	3	4	5
5. About how often did you feel restless or fidgety?	1	2	3	4	5
6. About how often did you feel so restless you could not sit still?	1	2	3	4	5
7. About how often did you feel depressed?	1	2	3	4	5
8. About how often did you feel that everything is an effort?	1	2	3	4	5
9. About how often did you feel so sad that nothing could cheer you up?	1	2	3	4	5
10. About how often did you feel worthless?	1	2	3	4	5
Total:					

Test: Kessler, R.C. (1996). *Kessler's 10 Psychological Distress Scale*. Harvard Medical School: Boston, MA.
Normative data: National Survey of Mental Health and Well-being, Australian Bureau of Statistics 1997.

PsyCheck Screening Tool

Client's Name:		DOB:		
Service:		UR:		
Mental health services assessment required?		□ No □ Yes		
Suicide/self-harm risk (please circle):		High	Moderate	Low
Date:	Screen completed by:			
Clinician use only				
Complete this section when all components of the *PsyCheck* have been administered.				
Summary				
Section 1	Past history of mental health problems	□ No	□ Yes	
Section 2	Suicide risk completed and action taken	□ No	□ Yes	
Section 3	SRQ score	□ 0	□ 1-4	□ 5+
Interpretation/score – Self-Reporting Questionnaire (SRQ)				
Score of 0* on the SRQ	No symptoms of depression, anxiety and/or somatic complaints indicated at this time. **Action:** Re-screen using the *PsyCheck* Screening Tool after four weeks if indicated by past mental health questions or other information. Otherwise monitor as required.			
Score of 1-4* on the SRQ	Some symptoms of depression, anxiety and/or somatic complaints indicated at this time. **Action:** Give the first session of the *PsyCheck* Intervention and screen again in four weeks.			
Score of 5+* on the SRQ	Considerable symptoms of depression, anxiety and/or somatic complaints indicated at this time. **Action:** Offer sessions 1–4 of the *PsyCheck* Intervention.			
Re-screen using the *PsyCheck* Screening Tool at the conclusion of four sessions.				
If no improvement in scores evident after re-screening, consider referral.				

PsyCheck General Screen

Clinician to administer this section

The following questions are about your emotional wellbeing. Your answers will help me get a clearer idea of what has been happening in your life and suggest possible ways that we might work together to relieve any distress you may be experiencing. We ask these questions of everybody, and they include questions about mental, physical and emotional health.

1	Have you ever seen a doctor or psychiatrist for emotional problems or problems with your "nerves"/anxieties/worries?	□ No	□ Yes
	Details		
2	Have you ever been given medication for emotional problems or problems with your "nerves"/anxieties/worries?		
	□ No, never		
	□ Yes, in the past but not currently	Medication(s):	
	□ Yes, currently	Medication(s):	
3	Have you ever been hospitalised for emotional problems or problems with your "nerves"/anxieties/worries?	□ No	□ Yes
	Details		
4	Do you have a current mental health worker, psychiatrist, psychologist, general practitioner or other health provider? **If "No", go to Question 5.**		
	□ **Psychiatrist** Name: Contact details: Role:	□ **Psychologist** Name: Contact details: Role:	
	□ **Mental health worker** Name: Contact details: Role:	□ **General practitioner** Name: Contact details: Role:	
	□ **Other – specify:** Name: Contact details: Role:	□ **Other – specify:** Name: Contact details: Role:	
5	Has the thought of ending your life ever been on your mind?	□ No	□ Yes — If "No", go to Section 3
	Has that happened recently?	□ No	□ Yes — If "Yes", go to Section 2

PsyCheck Risk Assessment

Clinician to administer this section

If the person says "Yes" to recently thinking about ending his/her life (Question 5), complete the suicide/self-harm risk assessment below. Specific questions and prompts and further guidance can be found in the *PsyCheck* User's Guide.

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	□ Previous low lethality	□ Moderate lethality	□ High lethality, frequent
	History of harm in family members or close friends	□ Previous low lethality	□ Moderate lethality	□ High lethality, frequent
2	Suicidal ideation: Consider how the suicidal ideation has been communicated; non-disclosure may not indicate low risk. Communication of plans and intentions are indicative of high risk. Consider non-direct and non-verbal expressions of suicidal ideation here such as drawing up of wills, depressive body language, "goodbyes", unexpected termination of therapy and relationships etc. Also consider homicidal ideation or murder/suicide ideation.			
	Intent	□ No intent	□ No immediate intent	□ Immediate intent
	Plan	□ Vague plan	□ Viable plan	□ Detailed plan
	Means	□ No means	□ Means available	□ Means already obtained
	Lethality	□ Minor self-harm behaviours, intervention likely	□ Planned overdose, serious cutting, intervention possible	□ 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	□ Lowered or unchanged mood	□ Enduring lowered mood	□ Depression diagnosis
	Mental health disorder	□ Few or no symptoms or well-managed significant illness	□ Pronounced clinical signs	□ Multiple symptoms with no management
4	Protective factors: These include social support, ability or decision to use support, family involvement, stable lifestyle, adaptability and flexibility in personality style etc.			
	Coping skills and resources	□ Many	□ Some	□ Few
	Family/friendships/networks	□ Many	□ Some	□ Few
	Stable lifestyle	□ Many	□ Some	□ Few
	Ability to use supports	□ Many	□ Some	□ Few

Psycheck 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?	□ No	□Yes	→ ○
2. Is your appetite poor?	□ No	□Yes	→ ○
3. Do you sleep badly?	□ No	□Yes	→ ○
4. Are you easily frightened?	□ No	□Yes	→ ○
5. Do your hands shake?	□ No	□Yes	→ ○
6. Do you feel nervous?	□ No	□Yes	→ ○
7. Is your digestion poor?	□ No	□Yes	→ ○
8. Do you have trouble thinking clearly?	□ No	□Yes	→ ○
9. Do you feel unhappy?	□ No	□Yes	→ ○
10. Do you cry more than usual?	□ No	□Yes	→ ○
11. Do you find it difficult to enjoy your daily activities?	□ No	□Yes	→ ○
12. Do you find it difficult to make decisions?	□ No	□Yes	→ ○
13. Is your daily work suffering?	□ No	□Yes	→ ○
14. Are you unable to play a useful part in life?	□ No	□Yes	→ ○
15. Have you lost interest in things?	□ No	□Yes	→ ○
16. Do you feel that you are a worthless person?	□ No	□Yes	→ ○
17. Has the thought of ending your life been on your mind?	□ No	□Yes	→ ○
18. Do you feel tired all the time?	□ No	□Yes	→ ○
19. Do you have uncomfortable feelings in the stomach?	□ No	□Yes	→ ○
20. Are you easily tired?	□ No	□Yes	→ ○
	Total score (add circles):		

DEPRESSION ANXIETY STRESS SCALE – DASS 21

Name: *Date:*

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all
1 Applied to me to some degree, or some of the time
2 Applied to me to a considerable degree, or a good part of time
3 Applied to me very much, or most of the time

1	I found it hard to wind down	0	1	2	3
2	I was aware of dryness of my mouth	0	1	2	3
3	I couldn't seem to experience any positive feeling at all	0	1	2	3
4	I experienced breathing difficulty (e.g., excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I found it difficult to work up the initiative to do things	0	1	2	3
6	I tended to overreact to situations	0	1	2	3
7	I experienced trembling (e.g., in the hands)	0	1	2	3
8	I felt that I was using a lot of nervous energy	0	1	2	3
9	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting agitated	0	1	2	3
12	I found it difficult to relax	0	1	2	3
13	I felt down-hearted and blue	0	1	2	3
14	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
15	I felt I was close to panic	0	1	2	3
16	I was unable to become enthusiastic about anything	0	1	2	3
17	I felt I wasn't worth much as a person	0	1	2	3
18	I felt that I was rather touchy	0	1	2	3
19	I was aware of the action of my heart in the absence of physical exertion (e.g., sense of heart rate increase, heart missing a beat)	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life was meaningless	0	1	2	3

Source: Lovibond, S.H. & Lovibond, P.F. (1995) *Manual for the Depression Anxiety Stress Scales.* 2nd edition. Sydney: Psychology Foundation.

THE PRIMARY CARE PTSD SCREEN (PC-PTSD)

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, in the past month, you:		
1. Have had nightmares about it or thought about it when you did not want to?	□ No	□ Yes
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	□ No	□ Yes
3. Were constantly on guard, watchful, or easily startled?	□ No	□ Yes
4. Felt numb or detached from others, activities, or your surroundings?	□ No	□ Yes

Source: Prins, A., Ouimette, P., Kimerling, R., Cameron, R. P., Hugelshofer, D. S., Shaw-Hegwer, J., Thrailkill, A., Gusman, F.D., Sheikh, J. I. (2004). The primary care PTSD screen (PC-PTSD): Development and operating characteristics. *Primary Care Psychiatry, 9*, 9-14.

PSYCHOSIS SCREENER

1. In the past 12 months, have you felt that your thoughts were being directly interfered with or controlled by another person?	□ No	□ Yes
1a. Did it come about in a way that many people would find hard to believe, for instance, through telepathy?	□ No	□ Yes
2. In the past 12 months, have you had a feeling that people were too interested in you?	□ No	□ Yes
2a. In the past 12 months, have you had a feeling that things were arranged so as to have a special meaning for you, or even that harm might come to you?	□ No	□ Yes
3. Do you have any special powers that most people lack?	□ No	□ Yes
3a. Do you belong to a group of people who also have these special powers?	□ No	□ Yes
4. Has a doctor ever told you that you may have schizophrenia?	□ No	□ Yes

Source: Degenhardt, L., Hall, W., Korten, A., & Jablensky, A. (2005). *Use of brief screening instrument for psychosis: Results of a ROC analysis. Technical Report No. 210.* Sydney: National Drug and Alcohol Research Centre

INDIGENOUS RISK IMPACT SCREEN (IRIS)

1. In the last 6 months have you needed to drink or use more to get the effects you want?			
1. No	2. Yes, a bit more	3. Yes, a lot more	
2. When you have cut down or stopped drinking or using drugs in the past, have you experienced any symptoms, such as sweating, shaking, feeling sick in the tummy/vomiting, diarrhoea/runny gonna, feeling really down or worried, problems sleeping, aches and pains?			
1. Never	2. Sometimes when I stop	3. Yes, every time	
3. How often do you feel that you end up drinking or using drugs much more than you expected?			
1. Never/Hardly ever	2. Once a month	3. Once a fortnight	
4. Once a week	5. More than once a week	6. Most days/Every day	
4. Do you ever feel out of control with your drinking or drug use?			
1. Never/Hardly ever	2. Sometimes	3. Often	4. Most days/Every day
5. How difficult would it be to stop cut down on your drinking or drug use?			
1. Not difficult at all	2. Fairly easy	3. Difficult	4. I couldn't stop or cut down
6. What time of the day do you usually start drinking or using drugs?			
1. At night	2. In the afternoon	3. Sometimes in the morning	4. As soon as I wake up
7. How often do you find that your whole day has involved drinking or using drugs?			
1. Never/Hardly ever	2. Sometimes	3. Often	4. Most days/Every day
8. How often do you feel down in the dumps, sad or slack?			
1. Never/Hardly ever	2. Sometimes	3. Most days/Every day	
9. How often have you felt that life is hopeless?			
1. Never/Hardly ever	2. Sometimes	3. Most days/Every day	
10. How often do you feel nervous or scared?			
1. Never/Hardly ever	2. Sometimes	3. Most days/Every day	
11. Do you worry much?			
1. Never/Hardly ever	2. Sometimes	3. Most days/Every day	
12. How often do you feel restless and that you can't sit still?			
1. Never/Hardly ever	2. Sometimes	3. Most days/Every day	
13. Do past events in your family still affect your wellbeing today (such as being taken away from family)?			
1. Never/Hardly ever	2. Sometimes	3. Most days/Every day	

Integrated Motivational Assessment Tool

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