A Counsellor's Guide to Working with Alcohol and Drug Users

2nd edition

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List of abbreviations and acronyms

AA	Alcoholics Anonymous
AOD	Alcohol and other drugs
CLD	Culturally and linguistically diverse
CBT	Cognitive behavioural therapy
CNS	Central nervous system
DTs	Delirium tremens
NA	Narcotics Anonymous
OTI	Opiate Treatment Index
PBS	Pharmaceutical Benefits Scheme
PTSD	Post Traumatic Stress Disorder
TGA	Therapeutic Goods Administration

Foreword

The Drug and Alcohol Office is pleased to publish the second edition of Western Australian evidence based practice materials, following their original publication in 2000.

Evidence based practice derives from a review of the literature and consultation with professionals in the alcohol and drug field, processes which formed the basis of these materials. As such, the term evidence based practice encompasses best practice.

The first edition published in 2000 was based on materials written by Ali Dale and Ali Marsh (Curtin University School of Psychology and Next Step Specialist Drug and Alcohol Services). This second edition was revised by Laura Willis (Curtin University School of Psychology) and Ali Marsh (Curtin University Schol of Psychology and Next Step Specialist Drug and Alcohol Services).

This document is one in a series of three, comprising:

- *A literature review for evidence based practice indicators for alcohol and other drug interventions.*
- *A summary of the evidence based practice indicators for alcohol and other drug interventions.*
- *A counsellors guide for working with alcohol and drug users.*

These documents identify current best practice and promote quality outcomes for clients. Their purpose is to support development of consistent, high quality service delivery.

The ***Counsellors guide for working with alcohol and drug users*** explores some of the key skills needed to work at an individual level with people who have substance use problems. The guide assumes the reader has a basic understanding of the development of alcohol and drug problems and already possesses basic counselling skills.

Both managers and counsellors are encouraged to use this manual as a reference, an educational tool and as an aid to quality management and professional supervision.

August 2007

Basic Elements of Treatment

1. Ingredients of effective treatment

General counselling approach

Over the last 25 years, there has been active debate and research regarding the active ingredients in successful therapy. The typical conclusion drawn concedes approximate equivalence among therapies. Various therapeutic approaches that have been demonstrated to be effective for particular problems should however be used. Cognitive behavioural strategies such as motivational interviewing, goal setting, problem solving and relapse prevention have been found to be helpful for addiction problems and should be incorporated into any theoretical approach when working with addiction clients.

While a significant advantage of one form of therapy over another is yet to be found, research has been able to demonstrate the fundamental importance of the therapeutic relationship. A sound therapeutic relationship provides an avenue to communicate respect, understanding, warmth, acceptance, commitment to change and a corrective interpersonal experience.

A number of counsellor qualities have also been found to be associated with improved outcomes. They include the ability to develop a therapeutic alliance, the extent to which the counsellor remains true to the techniques of their therapeutic philosophy, and the extent to which the counsellor is judged to be well adjusted, skilled and interested in helping their clients (Luborsky et al 1985).

These sorts of findings led Mattick et al (1998) to argue that the counsellor is largely responsible for the extent to which a client resists therapy, and client resistance, in turn, tends to be associated with poor progress in therapy. They propose that two important qualities contribute to the effectiveness of a counsellor. One is the ability to establish a therapeutic alliance relatively quickly, and the other is the skills and specialist knowledge about how to manage the relationship once it has been established. They argue that it is this level of skill and ability to work on a process level that may be the most important variable when working with more disturbed clients. According to Ackerman and Hilsenroth (2003), those counsellors who are most effective at establishing a strong therapeutic relationship tend to be flexible, honest, respectful, trustworthy, warm, confident, interested and open.

Other variables important to successful intervention include: the maintenance of well organised case notes, frequent consultations, consistently applied program rules, referral where appropriate, assisting clients to anticipate and deal with potential problems before they arise, and ensuring adequate case management.

Looking at the broader picture

When working with people with substance use issues there is a tendency to focus on substance use per se and forget the broader context of peoples' lives.

Clients' needs or food, safety, shelter and clothing need to be met before other counselling is likely to be effective. Initially, the counsellor's primary role may be to link the client to appropriate welfare, legal and social services. In doing so, the counsellor will have the opportunity to develop a stronger therapeutic relationship and help the client to develop the life circumstances that will give them the best chance at success.

In addition to the importance of ensuring that the client's basic needs are met, counsellors also need to learn to place substance use into the context of people's lives. This includes an understanding of the meaning and functionality of the client's substance use.

Ingredients of effective treatment – tip sheet

- Supportive and empathic counselling is a sound base.
- Therapeutic orientation is not as important as the therapeutic relationship.
- The therapeutic relationship is the most active ingredient in change.
- Maintain clear case and progress notes.
- The counselling approach should include specific evidence based interventions where appropriate eg motivational interviewing, problem solving, goal setting, relapse prevention.
- Anticipate client difficulties.
- Develop strategies with the client to cope with difficulties before they arise.
- Ensure each client has good case management and so are linked to other staff and services where appropriate.
- Consider the wider picture and help clients on a practical level (with food, finances, housing etc.) before considering deeper therapy.
- Receive regular clinical training and regular clinical supervision to assist in the maintenance and improvement of counselling skills.

2. Initial engagement and assessment

The initial meetings with a client should be focused on engagement and assessment. If a counsellor is unsure whether the client will return for further sessions, they should consider including harm reduction strategies in the initial session (see ***Brief Intervention*** and ***Harm Reduction*** in this guide and in the literature review).

A good assessment paints a thorough and detailed picture of the client's AOD problems and how they fit in the context of his or her life: past experiences, current circumstances, personal makeup and expectations for the future. Understanding this context for a client's AOD problems enables treatment plans to be individually tailored and enhances the success of the counselling endeavour.

There are two types of assessment: the assessment interview and standardised assessment. The assessment interview involves the client and counsellor working together to obtain a shared understanding of the nature of the client's difficulties and past and present life story. Groth-Marnat (2003) argues that the assessment interview is "probably the single most important means of data collection" and without it, more standardised assessment would be rendered meaningless. Standardised assessment involves the collection of information via standardised assessment tools such as questionnaires, preferably which have been evaluated as reliable and valid. Counsellors should be trained to use standardised assessment tools, as the inappropriate use may be detrimental to the client. Some of the problems that could arise include mislabelling clients, misinterpretation of test results and inappropriate feedback of results to the clients.

2.1 The assessment interview

That there are a number of important functions that the assessment phase should fulfil:

- developing a therapeutic relationship based on trust, empathy and a non-judgmental attitude;
- helping the client to accurately reappraise their drug use, which in turn may facilitate the desire for change;
- helping the client to link their current problems with their drug use;
- facilitating a review of the client's past and present and linking these to current drug use; and
- encouraging the client to reflect on the choices and consequences of drug using behaviour.

While assessment is an ongoing process between the counsellor and the client, the initial meeting should be primarily devoted to engaging with the client, assessing the client's current difficulties, and

developing an initial idea of the client's treatment needs. The next session or two tend to be primarily devoted to coming to understand the client's current difficulties in the context of their experiences throughout their life; presenting this understanding to the client, seeking their feedback and modifying your understanding as necessary; and as a result developing with the client a plan to meet the client's treatment needs.

The assessment interview should take the form of a semi structured narrative and evaluate a number of different areas including the following (Glass et al 1991; Gossop 2003; Groth-Marnat 2003):

- source of referral;
- presenting issues;
- drug use history and related harms;
- readiness to change AOD use (motivational interview);
- risks including suicidal ideation, thought of harming others, experiencing harm from others, safety of children in the client's care;
- previous treatment for drug use, psychological issues or serious illnesses;
- current situation, including accommodation, work/study, support networks;
- background and personal history (family composition and history, childhood and adolescent experiences, experiences of school, traumatic experiences, occupational history, sexual and marital adjustment, history of legal issues and behaviour, history of financial and housing issues, interests and leisure pursuits);
- how clients view themselves and others;
- strengths and weaknesses;
- presentation and mental state;
- summary or formulation which consists of a summary of the presenting problems their development and maintenance.

Source of referral

The source of the referral of the client should be noted.

Presenting issues

Presenting issues are evaluated through a thorough exploration of what the client perceives to be the difficulties that have brought them to treatment. Presenting issues are usually broader than just AOD problems and can include issues in any area of a person's life such as psychological, social, health, legal accommodation and financial problems.

Alcohol and drug use history

It is important to gain a clear understanding of the evolution and development of drug use as well as the client's current AOD use. The counsellor should explore a variety of issues including range of drugs used, quantity and frequency of use, circumstances of use, current and previous drug-related problems, risk behaviours in terms of blood borne virus transmission or overdose, and any previous attempts at change. Roisen's (1983) 4L model can be particularly useful for assessing drug-related problems across areas of a client's life:

- health (liver);
- relationships (lover);
- the law (legal); and
- finances, housing, work etc (livelihood).

Readiness to change

Readiness to change can be assessed with a motivational interview to explore the positives and negatives of the client's drug use, and how they feel about those positives and negatives. A client's motivation to change is important in determining the appropriate type of treatment. For example, the provision of harm reduction information is a more appropriate treatment strategy for a client in the

pre-contemplation stage whereas goal setting, problem solving and relapse prevention are more appropriate for clients in the action stage.

Risk assessment

Evaluation of a client's risk to self or others should be included in the assessment interview. Areas to be evaluated include current and previous suicidal ideation and attempts, self harm, perpetration of domestic violence, victimisation via domestic violence, homicidal ideation and attempts, and safety of children in client's care. A format for suicide risk assessment is included in Appendix 1.

For clients engaging in sex with casual partners or involved in sex work, sexual practices should be evaluated in terms of safety regarding blood borne virus transmission and personal safety.

Previous and current treatment for drug use, psychological issues or serious illness

In addition to listing previous treatment episodes, clients should be asked about their experiences of those episodes and what were particularly successful or unsuccessful ingredients in these experiences. This assists the counsellor to start to develop a picture of what needs to be included and avoided in the counselling process, and whether referral to or liaison with other agencies is needed.

Current situation

This should include gathering current information on accommodation, who the client lives with, children, significant people in the client's life, social support, work, study, source of income, legal issues, financial issues, and who the client may be able to use as support.

Background and personal history

The focus in this section should include a client's history from birth to the present. Exploration of this context can enhance understanding for both the counsellor and client of the aetiology of a client's AOD use as well as its function throughout the client's life. For some clients, drug use will have been central to them being able to manage very distressing emotions and memories, often stemming from adverse childhood experiences. For such clients, talking with the counsellor about how important drug use has been to them can help them to develop compassion and understanding for themselves. Exploring these areas can also help the client make links between the impact of drug use and his or her current life situation.

The following areas should be enquired into:

- family context;
- childhood experiences;
- adolescent experiences;
- experiences of school (academic, social, sporting, bullying);
- traumatic experiences (see later section "raising sensitive issues");
- occupational history;
- sexual/ marital adjustment;
- legal issues and illegal behaviour;
- financial and housing information; and
- interests and leisure pursuits.

See section below on "Raising sensitive issues" for tips on how and when to raise some of these issues.

How clients view themselves and others

Explore how the clients see themselves, in order to assess issues such as self esteem, sociability, and trust. Much of this information is gleaned from what clients directly say and how they report feeling.

Further exploration can be aided by using the "arrow down" cognitive behavioural technique (Beck 1995). When a client voices a negative belief about something, such as:

"I can't stop using drugs"

the counsellor can ask:

"What does that mean about you?"

This will help to identify core beliefs such as defectiveness:

"It means there's something wrong with me, I'm hopeless",

or failure:

"It means I'm a complete failure"

or entitlement:

"I shouldn't have to stop using drugs, what business is it of my partner anyway?"

Young's Schema Questionnaires (Young & Brown 2003a, 2003b) which assess people's core beliefs about themselves and others can also assist with this. Information on assessing schemas, as well as copies of assessment instruments can be found on Jeffrey Young's website: *http://www.schematherapy.com/id54.htm*

Strengths and weaknesses

Identify current strengths and weaknesses. These usually emerge from collecting information about the client's life throughout the assessment interview, though some direct enquiry can also be included when appropriate. Current strengths can be used during the course of therapy to help the client achieve their goal. Groth-Marnat (2003) argues that exploring a client's strengths is perhaps one of the most important aspects of an assessment.

Presentation and mental state

Counsellors should evaluate the client's presentation and mental state and document the evaluation in the assessment report. This evaluation is gained mainly through observation throughout the assessment interview. Some direct questions will need to be asked at appropriate times, particularly regarding thought content, perception and orientation. The mental state examination form and instructions included in Appendix 2 provides a guide to the sorts of comments that can be about those areas of a client's presentation and mental state. The areas to be covered include:

- appearance and behaviour (physical appearance, reaction to situation);
- speech (rate, volume, quantity of information);
- mood and affect;
- form of thought (amount and rate, continuity of ideas);
- thought content (delusions, paranoia, suicidal or homicidal thoughts, other);
- perception (hallucinations, other perceptual disturbances);
- sensorium and cognitions (level of consciousness, memory, orientation, concentration, abstract thoughts, cognitive impairment); and
- insight.

Although counsellors often only comment on these aspects of a client's presentation when they notice something unusual, it is worth making an effort to note when the presentation is normal as well, using comments such as "no unusual thought form or content noted, no perceptual disturbances noted, affect appropriate".

It should be noted that some type of impairment in cognitive functioning is common in clients using drugs, though these impairments are not always obvious upon presentation. For example, chronic drinkers often have subtle deficits in memory and executive functioning, and in extreme cases may develop Korsakoff's syndrome which consists of severe memory and learning impairments, inability to plan activities and comprehend abstract information (Lezak 1983). Long-term methamphetamine use can result in deficits in attention, memory, verbal skills, problem solving and abstract reasoning (Teichner et al 2002; Meredith et al 2005). In addition to the effects of drug use, many people involved in the drug using lifestyle are exposed to violence, or accidents (such as traffic accidents or accidents resulting from intoxication), which can also result in head injuries and cognitive impairment.

As part of assessing mental state, counsellors should make observations regarding any indications of poor cognitive functioning such as difficulty concentrating and comments from clients about poor memory or difficulties organising their lives. If cognitive impairment is suspected, it can be worth referring the client for a cognitive assessment if possible. Although these problems can be due to the drug using lifestyle per se, they can reflect cognitive impairment, in which case treatment strategies may need to be adapted. For more information, see ***Cognitive Impairment*** in this guide and the literature review.

Summary or formulation

This consists of a summary of the presenting issues, a formulation of these presenting issues in terms of their aetiology and maintenance within the context of the client's life, and a summary of client strengths. A simple model for formulating this information is the 5Ps model:

- presenting issues – summary;
- predisposing factors – these are issues in the client's childhood, adolescence and adulthood that predispose them towards experiencing their AOD and other current difficulties;
- precipitating factors – what has brought their difficulties to a head and resulted in them seeking treatment;
- perpetuating factors – what factors in the client's life, behaviour and psychological state maintain the presenting issues; and
- protective factors – the client's strengths.

Raising sensitive issues in the assessment phase

In conducting a thorough assessment, the counsellor may need to raise sensitive issues including childhood trauma, eating disorders, domestic violence and suicidal ideation. While raising such issues can be risky, this is often necessary for a full understanding of the context of AOD use.

When raising a sensitive issue the following should be considered:

- explain that these issues are common to people presenting with AOD issues;
- acknowledge how difficult it can be for people to talk about these issues;
- give a rationale for raising the issue (it can be important to treatment, therapy etc);
- be non judgmental and empathic;
- link it to presenting concerns, problems;
- use non threatening prefaces; and
- start with open ended questions.

It is often not appropriate to raise sensitive issues during the first session, and it is important that clients know they can choose not to discuss them. Counsellors providing only brief intervention should use of clinical judgement in relation to raising sensitive issues. It may not be appropriate for the counsellor to work with clients on some sensitive issues, and referral to a more appropriate agency or counsellor with the necessary knowledge and experience may be required.

A note on trauma

Many AOD clients have had traumatic experiences, often childhood physical or sexual abuse (Plant et al 2004; Swift et al 1996, Watson 2006). Although it is important to know whether a client has had these experiences, it is even more important to avoid further traumatising a client. Herman (1992) recommends that counsellors establish a safe environment and a strong therapeutic relationship prior to asking clients to discuss traumatic issues. These issues may need to be raised some weeks after the initial clinical interview. Even then, avoid asking the client to go into depth about such issues until they have developed the ability to manage the strong affect that accompanies them. Note that many clients who experienced early and repeated trauma may never be sufficiently stable to talk in any depth about their traumatic experiences without becoming overwhelmed and re-traumatised.

Some clients will volunteer information about traumatic experiences in the first session. If a client starts going into enormous detail, it may be necessary to stop them and explain that talking in detail about traumatic experiences may not be in their best interests at this stage as they can become further traumatised, and that you only need a broad overview of their experiences. It is also necessary to keep a check on the client's emotional state as it is easy for them to be overwhelmed when thinking or talking about traumatic experiences.

Other clients will not volunteer information on traumatic experiences at all, and counsellors will need to seek permission from the client to enquire about them, then ask broad questions, but make it clear that they do not want details and that the client can stop the process whenever they wish. For example:

"It's important that I know whether you've had traumatic experiences as it helps place your drug use into a broader context, but I don't need details. However I don't want to ask any questions right now that will be too distressing for you – it's important that you only give me this information when you feel ready. How would you feel about me asking you a few broad questions about whether you've had traumatic experiences? Make sure that you say "no" if you feel uncomfortable about this."

If the client consents, then quick questions requiring yes and no answers can be used such as:

"*Have you experienced physical abuse as a child? or adult? Have you experienced sexual abuse or assault as a child? or as an adult? Have you experienced other traumas?"*

Grounding strategies to help the client distract from emotional pain should be introduced in the first session with all traumatised clients (see Chapter 15, ***Grounding***).

2.2 Standardised assessment

Standardised assessment involves using standardised assessment tools such as questionnaires preferably that have been evaluated as reliable and valid as a means of gathering data.

Standardised assessment tools aim to achieve the following.

- provide support for hypotheses developed during the course of an informal assessment;
- highlight issues that may not have appeared salient during the informal assessment;
- provide an objective measurement of the client's circumstances;
- provide an objective means to measure change and treatment success; and
- provide the means to develop a data base that allows comparability between treatment approaches, comparability between clients accessing treatment services, enhance information regarding what works and for whom, as well as other research purposes.

Introduction and use of standardised assessment tools

Always provide clients with a rationale for assessment, explaining the purpose of each instrument prior to their use. Explain what the assessment results will be used for and who may have access to the results. Discuss how long the assessment is expected to take before asking whether the client is willing to complete the assessment (informed consent). It is important that consent is given willingly and that clients do not feel under any obligation to complete assessment instruments.

The counsellor should be aware of any difficulties that may arise for the client in completing the questionnaire (eg poor literacy skills). In such an instance the counsellor should offer to read the questions to the client, possibly over a number of sessions in order to reduce client fatigue.

Key areas for standardised assessment

The assessment instruments mentioned below are available free of charge. Most, though not all, have demonstrated reliability and validity.

For AOD treatment evaluation purposes, some key domains for standardised assessment include the measurement of:

- alcohol and drug use: quantity and frequency, level of dependence;
- blood borne virus risk exposure and behaviour;
- general health;
- social functioning;
- psychological functioning;
- criminality; and
- client satisfaction with treatment.

Several scales that assess most of these areas, have established reliability and validity and are available freely on the web include the Brief Treatment Outcome Measure (BTOM) (Lawrinson et al 2005), the Opiate Treatment Index (OTI) (Darke et al 1992), and the Maudsley Addiction Profile (MAP) (Marsden et al 1998).

- The BTOM has been adopted in New South Wales for routine AOD treatment outcome monitoring. It takes on average 21 minutes to complete. It assesses level of dependence, quantity and frequency of substance use, blood borne virus risk exposure, psychological functioning, social functioning and client satisfaction. This instrument does not ask about illegal activity other than arrests for offences allegedly committed in the last 3 months. The BTOM includes modules specific to counselling, detoxification, rehabilitation and methadone treatment.

- The OTI is another Australian scale which takes on average 20-30 to complete. It assesses quantity and frequency of substance use, blood borne virus risk exposure, physical health, psychological functioning, social functioning, and illegal activity. Depending upon the circumstances, clients may be unwilling to provide counsellors with the level of detail that is asked about, and it may be unwise for counsellors to have overly detailed information on a client's criminal behaviour in case notes are subpoenaed.

- The MAP is a British scale developed primarily for research purposes which takes about 12 minutes to complete. It addresses quantity and frequency of substance use, blood borne virus risk exposure, physical health, psychological functioning, social functioning, and illegal activities engaged in during the last month. As for the OTI, clients may not feel safe disclosing the level of information requested about illegal activity.

There are a number of scales to assess client satisfaction. A scale which is freely available and has demonstrated reliability and validity is the *Client Satisfaction Questionnaire (CSQ8)* (Larsen et al 1979) which has been included in Appendix 3.

There are also instruments freely available to assess or screen for other aspects of client functioning which can be useful in particular circumstances but would not be administered to all clients. Measures of withdrawal from heroin, alcohol, benzodiazepines, amphetamines and cannabis are included in Appendices 4-8 (note all the withdrawal scales included except the one for cannabis have evidence of reliability and validity). The measurement of withdrawal syndromes where objective signs are present and quantifiable (such as alcohol and opiate withdrawal) can provide cut off scores and indications for medication administration as is presently done with the *Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar)* scale (Metcalfe et al 1995) and the *Objective Opiate Withdrawal Scale (OOWS)* (Handelsman et al 1987). However, withdrawal scales for those syndromes where symptoms are subjective and no objective signs have been identified (such as scales for benzodiazepine, amphetamine and cannabis withdrawal) may be less useful. Given the subjective nature of withdrawal symptoms, for benzodiazepine, amphetamine and cannabis withdrawal, scales can only be used as a general guide to treatment.

Screening instruments to alert the clinician to possible psychological difficulties such as psychosis, depression, anxiety, dissociation or posttraumatic stress disorder (PTSD) can also be useful. An instrument with demonstrated reliability and validity, the *Depression, Anxiety, Stress scale (DASS)* (Lovibond & Lovibond 1995) has been included in Appendix 9. *The Psychosis Screener* (Jablensky et al 2000), which was developed to screen for psychosis in the general population, rather than just in the presence of psychosis, is in Appendix 10. This instrument, rather than one designed for use with clearly psychotic people, was included because quite often psychotic symptomatology in users of drugs such as amphetamines may not be obvious unless specifically asked about. The instrument is in the process of being evaluated for reliability and validity (see Degenhardt et al 2005). Note that none of the instruments is diagnostic. Other instruments to assess particular issues are readily available via searching the web, though some of these may questionable reliability and validity.

Assessment of the safety of children should also be made when working with parents with substance use problems (see ***Child protection issues***). If a level of suspicion exists as a result of the assessment interview, structured assessment instruments can be used to explore child safety in more detail. The *Hearth Safety Assessment Tool* (Robinson & Camins, 2001) is designed to help counsellors assess specific areas of risk and strengths to provide clinicians with an overall picture of the global level of the child's risk of harm. This tool has not been subjected to reliability and validity studies, but is widely used in AOD treatment services in Western Australia. The instrument covers a number of important areas, but does not ask about violence in the relationship between the parents or towards the child, or about the child's potential exposure to risk from associates of the parents, which should always be examined. Training is required to use the tool. Another instrument to assist with assessing parenting and child safety in the context of parental drug use that is freely available on the web, does not require training, and covers violence and exposure to potential risk, though has also not been evaluated for reliability and validity, is the *Risk Assessment Checklist for Parental Drug Use*[1].

The outcome measures referred to above rely mainly on the self-reported behaviour of clients. Self reported behaviour has been shown in previous studies to be generally consistent with biochemical markers and collateral interviews (Darke 1998; Kilpatrick et al 2000). Of course there are situations in which self-reported behaviour could be misleading. Such situations can include those in which clients may receive negative sanctions for accurate reporting such as when involved in the criminal justice system, or if they feel they can't report accurately to their counsellor for fear of disappointing them or because of shame and embarrassment. There are various ways to increase the accuracy of the data in these situations. For example for clients involved in the criminal justice system, urine tests can provide the information clients may not be prepared to divulge. In situations when clients fear telling the counsellor, normalising relapse and talking with clients about the importance of disclosing lapses for their treatment can help.

[1] Available from Drugnet website: http://www.drugnet.bizland.com/assessment/checklis1.htm

It is also worth noting that contrary to the concerns of some practitioners regarding the impact of administering standardised assessment measures, the literature and anecdotal evidence indicates that when conducted appropriately the process of standardised assessment can be a source of rapport building (Marsh & Dale 2006). It is acknowledged, however, that it can be difficult for counsellors to administer too many assessment instruments in addition to the general intake questions and interview. Realistically, with stretched resources and numerous demands on clinician time, the use of standardised instruments will often not occur, or will only occur if they are very brief or required by the agency. Something clinicians and clients often find easier is the use of simple rating scales to reflect the severity of key issues such as drug use, crime, depression etc. These ratings can be compared from start to finish of treatment to gain an idea of change, or they can be rated, for example from 1 (much worse) to 5 (much better).

Interpretation of assessment results

Results from standardised assessment tools should always be examined in relation to results obtained from the assessment interview. Counsellors should enlist the assistance of their supervisor in the interpretation of standardised assessment results where necessary.

While counsellors may be able to distinguish between those clients with a co-existing psychological disorders (eg anxiety disorders) and more severe psychiatric disorders (eg psychotic disorder), diagnosis of these conditions should only be undertaken by a clinical psychologist or psychiatrist. Scales to screen for the existence of symptoms of depression, anxiety and psychosis are included in the Appendices (*DASS* in Appendix 9 and *Psychosis Screener* in Appendix 10).

Outcome measures

By administering the same standardised assessment tools used during a formal assessment throughout treatment and on completion of treatment (and preferably at follow up as well) the counsellor and client will be able to note changes in relation to a number of areas.

Another that should be monitored is client engagement and treatment. Standardised measures are not usually used for this as different treatment programs will have different criteria for engagement and treatment success. Common ways of recording client engagement and treatment completion include recording the number of sessions a client attended, whether a client completed a treatment program, recording reasons for treatment drop out where possible and so on. This sort of information is important for individual clinicians, for agencies as a whole, and for research purposes as it can provide valuable information about what works for which clients, as well as direction in terms counselling and agency practices that might need improving.

2.3 Feedback of assessment results to clients

Feeding back assessment results to clients is one of the most important aspects of the assessment process. Counsellors should feedback results in a manner that clients can understand (ie don't just give them numerical test scores), and that focuses on both their strengths and weaknesses (ie don't just tell them that they are dependent, depressed, using in an unsafe manner and psychologically unhealthy). Finally, results should be fed back in the context of a treatment plan and directions for the future, as a means of providing hope for the client (Marsh & Dale, 2006). It is important that the client feels that there is hope for the future.

When feeding back assessment results consider the following.

- Focus first on the client's strengths.
- Gently and tactfully outline the client's difficulties.
- Focus on the pattern of results rather than just an overall score.

Example
"It seems as though you have had a lot to contend with in your life and so as a result you have been drinking lots of alcohol in order to cope. Unfortunately, all of these difficulties have left you feeling really depressed and as though there is no hope for the future any more."

- Pull the assessment results together and offer hope for the future by discussing a treatment plan.

Example
"Because you haven't got anywhere stable to live at the moment I think that we need to focus on finding you somewhere to live, and sorting out your Centrelink payments. Then we can start to tackle some of your feelings of depression and some of the problems that you have been experiencing from your drug use. How does that sound to you?"

2.4 Documenting the assessment

The results of the assessment interview should be integrated with results of any standardised assessments conducted and be documented. The form of the documentation will vary according to the purpose it is to be used for, whether for a record in the client's file or for reports for external parties.

Recording in the client's file

The assessment document in the client's file should include information under each of the headings listed above to be covered in the assessment interview. The structure of this document in terms of the order of presentation of the information will vary somewhat from agency to agency and with professional groups.

Reports for third parties

Assessment reports are often requested by third parties, requiring slightly different presentation of information. When writing an assessment report for an external party the following should be considered.

- Include only relevant and important information.
- Be concise – no one will read an overly long report.
- Write in a clear, simple and objective writing style.
- Avoid value statements.
- Do not use any ambiguous terms.
- Avoid jargon.
- Eliminate any biased terms or wording from the report.
- Always cite the source of the information. For example
  "Betty reported that…; the court assessment service revealed that…"
- Consider all sources of information in your conclusions. Don't base your conclusions solely on the basis of test scores.
- Mark all reports "STRICTLY CONFIDENTIAL".

Assessment - tip sheet

Upon entry into a treatment program clients should undergo an assessment interview, and standardised assessment as appropriate.

Clients should be provided with a rationale for the assessment procedures.

Clients should be provided with feedback summarising the results of the assessment.

Information gained from these sources of assessment should be used as a foundation of an individual's tailored treatment program.

Standardised assessment of core performance indicators should be conducted at treatment entry, exit and follow up to enable treatment evaluation and research.

Assessment interview

The assessment interview should cover:

- source of referral;
- presenting issues;
- drug use history and related harms;
- readiness to change AOD use (motivational interview);
- risks including suicidal ideation, thought of harming others, experiencing harm from others;
- previous treatment for drug use, psychological issues or serious illnesses;
- current situation, including accommodation, work/study, support networks;
- background and personal history (family composition and history, childhood and adolescent experiences, experiences of school, traumatic experiences, occupational history, sexual and marital adjustment, history of legal issues and behaviour, history of financial and housing issues, interests and leisure pursuits);
- how clients view themselves and others;
- strengths and weaknesses;
- presentation and mental state; and
- summary or formulation which consists of a summary of the presenting problems their development and maintenance.

If cognitive impairment or severe psychological difficulties are suspected expert consultation and referral should be sought.

Assessment - tip sheet (cont.)

Standardised Assessment

Standardised assessment:

- should complement the assessment interview;
- provides an objective view of the client's difficulties and current life situation;
- increases the accountability of both services and clinicians by providing an objective measurement of treatment success, comparability between treatment approaches and comparability between clients accessing treatment services; and
- should be completed upon entry into and exit from a treatment program, as well as at follow up.

Key areas for standardised assessment include:

- alcohol and drug use: quantity and frequency, level of dependence;
- blood borne virus risk exposure and behaviour;
- general health;
- social functioning;
- psychological functioning;
- illegal activity – note extent of information requested should be carefully considered; and
- client satisfaction with treatment.

Client engagement and treatment completion should also be recorded.

Other aspects of client functioning should be assessed as appropriate, for example withdrawal from various drugs, and symptoms of psychosis, depression, anxiety, or PTSD.

Counsellors should be trained to use and interpret formal assessment instruments as appropriate.

Feedback

After completion of assessment procedures, results should be interpreted in relation to the client's personal history.

Results of all assessment procedures should fed back to all clients.

Feedback should include exploration of strengths, then weaknesses, without using labels and in terms appropriate for the client.

Feedback should provide hope for the future by discussing a treatment plan.

3. Treatment matching

The fundamental purpose of assessment is to match the individual client to the appropriate treatment intervention, thereby maximising treatment effectiveness. Matching is based on the interaction between the client type (characteristics) and treatment type. Research into treatment matching examines the effects of treatment modality (group or individual psychotherapy), treatment duration or setting (residential or non residential), counsellor (peer or professional) and treatment goal (moderation or abstinence). To date however, conclusive evidence for the "matching hypothesis" is limited.

The following factors should be considered in treatment matching.

3.1 Dependence and problem severity

Clients who present with high levels of AOD dependence and severe substance-related difficulties are more likely to benefit from intensive, highly structured treatment programs such as AA/NA, residential treatment, and more frequent outpatient sessions and linking with other relevant services. Clients enmeshed into the AOD using lifestyle, associating primarily with other AOD users will require more intensive treatment. Conversely, those with a social network supportive of abstinence or moderate AOD use will require less intensive treatment.

For alcohol dependent clients, controlled drinking goals are more appropriate for clients with a lower severity of dependence, and who believe that controlled drinking is possible. A goal of abstinence is recommended for those with a prolonged and extensive history of drinking, a high degree of dependence, and who believe that abstinence is the only option. A period of abstinence should be encouraged prior to the introduction of controlled drinking.

3.2 Cognitive factors

Cognitive deficits often result from chronic use of alcohol, methamphetamine and volatile substances, and can hold significant implications for the process and outcome of treatment. Clients with some degree of cognitive damage are likely to benefit from highly structured residential treatment. When working with clients who have cognitive damage, generic research indicates the need for highly structured behaviourally based intervention strategies as opposed to insight oriented therapy. Therapy should include a strong life skills component addressing issues of finance, accommodation, domestic duties and involvement in a non AOD using community.

When working with this population, choice of treatment strategies should include consideration of the following areas of cognitive functioning in which deficits are commonly observed:

Alcohol:

- problem-solving;
- perceptual motor skills;
- non-verbal memory;
- visuospatial abilities;
- response inhibition;
- reasoning;
- planning abilities;
- memory recall;
- skill and information acquisition; and
- cognitive efficiency (focusing on relevant information while ignoring irrelevant information).

Methamphetamine:

- attention and concentration;
- visual and verbal memory;
- information processing;
- problem solving;
- decision making;
- response inhibition;
- sequencing; and
- emotional processing.

(See also chapters on ***Cognitive Impairment*** in this guide and the literature review, and ***Methamphetamine*** in the literature review.)

3.3 Life problems

Specific problems in various aspects of client's daily living may indicate the need to match clients to specific components of broad-based treatment. Factors to consider include finances, housing, social support, physical stability and psychological difficulties. For example, clients high in anxiety are likely to benefit more from additional relaxation training and coping skills training, than clients low in anxiety. The Project Match Research Group (1998) found that clients experiencing high levels of anger had better outcomes from motivation enhancement types of treatment than cognitive behavioural coping skills treatment.

3.4 Client motivation and choice

It is important that clients be allowed to make informed choices about treatment from a range of plausible alternatives, as this is associated with enhanced treatment outcome.

Client motivation and choice is also relevant for the use of addiction pharmacotherapies. Methadone maintenance and buprenorphine (Subutex[2], Suboxone[3]) which have opiate effects are effective treatment options for long term users with severe opiate dependence who are not motivated to be completely drug free. Naltrexone treatment is likely to be successful for those clients who are highly motivated for abstinence and who have a social network supportive of abstinence. (See ***Pharmacotherapies for Dependence*** chapter in this guide and in the literature review.

Prochaska and DiClemente's (1992) transtheoretical model of behaviour change, commonly referred to as the *Stages of Change model,* is also relevant to matching specific counselling strategies in terms of client motivation. This model suggests that in attempting to change behaviour people move through a number of stages of change:

- precontemplation (not interested in change);
- contemplation (seeing the need for change but not yet ready);
- preparation (putting plans in place for a change attempt);
- action (implementing change); and
- maintenance (maintaining change).

Tailoring clinical interventions to stages of change has been found to significantly enhance outcome (Prochaska & Norcross 2001). See ***Stages of Change*** in this guide for recommended interventions for clients at each stage.

3.5 Other client characteristics

Other client characteristics that should be considered include age, gender, financial, physical and emotional security, cultural issues, degree of coercion for treatment, nature and severity of underlying psychological difficulties.

Readers are referred to relevant chapters (eg ***Young people***, ***Women***, ***Men***, ***Clients with Complex Issues*** etc) in this guide and the literature review when considering treatment options.

[2] SUBUTEX® Reckitt Benckiser.
[3] SUBOXONE® Reckitt Benckiser.

Treatment matching - tip sheet

Treatment matching involves considering the interaction between the type of client, the nature of their problems and the most suitable treatment option. Factors that should be considered in treatment matching include problem severity, cognitive factors, life problems and client choice. The following treatment matching information should be considered.

- Clients with a higher degree of dependence should be encouraged to engage in more intensive programs that help develop a social network not supportive of AOD use.
- Residential treatment programs are more strongly indicated for clients who lack stable housing or primary relationships, and those clients with social networks supportive of continued using.
- If a client has a support base encouraging continued AOD use, recommend at least 3 sessions of Alcoholics Anonymous (AA)/Narcotics Anonymous (NA) in order to assess its appropriateness.
- Clients with a long drinking history and severe dependence should be encouraged to adopt a goal of abstinence rather than controlled drinking, though ultimately client choice must be respected.
- Clients with high levels of anger respond better to motivational enhancement.
- Treatment strategies may need to be matched to a client's level of cognitive functioning. This issue is particularly pertinent when working with long-term alcohol or methamphetamine users.
- More behaviourally based treatments are indicated for cognitively damaged or intellectually impaired clients.
- Methadone maintenance and buprenorphine (Subutex[4], Suboxone[5]) treatments have been found to be effective for long-term users with opiate dependence.
- Naltrexone maintenance treatment has been found to be effective for clients highly motivated for abstinence and who have networks supportive of ceasing use.
- Always consider the impact of other variables such as age, gender, financial, physical and emotional security, cultural issues, degree of coercion for treatment, nature and severity of underlying psychological difficulties.

4. Treatment planning

A treatment plan is a detailed overview of the planned intervention, much akin to a road map for therapy. The primary purpose of treatment planning documentation is to ensure individuality and continuity and consistency of care for clients, and to enhance communication between clinicians involved in the individuals care, clients and management (Darmer et al 2004 & National Treatment Agency for Substance Misuse UK 2006). Treatment plans ensure that counselling covers the particular concerns relevant to the client and also provide clients with a sense of hope by highlighting the fact that many of their seemingly insurmountable practical difficulties can be overcome (Marsh & Dale, 2006).

[4] SUBUTEX® Reckitt Benckiser.
[5] SUBOXONE® Reckitt Benckiser.

Detailed treatment plans as the basis for intervention with clients are particularly relevant given the complex and multidimensional nature of the problems many clients tend to present with (Gossop 2003), and research indicates they enhance treatment effectiveness (Mattick et al 1998).

Treatment plans should be:

- well developed and articulated, written and highly detailed;
- jointly negotiated between the counsellor and client;
- structured around meeting the client's articulated goals and needs;
- directly derived from the results of assessment, goal setting and client choice;
- contain practical, realistic goals and the strategies for achieving these goals; and
- where appropriate, include parents, partners, families and friends.

Treatment plans should contain the following.

- a summary of or formulation incorporating the 5P model for summarising an assessment – presenting problems, predisposing factors, precipitating factors, perpetuating factors and protective factors (see ***Assessment*** chapter);
- an assessment of client needs (support, psychological, parenting, other service needs etc)
- a statement of client goals;
- a list of strategies for achieving these goals;
- an assessment of constraints and opportunities for meeting client needs and goals; and
- an outline of methods for evaluating progress and outcome (see ***Best Practice Outcome Performance Indicators***).

Treatment plans should focus on practical skill acquisition, addressing psychological difficulties when necessary, building clients' strengths, addressing the support needs of the client, and evaluating the outcome, is believed to be integral to improving therapeutic success among this population.

If evaluation of the client's progress indicates the need for the renegotiation of the treatment plan, it is recommended that this process be done explicitly and together with the client to ensure that the client and the counsellor continue to be pursuing the same agenda.

Treatment planning - tip sheet

Treatment plans keep therapy focused as well as providing a means to reconsider where the therapy is going.

Treatment plans should be jointly negotiated between counsellor and client and be based on assessment results.

Treatment plans should contain the following:

- a summary of or formulation incorporating the 5P model for summarising an assessment – presenting problems, predisposing factors, precipitating factors, perpetuating factors and protective factors (see ***Assessment*** chapter);
- an assessment of client needs (support, psychological, parenting, other service needs etc)
- a statement of client goals;
- a list of strategies for achieving these goals;
- an assessment of constraints and opportunities for meeting client needs and goals; and
- an outline of methods for evaluating progress and outcome (see ***Best Practice Outcome Performance Indicators***).

A treatment plan should include a focus on practical skill acquisition, building clients' strengths, addressing psychological difficulties when necessary, addressing the support needs of the client, and evaluating the outcome.

5. Goals of intervention

Goals are an integral part of any therapeutic program as they provide directions for therapy, clarify the client's expectations of therapy, and clearly establish for both the counsellor and client what can and cannot be achieved in therapy. Goal directed therapy provides counsellor and client with concrete signposts guiding the process of treatment and enables progress to be measured over time. This allows clients to experience success, which may counter the learned helplessness that is commonly experienced by many drug users. Goal setting also ensures that counselling remains client focused and directed, irrespective of the theoretical orientation of the counsellor.

Although the goals of many treatment programs focus on the cessation of drug use, it is important to note that clients present with a range of goals relating to various aspects of their lives which may, or may not, incorporate abstinence. Thus, as well as acting as a source of motivation for clients, goals also allow counsellors to determine whether their skills, competencies and interests will be appropriate for working with a particular client towards a particular outcome. For example, a client's overall goal relating to their drug use (either abstinence or controlled use) may determine the suitability of a particular service, treatment approach, or counsellor.

Goal setting uses the information gained during the assessment process to facilitate the development of a "mutually agreed upon plan for the direction of treatment" (Jarvis et al 1995). Goals help to keep counselling on track and provide a basis for selecting and using particular therapeutic techniques and strategies, as well as providing a method of evaluating the success of therapy.

The literature suggests that goals should be:

Geared towards the client's stage of change

For example, a goal of complete abstinence is inappropriate for clients who are currently at the stage of contemplating whether they want to change their AOD use.

Negotiated

Although goals should be client directed, they should also reflect the counsellor's professional judgment. This ensures that the client is committed to the goals (since he or she was instrumental in developing them), and that the goals are also realistic and achievable (given that they were defined on the basis of a counsellor's professional expertise and knowledge).

Specific and achievable

Goals need to be defined in clear, specific and achievable terms. As an example, Helfgott (1997) suggests that the goal of "to be nice to my partner" is ambiguous. A more specific goal might be to "say three positive things to my partner this week" or "to go to the movies with my partner once per week". Goals also need to be achievable. For example, instead of the client committing to abstinence, it may be more realistic for the client to initially aim for two alcohol free days per week. It is important that the client begins to gain a sense of mastery by achieving his or her goals.

Short term

It is important that goals are achievable in the short term. While overall goals for therapy need to be set, these can be broken down into their smallest components to produce shorter-term goals. Ideally, these shorter term goals would be developed on a weekly basis thereby providing the client with a sense of success and achievement as they meet these goals, and thus increasing their motivation to stay dedicated to the long term goals.

Described in positive rather than negative terms

The importance of focusing on skill acquisition, rather than behaviour reduction has a long history in psychology and related disciplines. It is important that goals be phrased in terms of someone doing something, rather than someone not doing something. For example, the goal to "reduce drug use to only two days per week" is expressed in negative terms. The same goal, expressed in positive terms is, "I will increase the number of drug free days to five out of seven".

Not necessarily limited only to drug use

In most situations a number of different goals may be considered. These might include:

- reduction in drug use;
- improved physical health;
- improved psychological health;
- reduction in criminal behaviour;
- improved social adjustment and functioning; and
- reduced harm associated with drug use.

Cognisant of the treatment matching literature

The *Evidenced based practice indicators for alcohol and other drug indicators literature review* maps out a number of considerations with regards to the goals of controlled drug use or abstinence. For example, research suggests that clients with lower severity alcohol dependence are more likely to be capable of achieving controlled drinking outcomes, compared to those clients with a prolonged and extensive history of drinking and a high degree of dependence, who are more likely to benefit from abstinence-based goals. See the ***Treatment Matching*** chapter in this guide and the literature review.

Goal setting tip sheet

Always set goals when working with clients. They provided direction for counselling, give a standard by which progress can be reviewed, and give clients concrete evidence of their improvement.

When setting goals consider the following:

- Goals should be geared towards a client's stage of change.
- Goals should be negotiated between counsellor and client.
- Goals should be defined in clear, specific and achievable terms eg I will have three alcohol free days per week.
- Goals should be short term. Set an overall goal for therapy and then break it down into its smallest components. Small goals should be set on a weekly basis.
- Goals should be described in positive not negative terms. They should focus on skill acquisition. eg Rather than the client aiming to reduce drug use to two days per week, frame the goal in positive terms such as "I will increase the number of drug free days to five out of seven".
- The process of negotiating goals should include consideration of the treatment matching literature.

Don't limit clients to only formulating goals about their AOD use. Consider the following areas:

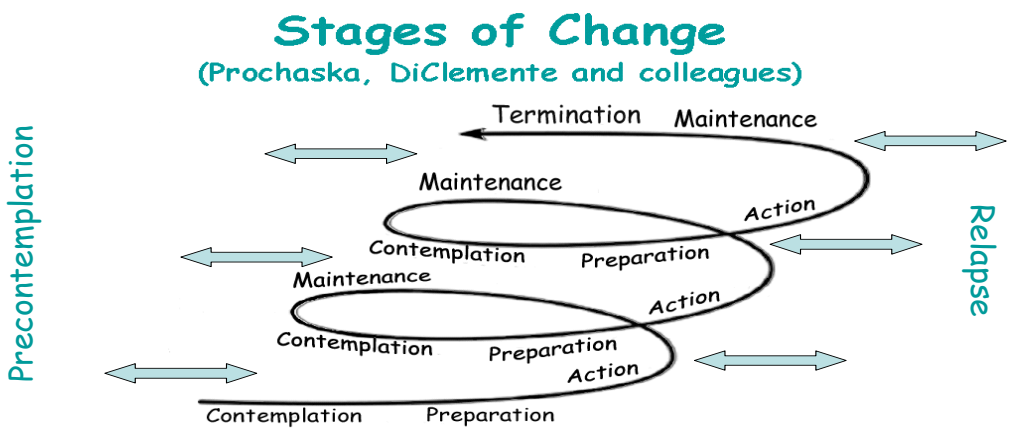
- improve physical health;
- improve psychological health;
- reduce criminal behaviour;
- improve social adjustment and functioning;
- reduce drug use; and
- minimise the harm associated with drug use.

Note: there is goal setting work sheet for clients in Appendix 11.

6. Stages of change

A well-known model in the addictions area is Prochaska and DiClemente's (1992) transtheoretical model of behaviour change, commonly referred to as the *Stages of Change Model*. The model was originally developed through an examination of the stages and process of self-change in smokers, and suggests that individuals attempting to change behaviour move through a sequence of stages of change: precontemplation, contemplation, preparation, action, and maintenance.

Clients do not necessarily go through the stages in an orderly, linear fashion. Rather progression through the model is conceptualised as a process of spiralling through the various stages. For example, a client may start the day at the stage of action but may then spiral back to the stage of contemplation following the onset of their withdrawals and their subsequent decision to go and use. In addition, most people make several attempts at changing their behaviour before they succeed, and they learn from each attempt (see diagram below adapted from Prochaska et al 1992).



In their review of 20 years research on the model, Prochaska and Norcross (2001) conclude that tailoring the counselling relationship and clinical interventions to stage of change can significantly enhance outcome. The stages of change and tips for working with clients in each stage are as follows.

Precontemplation

Clients in the precontemplation stage are not interested in changing their AOD use. For some clients, the positives of continued drug use may vastly outweigh the negatives. Alternatively, for some clients the negatives of change outweigh the positives. Some coerced clients and young people brought to treatment by their parents will be precontemplators.

For precontemplators it is best to provide harm reduction information and where possible negotiate safer methods of using.

Contemplation

For clients at the contemplation stage, AOD use has many benefits but there are rising costs that prompt tem to start thinking about change. These clients, however, have not yet made a firm decision to do so. Most clients entering treatment for the first time tend to be at the contemplative stage.

Contemplators are aware of both the costs and benefits of their AOD use but need to be nudged along the process of change. Counsellors can help contemplators to consider all aspects of their AOD use, what it means to them and whether they are ready to make a decision to change. Motivational interviewing is a particularly useful technique for these clients.

Preparation

During this stage of change the client has made a decision to change and is planning how to put it into effect.

Counsellors can help the client confirm their decision to change (motivational interviewing) as well as initiating goal setting, planning and problem solving. The client will need to consider some of the actions they will take to change their behaviour as well as recognising those things that will tempt them to relapse.

Action

Clients in the action stage are in the process of changing their behaviour. They are generally putting a lot of energy into abstinence and developing new interests and activities to replace the AOD using

lifestyle. Early on in this stage people often get very bored and disillusioned before they have new and interesting things in place to replace their previous lifestyle. They are usually also having to deal with cravings to use. Clients in the action stage also tend to feel very isolated and anxious and can find it very difficult to relate to the "non-using" world.

The counsellor can assist with relapse prevention and management skills, act as cheerleader by reinforcing the positive changes clients have made, and continue to help clients find alternative rewards. Clients should also be encouraged to think about longer term goals and general life style issues such as study, work and leisure activities.

Maintenance

During the maintenance stage, clients are focused on maintaining the positive changes they have made to their lifestyle. For the changes to remain worthwhile, they need to experience post change rewards.

Counsellors can continue to reinforce the positive changes that have been made and encourage clients to begin working towards their longer-term lifestyle goals.

It should be noted that clients are likely to relapse from any stage of change to a previous one. For example, a client may move from the action stage back to the preparation stage. See the Relapse Prevention chapter in this manual for more detail.

Stages of change tip sheet

The stages of change model suggests that individuals attempting to change behaviour move through a sequence of stages of change:

1. Precontemplation – not interested in changing AOD use. Provide harm reduction information and where possible negotiate safer methods of using.

2. Contemplation – starting to think about changing their behaviour. Motivational interviewing is useful for clients in this stage.

3. Preparation – a decision to change has been made. The client is now thinking about putting it into effect. Goal setting, planning, identifying triggers for relapse and problem solving are useful for clients in this stage.

4. Action – clients are changing their behaviour. The counsellor can assist with relapse prevention and management and reinforcing positive changes.

5. Maintenance – clients are focused on maintaining the positive changes. Continue to reinforce the positive changes that have been made and encourage clients to begin working towards their longer-term lifestyle goals.

Clients may relapse from any stage of change to previous one. See ***Relapse Prevention*** chapter in this guide for more information.

7. Motivational interviewing

Motivational interviewing is a counselling technique based on the belief that all behaviour is motivated. Thus, drug use is a motivated behaviour, with many drug users being more motivated to

keep using than to give up. Motivational interviewing is also based on the notion that the decision to engage in or give up a particular behaviour involves weighing up the potential costs and benefits.

Motivational interviewing encourages the client to consider both the good and less good things about drug use. It is particularly useful during the initial sessions as it helps establish how clients feel about their drug use, how functional it is for them, and their level of motivation to change. It is also an excellent reinforcer for those clients already highly motivated to change, and it can increase a client's commitment to change if they are ambivalent. Motivational interviewing can also contribute to the development of the therapeutic relationship as involves assisting clients to articulate their own thought and feelings about AOD use as opposed to imposing opinions and judgements about their AOD use.

The overall goal of motivational interviewing is for the client to explore their feelings and thoughts about their AOD use and convince him or her self to change. There are a number of components central to motivational interviewing, as outlined below.

7.1 The good things about AOD use

It is always important to initially focus on the good things about a given behaviour. This acknowledges the functionality of AOD use to the client (and counsellor), as well as promoting an atmosphere of non-judgmental acceptance of the client. The good things about drug use can be explored by asking some open-ended questions such as:

"Can you tell me some of the good things about using heroin"

"What are some of the good things about drinking?"

"What are some of the things you like about using speed"

Before moving on, acknowledge each of the good things and, ask the client if there are any other good things they neglected to mention. Briefly summarise the good aspects of AOD use. (Note that alternative ways to achieve at least some of these functions of drug use will need to be explored later when devising a treatment plan.)

7.2 Less good things

Next, ask the client about the not-so-good things about their AOD use. Try to avoid using negative words such as the "ad things"or problems. The counsellor can ask questions such as:

"So we have talked about some of the good things about using drugs, now could you tell me some of the less good things?"

"What are some of the things that you don't like about your drug use?"

"What are some of the not-so-good things about using?"

Unlike the good things, the less good things need to be explored in detail. It is important to remember you are after the client's perspective of the less good things. The counsellor can ask follow up questions such as:

"How does this affect you?"

"What don't you like about it?"

Always look for an opportunity for the client to be able to provide more detail. For example, if a client was to say "I don't like being hassled by the cops" or "I'm sick of people not trusting me" you could ask for more detail, such as:

"Could you tell me a little more about that?"

"Could you give me a recent example of when that happened?"

7.3 Highlighting concerns

The next stage of motivational interviewing is to examine whether the less good things about drug use are actually of concern for the client. Many counsellors make the mistake of assuming that just because the client acknowledges a less good thing about AOD use, then the client acknowledges that this concern is directly related to them. For example, young cigarette smokers often mention lung cancer as a less good thing. While young people are aware of the strong association between smoking and lung cancer, the absolute risk of them developing lung cancer in the near future is small. Therefore, the possibility of developing lung cancer is not usually a current concern.

In order to clarify whether or not something is of concern for the client, the counsellor should follow up the client's statements about less good things with open questions. This will allow for further exploration of those issues that are of concern for the client.

For example:

"Does that concern you?"

"How do you feel about that?"

"Is that a problem or does that worry you in anyway?"

"On a scale of 1 to 10 where 10 is very concerned, how much does that concern you?"

It is important that the counsellor does not give their opinions regarding what should, or should not, be of concern. Counsellors should never suggest that an issue should be of concern, nor put any value judgment on the beliefs of the client by saying something like "Don't you think that overdosing twice is a bit of a problem?" The success of motivational interviewing depends on the counsellor's ability to facilitate client exploration of their AOD use, and the good and not so good effects that it has on them.

7.4 Summary

Following an exploration of the good and less good things about AOD use, the counsellor should summarise all of the major points discussed. Try to avoid presenting a one-sided argument focusing either entirely on the good or the less good things. Such summaries may include statements like:

"It seems that on one hand you….and on the other you…"

Finally, always ask the client for their opinion of your summary.

7.5 Enhancing cognitive dissonance

There are several ways in which counsellors can attempt to engender cognitive dissonance re continue AOD use. As you examine any of the areas described below be careful that the client is not overcome by feelings of hopelessness and despair and left feeling this way. Instead, be empathic and non-judgemental, acknowledge these feelings, and then focus on the fact that while it is difficult, the client can make choices that will result in changes to their current and future life circumstances.

Looking back

The counsellor explores with the client how past expectations differ from their current situation. The counsellor can ask questions such as:

"When you were fifteen what did you imagine that you would be doing now?"

"How is that different from what you are doing now?"

"How do you think that your use of ... has influenced things?"

"How do you feel about that?"

Looking forward

The same principles apply when asking the client to look into the future. For example:

"What would you like to be doing in two years time?"

"What do you think will happen if you keep using?"

"How do you feel about that?"

Self versus user

Another strategy to increase cognitive dissonance is to encourage the client to examine the discrepancy between their idea of self as a substance user, versus self as a person. For example:

"How would your friends describe the good things about you?"

Explore in more detail before asking:

"How would you describe yourself as a...user?"

Again, explore in more detail before asking:

"How do these things fit together?"

As clients discuss those aspects of themselves that they may be ashamed or embarrassed about, so it is important to be empathic and non-judgmental. Conclude with a summary of the discrepancies highlighted by your client.

7.6 The decision

After exploration of the above, some clients may still need some assistance in making the decision about altering their AOD use. Therefore, it is useful to summarise the entire motivational interview, placing emphasis on the costs of substance use and restating any intentions stated by the client to reduce their use. The aim of the summary is to assemble as many reasons as possible for change, while at the same time acknowledge the client's ambivalent feelings about change. Following the summary, encourage the client to commit to some change in their AOD use.

The counsellor could ask the following questions:

"Where does this leave you now?"

"What does this mean for your drug use?"

It is important that the client chooses what he or she wants to do, not what the counsellor thinks he or she should do. Once the client has expressed some sort of goal, the counsellor can then use their expertise to gently shape it, offering treatment options but allowing the client to choose his or her preferred option. Sometimes the preferred option might be to continue using as before but a little more safely. Other decisions will be to cut down or give up. For clients deciding not to change, it may be worthwhile asking them to monitor their drug use for a week.

Whatever goal the client sets, it is important that it is specific, achievable, short term and concrete. Readers are referred to the ***Goals of Intervention*** chapter in this guide for more detailed information.

Motivational interviewing has a variety of applications, and can be used to examine almost any issue, particularly those that clients are ambivalent about. Counsellors are also encouraged to use it throughout the therapeutic process.

Motivational Interviewing – tip sheet

Motivational interviewing is a counselling technique that encourages the client to consider the good and less good things about drug use.

Motivational interviewing can be used to explore the functionality of clients' drug use, to encourage ambivalent clients to consider change, and to reinforce motivation for change. Motivational interviewing can also be helpful for establishing the therapeutic alliance, promoting an atmosphere of non-judgemental acceptance of the client.

Accept whatever the client says and encourage them to explore their own beliefs and feelings, not what you think they should think and feel.

Components of motivational interviewing include the following:

- Explore the good things about drug use.
- Explore the less good things about drug use in more detail.
- Explore which of the less good things concern the client and why.
- Summarise the good and less good things and ask the client's opinion of you summary.
- Enhancing cognitive dissonance. Several methods:
    1. looking back - how do past expectations compare with current situation;
    2. looking forward - compare what the client would like to be doing in the future compared to what they think they will be doing if they keep using; and
    3. exploring the discrepancy between them, a user, compared to them, as a non-user.
- Summarise all of the above and ask the client how it all fits together.
- Encourage the client to make a decision about their drug use before moving to goal setting.

If the client does not want to change, explore harm reduction strategies where appropriate.

8. Problem solving

Encountering and successfully negotiating problems is a part of everyday life. In the AOD field, research shows that the ability to successfully solve problems is strongly associated with a positive

treatment outcome. Consequently, teaching clients problem solving skills is a simple yet important aspect of treatment.

Many clients incorrectly believe they do not have problem solving skills. It is important that the counsellor affirm with the client that they have the necessary skills to solve problems. A way of doing this is to ask clients what steps he or she has employed in the past in order to solve problems.

A variety of techniques are beneficial when teaching clients problem solving skills. Such techniques include verbal instruction, written information and skill rehearsal. People with cognitive damage may find problem solving a difficult exercise, which may require a lot of practice and simple, easy to follow information. For suggestions on techniques to use with cognitively impaired clients, see ***Cognitive Impairment*** in this guide.

Problem solving steps are outlined in the following.

Orientation

Allsop (1997) argues that it is important to stand back from the problem and view it merely as a challenge rather than a catastrophe. Many people find this difficult and may find it helpful to imagine that it is a friend's problem rather than their own.

Define the problem

People often catastrophise when faced with a problem. Therefore, it is important to clearly define the problem. Be as specific as possible.

Brainstorm solutions

After defining the problem, the next step is to think of possible solutions and make a list of them. Encourage clients to think of as many solutions as possible, it doesn't matter how silly or unrealistic. Counsellors can contribute solutions as well at this stage. At this stage the solutions should not be evaluated as the client may become overly concerned with the quality of solutions and become convinced that "nothing can be done". In steering the client clear of any evaluation, the counsellor can suggest brainstorming some of the more "silly" solutions. Brainstorming should be fun - anything goes.

Decision making

This stage involves making a choice about the best solution. Ask the client to consider the list of solutions and delete any that he or she believes to be unfeasible. With the remaining list of solutions, work with the client to evaluate the probable negative and positive outcomes of each. Is the strategy possible? Is it likely to be effective? What are the possible short and long-term consequences? Following evaluation of potential solutions, the client (not the counsellor) should choose a solution.

Implementation

Once the preferred solution has been selected, the next step is to put it into action. A plan of action will enable the client to rehearse putting the solution into action. This rehearsal can be either cognitive (thinking it through) or behavioural. Rehearsal is important as it may identify some of the problems that the client may encounter, as well as increasing clients confidence about implementing the strategy.

After rehearsing the strategy it is important to evaluate how effective it was. Did it work? Can it be improved? Can we employ another strategy?

The aim of problem solving is not for the counsellor to solve the client's problems, but rather for the counsellor to teach the client a method by which they can solve their own problems. There is a problem solving practice sheet for clients in Appendix 12.

Problem solving tip sheet for counsellors

Teaching problem solving skills is an integral part of any drug and alcohol treatment program. Give written information (see client tip sheet), verbal instruction and skill rehearsal.

Problem solving steps:

- Orientation - step back from the problem.
- Define the problem - be specific.
- Brainstorm solutions - anything goes.
- Decision making - consider pros and cons of each solution. Choose a solution. Consider how to put the solution into action.
- Implementation - rehearse the strategy, evaluate its effectiveness and then try it out.

Note: there is a problem solving practice sheet for clients in Appendix 12

9. Relapse prevention and management

It is estimated that up to 90% of individuals will lapse (at least one drink or one occasion of other drug use after a period of abstinence) within the first year. A lapse frequently turns into a relapse (a return to pre-treatment AOD use levels). Research indicates that 60% or more clients will relapse within 12 months. Consequently, the probability of client relapse is high and needs to be considered with all clients.

It is important to consider some of the factors associated with higher rates of relapse. Overall, the literature suggests the following.

- Clients are more likely to relapse when they have support systems not conducive to abstinence.
- Clients are more likely to relapse when they do not believe that they can achieve their goals.
- Clients with complex psychological issues are more likely to relapse when their underlying psychological issues are not dealt with.
- Clients with cognitive impairment are more likely to relapse.
- Young people are extremely likely to relapse.
- Relapse is often dependent on the quality of the post - change lifestyle.

It is important to note that relapse prevention strategies can be applied to any goal. They are simply strategies that enable the client to feel a sense of control over their decisions and activities, as well as giving them the sense of active involvement in the change process.

The goals of relapse prevention are to provide clients with:

- a variety of skills and confidence to avoid and deal with any lapses; and
- a set of strategies and beliefs that reduce the fear of failure and prevent lapses turning into relapses.

Stages in relapse prevention training are outlined below.

Rationale and demystification of relapse

The issue of relapse should be raised in the early stages of the therapeutic relationship. There is no evidence to suggest that raising the issue of relapse is associated with the occurrence of relapse. When raising the issue it is important that relapse is normalised. When discussing relapse, the counsellor and client can develop strategies to reduce the chance of relapse and ensure that if a lapse does occur, the client can resume treatment as quickly as possible.

Enhancing the commitment

A key aspect of relapse prevention is to enhance the client's commitment to change. Coping strategies will prove ineffective if the client is not truly committed to change. Many clients find it useful to review the costs associated with using and the benefits of change. Keeping a list of these readily accessible can be useful as a reminder and motivator. It is also important that the client experience some of these benefits of change. Therefore, it can be helpful to encourage clients to observe and acknowledge one good thing that occurs every day because they are no longer using (or are using less).

Identifying high risk situations

High-risk situations are those in which the client finds it particularly difficult to resist AOD use. High-risk situations can include emotions, thoughts, places, events and people. Self-monitoring is the easiest way to identify these high-risk situations. If the client is willing, it can useful for the client to spend a week recording those times when they used, or felt most tempted to use. Alternatively, high-risk situations can be identified from a discussion with clients about situations that have caused them difficulties in the past.

Developing coping responses

During the early stages of change, clients may find it easier to avoid high-risk situations. As it is not always possible to avoid high-risk situations the client needs to develop a plan to cope with them when they arise. Problem solving techniques can be useful and should be practiced prior to high-risk situations occurring. Problem solving can be taught during counselling sessions and the client can work on practice exercises at home. For further information regarding problem solving see the ***Problem Solving*** chapter in this guide.

Common themes often underlie high-risk situations. For example, a client may be particularly likely to use when stressed or angry, when something goes wrong, they become very distressed or feel like a failure. In such cases, relaxation training, grounding or cognitive restructuring may be of benefit. For further detail, refer to ***Relaxation Training***, ***Grounding*** and ***Cognitive Restructuring*** chapters in this guide.

Helpful hints

Encourage clients to plan ahead, anticipate high-risk situations and develop a plan to cope with them.

After a lapse clients are often heard saying "I don't know how it happened, it just did". They often fail to see the choices that they made in relation to their lapse, and therefore fail to take responsibility for their actions. It is useful to examine the chain of events that occur prior to a lapse and ask the client about whether the lapse just happened, or whether the client made choices that precipitated the lapse.

Preparation for a lapse

Harm reduction strategies should be explored as part of preparation for a lapse. Due to the period of abstinence generally preceding a lapse, the client's tolerance to their drug of choice will have reduced. Furthermore, many clients use alone due to issues of shame and not wanting others to know about a

lapse. These circumstances make drug use more dangerous in relation to overdose and exploring harm reduction important. For further detail, refer to ***Harm Reduction***.

In addition to harm reduction strategies, it is also important to examine how the client would deal with a lapse and prevent it from turning into a relapse. Negative emotions such as shame and self blame need to be explored, as well as challenging the belief that one lapse will inevitably turns into a full blown relapse. Problem solving techniques can be useful to brainstorm some ideas about how to prevent relapse.

Relapse management

In the event that the client does lapse, it should be explored in detail. It is also useful to do the following:

- explore and acknowledge any negative feelings of shame, failure, self blame;
- explore what the lapse means for the client in terms of their decision to change (challenge any beliefs about lapses becoming relapses, and normalise lapses;
- explore in detail the chain of events that led to the relapse;
- explore what the client could have done differently; and
- help the client to renew their commitment to change.

It is important that relapse is discussed in an empathetic and understanding environment, completely devoid of any judgment.

Relapse prevention and management - tip sheet

Goals of relapse prevention are to provide clients with:

- skills and the confidence to avoid, and deal with, any lapses; and
- a set of strategies and beliefs that reduce the fear of failure and prevent lapses turning into full-blown relapses.

Stages in relapse prevention

- Provide a rationale and demystification of relapse.
- Enhance commitment.
- Identify high risk situations.
- Develop coping responses.
- Encourage client to take responsibility - without blame, for a lapse.
- Explore harm reduction strategies.

Relapse management strategies

- Explore and acknowledge any negative feelings of shame, failure and self blame.
- Explore what the lapse means for the client in terms of their decision to change - challenge any beliefs about lapses becoming relapses, and normalise the lapse.
- Explore in detail the chain of events that led to the lapse.
- Explore what the client could have done differently next time.
- Help the client renew their commitment for change.

Note: Relapse prevention worksheet for clients is in Appendix 13.

10. Cognitive restructuring

Cognitive restructuring rests on the notion that our behaviours and feelings are a result of our automatic thoughts (those thoughts which happen so quickly that we are unaware of them happening), which in turn are related to our core beliefs (deeply held beliefs about ourselves, others and the world, also termed “schemas”). Relapse, anxiety, feeling depressed, and other life problems are considered to be linked to core beliefs which can be observed through feeling, actions and automatic thoughts. Note that whether clinicians wholeheartedly agree with this perspective or not, it is hard to argue that with the notion that what we say to ourselves at least influences our feelings and behaviours.

Cognitive restructuring forms the basis of cognitive behavioural therapy (CBT) and involves identifying and challenging automatic thoughts and the underlying core beliefs that result in negative feelings and problematic behaviours. Automatic thoughts are commonly based on incorrect beliefs which can be challenged by using cognitive restructuring exercises.

Common incorrect beliefs include the following.

All or none thinking
"If I fail one test it means I am a total failure."

Mental filter
Interpreting events based on what has happened in the past.
"I can't trust men, they only let you down."

Overgeneralisation
Expecting that just because something has failed it always will.
"I tried to give up once before and relapsed. I will never be able to give up."

Catastrophising
Exaggerating the impact of events. Imagining the worst case scenario.
"I am never going to be able to find somewhere to live. I am going to become homeless and starve to death."

Mistaking feelings for facts
People are often confused between feelings and facts. It is important to be able to differentiate between these, no matter how strong the feelings are.
"I feel like a failure, so therefore I am a failure."

Should statements
Living in the world of the "shoulds", "oughts" and "musts" is one of the most common thinking errors. Thinking this way results in feelings of guilt, shame and failure.
"I must give up heroin."
"I should be nicer to him."

Personalising
People frequently blame themselves for any unpleasant event and take responsibility for others feelings and behaviours.
"It's all my fault, I must have done something wrong."

Discounting positive experiences
When positive things happen, people discount them and insist that they don't count.
"I stayed clean because I didn't run into any of my using mates."

Note: a client handout listing these common incorrect beliefs is included in Appendix 14.

The first part of cognitive restructuring is to help clients understand the importance of thoughts. Try the "don't think" exercise (explained below) and then give examples where thoughts can really influence the way we feel.

Don't think exercise

- Explain to clients that our thoughts have a major impact on how we feel and what we do. We often aren't aware of what we are thinking, or even that we are thinking. We can't stop thinking even if we want to.

- Then explain to clients that you are going to get them to do an exercise where you are going to give them one minute and in that time, you want them to stop thinking. For one minute, your client is not to think at all.

- Time one minute.

- Ask your clients if they managed to stop thinking. We are willing to bet that they spent that minute thinking about not thinking.

- Next, give clients some examples of people feeling differently in response to exactly the same event.

  Example
  Sally had been clean for approximately 3 months. One night she goes out with friends and they decide to get on. Sally has had a bit to drink and decides to use as well. She does use, and enjoys herself thoroughly. The next morning, she wakes up and remembers that she used the night before. She remembers the fun that she had, and tells herself that it was simply a lapse. That she had been out with her friends and because she had been drinking, she was not thinking clearly enough to say no. She thinks "Oh well", renews her commitment to not using and stays clean.

  John has also been clean for approximately three months. One night he also goes out with friends who also decide to get on. John has also been drinking, and also decides to use. However, the next morning he wakes up in horror at using the night before. He tells himself that he is a failure and that he has blown it. He decides that all the hard work of the last three months has been flushed down the toilet, and that he is again a junkie. Once a junkie always a junkie, or so John thinks. As a result John feels depressed, disappointed and like a failure. John returns to using.

These stories demonstrate that it is not the event that makes us feel a certain way but our interpretation of it.

Cognitive restructuring involves teaching clients to catch their automatic thoughts and examine them to see how rational they are. It is useful to teach clients the ABCDE model of thinking and use real life situations (yours and then of your clients) in order to demonstrate how it works.

The ABCDE model

A Antecedent event
This is the event that triggers our automatic thoughts and resulting feelings. It can be situational, interpersonal, or particular thoughts themselves. For example: a friend offering a taste, someone stealing your parking space, dropping a bowl of sugar, or thinking of a past experience of failure.

B Beliefs about the event
These are the automatic thoughts or what we say to ourselves. For example: "I can't turn down a free taste, I am so stupid, I am a failure".

C Consequences
What we do, or how we feel as a result of what we are saying to ourselves. For example using, getting into a fight, feeling irritable, depressed, angry.

D Disputing the automatic thoughts
This involves looking for evidence to support the automatic thoughts (not feelings or beliefs but objective factual evidence). In doing so, the client will probably find some evidence in support of the belief, but hopefully loss of evidence against the belief.

E Alternative explanation
After disproving the automatic thoughts it is necessary to produce more rational alternative thoughts. For example: *"I am not a failure, I just had one hit because I was out with my mates and had too much to drink."*

Another important step, suggested by the example given earlier in which John continued to beat himself up for his lapse and relapsed, whereas Sally moved on, is to move on. We can refer to this as F, Forging ahead:

F Forging ahead
Once the issue is resolved, it is important to move on rather than continue to keep going back over the situation time and time again. The client cannot change yesterday, only tomorrow.

As noted, it is useful to practice the model during sessions before setting homework tasks that require the client to practice challenging their thoughts. There is client handout sheet listing common thinking errors in appendix 14, which clients can use as a basis for identifying dysfunctional thoughts to be challenged. If clients are keen to write things down, a table can be drawn up for them with five columns corresponding to A, B, C, D and E above.

It is also important that this work is followed up by counsellors continuing to ask clients what they said to themselves to make them feel a certain way, and what evidence they have for those beliefs. The more counsellors continue to inquire, the more clients will challenge their own beliefs independently. Counsellors should also continually encourage clients with step F, Forging ahead.

Cognitive restructuring - tip sheet

Cognitive restructuring rests on the notion that our behaviours and feelings are a result of our automatic thoughts (those thoughts which happen so quickly that we are unaware of them happening), which in turn are related to our core beliefs (deeply held beliefs about ourselves, others and the world, also termed “schemas”).

Relapse, anxiety, feeling depressed, and other life problems are often linked to core beliefs which can be observed through feeling, actions and automatic thoughts.

Automatic thoughts are often based on common thinking errors..

Cognitive restructuring involves teaching clients to catch their automatic thoughts and examine them to see how rational they are. It is useful to teach clients the ABCDE model of thinking.

ABCDE model

A Antecedent event - the event that triggers our automatic thoughts and resulting feelings.

B Beliefs about the event - the automatic thoughts.

C Consequences - what we do, or how we feel as a result of our automatic thoughts.

D Disputing automatic thoughts - look for evidence to support, and dispute the automatic thoughts.

E Alternative explanation - rational alternative thoughts.

Cognitive restructuring - tip sheet (cont.)

Practice using this model during sessions.

Encourage the client to practice challenging thoughts as homework – if the client is keen to do formal homework, a table can be drawn up with five columns corresponding to A-E in the model.

Also emphasise step F: Forging ahead rather than continuing to go over and over the same situation and beat oneself up.

Note: a common thinking errors tip sheet for clients is in Appendix 14.

11. Group work

Group work is a common and useful form of therapy in the AOD field. There are many different types of groups, ranging from experiential and support groups to task focused and educative groups. The intricacies of group work are beyond the scope of this guide. Therefore this chapter will provide an overview of the broad issues underpinning basic group work and information applicable to group work in general.

Group work has many benefits including:

- providing peer support;
- offering inspiration;
- enhancing motivation;
- reducing feelings of isolation and defectiveness;
- providing role models who have overcome similar problems; and
- offering opportunities for clients to practice communication or assertiveness skills.

Many clients require individual counselling in addition to group work, and where possible this should be offered. Group work should not be used to replace individual counselling.

It is important that group members share a common goal. Conflict can arise when group members have discordant goals (eg abstinence and controlled use). When it is not possible for all group members to share a common goal, differing goals should be acknowledged as a possible source of conflict.

Group size is an important aspect when considering group work. The group must be large enough for discussion to occur but small enough for everyone to participate. People also need to feel comfortable enough to share their own personal experiences. Between 6 and 9 people is an ideal number as this allows the larger group to be broken down into subgroups for certain activities. Group size restrictions may not apply to education groups and may be influenced by the nature of the group or type of group members (eg young people in detention will require a smaller group such as 4-6 members).

The gender composition of the group should also be considered. There is evidence to suggest that women tend to do better in women only groups however men tend to do better in mixed gender groups. Therefore, it is important to consider the nature and focus of the group when determining its gender composition. For example, if issues such as sexual abuse or domestic violence are likely to be raised, single gender or predominantly single gender groups may be more appropriate. Alternatively, mixed gender groups may be appropriate for educationally structured related groups (eg relapse, problem solving, identifying high-risk situations).

The rules of the groups should be clearly established at the outset of any group work. Clients should know what is expected of them, as well as the purpose of the group and any boundaries or limitations that are placed on the nature of the group work. Ground rules might include the following.

- The minimum number of sessions that the client is expected to attend.

- The expectation of punctuality. Clients should give advance notice when they are unable to attend.

- Clients should not attend the group under the influence of alcohol or drugs. Explain that such behaviour may act as a distraction to the group and make it hard for the group to stay task focused. Such behaviour may place other members who are struggling with their own substance use issues at risk. Make it clear that if a group member breaks this rule they will be asked to leave the session, although they are encouraged to come to the next group meeting. (Hint: if this does occur try to contact the group member before the next group meeting. Discuss any concerns or shame that they may be experiencing about their intoxicated behaviour and coming to the next session). If you have a co-facilitator, it can be useful to take the intoxicated person away and discuss issues of safety and contacting before the next group meeting.

- Confidentiality – any issues discussed during the group should remain confidential and not be discussed with family members or friends outside of the group.

An extremely important component of all group work involves the sense of togetherness experienced by group members. Therefore encouraging group togetherness and cohesion is a crucial task of group facilitators. This is often facilitated with the group learning to communicate with each other and not the facilitator. Instead of always referring to you (the facilitator) when making comments, encourage group members to communicate with each other by talking to each other and asking each other questions.

Example
"Fred it sounds like you agree with Freda about how difficult it is not to relapse. Does any one else feel like that? Why don't you all work together and talk about the strategies that each of you uses to avoid relapse."

Reinforcing comments by group members that show interest, concern and acceptance of other group members is also important. This further builds a sense of togetherness and group cohesion. Simply acknowledging any words of support, concern or encouragement offered by group members can do this.

Finally, groups may experience conflict between its group members (and facilitators). This is natural and to be expected. Indeed, if talked about honestly and openly it can be very beneficial to the group process. However, note that conflict is different to hostility. If group members become hostile to each other, it is important that this be deflected by honest communication and expression of concerns. Often it is better to encourage hostile group members to tell you about their concerns rather than abusing other group members.

Group work - tip sheet

Group work is an effective component of AOD treatment.

There are many different types of groups, but the following information relate to generic therapeutic groups. There are a number of important factors that can influence the success of the group. These include the following.

- Group members working towards a common goal.
- Group size - optimal numbers are 6-9 participants
- Gender makeup of the group - single sex groups may be referred when groups relate to sensitive issues (domestic, violence, sexual abuse).
- Group rules being clearly established at the outset of the group. These rules may include:
  - minimum number of sessions participants are expected to attend;
  - being on time and giving advance notice when unable to attend;
  - not coming to the group under the influence of alcohol or drugs; and
  - confidentiality – any issues discussed during the group should remain confidential.

Group togetherness and group cohesion are also important components of group work. Encourage group members to communicate with each other and reinforce comments by group members that show interest, concern and acceptance of other group members.

Conflict between group members and facilitators is normal and expected. When it occurs encourage direct, honest and open communication.

12. Brief intervention

Brief interventions are appropriate for clients presenting at a general health setting and who are unlikely to seek or attend specialist treatment, when contact time and/or resources are limited, and when more intensive interventions are not deemed necessary. Brief intervention can range from one to five or so contacts.

Brief interventions often include the provision of self help materials and may extend to a brief assessment, providing advice or information (in a one off session), assessment and feedback of the client's readiness to change (motivational interview), problem solving, goal setting, relapse prevention, harm reduction and follow up.

Brief interventions can be useful for clients who are experiencing relatively few problems related to their substance use, have low levels of dependence, or are not wishing to substantially reduce their drug use. They are also a useful means of accessing clients who are resistant to the idea of entering treatment and can prompt clients to access more structured and intensive treatment services.

Brief interventions are not considered suitable for more complex clients with additional psychological/ psychiatric issues, clients with severe dependence, clients with poor literacy skills, or clients with difficulties related to cognitive impairment. In these instances, more in-depth intervention is recommended.

Brief interventions can be a good way to communicate and implement harm reduction strategies.

Brief intervention - tip sheet

Brief interventions are appropriate for clients presenting at a general health setting and who are unlikely to seek or attend specialist treatment, when contact time and/or resources are limited, and when more intensive interventions are not deemed necessary. Brief interventions range from one to five contacts.

Brief intervention is recommended for clients with a:

- low to moderate dependence on alcohol, amphetamines, opiates or cannabis; or
- dependence on nicotine.

If brief intervention consists of only one session, it should include:

- advice on how to reduce drug use or drinking to a safer level;
- provision of harm reduction information; and
- discussion of harm reduction strategies.

Multiple sessions could include:

- assessment of dependence;
- motivational intervention;
- goal setting; and
- assessment of high risk situations.

Brief interventions are not recommended for clients with severe dependence, cognitively impaired clients, complex clients, or clients with poor literacy levels.

13. Harm reduction

Given the high rates of relapse among clients, and the varying goals that clients bring to treatment, attention should be paid to harm reduction strategies in the delivery of all treatment programs. Other contexts for intervention where only brief intervention is possible also need to incorporate harm reduction strategies.

Harm reduction can be incorporated into abstinence based programs without compromising the program when placed in the context of potential relapse. Harm reduction strategies aim to reduce problems associated with continuing AOD use or relapse, such as:

- overdose (eg avoid mixing drugs or using alone);
- family violence (eg avoid using when feeling angry or aggressive; go to a sobering up shelter rather than going home to the family);
- driving under the influence of alcohol and other drugs (eg think about alternative methods of transport); and
- blood borne viruses (eg use clean injecting equipment).

Given the high risk of death following opiate overdose, the following risks have been identified as associated with both fatal and non-fatal overdose and are useful targets for harm reduction discussion with clients:

- general health issues, including malnutrition, HIV, tuberculosis, diarrhoea, malaria and sleep apnoea;
- low tolerance;
- poly drug use;
- rapidity of use and speed of onset of drug effect;
- 'dirty hits' and other contamination problems;
- location of use, particularly use in non-familiar surroundings;
- hepatitis C and other sources of liver damage;
- factors impacting on respiratory function;
- psychiatric issues, particularly where they might affect the individual's ability to make rational judgements with respect to dose size or other directly relevant issues;
- drug treatment which may reduce tolerance and hence increase vulnerability to overdose on resumption of use; and
- intervention factors, including the ability of others to recognise that the victim is in danger and act appropriately.

Due to the growing prevalence of chronic methamphetamine use, an increasing number of long and short term harms are being observed which counsellors need to be cognisant of when working with clients who regularly use methamphetamine. These include:

- increased incidence of aggressiveness, hostility and violent behaviour;
- symptoms of psychosis (paranoia, hallucinations, thought disorder);
- hepatitis C and HIV infection;
- unsafe sex;
- overheating and dehydration;
- sleep deprivation;
- marked weight loss;
- loss of insight;
- depression;
- anxiety;
- impaired cognition and motor performance;
- memory and concentration difficulties; and
- agitation

A useful framework for conceptualising the harms associated with drug use involves Roizen's 4L model. Using such a framework, the main harms associated with drug use can be conceptualised as follows.

- *Liver* - health problems (eg liver damage, Hepatitis C, overdose, physical harm from car accidents, fights etc).

- *Lover* - social and relationship problems (eg domestic violence, family breakdowns, loss of friends etc).

- *Livelihood* - financial and occupational harm (eg job loss, debt, lack of interest in leisure or study activities etc).

- *Law* - legal problems (eg being arrested for drunk and disorderly conduct, or dealing etc).

There may be a number of barriers that prevent clients from engaging in safer using practices (eg the "using" ritual). These barriers will often relate to the purpose or function served by unsafe using practices. Counsellor and client should together explore these constraints, their relevance to the client and their reality. When working with clients who, due to these constraints, are not willing to

implement those harm reduction strategies which are deemed "best", it is recommended that counsellors use an approach called "negotiated safety" (Dear 1995). This is an approach to harm reduction which goes beyond the simple dissemination of information and involves attempting to work with the client to find strategies that are acceptable, and that they are willing to put into practice.

Motivational interviewing can be used to explore the good and not so good things about safer behaviour (especially in relation to the constraints that the client identifies about safer using). It is also an effective method of exploring the client's perceptions of safer practices, their level of knowledge about the subject, as well as reducing their ambivalence and encouraging change.

In doing the motivational interviewing remember to explore the following.

1. The good things about continuing to use in the current fashion (sharing needles, using large amounts of the substance, mixing drugs etc).

2. The less good things about continuing to use in the current fashion, and why and how much they concern the client.

3. How the good and less good things about unsafe using practices weigh up.

4. What the client thinks the future will hold if he or she continues to use in the present fashion.

5. How do the good and less good things about safer using, as well as the client's projection of the future weigh up.

6. Summary of all of the above.

7. What does the client want to do, what compromises can be drawn.

(See the ***Motivational Interviewing*** chapter in this guide.)

The counsellor and client can then work together to negotiate safer behaviours that the client is prepared to implement. Once a list of possible harm reduction strategies have been formulated it is important to make a contract with the client and help them strengthen their resolution about implementing the agreed harm reduction strategies.

All counsellors should make sure that they thoroughly assess the areas in which clients are at risk of experiencing harm and ensure that clients have the information and resources necessary to reduce as much harm as possible. Counsellors should be well informed on how to prevent overdose and blood borne viruses transmission, as well as prevent the onset or reduce the severity of psychotic symptoms.

In Western Australia information and training on overdose is obtainable from WASUA (Western Australian Substance Users' Association). Information on blood borne viruses is available from the AIDS Council, Hepatitis Council, and WASUA.

Harm reduction - tip sheet

Harm reduction strategies are appropriate for clients who continue to use alcohol or other drugs, or who are likely to relapse. Counsellors are advised to work with clients to develop harm reduction strategies that they are prepared to implement.

Harm reduction strategies aim to reduce the problems associated with AOD use, such as overdose, family violence, aggressive behaviour, driving under the influence of AOD, psychosis, and blood borne viruses.

In determining harm reduction strategies, attention should be given to:

- understanding the functionality of drug use;
- understanding that potential harms can fall into a number of categories; and
- potential risks of polydrug use and interactions of different drugs.

Motivational interviewing can be used to formulate and negotiate the implementation of appropriate harm reduction strategies. The client should explore the following.

1. The good things about continuing to use in the current fashion (sharing needles, using large amounts of the substance, mixing drugs etc).
2. The less good things about continuing to use in the current fashion, and why and how much they concern the client.
3. How the good and less good things about unsafe using practices weigh up.
4. What the client thinks the future will hold if he or she continues to use in the present fashion.
5. How do the good and less good things about safer using, as well as the client's projection of the future weigh up.
6. Summary of all of the above.
7. What does the client want to do, what compromises can be drawn.

After a list of possible harm reduction strategies has been formulated make a contract with the client and help them strengthen their resolution about implementing the agreed upon harm reduction strategies.

14. Relaxation strategies

There is a strong association between drug use and feelings of anxiety and stress. People often begin to use drugs to reduce these feelings. However, over time these feelings become triggers for drug use and are strongly associated with relapse. Consequently, relaxation training can play an important role in a client's treatment program. Clients who suffer significantly high levels of anxiety and stress may find relaxation training particularly beneficial.

Note that traumatised clients can have unpredictable and at times negative reactions to relaxation strategies, so when introducing such strategies such clients must be given permission to halt the process if feeling uncomfortable. Grounding strategies (see Chapter 15) can be more useful for some traumatised clients, and are particularly useful for all traumatised clients in moments of extreme distress.

There are a number of different relaxation techniques and several of the most popular are described below. The success of these techniques will vary from one individual to another. The client and counsellor need to work together to find acceptable and useful forms of relaxation.

Controlled breathing

A person's breathing is a direct reflection of the amount of tension carried in the body. When tense, people tend to breathe much more shallowly and rapidly. For example, panic attacks are often characterised by rapid, shallow breathing. Breathing becomes slower and deeper in states of relaxation.

When teaching clients breathing retraining it is important they understand and feel the difference between shallow, chest level breathing and abdominal breathing. A good way to do this is to ask clients to practice each type of breathing.

- First, encourage clients to increase the rapidity of their breathing. Ask them to place their hand gently on their abdomen and feel how shallow and rapid their breathing is. Now, ask them to increase the rapidity of their breathing in order to experience shallow breathing.

- Next, teach clients abdominal breathing. (Note it is important to prepare clients for the fact that people who are extremely anxious will have trouble breathing deeply enough and may need to try this when feeling less anxious, and some clients will always have trouble with this.) The following are instructions for the client:

  1. Rate your level of anxiety on a scale from 1 to 10.

  2. Place one hand on your abdomen right beneath your rib cage.

  3. Inhale deeply and slowly, send the air as low and deep into your lungs as possible. If you are breathing from your abdomen you should feel your hand rise.

  4. When you have taken a full breath, pause before exhaling through your nose or mouth. As you exhale imagine all of the tension draining out of your body.

  5. Do ten slow abdominal breaths. Breathe in slowly counting to four, before exhaling to the count of four. Repeat this cycle ten times.

  6. Now re-rate your level of anxiety and see if it has changed.

- Clients should be encouraged to practice this for between 10 and 20 minutes per day. Deep breathing can help to reduce overall levels of tension and provide clients with a strategy to use in anxiety provoking situations or high-risk situations when they are tempted to relapse.

Progressive muscle relaxation

Progressive muscle relaxation involves tensing and relaxing different muscle groups in succession. This technique can be particularly useful for clients who have difficulties with intrusive thoughts, don't like using their imagination or tend to dissociate as it is very directed and focused.

Before starting make sure clients are sitting in a quiet and comfortable place. Ask clients that when they tense a particular muscle group, they do so strongly and hold the tension for 10 seconds. Encourage clients to concentrate on the feelings in their body and on the feelings of tension and release. Tell clients when relaxing muscles to feel the tension draining out of their body and enjoy the sensation of relaxation for 15 seconds. Isolate each muscle group at a time, allowing the other muscle groups to remain relaxed. The following instructions are based on Bourne (1995, pp. 75–6).

1. Take three deep abdominal breaths, exhaling slowly each time, imagining the tension draining out of your body.

2. Clench your fists. Hold for ten seconds (counsellors may want to count to ten slowly), before releasing and feeling the tension drain out of your body (for 15 seconds).

3. Tighten your biceps by drawing your forearms up toward your shoulders and make a muscle with both arms. Hold, then relax.

4. Tighten your triceps (the muscles underneath your upper arms) - by holding out your arms in front of you and locking your elbows. Hold, then relax.

5. Tense the muscles in your forehead by raising your eyebrows as high as you can. Hold, then relax.

6. Tense the muscles around your eyes by clenching your eyelids shut. Hold, then relax. Imagine sensations of deep relaxation spreading all over your eyes.

7. Tighten your jaws by opening your mouth so widely that you stretch the muscles around the hinges of your jaw. Hold, then relax.

8. Tighten the muscles in the back of your neck by pulling your head way back, as if you were going to touch your head to your back. Hold, then relax.

9. Take deep breaths and focus on the weight of your head sinking into whatever surface it is resting on.

10. Tighten your shoulders as if you are going to ouch your ears. Hold, then relax.

11. Tighten the muscles in your shoulder blades, by pushing your shoulder blades back. Hold then relax.

12. Tighten the muscles of your chest by taking in a deep breath. Hold, then relax.

13. Tighten your stomach muscles by sucking your stomach in. Hold, then relax.

14. Tighten your lower back by arching it up (don’t do this if you have back pain). Hold, then relax.

15. Tighten your buttocks by pulling them together. Hold, then relax.

16. Squeeze the muscles in your thighs. Hold, then relax.

17. Tighten your calf muscles by pulling your toes towards you. Hold, then relax.

18. Tighten your feet by curling them downwards. Hold, then relax.

19. Mentally scan your body for any left over tension. If any muscle group remains tense repeat the exercise for those muscle groups.

20. Now imagine a wave of relaxation spreading over your body.

Visual imagery to create a safe place

Another popular relaxation technique is the use of visual imagery to create an imaginary sanctuary or safe place. Some clients find it difficult to imagine a safe scene, so it is important to inform clients that if having trouble they should cease the exercise.

Counsellors should ask the client to describe a scene that they find safe and peaceful. The scene needs to be as real as possible. Useful things to consider include the following.

- How did you get there?
- What does it smell like?
- How warm is it?
- How does the air feel against you skin?
- What does the atmosphere smell like?
- What can you see around you?
- What can you hear?

These questions are not intended to be answered, they are just key things for the client to consider.

Other forms of relaxation include meditation, yoga and exercise. Exercise is a particularly useful form of relaxation as it promotes stress relief, a sense of well being and achievement as well as improved sleep.

Appendices 15, 16 and 17 contains tip sheets for clients on the relaxation techniques described above.

15. Grounding

The majority of clients in AOD treatment have experienced trauma, with most research finding at least 25-35% of clients meet criteria for current PTSD (Mills et al. 2003).

Trauma reactions such as flashbacks, intrusive memories, panic, fear and dissociation can be prompted very easily in clients with PTSD, even by seemingly innocuous things such as a particular smell in the room, practicing a breathing exercise, or the colour of the counsellor's jacket. Relaxation strategies are not effective in these situations, and are often not very useful for traumatised clients because of their unpredictable reactions. AOD counsellors can play an important role in assisting traumatised clients to stop these trauma reactions. This role does not include exploring the trauma, but assisting clients to find "grounding strategies" to help them focus their attention onto the outside world rather than inward on the traumatic memories. Grounding is also referred to as distraction, centring, or healthy detachment (Najavits 2002).

Grounding strategies can be categorised as mental, physical, or soothing (Najavits 2002).

- Mental grounding can include activities such as describing objects in the environment in great detail, thinking of categories of things or counting backwards from 20.
- Physical grounding can include activities such as gripping the back of a chair, jumping up and down or running hands under hot or cold water.
- Soothing grounding includes activities such as rubbing nice smelling hand cream slowly onto hands and arms, having a bath, or saying encouraging things to oneself.

The following points should be considered when introducing grounding.

- Grounding can be described to the client as “strategies to use for extreme emotional distress which distract you from that distress and focus you outside yourself”.

- It is useful to ask clients whether they have strategies they already use that help with extreme emotional distress.

- Introduce the grounding handout for clients in Appendix 18. Go through the handout with the client, asking them to note any strategies that particularly appeal to them. Counsellor and client can also use their imaginations to come up with other helpful grounding strategies that are more personal.

- Ask the client if they’d be prepared to practice a couple of strategies from the list in session. Assist them with this and ask for feedback.

- Ask them to look over the list at home, and add strategies that already work for them, try out more of the new strategies, and highlight those that work with highlighter pen or ticks.

Clients should practise the strategies and reminders to use them in various places (such as a note in a diary, or a note stuck in their car or on the fridge) can also be helpful. Particularly useful grounding strategies can be listed on these reminder notes, along with a reminder to start practicing grounding early on in the distress cycle. It is also helpful if clients rate their distress levels before and after grounding, so that they notice when the grounding techniques work, as this will encourage them to use them more often.

The counsellor should also be familiar with one or two grounding strategies that work particularly well for the client so these can be introduced in session if distress levels escalate. A couple of examples that seem to work well in session are:

- having a picture on the wall to direct a client’s attention to and ask them to describe it in great detail, and
- keeping hand cream nearby and asking clients (in general female clients) if they’d like to take some and rub it slowly on their hands and arms while noticing the sensations as they do so.

16. Anger management

Many clients experience difficulties related to anger management. This is often the result of deeper personal issues such as power, a lack of sense of worth and feeling threatened. For anger management strategies to be most effective, these underlying personal or psychological issues will often need to be addressed. However, before clients will allow, or are able to cope with, a deeper level of work, they will need to be provided with symptom-control strategies.

Not all clients will be motivated to manage their anger, in which case anger management strategies should not be incorporated into treatment until the client starts to consider the management of their anger a goal they would like to work towards. Motivational interviewing can be a very useful technique for clients who demonstrate ambivalence about their anger management.

It is also important to normalise the client’s experience of anger, which is a common and often understandable emotional reaction. This can allow for their difficulties with anger to be framed in terms of its frequency, the way it is expressed (eg violence, aggression), or what it is triggered by (eg misinterpretations of situations).

16.1 Symptom control approach

The symptom control approach allows the client to experience rapid improvement, give the counsellor credibility and give the therapeutic relationship a chance to develop.

Step 1 Recognition

The first part of any anger management program is to teach the client to recognise when they are angry. When anger is provoked there are not only strong emotions but also physical symptoms. The following is a list of physical symptoms commonly associated with anger.

- Face feels flush or hot.
- Tight, acid or painful stomach.
- Clenched fists.
- Grinding teeth, clenched jaw.
- Pounding heart.
- Shaking.
- Eye tension or twitching.
- Dry mouth or throat, voice quivering.
- Butterfly stomach, nauseous.
- Shallow, rapid breathing.
- Skin rashes.
- Back or neck ache.
- Headaches.

Step 2 Identify triggers

Next it is important to teach the client to recognise the triggers associated with outbursts of anger. An effective way of doing this is to ask clients to self monitor their anger for up to a week. A written record is desirable, however a mental record will suffice. This stage examines high-risk situations (refer ***Relapse Prevention***) and includes identifying situations, people, places, thoughts and emotions. The client should also examine the role of the substance use in provoking anger. For example, the use of substances such as alcohol or amphetamines can directly contribute to difficulties with anger management, and feeling defensive following a disagreement often precipitates an outburst of anger.

Step 3 Identify and challenge anger-inducing thoughts

Explore the link between thoughts and anger outbursts. Focus on the interpretation of the situation, rather than the situation itself. Once the thoughts that result in anger outbursts have been examined, they can be challenged in terms of their accuracy and validity given the situation (refer ***Cognitive Restructuring***).

Step 4 Reduce levels of anger

Once the individual has learned to recognise anger and associated high-risk situations, there are a number of strategies that can be used to reduce levels of anger. Learning how to reduce levels of anger is an integral component of anger management, as it is difficult to respond to situations rationally when one is experiencing high levels of anger.

Deep breathing

As anger levels increase, breathing tends to become more rapid and shallow. The abdominal breathing technique (refer ***Relaxation Training***) can be an effective means of reducing immediate levels of tension.

Backwards counting

Silently count backwards at an even pace, from 20 to 1. This will give the client time for some of the anger to dissipate and to think of a rational response to the situation.

Pleasant imagery
If anger is not too high, imagine a peaceful and pleasant scene. This is too difficult to do when high levels of anger are being experienced.

Step 5 Find alternative ways to express anger

In the event that the strategies outlined in step 4 do not help the client to reduce their levels of anger, it is necessary to help them find ways of expressing their anger that do not result in negative consequences for themselves or others. It is important to find strategies that are suited to the individual client. Problem solving can be a useful way of exploring possible strategies.

Step 6 Differentiate aggression from assertiveness

Assertiveness is typically referred to as the expression of needs, wants, and opinions in a direct manner that does not involve hostility or rudeness (Jarvis et al., 1995). For tips on assertiveness training see below.

Step 7 Relapse prevention and management

This process of preventing the return to the problematic expression of anger, and effectively managing situations in which this does occur, is not dissimilar to the process of relapse prevention and management used to address drug use(refer ***Relapse Prevention and Management***).

The above steps should be effective in reducing anger outbursts and helping clients gain control over their anger. However, counsellors need to remain mindful of the fact that while symptom reduction will be sufficient for some clients, others may require more intensive, specialised therapy to deal with the underlying psychological issues which may be driving their anger.

16.2 Assertiveness training for angry clients

As part of the symptom control approach, clients need to be taught the difference between anger and assertiveness. Assertiveness is a method of expressing feelings, needs, wants and opinions directly and honestly without hostility or rudeness. It is important for the counsellor to outline the advantages of assertiveness. Such advantages include the ability to express their opinion without getting angry, which means they are more likely to be listened to and not suffer the negative consequences of an anger outburst. Assertive behaviour will also enable clients to have more choice and control in their lives and reduce their experience of negative emotion that currently ensues from the aggression.

During assertiveness training it is important that clients have an understanding of their rights as human beings – and importantly for angry people, the rights of others. Jarvis et al (1995) generated a Bill of Rights, which states that everyone has the right to:

- make mistakes;
- change their mind;
- offer no reasons or excuses for their behaviour;
- make their own decisions;
- not to have to work out solutions for other people's problems;
- criticise in a constructive and helpful manner;
- say "no" without feeling guilty;
- tell someone that they do not understand their position or else "do not care";
- not have to depend on others for approval;
- express feelings and opinions;
- be listened to by others;
- disagree with others; and
- have different needs wants and wishes from other people.

Note: this list is included as a client handout in Appendix 19

Assertive Responses

In order to be assertive an individual must explain to people how they feel without blaming them. It is useful to tell clients to make "observer" comments (commenting on the behaviour) before saying how that makes them feel ("I" statements).

Example

"When you pick your nose and eat it, I feel sick" instead of "You are absolutely revolting. Picking your nose is just typical of you. I can't stand you."

Responding to certain situations (eg dealing with criticism or requests) with assertion rather than aggression can be particularly difficult. It is recommended that counsellors practice utilisation of the skill of assertion in challenging situations with clients by role playing assertive responses in session.

Examples

Dealing with criticism:

A friend continues to call Bob a junkie even though he has not used illicit drugs in a year.

- Aggressive response: "get lost and get over it"
- Assertive response: "I understand that you are resentful about my previous behaviour, but I would prefer that you acknowledge that my using behaviour is now in the past. When you talk about it as ongoing, I feel hurt and unsupported".

Dealing with requests:

Fred is good fixing computers and his friends are always asking him to come over and fix his computer at home for free, even though Fred is very busy with work and looking after his kids and doesn't have the time to fix his brother's computer.

- Aggressive response: "I've had a gutful of being used by you to fix your computer for free"
- Assertive response: "I'm sorry but I've got no spare time because of work and the kids so I can't fix your computer. But I can recommend a good service".

Assertive responses have been distinguished here from aggressive responses because the chapter focuses on anger management. However for submissive clients, it is important to also distinguish assertive responses from submissive responses. The "Bill of Rights" can be particularly useful for submissive clients.

Anger management - tip sheet

Step 1: Learn to recognise anger, including the physical and emotional signs of anger.

Step 2: Identify the triggers associated with angry outbursts and identify high-risk situations.

Step 3: Identify and challenge anger-producing thoughts, use the cognitive restructuring techniques discussed in the ***Cognitive Restructuring*** chapter.

Step 4: Reduce levels of anger by teaching the following strategies:

- deep breathing;
- backwards counting - counting backwards from 20-1; and
- pleasant imagery - imagine a peaceful and pleasant scene.

Step 5: Find alternative ways to express anger that the client finds useful (eg physical exercise).

Step 6: Differential aggression from assertiveness and teach assertion.

Step 7: Consider ways of preventing and managing relapse for anger management.

Note: a Bill of Rights list is included as a client handout in Appendix 19.

17. Suicide assessment and management

Clients presenting for alcohol and other drug treatment are at a greater suicide risk compared to the general population. Do not ignore any suspicions of suicidal ideation and remember that ensuring client safety is of prime importance.

It is strongly recommended that counsellors conduct suicide risk assessments as a matter of course when working with clients. A suicide risk assessment should be conducted at the initial consultation, with suicide risk continually being monitored over the course of therapy.

Raising the issue of suicide is the first step in a suicide assessment. Many counsellors may feel uncomfortable about raising the issue of suicide because they:

- believe they lack the expertise or experience to assess suicide risk;
- fear that questions about suicidal thoughts will embarrass the client, seem inappropriate or produce invalid responses;
- would not know what to do if the client has suicidal thoughts;
- worry that questions about suicide may instil the idea in the client's mind;
- believe that ignoring, discounting or minimising a client's talk of suicide will defuse the situation; and/or
- see suicide attempts as a manipulative and attention seeking behaviour.

When raising the issue of suicide, it is important to remember that people who are suicidal are experiencing pain; they don't necessarily want to die but want to escape the pain and may believe death is their only option.

When raising the issue of suicide remember the following.

- Talk to the client alone - without any family or friends present.

- Allow sufficient time.
- Discuss limits of confidentiality.
- Introduce suicide in an open, yet general way.
- Link it to presenting concerns and problems.
- Be non judgmental and empathic.
- Use non threatening prefaces.
- Start with open ended prefaces.

The counsellor may wish to use one of the following quotes to introduce the issue of suicide.

"When things get really bad for people, they often start to think about finding a way out. Have you ever felt so bad that you didn't want to go on and wanted to kill yourself?"

"It is common for people in your situation to start thinking about suicide as a way out. Have you ever felt so bad that you have started thinking about this?"

"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?"

Ask about suicide directly. If the client perceives that you are non-judgemental and are willing to talk about suicide, he or she may be more willing to talk about their feelings of desperation, worthlessness, loneliness and isolation.

Suicide risk assessment

When considering a client's suicide risk, the following factors should be explored.

Current thoughts of suicide
Suicide ideation/ fantasies
What previous experience of suicide has the person had?
What does death mean to the person?

Suicide plan and method
The more detailed and feasible the plan, the greater the risk. Assess the lethality of the plan.

Availability
If the means for carrying out the plan are readily available, the risk increases.

Rescue
When someone plans to attempt suicide in an isolated location with low chance of discovery, the risk for completed suicide increases.

Previous attempts or threats of suicide
Previous attempts.
What was the person's concept of the results of the attempt.
Assess the circumstances, intent, lethality of the contemplated previous attempt.
What was the meaning or goal of the attempt.

Alcohol and other drug use
Up to 70% of adolescent suicides occur in the context of AOD use.

Social supports
Having good social support is a protective factor against suicide.

Evaluate depression
Use a depression measure such as the DASS (Appendix 9) to assess levels of depression.

Evaluate barriers for suicide
Is there anything in the client's life that can act as a deterrent to the suicidal behaviour?

Explore each of these factors in detail. Where suicidal ideation is present, encourage the client to talk about the parts of them that want to die and the parts that want to live. This will give the client insight into the functionality of the suicidal thoughts, as well as providing an avenue for exploring ways of delaying the suicide attempt. Counsellors are referred to Appendix 1 for a structured interview to assist with assessing suicide risk.

Determine the suicide risk of the client on the basis of the suicide assessment. If the client is not considered to be a high suicide risk, has acknowledged that there are things preventing them from committing suicide and does not have a well developed plan, ask the client to agree to a no suicide contract for a certain period of time, such as until your next session with the client. Assuming that the client is willing to do this, arrange another meeting to renew the no suicide contract.

If you determine that the client is of high suicide risk, consult your supervisor or a mental health professional immediately. Thoroughly document all steps taken to explore the suicidal beliefs and the action taken. If the client is not willing to agree to a no suicide contract, consider hospitalisation and contact either Royal Perth Hospital or the Psychiatric Emergency Team. Do not leave highly suicidal people unattended.

Always give even mildly suicidal people emergency telephone contact numbers.

Suicide management - tip sheet

Raising the issue of suicide should be done routinely as part of any initial assessment, as well as ongoing assessment.

When raising the issue of suicide remember:

- talk to the client alone - without family or friends present;
- discuss limits of confidentiality;
- allow sufficient time;
- introduce suicide in an open, yet general way;
- ask about suicide directly;
- be non judgmental and empathic;
- use non threatening prefaces; and
- start with open ended prefaces.

Suicide management - tip sheet (cont.)

Suicide risk assessment

When considering a client's suicide risk, explore the following factors:

- current thoughts of suicide;
- suicide plan and method;
- availability;
- rescue;
- previous attempts or threats of suicide;
- alcohol or other drug use;
- social supports;
- evaluate depression; and
- barriers to the suicidal behaviour in the client's life?

Explore each factor in detail, and encourage the client to talk about the parts of them that want to die and the parts that don't.

On the basis of the suicide assessment determine the suicide risk of the client.

Actions in relation to assessed suicide risk

If the client is not considered to be of high risk, has acknowledged that there are things stopping them from committing suicide, and does not have a well developed plan, ask the client to agree to a no suicide contract and arrange a date for this to be reviewed.

If you determine that the client is of high suicide risk:

- Consult your supervisor or mental health professional immediately.

- Consider hospitalisation.

- Do not leave suicidal people unattended.

ALWAYS thoroughly document all steps taken to explore the suicidal beliefs, and the action taken.

18. Managing intoxicated clients

Intoxicated clients can be difficult to manage. They can be loud, verbally and/or physically abusive to counsellors or other clients, disobedient or fall asleep in sessions. Some clients will continually attend sessions under the influence of alcohol and/or other drugs It is extremely important that the counsellor establish boundaries concerning acceptable levels of intoxication. This will depend on the agency, the client, the goal of therapy and client behaviour while intoxicated.

When clients are intoxicated they need to be oriented to who you (the counsellor) are and where they are. Intoxicated clients may find it difficult to understand what the counsellor says and take offence if they believe you are condescending.

Clients who present with methamphetamine intoxication may display symptoms of psychosis, including paranoia, delusions (of grandiosity, control and persecution), misperceptions, and hallucinations. When clients are exhibiting symptoms of psychosis it is important to consider how odd

thoughts might relate to drug use and withdrawal, explore whether the symptoms are transient, episodic or prolonged, and assess whether the client has any insight into their symptoms.

Managing intoxicated - clients tip sheet

How to approach intoxicated clients.

- Introduce yourself. Explain your role.
- Ask the client's name.
- Tell the client where they are and what is happening
- Speak clearly and with short sentences. Talk slowly and gently. Don't yell.
- Don't be condescending or moralistic.
- Be firm and directive.

Some general guidelines for managing intoxication:

- Breathe (don't panic).

- Assess the situation including your safety, client safety, and the safety of others. Enlist other staff to help you manage the situation if necessary.

- Where possible, identify the substances that have caused the intoxication to assess levels of risk and anticipated behaviour.

- Duty of care. Consider your responsibility to your client safety (eg try to stop very intoxicated clients from driving or going off alone).

- Limit therapy. Don't try deep and meaningful therapy with a very intoxicated client. Listen to the client and explain that being intoxicated interferes with counselling. Negotiate that they will be less intoxicated for next session. Avoid being judgemental.

Methamphetamine intoxicated clients should be provided with a non-stimulating environment, support and reassurance, and be prevented from harming themselves or others. These overall aims can be achieved by:

- reducing environmental stimuli as much as possible, including removing the person to a quieter environment;
- avoiding confrontations or arguments while allowing the client to satisfy their need to talk;
- approaching the person slowly and with a sense of confidence, and relaying to them the fact that the situation is under control;
- reassuring the client that the symptoms will resolve with time;
- encouraging supportive friends or relatives to stay with the client, or contacting appropriate sources of support;
- monitoring their vital signs and mental state;
- Encouraging the client to maintain a steady intake of fluids; and
- removing the client to a cool place and removing any restrictive clothing.

19. Managing aggressive clients

Aggressive behaviour can be provoked by feelings of inadequacy, frustration, things not being the way they expected, trying to maintain an image and being intoxicated. Aggressive or hostile behaviour is

also a common effect of methamphetamine intoxication. Counsellors need to be able to manage aggressive clients.

The following are some basic guidelines to consider when working with aggressive clients.

- Your safety, the safety of your staff and your client's safety is paramount.
- Prior to entering a counselling room with a client, assess their level of aggression. If uncomfortable, do not lock yourself in a room with them. Ideally, try to speak to them in a public place, remain in view of another member of staff or leave the door open. If you are in a room with an aggressive client, make sure both of you have an easy exit.
- Ensure there is easy access to help, be it through a telephone, emergency button, duress alarm, or yelling.
- Speak slowly and gently. Do not make any sudden movements or behave in ways that could be interpreted as threatening
- Don't take the client's comments or behaviour personally.
- Reassure the client that you want to hear what they have got to say and listen to them carefully.
- Avoid confrontation, as well as anything the client can interpret as insincerity and ridicule (this may include smiling)
- Acknowledge that the client is feeling very angry and empathise with them eg "I understand that you angry right now and finding it very frustrating. I want to be able to understand what is really getting you going and how we can sort it out again."
- Think of alternatives to reacting negatively (eg let the client set the pace, ask if you can do anything to help).
- Find a rational response (eg remind the client they are experiencing the effect of the drugs).
- Don't crowd aggressive clients. If you are enlisting the help of other people, just get them to stand at the periphery.
- Managing intoxicated clients can be a harrowing and traumatic experience for counsellors. Make sure you debrief to another member of staff or your supervisor after the incident.

Managing aggressive clients tip sheet

The following are some basic guidelines to consider when working with aggressive clients.

Your safety, the safety of your staff and your client's safety is paramount.

Assess clients' levels of aggression prior to entering a counselling room with them.

If you are in a room with an aggressive client make sure both of you have an easy exit. If the room has only one door, keep between the client and the door.

Make sure you can instantly access someone to assist you.

Speak slowly, gently and don't make any sudden movements or behave in ways that could be interpreted as threatening.

Don't take the client's comments or behaviour personally

Reassure the client that you want to hear what they have got to say and listen to them carefully.

Avoid confrontation, as well as anything the client can interpret as insincerity and ridicule (this may include smiling).

Acknowledge that the client is angry and demonstrate empathy.

Think of alternatives to reacting negatively (e.g. let the client set the pace, ask if you can do anything to help).

Find a rational response (e.g. remind the client they are experiencing the effect of the drugs).

Don't crowd aggressive clients.

Debrief to someone after the incident.

20. Case management

Case management is a process that coordinates the acquisition and delivery of services to meet individual client needs. It facilitates a holistic approach to client care. Case managers are not expected to provide all the necessary services themselves, but instead to refer to and facilitate engagement with appropriate agencies. Substance users generally present with a myriad of additional issues that need to be addressed during the course of treatment, including general health, living issues, psychological or co-existing psychiatric disorders, employment, education and skills training, legal issues and family difficulties. The aims of a case management approach are to increase the likelihood that clients receive specialist assistance where needed, and to facilitate client retention and contact with treatment providers, both of which are strongly associated with better treatment outcomes for both AOD using and not using clients (Mejta et al 1997).

Core elements of case management include:

- assessment of the health and social service needs;
- planning and coordination of these services;
- monitoring to ensure the client is receiving the services; and

- client advocacy.

Case management can also include any number of other activities including relapse prevention, counselling on other life issues, outreach and taking clients to appointments. The range of activities of case managers is often limited by agency guidelines and the size of the client load case managers are expected to carry.

There are a number of broad principles to case management: as follows.

- Case management offers the client a single point of contact with health and social services.
- Case management is client driven and driven by client need.
- Case management involves advocacy.
- Case management is community based.
- Case management is pragmatic.
- Case management is anticipatory.
- Case management is flexible.
- Case management is culturally sensitive.

In Australia the most common forms of case management are primary and combined (or shared care).

20.1 Primary case management

Primary case management involves one case manager who personally establishes a series of separate relationships with other professionals or services as required. The case manager retains full and autonomous control over the case and is responsible only to the parent agency.

For example, a community corrections officer working with a young, homeless, clinically depressed substance user may contract the services of a welfare worker (to deal with issues of accommodation and income), a clinical psychologist (to address the depression) and an addictions counsellor (to address the substance use). In this example, each specialist is responsible to the corrections officer who has ultimate responsibility to ensure that the client's overarching needs are addressed.

20.2 Shared case management

Shared case management involves several professionals (often interagency) who work collaboratively as a team in order to provide multiple services for clients on a case by case basis. While each member of the team provides a specialist service to the client, the team works together and shares information in order to integrate and co-ordinate services in response to the client's needs. The responsibility for meeting the client's needs is shared, although accountability for the provision of each service remains with the relevant agency or individual.

For example, a mental health service and an AOD treatment service may work together to meet the needs of the client. The mental health service may be responsible for addressing medication and psychotherapy while the AOD treatment service may be responsible for assisting the client to address drug use issues. Addressing issues such as welfare needs and family support would need to be negotiated with the agencies. The two services could be expected to communicate frequently and share information on client progress, barriers impeding progress, aims of treatment, and short term goals. This open communication ensures the client receives a co-ordinated and complementary overall service from both agencies.

Other common examples of combined case management include addictions counsellors working with sexual abuse counsellors, medical practitioners, child protection services and schools.

Other important ingredients for good case management include:

- ensuring continuity of services during staff turnover;
- clear lines of authority and control over various aspects of the case management process;
- providing a formal record of agencies agreements and responsibilities; and
- holding agencies accountable.

Case management - tip sheet

Case management facilitates a holistic approach to client care by providing the client with a single point of contact with health and social services.

Case management is client driven and driven by client need, involves advocacy, is community based, pragmatic, anticipatory, flexible, and culturally sensitive.

Case managers are not expected to provide all the necessary services themselves, but instead to refer to and facilitate engagement with appropriate agencies.

The most common forms of case management are primary and shared. Primary case management involves one case manager who establishes a series of relationships with other services or professionals as required. Combined case management involves several professionals working collaboratively as a team.

Case managers should:
- identify clients' treatment and service needs;
- obtain written informed consent from the client prior to sharing any client related information with associated professionals or otherwise;
- locate service options;
- link clients with appropriate services;
- monitor clients' progress in treatment;
- evaluate services provided to clients; and
- advocate for the client as necessary.

Effective case management involves:
- clear and open communication between the professionals involved;
- clarification of the requirements and boundaries of each specialist;
- clear establishment of the boundaries of confidentiality and what will be communicated with the case manager (or team);
- knowledge of other professionals involved and the nature of their involvement in the case; and
- having a contract (written or verbal) that outlines the expectations and boundaries of service provision.

21. Referral

In designing a treatment plan for a client it is often necessary to consider referral to other services or counsellors. This can be for additional services, or because the counsellor finds the client's problems are beyond their level of expertise or training. Referral is a sign of ethical and mature practice, and should not be viewed as failure.

The issue of referral should be raised sensitively with the client, who should be encouraged to air any concerns about the proposal. With written permission from the client, the counsellor should make contact with the agency, and if possible the counsellor, who they are referring the client to.

The process of referral should be as smooth as possible to ease the transition for the client. Some clients, especially young people, may wish counsellors to accompany them to the first session with the new person. Case notes from the referring agency can only be released with written permission from the client. Confidential information about a client should not be posted rather than faxed when possible.

Referral - tip sheet

In designing a treatment plan for the client always consider the issue of referral: is there a service, or an individual more equipped to better meet particular needs of the client?

Referring clients to appropriate services or counsellors is at the heart of client centred and ethical practice.

The process of referral should be as smooth as possible. A suggested process is as follows.

- Consider a more appropriate service or counsellor for the client.
- Discuss the issue of referral with the client, and give the client a chance to air any concerns.
- With written permission from the client contact the referring agency and if possible, the appropriate counsellor.
- Continue to support the client until an appointment with the new agency can be arranged
- Some clients may wish counsellors to accompany them to their first session with the new counsellor. This can ease the transition for the client.

When case notes are requested by the new agency, always obtain written permission from the client to release this information.

Avoid faxing confidential information about a client – post it instead.

22. Follow up

Despite the difficulties of following up clients, mainly due to the transient nature of this population, the practice of follow up has great utility. Follow up can provide a forum for brief intervention to diminish the build up of crises that often result in clients re-seeking treatment. It provides clients with a sense of care and commitment from the service provider and may result in the client being more likely to re-engage in treatment should the need arise. Follow up can also provide useful information regarding treatment efficacy, effective components of treatment and relapse rates.

The importance of, and format for, follow up should be explained to clients prior to the cessation of treatment. The follow up session should be scheduled while the client is still engaged in treatment. Reminder phone calls can also help to keep track of clients as well as increasing the chance of clients attending follow up.

Ideally, follow up should be conducted within one to three months following the conclusion of treatment. Follow up sessions should primarily consist of rapport re-establishment, discussions of drug use and current issues, and the completion of the standardised assessment instruments that were used on entry into the program and are to be used to evaluate treatment outcome.

Follow up can be offered via an individual or group format. Group follow up procedures may be more cost and time effective and provide clients with a support network. In instances where face to face contact is not possible, telephone or written contact is sufficient.

Follow up - tip sheet

All clients should be engaged in followed up within one to three months at the conclusion of treatment. The follow up session should be scheduled while the client is still engaged in treatment.

Follow up provides clients with a sense of care and commitment.

The importance of, and format for, follow up procedures should be explained to the client prior to discharge.

Preference should be given to face to face or telephone contact, however even written contact has benefit.

Clients should be followed up (where possible) regardless of whether they have relapsed.

Follow up procedures should offer continued support, referral to another service, referral to self help groups or re-engagement in the program where appropriate.

23. Case notes

Maintaining concise and up to date case notes are an important means of tracking client progress. Counsellors should inform clients about the rationale of maintaining case notes, the presence of case files, where the files are stored and who has access to them. Such an explanation and rationale might be:

"As part of our counselling I am required to keep some case notes. What this means is that after each session I take some basic notes about what we discussed and did during the session This helps me keep a track of where we are up to, and helps me review what we are doing in therapy so that we can make sure that you are getting the best service possible. All client files are kept in a locked cabinet, and only agency staff can access to them. They will not be released to any one else without your permission. The only exception to that is if they get subpoenaed to court, in which case I have no option but to release them. I am careful about what I record, and only record the most important information. You can read your case notes if you ask me."

This explanation will vary according to agency policies and procedures. When clients request to view their case notes, allow them to view the ones you have written but not those of other staff without seeking their permission. If a client wishes to have copy of their whole file, most agencies have procedures clients should follow to request this. They usually include a request in writing, and all staff with notes in the file should be contacted if possible regarding this request. Note that clients can ultimately gain access to their file notes through freedom of information even if agency staff do not wish them to.

23.1 Principles of client record documentation

- Clients have a right to apply for access to their files under both Commonwealth and State Freedom of Information acts. Counsellors should record information in a concise and non-judgemental manner.

- Any written information may be subpoenaed and required as evidence in a court case. The author of the notes may also be subpoenaed and required to appear in court for cross-examination regarding the content of the notes. Therefore, avoid recording statements of opinion, judgments or value statements about the client. Record information related to what you observe and hear. Information should be recorded in clear, specific, concise and objective language.

- Notes should be written in pen (preferably black), signed and dated. Correction fluid should not be used, cross out mistakes. If you make an alteration or addition to notes, after the time that they were originally written, sign and date the correction.

- Write what you observe. If you do record interpretations and opinions, justify your conclusions.

  Examples
  "Susan said she had not used but her pupils were very small and she was scratching her nose, leading me to suspect that she had used heroin recently."

  "Peter appeared depressed in that he spoke slowly, was tearful and said he was sleeping badly."

- Do not record suspected psychological diagnosis unless qualified to make such a diagnosis. If the client has been diagnosed with a psychiatric or psychological disorder (by a psychiatrist or clinical psychologist), it is appropriate for the counsellor to record this information as part of the assessment information. The records should clearly state how the counsellor obtained this information. Note that some diagnoses such as "borderline personality disorder" have the potential to be misinterpreted by others and can be damaging to the client. It can be better to describe the symptoms the person is displaying rather then label them.

  Example
  "Betty reported that in 1978 she was committed to Graylands hospital and diagnosed by the attending psychiatrist with paranoid schizophrenia."

- When recording what a client has said to you, clearly state in the notes where the information came from.

  Example
  "Betty reported that she fights with her husband when coming down off amphetamines."

- Where possible and appropriate, avoid naming other people in the case notes. This protects their confidentiality.

- If a client expresses suicidal ideation of self-harming thoughts or behaviours, it is important to record all of the steps taken to explore the issue, and ensure client safety. In such situations also consult with your supervisor where possible, and record this interaction.

  Example
  "Betty expressed thoughts about wanting to die. I explored this further, whereby Betty reported that she does not have a plan for suicide, and stated that she is not seriously considering suicide as an option. She stated that when life seems difficult, sometimes it seems like the easy option. However, Betty stated that she has too much to live for, with her sons to raise and husband to look after. When asked on a scale of one to ten (ten being definitely wanting to die, and one being just a fleeting thought with no intent behind it), how much Betty wishes to commit suicide, Betty reported that the ideation was only about a one out of ten. Betty contracted to remain safe and do nothing to harm herself for the next week. She agreed to reconsider renewing this contract next week in our session on Tuesday at 10.30 am. I also supplied Betty with emergency telephone contact numbers in the event that the suicidal ideation grows in strength."

Incident reports
In the event of a critical incident it is important to record the following factual information:

- when it occurred (date and time);
- where it occurred;
- what happened (observations only, not opinions);
- who was involved in the incident and who was present;
- in the event of an injury, record the individual's condition before and after the injury;
- what action was taken by staff; and
- was the incident reported, and if so to whom? (give name, position and agency).

Refer to the ***Critical Incidents*** chapter for further information.

23.2 Recording information related to liaison

It is also important to record any information about liaison regarding the client. When documenting exchanges of information about a client between your agency and another, the following information should be recorded.

- Who supplied the information (Name, title, agency, position in the agency, their relationship to the client).

- How the information was supplied (letter, face to face, fax, email, phone).

- Why the information was supplied (who asked for it and why).

- If any action is planned as a result of the liaison, what is the action, who is responsible for its implementation, and by when should it be completed.

- Whether your client (the agency, or others) are at risk, and what steps are to be taken to minimise that risk.

Case notes - tip sheet

- Always maintain clear and up to date case notes.
- Always tell clients about the presence of client files, where they are stored, who has access to them and why client files are maintained.
- Do not transport case files or client notes. You never know when your car will be broken into, your house burgled, your bag stolen. If you must transport client notes for the purposes of supervision for example, only ever transport photocopies of the original documents, with all identifying information blotted out.
- Clients have the right to apply for access to their files under the Commonwealth and State Freedom of Information acts. Record notes with the assumption that clients will read them
- Any written information may be subpoenaed and required as evidence in court. Avoid any statements of opinion, judgments or value statements about the client.
- Only record information that is considered important to treatment.
- Notes should be written in pen, signed and dated. Do not use correction fluid, if you make a mistake cross them out. If you make alterations to notes at a later date, sign and date the alteration.
- Write what you observe. If you must record interpretations and opinions, provide the evidence that led to the conclusions.
- Don't record suspected psychological or psychiatric diagnosis unless qualified to do so, or unless the client reports past psychological or psychiatric assessments and diagnosis. If this diagnosis is recorded, clearly state how you gained this information
- When you write about what a client has said to you, make it clear where the information came from. For example, "George reported that..."
- Avoid naming other people in the notes when possible and appropriate.
- When a client expresses suicidal ideation or self harming thoughts or behaviours carefully record all of the steps taken.

24. Critical incidents

Critical incidents are sudden unexpected events that can be perceived as psychologically or physically threatening, such as verbal threats or physical assaults. These events often make overwhelming demands on the person's ability to cope in the short term and can result in strong emotional and physiological reactions. People react to stress differently. Following a critical incident, some people may find it extremely difficult to function normally in the workplace. These more severe reactions are normal, although for recovery to occur it is important that people are able to process the event appropriately. When dealing with stressful incidents, there are three stages (although they may not always occur in this sequence).

Shock

This is usually immediate, and may involve the sense of feeling stunned, and physically or mentally numb. There can be a sense of "it didn't happen to me".

Impact
People differ significantly in their responses at this stage. Common reactions include sleep disturbances, aggressiveness, anxiety and physical symptoms such as headaches, rash and perspiration. People may withdraw, or act out.

Resolution
There is no set time for a person to come to a point of resolution about the critical incident. Severe stress will often cause the person to question their beliefs and interpretations about the world. Resolution comes when they are able to integrate your "new world" view in a positive way.

There are five levels of intervention following a critical incident: practical support, stress defusion, stress debriefing, counselling and therapy. It is recommended that the provision of these interventions be tailored to the needs of the individual staff member and that debriefing should not be mandatory (Mayou et al 2000; Devilly et al 2006).

24.1 Support

Research has shown that one of the most effective ways of intervening after a crisis situation is having a fellow worker not involved in the event providing support and assistance. It is important following a critical incident that practical and immediate support be provided to those who are distressed (Mayou et al.). Indeed recovery from traumatic events is associated with the amount of positive social supports an individual has access to, as well as their inclination to utilise those supports (Litz et al 2002). Offering support to someone who has experienced a critical incident is not counselling. Confidentiality should be adhered to. Some guidelines for offering support include the following.

- Be available to those affected. Initiate contact but avoid intruding.
- Accept the response you get from the person under stress. Don't judge their feelings or make interpretations about motives. Don't take their anger or feelings personally.
- Be interested in the person not just the situation.
- Be supportive in a practical way - make them a cup of tea.
- Listen to what is being said. Most people feel reassured and assisted by just having someone to talk to.
- Give choices and options for consideration. Share ideas on what you think would help, or what has worked for you and others you know.
- Don't tell the person that they are lucky it wasn't worse, or that they are better off than some people.
- Remember that you are not responsible for how the person handles the situation or incident.
- Don't expect to always have the answers to people's questions, or to be able to fix their problems.
- Know your limits. Be aware of any ongoing problem behaviours, declining emotional condition, or other reactions that indicate that the person may need professional help.
- Diffusing. This involves listening to the affected person's problems and concerns and acknowledging that they may be having difficulties. You can tell them what you as an organisation can offer to support them and what options they can consider, and encourage them with a positive comment or validation for the way that they managed the critical incident.

If you find that the person who experienced the critical incident continues to have difficulties, more intensive intervention may be required.

24.2 Stress defusion

Stress defusing is the process of allowing individuals to talk about their reactions and feelings and allows the individual to mobilise their personal coping to more effectively deal with a stressful situation (Tunnecliffe, 1997). Defusing takes place as soon as possible after the event and is usually on a one to one basis but may also take place in a group situation. Defusing should be guided by the needs of the person affected and should be conducted by a support person in the work environment, or at the scene. It should not be mandatory as this can increase distress in some people.

One technique of stress defusion is called the LATE approach (Tunnecliffe, 1997):

L – Listen to the person you are supporting and the problems or concerns they have.
A – Acknowledge their concerns.
T – Tell them what you are able to do or the options they could consider.
E – Encourage them with a positive comment or some assurance about their reaction management.

Counsellors should note that stress defusing is often combined with the support strategies mentioned above.

Some research also suggests that the provision of anxiety and stress management training may also reduce the risk of the person experiencing ongoing problems, as hyperarousal following a critical incident has been shown to predict the development of symptomatology (Litz et al., 2002).

24.3 Stress debriefing

Stress debriefing assists those involved to clarify and deal with any problem emotions, thoughts or behaviours that result from the critical incident. Compared to stress defusion, stress debriefings are conducted 24 to 72 hours after the event and are a group process only. Stress debriefing assists individuals with the integration of their thoughts and feelings, relating to their personal experiences at a level which will assist in the prevention of problem reactions later (Tunnecliffe 1997). Stress debriefing should be conducted by a trained facilitator and may be best offered by someone external to the agency. Again attendance should not be mandatory.

24.4 Counselling

This is required when a person's problems are not sufficiently dealt with by the above support procedures. Common signs and symptoms which indicate an individual is still having problems include the following (Tunnecliffe 1997):

- panic or excessive anxiety on the job;
- an increase in argumentative behaviour;
- avoiding contact with workmates or colleagues;
- talking repeatedly about the incident and his or her involvement;
- complaints of headache or nausea;
- complaints of insomnia or sleep disturbance; and
- mentions of being apprehensive or fearful about the future.

It is important that this person be referred for appropriate professional assistance, such as to an employee assistance program which usually offer about 5 sessions of counselling.

24.5 Therapy

There may be individuals who become significantly traumatised due to past personal experiences and or traumatic events and may require more intensive, long term therapy.

24.6 Self care

It is important to consider self care strategies in the event that you are involved in a critical incident. Looking after yourself can lessen the impact of the incident.

Self care strategies include:

- knowing reactions and what to expect from yourself;
- accept stress reactions;
- exercise;
- adequate rest and sleep; and
- relaxation and meditation.

Critical incidents - tip sheet

Critical incidents involve sudden unexpected events that can be perceived as threatening either psychologically or physically, such as verbal threats or physical assaults.

A whole range of reactions are common after a critical incident. There is no right or wrong way to respond.

When dealing with stressful incidents, people tend to go through three stages. These include:

- shock;
- impact; and
- resolution.

There are five levels of intervention following a critical incident, the provision of which should be tailored to the needs of the individual staff member:

- support;
- stress defusion;
- stress debriefing;
- counselling; and
- therapy.

Note: mandatory involvement in any form of intervention should be avoided as it can increase distress for some people.

If you are involved in a critical incident look after yourself (eat well, get lots of sleep)

Critical incidents: guidelines for offering support

Support is very important after a critical incident. Support is not counselling or therapy. All workers in an agency can be involved in offering support. When offering support:

- Be available to those affected. Initiate contact but avoid intruding.
- Accept the response you get from the person under stress.
- Be interested in the person not just the situation.
- Be supportive in a practical way - make them a cup of tea.
- Listen to what is being said. Most people feel reassured and assisted by just having someone to talk to.
- Give advice and share ideas on what you think would help or what has worked for you and others you know. Give choices and options for consideration.
- Don't tell the person that they are lucky it wasn't worse, or that they are better off than some people.
- Remember that you are not responsible for how the person handles the situation or incident.
- Don't expect to always have the answers to people's questions, or to be able to fix their problems for them.
- Know your limits. Be aware of any ongoing problem behaviours, declining emotional condition, or other reactions that indicate that the person may need professional help.
- If you find the person who experienced the critical incident continues to have difficulties, more intensive intervention may be required.

Documenting critical incidents tip sheet

In the event of a critical incident it is important to record the following.

- When it occurred (date and time).
- Where it occurred.
- What happened (observations only, not opinions).
- Who was involved in the incident and who was present.
- In the event of injuries, what was the person's condition before and after the injuries.
- What action was taken by staff.
- Was the incident reported, and if so, to whom? (give name, position and agency).

25. Withdrawal management

Withdrawal from dependence upon a drug involves various physical and psychological reactions experienced as the person adjusts to not having the drug present in their body. Withdrawal can be managed in an inpatient or home setting, and may be medicated or non-medicated.

Assisting clients with withdrawal ideally entails putting the following in place prior to the client beginning the withdrawal process:

- providing information about what to expect to clients and support people
- helping the client develop a plan to cope with the withdrawal
- ensuring appropriate support
- organising access to medication as needed by linking the client with doctor or a home-based withdrawal service – there are some very effective medications available for some drugs
- helping the client to plan follow-up support and treatment.

Clients are often quite fearful of the process of withdrawal, including concerns about the setting, physical consequences, medication, and the prospect of an abstinent future. The client should be encouraged to talk about these concerns, and counsellors will generally find that providing information about what to expect and helping the client develop a plan of how to cope will help reduce the extent of these fears. Clients often do not take in all the information provided by counsellors, and should therefore also be provided with written information. Various self help booklets are available for clients that provide information about withdrawal, tips for managing the process, and help with relapse prevention. For example, Turning Point Alcohol and Drug Centre in Victoria produces a range of small booklets for clients to assist them with giving up alcohol, amphetamine, heroin and methadone, and the National Drug and Alcohol Research Centre in NSW produces one to assist clients with quitting cannabis.

The course a withdrawal process takes, and hence the appropriate treatments and supports needed, depend upon:

- the drugs being used
- the severity of dependence and hence the degree to which neuroadaptation must be reversed
- co-existing medical, psychological or psychiatric issues
- psychosocial factors such physical environment, support, expectations, motivation and fears

- the client's reasons for withdrawing
- the client's motivation for abstinence

(Saunders et al., Mattick & Hall, 1993; Allen et al., 2005)

Specialist inpatient withdrawal is most appropriate when (Saunders et al., 2002):

- withdrawal symptoms are likely to be moderate to severe
- there are complicating medical, psychological or psychiatric issues
- there have been previous complicated withdrawals
- there is polydrug use
- previous attempts to detoxify as an outpatient have been unsuccessful
- there is a lack of social support
- the client is pregnant

Outpatient withdrawal is most appropriate when (Saunders et al., 2002):

- the client is not severely dependent
- there have been no previous complicated withdrawals
- there are no significant complicating medical, psychological or psychiatric issues
- there is no significant polydrug use
- the person has a stable home environment
- a non-using carer is present to provide support, monitor progress and control medications
- the client is strongly motivated for abstinence

As medical assistance is often required for out-patient withdrawal clients should be linked with a home withdrawal service whenever possible.

Several other issues of note:

- In the case of polydrug dependence, the literature supports a gradual withdrawal process whereby clients withdraw from one drug at a time (Wesson 1995; Gossop 2003).

- Inpatient withdrawal management should never be insisted upon. For example some women may feel unsafe in an inpatient environment (Swift & Copeland, 1998), particularly if they have a history of sexual abuse. In such instances premature discharge can occur.

- Pregnant women should always be referred to a specialist drug and alcohol services and linked with obstetric services, and withdrawal management should usually occur as an inpatient as some withdrawal symptoms can place the pregnancy at risk.

Below is brief information about withdrawal from the more common drugs client use.

25.1 Alcohol

Alcohol dependent clients can be at risk of severe and life-threatening withdrawal symptoms, depending upon the extent of their consumption. Therefore the help of a medical practitioner should always be sought when a client has significant level of alcohol dependence.

Residential medical withdrawal is indicated when there is a high probability of the client experiencing a severe withdrawal syndrome. Four factors predict the likely severity of the alcohol withdrawal syndrome:

- past history of withdrawal syndrome, particularly delirium tremens;
- a long history of regular heavy alcohol use;

- presence of concomitant physical or psychological illness, injury, pregnancy or recent surgery; and
- use of other psychotropic drugs, particularly CNS depressants.

Clients with an unfavourable home environment should also be encouraged to enter a residential withdrawal setting. Conversely, clients can be encouraged to undergo home withdrawal when there is no history of severe withdrawal or delirium tremors, and if they have good non drinking social supports.

Various medications, including benzodiazepines, are useful and at times necessary to safely manage with alcohol withdrawal symptoms, and particularly to assist with managing or preventing seizures.

25.2 Benzodiazepines

The sudden cessation of benzodiazepines can be dangerous if the client has developed a benzodiazepine dependency. In rare cases, abrupt discontinuation of benzodiazepines can lead to full tonic-clonic seizures, and even death. The more common withdrawal symptoms include anxiety, restlessness, agitation, headaches, sensitivity to light and sound, palpitations, delirium, visual hallucinations, paranoid thoughts, muscle spasms. The correlation between benzodiazepine dose and duration of use to the incidence and severity of benzodiazepine withdrawal remains to be quantified (Copeland 1998).

The assistance of a medical practitioner should be secured prior to beginning the withdrawal process due to the potentially life-threatening nature of the benzodiazepine withdrawal symptoms from high levels of benzodiazepine use. Withdrawal from dependence on benzodiazepines usually entails switching the client from short to long acting benzodiazepines (usually diazepam), and then gradually reducing the dose. Although the literature recommends that withdrawal from benzodiazepines occur in an in-patient setting (Gossop, 2003), a slow outpatient withdrawal regime under medical supervision is usually quite safe.

25.3 Opiates

Withdrawal from opiates results in a number of flu-like symptoms, including irritability, restlessness, nausea, vomiting, diarrhoea, insomnia, muscular and abdominal pains, hot/cold sweats, runny nose and 'goose flesh'. These symptoms can be managed effectively in both an inpatient and outpatient settings. However, the research suggests that clients are more likely to complete withdrawal when in an inpatient setting (Gossop et al 2000).

The management of withdrawal symptoms may be medicated or non-medicated. Opiate agonist pharmacotherapies (methadone and buprenorphine) and clonidine hydrochloride[6] are effective in relieving withdrawal symptoms and can be used on an inpatient or outpatient basis (Mattick & Hall 1993). However, the effects and pattern of symptoms observed with opiate pharmacotherapies as opposed to clonidine hydrochloride are different, with unpleasant side-effects more likely with clonidine, but a longer withdrawal period with opiate agonist pharmacotherapies. Clonidine markedly reduces blood pressure, and is not suited to some clients as it drops their blood pressure to dangerously low levels. Therefore blood pressure needs to be monitored when clonidine is used to aid opiate withdrawal.

Clients on opiate agonist pharmacotherapies as maintenance treatment should not be encouraged to withdraw from methadone if it is against the wishes of the client or the prescribing doctor. When concurrent benzodiazepine dependence is present, it is recommended that the client be encouraged to withdraw from the benzodiazepines prior to withdrawal from opiates.

[6] CATAPRES® Boehringer Ingelheim.

Abrupt withdrawal is not recommended during pregnancy as it can place the pregnancy at risk, with methadone maintenance treatment recommended in this instance.

25.4 Amphetamines

Typically the symptoms of amphetamine withdrawal can include dysphoria, lethargy, poor concentration, hunger, anxiety, depression, irritability or restlessness, and sleeping difficulties (long but disturbed sleep or insomnia). Generally the acute symptoms of withdrawal last for 1-2 days, with some symptoms lasting for a period of months (e.g. sleeping and mood difficulties).

As the symptoms of amphetamine withdrawal are rarely life threatening, withdrawal management does not need to occur in an inpatient setting. However, a client's medical, psychiatric and social functioning needs to be considered when making this decision. Due to the severe cravings often experienced by clients withdrawing from methamphetamine, inpatient withdrawal is often recommended.

While medication is not always necessary, clients may benefit from individualised symptomatic prescription of benzodiazapines, antidepressants or antipsychotics, though evidence regarding the efficacy of pharmacological treatments of amphetamine withdrawal is limited (Srisurapanont et al., 2007).

25.5 Cannabis

Symptoms of cannabis withdrawal can include restlessness, physical tension, insomnia, sweating, upset stomach, loss of appetite, tremors, irritability, anxiety, and depressed mood. These symptoms tend to be more mild than those for other drugs because cannabis leaves the body slowly and they symptoms start on the first day of abstinence. Estimates of the duration of withdrawal symptoms vary, with some reports indicating they peak at 2-4 days abstinence (Budney et al, 2001; Huestis et al, 2001), and other indicating 7-10 days (Kouri & Pope, 2000). Many symptoms have been found to last in mild form for up to a month, with irritability and physical tension persisting longer for some people (Kouri & Pope, 2000).

To date there are no medications approved specifically for treating cannabis dependence and withdrawal though research is underway (Hart, 2005). However, depending upon the severity of the symptoms and the other physical or mental health issues the client has, medication for symptomatic relief can at times be useful. Inpatient withdrawal treatment is rarely appropriate for cannabis dependence.

25.6 Scales for assessing withdrawals

It is worth noting that the measurement of withdrawal syndromes where objective signs are present and quantifiable (such as alcohol and opiate withdrawal) can provide cut off scores and indications for medication administration as is presently done with the Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) scale (Metcalfe et al, 1995) and Objective Opiate Withdrawal Scale (OOWS) (Handelsman et al. 1987). However, withdrawal scales for those syndromes where symptoms are subjective and no objective signs have been identified (such as benzodiazepines, amphetamine and cannabis withdrawal) may be less useful. Given the subjective nature of withdrawal symptoms, in benzodiazepine, amphetamine and cannabis withdrawal, scales can only be used as a general guide to treatment.

Withdrawal scales for alcohol, opiates, benzodiazepines, amphetamines and cannabis are included in Appendices 4-8 of the Counsellor Guide. All except the Cannabis withdrawal scale have research evidence indicating adequate reliability and validity. The research has not yet been conducted on the cannabis scale.

25.7 For more detailed information

For more detailed information on assisting clients with withdrawal, see Saunders et al. (2002) Clinical protocols for detoxification: General practise and community settings:
http://www.health.qld.gov.au/atods/documents/24905a.pdf
http://www.health.qld.gov.au/atods/documents/24905b.pdf

Withdrawal management - tip sheet

Withdrawal is the process whereby the body gets used to functioning without a particular drug. Its intensity and duration depends on:

- severity of dependence and tolerance;
- motivation to give up; and
- type of drug.

Withdrawal may be may be managed at home as an outpatient or in a residential setting and may be with or without medication depending on the severity of dependence and client choice.

In general residential withdrawal is suggested by:

- severe dependence;
- unstable home environment;
- concurrent psychiatric or health problems; and
- lack of non drug using supports.

In general outpatient or home withdrawal is suggested by:

- low levels of dependence;
- stable home environment; and
- good non drug using supports.

Attention should be given to the following issues.

- When clients are considering withdrawal always tell them what to expect, how long symptoms will last and problem solve coping strategies and relapse prevention. It is useful to provide self help booklets.
- If clients are wishing to undergo home withdrawal, provide information regarding what to expect to the client and significant others and involve a home withdrawal service if desired and appropriate.
- Attempt to engage non-using significant others as supports for the client.
- Ideally, treatment to manage withdrawal should be a gateway to further treatment, including a link to ongoing treatment services or relapse prevention pharmacotherapies. Commitment to ongoing treatment should not, however, be a prerequisite for admission to a withdrawal management program.
- Withdrawal should occur from one substance at a time.
- Pregnant women should be referred to a specialist drug and alcohol service or obstetric service as withdrawal from some drugs places the pregnancy at risk.

Withdrawal management - tip sheet (cont.)

Alcohol

- Residential withdrawal is indicated for clients with a history of moderate to severe withdrawal symptoms, the probability of severe withdrawal syndrome, serious concurrent physical or psychiatric disorders, or a lack of non drinking social support.

- Outpatient withdrawal is indicated for clients with mild to moderate withdrawal symptoms; no history of delirium tremens or withdrawal fits; and the existence of a non drinking significant other, support or encouragement.

- Clients with alcohol dependence should always be linked with a medical practitioner as medication is often needed to safely manage withdrawal.

Benzodiazepines

- Sudden cessation of use of use of benzodiazepines can be associated with serious health consequences and risk of relapse.

- Withdrawal from benzodiazepines should involve swapping from a short to a long acting benzodiazepine (usually diazepam) and a gradual reduction in dose as sudden cessation.

- A medical practitioner should always be engaged to assist with managing withdrawal from benzodiazepines.

Opiates

- Clients on methadone maintenance treatment and benzodiazepines should not be encouraged to withdraw from both substances at same time.

- Clients should not be encouraged to withdraw from methadone if it is against their wishes. Withdrawal should be discussed with the prescribing doctor.

- Opiate withdrawal should not be encouraged during pregnancy, methadone maintenance is recommended instead.

- There is medication to assist with withdrawal.

Withdrawal management - tip sheet (cont.)

Amphetamines

- Withdrawal can be managed in a residential or outpatient setting depending upon level of functioning of the client, availability of support at home, and severity of dependence and withdrawal symptoms.
- No evidence-based psychosocial or pharmacological treatment has yet been found to be effective for amphetamine withdrawals though research is underway.
- Medication for symptomatic relief should be prescribed on an individual basis as indicated.

Cannabis

- Cannabis withdrawals tend to be milder than withdrawals from other drugs.
- Residential withdrawal is rarely appropriate for cannabis withdrawals.
- To date no medication has been found to be effective for cannabis withdrawals but research is underway.
- Medication for symptomatic relief can at times be useful.

26. Pharmacotherapies for dependence

There are a number of pharmacotherapies for opiate and alcohol dependence. Pharmacotherapies should not be seen as stand alone treatments but are optimally used in conjunction with counselling as outcomes tend to be better. Counsellors need a basic understanding of pharmacotherapies as they may find themselves working with increasing numbers of clients who are prescribed these medications. Counsellors should inform clients of relevant addiction pharmacotherapy options and refer them to a medical doctor for further discussion and possible prescription if they are interested.

Note that methadone and buprenorphine, which are opioids, can only be prescribed by medical practioners who have undergone a training program and become approved prescribers. Other addiction pharmacotherapies can be prescribed by any medical practitioner.

26.1 Pharmacotherapies for opioid dependence

Pharmacotherapies for opioid dependence generally fall into two categories:

Agonists. These drugs produce opiate like effects. The rationale is the substitution of a legal opioid for an illegal opiate (heroin) alleviates the need for users to engage in the activities needed to obtain illegal drugs (eg prostitution, stealing and dealing). This then allows them to stabilise their lives and look at employment, accommodation, study etc as well as reducing health risks. Agonists include methadone and buprenorphine.

Antagonists. These drugs block the effect of opioids. The rationale is that if opioid use produces no euphoric effects, there is no incentive to take them. Natrexone is an opioid antagonist.

Methadone

Methadone is a synthetic opioid that was developed in 1941 in Germany for the relief of pain. It has been used as a treatment for opiate dependence for nearly 40 years and is the most common addiction pharmacotherapy used in Australia. Methadone in the form of methadone syrup[7] or methadone liquid[8] is approved by the Therapeutic Goods Administration (TGA) as a maintenance and withdrawal treatment for opiate dependence. It is a schedule 8 drug.

Methadone is long acting (24-36 hours, compared to 6-12 hours for heroin), provides a sense of euphoria, suppresses opioid withdrawal symptoms and relieves the craving. Long term effects of methadone include increased sweating and constipation. It is used occasionally to treat opiate withdrawal, but is more commonly used as a substitution or "maintenance" treatment. Withdrawal from methadone is usually more protracted but less intense than withdrawal from heroin.

Methadone maintenance treatment results in:

- reduced heroin use, crime, deaths from overdose, and blood borne virus risk behaviours; and
- improvements in physical health, psychological health, social functioning and occupational functioning.

Methadone treatment is only suitable for those clients with a history of illegal opioid dependence usually longer than 12 months. Opioid dependence is characterised by:

- the presence of tolerance;
- withdrawal symptoms when opiate use is ceased;
- the use of opioids to avoid the onset of withdrawal;
- continued desire to use opioids despite persistent and recurrent problems associated with their use;
- opioid seeking acquiring priority over other activities; and
- repeated unsuccessful attempts to cease drug use.

Methadone is generally taken orally under supervision on a daily basis. Some take home doses are made available with increased time on the treatment and demonstrated client stability. Long term treatment (ie two years or more) is generally more effective.

The client generally initiates withdrawal from treatment and the rate of reduction in methadone is dependent on the client's ability to tolerate withdrawal symptoms. Follow up counselling after completion of treatment with methadone is associated with improved outcomes.

Methadone is safe in pregnancy, though many babies experience a significant neonatal abstinence syndrome. Sudden withdrawal from either methadone or other opioids is associated with high incidences of premature birth and other complications so withdrawal, if undertaken, should be slow. Methadone dose is usually increased during pregnancy. When working with pregnant opioid dependent clients, counsellors should consult with the relevant medical personnel to help ensure the client is linked with obstetric services, and preferably those specialising in pregnancy and AOD use.

Buprenorphine (Subutex[9], Suboxone[10])

Buprenorphine is an opioid analgesic with partial agonist effects and high receptor affinity. Its action is similar to that of full agonist drugs such as methadone, except that increases in dose have progressively less effect as receptor sites become saturated. The partial agonist effect results in less respiratory depression and overdose is less common with buprenorphine. High receptor affinity means

[7] METHADONE SYRUP® Glaxo Wellcome.
[8] BIODONE FORTE® National Sales Solutions
[9] SUBUTEX® Reckitt Benckiser.
[10] SUBOXONE® Reckitt Benckiser.

that buprenorphine displaces other opioids from the receptors, and this can result in precipitated withdrawal for people highly dependent on opioids.

Buprenorphine in the form of Temgesic[11], an injection, has been used in many countries since the 1980s for the treatment of pain. More recently, two sublingual tablet forms of buprenorphine have been approved by the TGA for treatment of opioid dependence: Subutex was approved in 2000 and Suboxone was approved in 2005. Suboxone is a combination of buprenorphine and naloxone. Naloxone is an opioid antagonist that when absorbed into the blood stream precipitates withdrawals in opioid dependent people. It is not well absorbed when swallowed, but is active when injected. The rationale for including naloxone in Suboxone is to discourage clients injecting.

Buprenorphine has less euphoric effects than heroin or methadone and withdrawal symptoms appear to be milder. It has a very long duration of action, making alternate day dosing possible.

Buprenorphine appears to be as effective as methadone in terms of reductions in illicit opioid use and improvements in psychosocial functioning, but may be associated with lower retention in treatment.

Buprenorphine is not currently approved for use in pregnancy. However some pregnant women continue buprenorphine knowing its effects have not been properly researched. Pregnant women taking buprenorphine should be on Subutex as it does not contain the added drug naloxone. Babies born to mothers on buprenorphine experience a milder neonatal abstinence syndrome than babies born to mothers on methadone.

Naltrexone[12]

Naltrexone is an opioid antagonist that displaces opioids from the receptors in the brain and has no opioid effect. When taken by opiate dependent people, naltrexone will precipitate opioid withdrawals, and when opioids are taken in the presence of naltrexone they have no euphoric. Naltrexone is long acting and has minimal side effects for most people, though it can cause liver damage and is contraindicated for use for people with acute hepatitis or liver failure. The most common side effects are headaches and nausea which are experienced by about 10% of clients.

Naltrexone is listed as a schedule 4 drug, and in the form of oral tablets has TGA approval for use following opioid withdrawal to assist with relapse prevention in the context of a comprehensive treatment program. It is also used to accelerate withdrawal but such uses are currently experimental and off-label.

Naltrexone can reduce cravings to use opioids during treatment, and is associated with improvements in psychosocial functioning, but has limited acceptability, uptake and retention in treatment. Retention in treatment is much lower for oral naltrexone than for methadone or buprenorphine. Higher retention and completion rates are found for clients who are highly motivated to cease using and remain abstinent. In general people who are stable and have a non-using supportive environment are more likely to achieve positive treatment outcomes, as with all forms of treatment.

A problem associated with oral naltrexone is the increased risk of fatal overdose should the tablets be ceased and heroin used due to markedly reduced tolerance. It is therefore important that only clients highly motivated for abstinence are encouraged to enter naltrexone programs, and that clients are made aware of the increased risk of overdose in the event of a lapse.

Implantable or depo forms of naltrexone may be more successful in treatment of opioid dependence because they do not require a daily decision as to whether to take them. Research is being undertaken to establish the effectiveness of naltrexone implants.

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[11] TEMGESIC INJECTION® Reckitt Benckiser.

[12] REVIA® Orphan Australia. (Approved at the 200th meeting of the Australian Drug Evaluation Committee 3-4 December 1998.)

26.2 Pharmacotherapies for alcohol dependence

Naltrexone

Naltrexone is approved by the TGA and is PBS listed for use within a comprehensive treatment program for alcohol dependence. It is usually taken once a day.

Naltrexone appears to be safe and moderately effective in the treatment of alcohol dependence. It appears to reduce craving to drink and amount drunk per drinking episode, has little effect on returning to drinking per se, but does appear to reduce the rate at which clients return to heavy drinking particularly when combined with CBT focussed on stopping the progression of drinking. It also appears to be effective if taken in high-risk situations rather than on a regular daily basis.

Acamprosate

Acamprosate[13] has been approved by the TGA and is indicated as a therapy to maintain abstinence in alcohol dependent patients, to be combined with counselling. It is PBS listed for this purpose. It is taken 3 times a day. The only common side effect is mild transient diarrhoea.

Acamprosate appears to be effective treatment in reducing alcohol intake, prolonging the duration of abstinence and reducing alcohol craving. Foy (2007) cites recent research suggesting that it may be less effective than naltrexone.

Acamprosate can be safely combined with naltrexone but whether it is more effective than naltrexone alone is uncertain.

Disulfiram (Antabuse)

Disulfiram is a drug that has been used in the treatment of alcohol dependence for many years. Disulfiram alters the metabolism of alcohol and increases the level of acetaldehyde in the body, causing uncomfortable and potentially dangerous symptoms if alcohol is drunk: unpleasant facial flushing, rapid pulse rate, increased blood pressure and headache. It is therefore used infrequently.

Disulfiram (Antabuse)[14] is approved by the TGA but is not listed on the PBS. It is indicated as a deterrent to alcohol consumption and as an aid in the overall management of selected alcohol dependent people.

Disulfiram appears to be effective with clients who are very motivated towards abstinence, have good non drinking social support networks, and have someone (such as a significant other) to encourage and support disulfiram being taken regularly.

Disulfiram is not suitable for people with cardiovascular, liver or renal disease. Many clients who have a long standing history of alcohol dependence have a number of associated medical problems. When considering disulfiram, clients should be subject to a thorough medical examination and ongoing medical review.

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[13] CAMPRAL® Alphapharm.
[14] ANTABUSE® Orphan Australia.

Pharmacotherapies for opioid dependence – tip sheet

Addiction pharmacotherapies should not be seen as stand alone treatments but used in conjunction with other treatment components such as counselling.

Clients with alcohol or opioid dependence should be informed of the existence of the appropriate pharmacotherapies and if interested be referred to an appropriate service or medical practitioner for more information and prescription.

Methadone

Methadone is an opioid agonist used as a maintenance treatment to stabilise opiate use.

Indications that methadone treatment might be suitable include the client:

- having an established history of dependence;
- having attempted to give up a number of times;
- being significantly involved in the drug using lifestyle;
- engaging in behaviours that increase the risk of blood borne virus (HIV, hepatitis B and C); or
- being pregnant.

Methadone maintenance treatment tends to be more successful when provided over extended time periods (2-3 years at least)

When considering withdrawal from methadone, counsellors should be aware that:

- the long acting nature of methadone requires reduction and eventual withdrawal over a period of several months if successful outcomes are to be achieved; and
- the sudden withdrawal from methadone while pregnant should be discouraged.

Buprenorphine

Buprenorphine is a partial opioid agonist with high receptor affinity. It is used as a maintenance treatment to stabilise opioid use or as part of a withdrawal regime.

In Australia it is available in two forms: Subutex and Suboxone (which contains naloxone).

Indications that buprenorphine treatment might be suitable include the client:

- having an established history of dependence;
- having attempted to give up a number of times;
- being significantly involved in the drug using lifestyle; or
- engaging in behaviours that increase the risk of blood borne virus (HIV, hepatitis B and C)

Buprenorphine maintenance treatment is more successful when provided over extended time periods (2-3 years at least)

When considering withdrawal from buprenorphine, counsellors should be aware that:

- the long acting nature of buprenorphine requires reduction and eventual withdrawal over a period of several months if successful outcomes are to be achieved; and
- although buprenorphine is not approved for use in pregnancy as it is yet to be properly researched, some pregnant women continue buprenorphine, and there is evidence that the neonatoal abstinence syndrome is milder than that associated with methadone.

Pharmacotherapies for opioid dependence – tip sheet (cont.)

Naltrexone

Naltrexone is an opioid receptor antagonist that displaces opioids from the opioid receptors in the brain. It has no opioid effect, and precipitates opioid withdrawals in the presence of opioid dependence.

Naltrexone in oral form is approved for use following opioid withdrawal to assist with relapse prevention in the context of a comprehensive treatment program. It is also used to accelerate withdrawal but such uses are currently experimental and off-label.

Naltrexone is appropriate for clients who:

- are highly motivated for abstinence
- are socially and psychologically stable; and
- have good non-using social supports.

Implantable or depo forms of naltrexone may prove to be more successful in treatment of opioid dependence.

Pharmacotherapies for alcohol dependence – tip sheet

Addiction pharmacotherapies should not be seen as stand alone treatments but used in conjunction with other treatment components such as counselling.

Naltrexone

Naltrexone is an effective treatment for alcohol dependence.

Naltrexone appears to reduce cravings, decrease the amount drunk per drinking episode, reduce rate of return to heavy drinking but not reduce rate of return to drinking per se.

Naltrexone can be effective when used in high risk situations rather than on a regular daily basis.

Acamprosate

Acamprosate appears to reduce cravings, decrease drinking and reduce relapse when combined with a psychosocial program.

Acamprosate may be less effective than naltrexone.

Acamprosate can be combined with naltrexone but whether the combination is more effective than naltrexone alone is uncertain.

Pharmacotherapies for alcohol dependence – tip sheet (cont.)

Disulfiram (Antabuse)

Disulfiram alters the metabolism of alcohol and increases the level of acetaldehyde in the body, causing uncomfortable and potentially dangerous symptoms if alcohol is drunk. It is therefore used infrequently.

Disulfiram:

- should only be used with clients who are very motivated towards abstinence, have good non drinking social support networks, and have someone (such as a significant other) to encourage and support taking disulfiram regularly; and
- is not suitable for people with cardiovascular, liver or renal disease.

27. Methamphetamine

A number of issues are of particular concern when working with clients who regularly use methamphetamine. The immediate and long-term management of methamphetamine dependent clients is proving to be particularly challenging for counsellors. The following issues should be considered when working with this population.

27.1 Managing intoxication

If a client presents with methamphetamine intoxication counsellors may be faced with the challenge of managing potentially violent and aggressive behaviour and/or the display of mental disturbances. In these instances it is recommended that counsellors aim to provide clients with a non-stimulating environment, support and reassurance, and assist in preventing the client from harming themselves or others. These overall aims can be achieved by the following.

- Reducing environmental stimuli as much as possible, including removing the person to a quieter environment.
- Avoiding confrontations or arguments while allowing the client to satisfy their need to talk.
- Approaching the person slowly and with a sense of confidence, and relaying to them the fact that the situation is under control.
- Reassuring the client that the symptoms will resolve with time.
- Encouraging supportive friends or relatives to stay with the client, or contacting appropriate sources of support.
- Monitoring their vital signs and mental state.
- Encouraging the client to maintain a steady intake of fluids.
- Removing the client to a cool place and removing any restrictive clothing.

Given that aggressive or hostile behaviour is also a common effect of methamphetamine intoxication it is recommended that counsellors be aware of strategies for managing extreme hostility or agitation. The following guidelines may be of assistance.

- do not take it personally;
- keep voice low and controlled;
- remain calm;,
- listen to the client;
- avoid anything that could be construed as insincerity or ridicule (eg smiling);
- remind the client of the effect the drugs are having on their thoughts/behavioursl
- where possible manage the physical environment so that you are able to leave if necessary; and
- make sure you advise others if you are about to enter a high risk situation.

27.2 Psychosis

Amphetamine-induced psychosis is common with prolonged heavy methamphetamine use. Common symptoms of psychosis include paranoia, hallucinations (particularly auditory), delusions and misperceptions. Sub-clinical psychotic symptoms are also common in regular users, in particular hostility, suspiciousness, paranoia and disordered thought processes. Clients who have experienced repeated amphetamine-related psychotic episodes are at risk of experiencing further psychotic episodes, even if lower doses of amphetamine are consumed or in relation to non-specific stressors. Psychotic symptoms associated with methamphetamine use tend to be much longer lasting than with the less potent amphetamine, often requiring antipsychotic medication

Due to the increased likelihood that clients who regularly use methamphetamine will experience persistent psychotic symptoms it is recommended that these clients be screened for psychotic disturbances. Various tools to assist with screening for psychotic symptoms are available. A psychosis screener developed by Jablensky et al (2000) is contained in Appendix 10. It contains questions relating to delusional mood, grandiose delusions, delusions of reference/persecution, delusions of control, hallucinations, and whether the person has ever received a diagnosis of psychosis or been prescribed antipsychotic medication.

When screening for psychotic symptoms it is also recommended that counsellors:

- ask how any odd thought relates to drug use and withdrawal;
- check on whether the symptom/s are transient, episodic, or prolonged; and
- look for insight

It is also recommended that counsellors provide clients with information about amphetamine-related psychosis and about repeated psychotic episodes lowering the threshold for further episodes.

27.3 Withdrawal

Clients withdrawing from methamphetamine may experience a variety of symptoms, including:

- dysphoria;
- lethargy;
- poor concentration;
- feeling angry or upset;
- long but disturbed sleep, insomnia, tiredness;
- drug cravings;
- hunger;
- anxiety;
- depression; and
- irritability or restlessness.

Acute symptoms of withdrawal tend to peak within 1-2 days of abstinence, while some symptoms (eg sleep and mood difficulties) can last for a period of months. The duration and severity of withdrawal symptoms may be influenced by:

- age (older and more dependent users may experience more severe withdrawal);
- general health;
- mode of administration;
- quantity and quality of methamphetamine consumed prior to cessation; and
- polydrug use.

Methamphetamine withdrawal does not need to occur in an inpatient setting, however, the client's medical, psychiatric and social functioning needs to be considered when making this decision (Baker & Lee 2003). If the client has a long history of methamphetamine use they should be monitored for the presence of symptoms of psychosis and a thorough mental health assessment should be conducted.

27.4 Harm reduction

Given the high rates of relapse among clients, as well as the varying goals that clients bring to treatment, attention should be paid to harm reduction strategies when delivering treatment. In conjunction with the harms associated with injecting (see chapter on ***Harm Reduction***), people who regularly use methamphetamine are also at risk of experiencing the following harms:

- increased aggressiveness, hostility and violent behaviour;
- symptoms of psychosis (paranoia, hallucinations, thought disorder);
- results of unsafe sex;
- overheating and dehydration;
- sleep deprivation;
- marked weight loss;
- poor nutrition;
- loss of insight;
- depression;
- anxiety;
- impaired cognition and motor performance;
- memory and concentration difficulties;
- agitation;
- accidents; and
- overdose/toxicity.

Counsellors may need to employ motivational interviewing strategies to facilitate the process of "negotiating" safer using practices that are acceptable to the client (see chapter on ***Harm Reduction***).

27.5 Cognitive impairment

Clients with a history of heavy methamphetamine use often present with cognitive impairments that hold significant implications for the content, process and outcome of counselling. It is recommended that counsellors endeavour to assess a client's level of cognitive functioning and tailor specific intervention strategies and the delivery of counselling accordingly.

Generally the cognitive deficits observed in long-term users of methamphetamine relate to all areas of cognitive functioning:

- attention and concentration;
- visual and verbal memory;
- information processing;

- problem solving;
- decision making;
- response inhibition;
- sequencing; and
- emotional processing.

Often the presentation of current and former methamphetamine users is characterised by the manifestations of such deficits in cognitive functioning. Typically the clinical presentation of these clients is characterised by:

- excessive distractibility;
- difficulty concentrating;
- difficulty sustaining attention; and
- difficulty suppressing irrelevant task information.

Given that numerous cognitive functions are required to derive benefit from many of the strategies commonly used in the treatment of drug and alcohol difficulties (eg attention, memory, verbal skills, problem solving and abstract reasoning), clients who experience deficits in any of these areas of cognitive functioning are less likely to experience positive treatment outcomes if their level of cognitive functioning is not taken into consideration. Counsellors also need to be cognisant of the fact that cognitive deficits can impact upon client engagement behaviours (eg irregular attendance, non-compliance with homework completion) rather than automatically assuming these behaviours are the consequence of more typically salient explanations (eg resistance, ambivalence to change, drug use etc). Thus when engaging methamphetamine users in treatment counsellors need to be able to tailor the counselling to any cognitive deficits the client displays. For tips on how tailor treatment to the client's level of cognitive functioning see below.

27.6 Treatment

Cognitive behavioural treatment has been found to show the greatest improvements in the treatment of amphetamine dependence. A stepped care approach has been recommended as the most effective method for managing the treatment of amphetamine users (Baker et al., 2004). This approach involves determining the intensity and range of treatment approaches on the basis of client presentation in terms of co-occurring psychiatric disorder (psychosis, anxiety, depression) and other needs. Step 1 involves assessment plus self help materials and scheduled monitoring; Step 2, for those who did not respond to step 1, is two sessions of CBT; Step 3, for clients who do not respond to previous steps, or who have clinically significant depression is 4 sessions of CBT; and more intensive interventions for clients do not respond to these interventions, or are experiencing psychosis or suicidality.

The advantages of this graded approach to treatment are that it:

- allows for flexibility in intervention and match treatment to the client's needs;
- accommodates differences between individuals with co-occurring problems in terms of type and severity of use and readiness to change; and
- optimises use of resources such as practitioner time.

Given the difficulties methamphetamine users with cognitive impairment are likely to have with successfully participating in treatment, it is recommended that counsellors tailor cognitive behavioural addiction treatment interventions to take into account potential cognitive impairment. Thus when working with clients who use methamphetamine and present with symptoms of cognitive impairment it is recommended that counsellors use the following strategies, targeting the appropriate area of dysfunction if possible, in conjunction with traditional components of treatment (eg therapeutic alliance, assessment, motivational interview, goal setting, harm reduction, relapse prevention and

management etc.). The following strategies are recommended by Collins[15] (2007, personal communication):

Verbal and visual memory problems:

- Remind client of appointments
- Keep appointments at regular times.
- Review important issues from previous session at the beginning of the next one to accommodate poor memory continuity across sessions.
- Limit the amount of content covered each session.
- Repeat key ideas.
- Provide instructions one at a time.
- Encourage clients to:
    - Write things down
    - Use memory aids (e.g. pair unusual visual images with words)
    - Develop routines

Attentional Problems

- Encourage focus of attention on important issues.
- Help with steps to explicitly encode important information.
    - Focus attention.
    - Repeat content.
- Problem solve with clients how they can minimise distraction in problem situations (e.g. go to a quiet place to think, shut the door, turn off the TV).

Information Processing (speed of understanding and linking information)

- Go slowly.
- Allow plenty of time for questions.
- Use lots of repetition and summarisation.
- Have clients repeat to you their understandings.

Executive Functioning (planning, problem solving, sequencing etc)

- Be more explicit when helping clients think issues through.
- Teach how to identify issues.
- Teach step-by-step problem solving.

[15] Marjorie Collins (M.Clin.Psych; M.Neuropsych; PhD), Senior Lecturer, Psychology, Murdoch University

- Help clients plan out everyday timetables when having trouble organising themselves.
- Have clients rehearse sequences in session.
- Encourage them to develop routines.
- To inhibit impulses use aids such as breathing, counting to 10 before acting, notes they keep with them before acting, signs around the house.

Methamphetamine – tip sheet

When a client presents as intoxicated, counsellors should aim to establish a non-stimulating environment, support and reassurance, as well as assistance in preventing the client from harming themselves or others.

When discussing options for withdrawal from methamphetamine the client's medical, psychiatric and social functioning should be considered.

Symptoms of psychosis are common in regular users of methamphetamine, including paranoia, hallucinations, hostility, suspiciousness, delusions and misperceptions. Counsellors should screen clients for psychosis and refer for a full psychiatric assessment if significant symptoms appear to be present.

In addition to the risks associated with intravenous drug use, methamphetamine users are at risk of experiencing a variety of harms. Counsellors should attempt to negotiate the implementation of safer using practices with clients, where possible.

Widespread deficits in cognitive functioning can be a consequence of heavy, prolonged methamphetamine use, which has implications for the content, process and outcome of treatment. Clients experiencing manifestations of cognitive impairment will often present with:

- excessive distractibility;
- difficulty concentrating; and
- difficulty suppressing irrelevant task information.

Counsellors should endeavour to have a client's level of cognitive functioning assessed and tailor their intervention strategies and delivery of counselling accordingly. It is recommended that standard cognitive behavioural strategies for AOD counselling form the basis of the approach, and be adapted as appropriate.

Methamphetamine users tend to suffer from more intense and long lasting psychological disturbances compared to users of most other drugs. Patience is required when working with this population and counsellor and client should themselves tackle the issues bit by bit.

A tip sheet for clients coming off methamphetamine is in Appendix 20.

28. Co-occurring mental illness

Psychological disorders are extremely common in clients in AOD treatment and the relationship between psychological disorders and substance use is complex and dynamic. It is often difficult to establish the causal connection between substance use problems and psychological disorders.

Problematic AOD use may develop in response to a primary psychological condition as an attempt to relieve the distress of painful thoughts and feelings (Khatzian 1985). In other cases, problematic AOD use may develop independently, with adverse consequences on psychological health.

Counsellors should distinguish at assessment between those people with substance use issues who have co-existing psychological disorders (eg anxiety disorders) and those with more severe mental illness (eg bipolar disorder, psychotic disorders and severe borderline personality disorder) that may require psychiatric intervention. However, due to the fact that long or short-term AOD use, as well as withdrawal, can cause clients to experience symptoms of psychological disorders, the diagnosis of psychological disorders among the substance using population is often complicated.

28.1 Guidelines for working with people with severe mental illness in an AOD context

Engagement

The network of helping professionals

Often by the time clients with severe mental health issues come into contact with the AOD field they will have had extensive experience with mental health specialists. While many of these experiences may have been positive, many clients also report negative experiences. Engagement can be assisted by exploring the client's experiences of other helpers and identifying what the client has found helpful and not helpful in their interactions with other professionals.

Clients may also remain engaged with other service providers. The nature of these relationships may benefit from exploration in order to clarify the roles for each worker and to give meaning to the current request for support (see chapter on ***Case Management***).

Bringing the family and significant others into the picture

Families are often the major caregivers for clients with severe co-existing mental health issues and will remain so after services have ceased. Because of this, it is valuable to take a holistic or systemic view, and engage families early, after negotiation with the client. The aim of this is to examine the role the family would like to assume in the treatment process and to offer them support. Inquiring about the impact of the problems on their lives and on their responses to the user acknowledges their efforts as well as providing a clearer contextual picture surrounding the client and the problem. Involving families in treatment can contribute to positive treatment outcomes for all.

Exploring client's strengths and looking for exceptions

Exploring client strengths is important for both engagement and assessment purposes and can be applied to both individual clients and relatives. Exceptions are those past experiences in a client's life when the problem might have been expected to occur but somehow did not (de Shazer, 1985). Discovering times when the client has experienced a reduction or disappearance of psychiatric symptoms or substance use introduces the notion of the presence of change, and helps to minimise a belief that situations are permanently stable. Successful engagement acknowledges those aspects of an individual's life that can become obscured by mental illness and substance use.

Client's ways of coping

Another significant contributor to successful engagement with clients and their families is to consider the ways in which the client and family has coped with the twin problems of substance use and serious mental illness. Questions that illuminate the ways in which the client copes with these problems shows acknowledgment of their efforts to change their lives as well as bringing these strategies forward so that they can be included in treatment plans.

Assessment

Considering the interplay between stressors, psychiatric symptoms and drug use

The assessment principles outlined earlier in this guide apply. However when working with clients with co existing psychiatric and substance use problems the complexity and range of variations in both diagnostic groups needs to be considered. That is, there are different substances, different types of substance use, different types of psychiatric disorders, and complex and dynamic interactions between them.

An assessment that pays attention to the relationships between stressors experienced by the client, psychological symptoms and drug use can be of benefit for both the client and counsellor. Similarly, exploring the influence of psychiatric medication on the level of drug use and vice versa and exploring the influence of drug use on psychiatric symptoms is worthy of attention. The clarification that emerges from this line of inquiry can contribute to a comprehensive treatment plan and setting appropriate goals.

The influences of the problem

Clients with both substance use and mental illness problems often experience a plethora of other difficulties. These may include relationship problems, impending legal action, financial difficulties, unstable accommodation and poor self-care. These difficulties in turn can have an impact on feelings of self worth and contribute to the perpetuation of substance use and depression or other psychological symptoms. Asking the client to rank the more pressing problem so as to distinguish the contexts of each problem and identify the influences of these problems on their life and relationship with others can form part of a collaborative approach towards assessment and intervention

Describing how the counselling works

If any delusional beliefs or strange behaviours are identified by the counsellor it is important that the client is informed early on about the course counselling will take. Some counsellors may wish to consult with a mental health practitioner and these decisions need to be discussed with the client at the beginning of counselling. Keeping the client informed and involved with the counsellor's plans and actions are important aspects of building respectful and collaborative relationships.

Looking at what the client has tried and looking for solutions

The literature shows a strong link between stress and relapse of serious mental health symptoms. Giving up substance use can further increase stress especially if the substance is being used as a method of stress reduction. Therefore, it is helpful to explore with the client their previous attempts to alleviate the symptoms of stress and to develop a dialogue towards identifying alternative solutions.

Understanding the family's experience first

An assessment of the family context should primarily concern itself with understanding the family's experience of living with substance misuse and a co-existing psychiatric problem. Traditionally, most professional responses to families have been guided by interventions that aim to change the family. These stem from theoretical constructs that view family relationships as implicated in the causes and maintenance of the problem. As a consequence, families have communicated their frustration with service providers for applying a narrow framework that is experienced as blaming and not sensitive to their diverse needs and situations. The result has been the adoption of a more family sensitive model of working that places importance in counsellors and agencies having a collaborative and inclusive mindset with respect to families (see ***Working with Significant Others*** for family sensitive practice guidelines). This approach involves looking at current and previous solutions, evaluating their success, and exploring different possibilities which may lead to improved outcomes for both the client and the family. It should also be noted that training in formal family therapy is not needed to work with families.

Co-occurring mental illness - tip sheet

- Engage with the client by adopting a perspective that amplifies strengths and solutions and acknowledges efforts to cope.
- Involve families and care givers early on. Be proactive in introducing family involvement with your client. The terms of confidentiality can be negotiated between family and client.
- During assessment explore the relationships between clients' substance use, mental illness, current medication regime and stressors. If a mental illness is suspected, but not yet diagnosed, discuss with the client and liaise with mental health professionals if appropriate.
- Explore what has been tried, what has worked.
- Be practical – help with practical difficulties such as housing, finances, food, legal difficulties and self care.
- Link clients into services and day centres that offer practical help and activities to give clients something to do during the day.
- Explore stress reduction methods – there is a strong link between stress and relapse in mental illness. Giving up substance use can increase stress levels so make sure you explore ways that the client can reduce stress.
- Psychiatric intervention should be sought for clients with severe co-existing psychiatric disorders.
- It is often difficult to establish the causal connection between problematic substance use and psychological and/or psychiatric disorders.
- Liaise with appropriately trained medical and allied health personnel and mental health service providers.

29. Depression

Research indicates that depression is more prevalent among drug users in treatment than in the general population (Gossop, 2003). Depression is characterised by a range of symptoms including:

- low mood;
- loss of pleasure or interest in activities;
- lethargy;
- poor concentration;
- appetite or sleep disturbances;
- irritability or agitation;
- feelings of guilt and worthlessness; and
- suicidal ideation.

Alcohol and other drug use tends to have a reciprocal relationship with the experience of depression. This means that although for many clients the experience of symptoms of depression may precede the onset of their difficulties with alcohol or other drugs and indicate an underlying disorder, AOD use can also cause depression when it did not previously exist, or exacerbate pre-existing depression. It is also common for clients to experience symptoms of depression during withdrawal and early periods of abstinence from substance use. Although these symptoms tend to resolve in the first few weeks after

abstinence, in some cases they can persist, which is often an indication that depression is the primary disorder and needs to be targeted during treatment. Thus it can be difficult to tease apart the relationship between a client's substance use and symptoms of depression. Counsellors who are not trained to work with depression are encouraged to engage with supervisors for assistance with containing and managing a client's symptoms or to refer to specialist clinicians (eg clinical psychologist).

Generally it is imperative that counsellors endeavour to target symptoms of depression during treatment to avoid the risk of poor outcomes. This applies whether these symptoms are related to the drug use and hence should resolve over time, or whether they are due to an underlying depressive disorder. This is because the symptoms of depression (eg lethargy, social withdrawal, low affect) can potentially interfere with the components of traditional AOD treatments such as acquisition of new coping behaviors, attendance at self-help meetings and being self-motivated to complete homework tasks. Because negative mood is often a trigger for relapse, integrating the treatment of depressive symptoms into treatment plans is also an integral component of relapse prevention for depressed AOD clients. Clients should also be informed that early abstinence is often associated with increased levels of depression as and that unless there are pre-existing problems with depression, the symptoms should gradually decrease over the initial few weeks of abstinence.

29.1 Recommended treatment approach

Cognitive behavioural therapy has been identified as one of the most effective ways of treating co-occurring depression and substance use difficulties (Brown et al 2005). CBT strategies commonly used to treat symptoms of depression include:

- cognitive restructuring;
- pleasure and mastery events scheduling;
- goal setting; and
- problem solving

These strategies should be integrated with other addiction counselling interventions.

Cognitive restructuring

Cognitive restructuring rests on the notion that our behaviours and feelings are a result of our automatic thoughts (those thoughts which happen so quickly that we are unaware of them happening), which in turn are related to our core beliefs (deeply held beliefs about ourselves, others and the world). Cognitive restructuring is a strategy that forms the basis of CBT and involves identifying and challenging negative thoughts and beliefs. For example, the belief that "I am totally useless because I use drugs" may result in feelings of sadness, guilt, worthlessness, and also result in negative behaviours (eg social withdrawal). Depression, relapse, anxiety or other life problems are linked to core beliefs which can be observed through feeling, actions and automatic thoughts. Automatic thoughts are commonly based on incorrect beliefs which can be challenged by using cognitive restructuring exercises (see ***Cognitive Restructuring***).

The *Don't Think* exercise helps clients to understand that thoughts are important and cannot be simply pushed out of mind. Explain to clients that our thoughts have a major impact on how we feel and what we do. We often aren't aware of what we are thinking, or even that we are thinking. We can't stop thinking even if we want to. Then explain to clients that you are going to get them to do an exercise where you are going to give them one minute and in that time, you want them to stop thinking. After a minutes ask the clients if they managed to stop thinking. We are willing to bet that they spent that minute thinking about not thinking.

Next give the client an example to demonstrate that it is not an event that causes us to feel a certain way but rather the way we interpret it, or think about it. An example might be:

Situation: Getting a phone call from an old friend, Sarah, who wants to catch up. She tells you about her new job and how well her relationship is going.

> Sally says to herself: "Sarah is doing so well; she has got a job and a great relationship. I wish my life was more like hers, I can never hold down a job or a relationship, I am such a failure." Sally feels really sad and finds herself dreading catching up with Sarah. Sally then starts to feel guilty that she does not want to see Sarah.
>
> Jane says to herself: "Wow, Sarah has come so far since we first met; maybe it really is possible for people to sort themselves out and get life back on track." Jane feels hopeful and finds herself looking forward to catching up with Sarah.

Using this example, counsellors can demonstrate to clients that the same situation can cause people to have very different emotional responses. Thus it is not the situation which makes us feel a certain way, but rather the beliefs we have when faced with that situation.

Counsellors can also use the *ABCDE Model* (see ***Cognitive Restructuring***) to teach clients how to first catch their automatic thoughts and then examine them to see how rational they are. For example, in the case of Sally:

A Antecedent – phone call from Sarah
B Beliefs – "I am a failure"
C Consequences – feeling sad, guilty
D Disputation – I might not have a job but I have cut down my drinking by half
E (Alternative Explanation) – Just because I don't have a job doesn't mean I am a failure; there are other things that I have succeeded in.

Note also another important step that counsellors should reinforce with clients:
F Forging ahead - Once you have resolved the issue move on. Don't continue to keep going back over the situation time and time again. You can't change yesterday only tomorrow.

Pleasure and mastery events scheduling

When clients who are feeling depressed stop engaging in behaviours that give them a sense of pleasure and achievement, they set themselves up for a cycle in which they become very inactive which leads to more feelings of guilt or low mood and energy, which leads to even less engagement in pleasant events, and so forth.

Thus an important part of treating depression is pleasure and mastery events scheduling which facilitates clients engaging in increasing levels of activity that give them a sense of pleasure and achievement in a structured way. It can be very difficult for clients to simply resume previous levels of activity, so this strategy enables clients to use a weekly timetable in which they can schedule particular activities. It is important for clients to start with activities that are simple and achievable.

To start with, some very depressed clients might be encouraged to think of one activity they can do for achievement each day (eg wash x number of dishes each day, water the pot plants), and one they can do each day that is even slightly pleasurable (eg watch a program on TV that they get some pleasure from, pat the dog). They should write these down on a list to work to each day. Each week more activities can be added. There are also lists of activities available for clients to choose from. The Centre for Clinical Interventions (CCI) website (www.cci.health.wa.gov.au) includes one in their "Back from the Bluez" workbook for clients.

Clients may also need to be reminded of the fact that they deserve to feel good and that in many cases feelings of motivation generally only arise *once we are active*, rather than visa versa.

Thus the aim is for clients to *gradually* begin experiencing the emotional and physical benefits of experiencing pleasure and achievement, which can break the cycle of their low mood, lack of energy and feelings of guilt.

Goal setting

As well as goals related to their substance use, counsellors can also help clients to use goal setting as a strategy for treating symptoms of depression. For example, they could set a goal of keeping track on a week-by-week basis of their progress in therapy. An example is a goal of monitoring their participation in pleasurable events and how they feel as a result. Not only does this provide information regarding the utility of particular strategies but also allows clients to experience success, which can be an effective way of targeting their feelings of hopelessness and worthlessness.

It is important that the goals are specific, achievable, short term, described in positive terms and negotiated (see ***Goal Setting*** tips).

Problem solving

Clients with depression often believe they are not capable of solving problems, teaching them a structured way of achieving this task can be useful for demonstrating to them the skills they already have, and is related to more positive treatment outcomes. Problem solving can also be used to facilitate other treatment strategies, such as working out how to overcome obstacles to engaging in pleasure/mastery activities.

The steps involved in problem solving are as follows:

- Orientation - step back from the problem.
- Define the problem - be specific.
- Brainstorm solutions - anything goes.
- Decision making - consider pros and cons of each solution. Choose a solution. Consider how to put the solution into action.
- Implementation - rehearse the strategy, evaluate its effectiveness and then try it out.

(See ***Problem Solving*** chapter for more details.)

Clients with cognitive damage may find problem solving a difficult exercise, as may clients in the grip of a deep depression as this also temporarily affect cognitive functioning. These clients may require a lot of practice and simple, easy to follow information. For suggestions on techniques to use with cognitively impaired clients, refer to ***Cognitive Impairment***.

These specific CBT strategies should be integrated with other components of treatment such as motivational interviewing, relapse prevention and management, pharmacotherapy etc. The Centre for Clinical Interventions (CCI) website (www.cci.health.wa.gov.au) also provides information and resources for the treatment of depression using CBT, which are designed for use by both professionals and clients.

Clients may also benefit from antidepressant medication. However, it is recommended that the prescription of antidepressants occur concurrently with the provision of therapy targeting specific depressive symptoms and AOD difficulties, as this has been shown to improve treatment outcome (Nunes & Levin, 2004).

Counsellors also need to be aware of the increased risk of suicide among clients who suffer from both AOD difficulties and depression. Careful assessment and periodic monitoring of clients' levels of suicidal ideation and risk of suicide completion is recommended. Counsellors are referred to the ***Suicide Management*** chapter for further information on this.

Depression tip sheet for counsellors

Many clients will present with co-occurring AOD difficulties and depression.

It can be difficult to tease apart the relationship between a client's substance use and symptoms of depression.

Counsellors should endeavour to target symptoms of depression during treatment to avoid the risk of poor outcomes.

Because negative mood is often a trigger for relapse, treating depressive symptoms is also an integral component of relapse prevention.

Cognitive behavioural therapy has been identified as one of the most effective ways of treating co-occurring depression and substance use difficulties.

The following CBT strategies can be used to target symptoms of depression:

- cognitive restructuring;
- pleasure and mastery events scheduling;
- goal setting; and
- problem solving.

These specific CBT strategies should be integrated with other components of treatment such as motivational interviewing, relapse prevention and management and pharmacotherapy.

It is recommended that the prescription of antidepressants occur concurrently with the provision of therapy targeting specific depressive symptoms and AOD difficulties.

Careful assessment and periodic monitoring of clients' levels of suicidal ideation and risk of suicide completion is recommended.

30. Anxiety

Many clients who experience difficulties with alcohol or drug use will concurrently be experiencing difficulties with anxiety. Anxiety-related problems can manifest in a variety of different psychological disorders, the most common of which (among AOD populations) are post-traumatic stress disorder (PTSD), generalised anxiety disorder (GAD), panic disorder, social phobia and obsessive-compulsive disorder (OCD) (Marsh & Dale 2006).

Research indicates that clients with an AOD disorder are 5 times more likely than the general population to develop an anxiety disorder, and visa versa (Barlow 2002). Thus, there is a strong relationship between the experience of anxiety and AOD difficulties but the nature of this relationship can be difficult to tease apart.

Many clients report that their symptoms of anxiety preceded their substance use, and/or that they began to use substances as a means of coping with their anxiety. However, anxiety symptoms can also develop as consequence of drug or alcohol use.

Suffering from symptoms of anxiety (eg muscle tension, increased heart rate, nausea, sweating, breathlessness, dizziness, depersonalisation, worrying etc.) is common during the withdrawal period and the first few weeks of abstinence. Similarly, people may experience symptoms of anxiety while intoxicated. Clients should also be informed of these associations with anxiety, and that if there is no underlying anxiety disorder then the anxiety symptoms should gradually decrease with abstinence. If anxiety symptoms persist when the client is not intoxicated or following an extended period of abstinence, counsellors should investigate the presence of a primary anxiety disorder. If counsellors are not trained to work with anxiety disorders they should refer to special clinicians such as clinical psychologists or liaise closely with a supervisor for help with containing and managing the client's symptoms.

If anxiety symptoms are not targeted through treatment, poorer outcomes, including increased risk of relapse, are likely. Thus counsellors should endeavour to integrate strategies which target anxiety symptoms into their treatment plans.

30.1 Recommended treatment approach

Cognitive behavioural approaches are recommended for the treatment co-occurring anxiety and AOD disorders. CBT strategies commonly used to treat symptoms of anxiety include:

- relaxation and/or grounding;
- cognitive restructuring;
- problem solving; and
- goals setting.

These strategies should be integrated with other addiction counselling interventions.

Relaxation

There are many relaxation strategies clients can use. It is worth asking the client what strategies they already use to relax as for some clients paradoxical strategies such as listening to loud music or engaging in strenuous physical exercise are more effective than slow and gentle approaches.

Three common methods of relaxation that can assist with managing a variety of anxiety-based symptoms are described in detail in the ***Relaxation*** chapter. The first of these strategies is *controlled breathing* which involves focusing on breathing very slowly and deeply. This strategy cannot only directly reduce tension but can also help clients to manage distress by distracting their attention away from their symptoms of distress. The second relaxation strategy is *progressive muscle relaxation*, which involves tensing and relaxing specific muscle groups. Because this exercise provides clients with a concrete focus it can also facilitate distress reduction as well as increased relaxation. The final relaxation technique is the use of visual imagery to create an imaginary sanctuary or safe place.

Introduce these strategies by saying no one approach suits everyone and that if a particular strategy has untoward effects such increasing their anxiety they should not persist with it. These strategies should be introduced in session so clients can try them and give you feedback.

Grounding

Grounding strategies are useful tools which can be used by counsellors when assisting clients to manage acutely distressing symptoms of anxiety such as flashbacks, intrusive memories, panic, fear and dissociation. These strategies, categorised as mental, physical or soothing, help clients to focus

their attention onto the outside world rather than inward on traumatic memories or feelings of distress/anxiety (see ***Grounding*** chapter for more detail).

Cognitive restructuring

Cognitive restructuring rests on the notion that our behaviours and feelings are a result of our automatic thoughts (those thoughts which happen so quickly that we are unaware of them happening), which in turn are related to our core beliefs (deeply held beliefs about ourselves, others and the world). It is a strategy that forms the basis of CBT and involves identifying and challenging negative thoughts and beliefs that result in feelings of anxiety, and also result in negative behaviours (eg social avoidance). Anxiety, relapse, feeling depressed, or other life problems are the result of core beliefs which can be observed through feeling, actions and automatic thoughts. Automatic thoughts are commonly based on incorrect beliefs which can be challenged by using cognitive restructuring exercises (see ***Cognitive Restructuring*** chapter).

The *Don't Think* exercise helps clients to understand that thoughts are important and cannot be simply pushed out of mind. Explain to clients that our thoughts have a major impact on how we feel and what we do. We often aren't aware of what we are thinking, or even that we are thinking. We can't stop thinking even if we want to. Then explain to clients that you are going to get them to do an exercise where you are going to give them one minute and in that time, you want them to stop thinking. After a minutes ask the clients if they managed to stop thinking. We are willing to bet that they spent that minute thinking about not thinking.

Next give the client an example to demonstrate that it is not an event that causes us to feel a certain way but rather the way we interpret it, or think about it. An example might be:

> Situation: Being on the train and the person sitting opposite you smiles at you before getting off.
>
> Peter says to himself: "Why was that person laughing at me? He must have thought my clothes make me look like a loser. How embarrassing. I am a loser and everyone can tell." Peter then starts to feel very anxious and worried that everyone on the train will think he is a loser.
>
> John says to himself: "I wonder why that person smiled at me? Maybe he had mistaken me for someone he knows." John feels neutral.

Using this example, counsellors can demonstrate to clients that the same situation can cause people to have very different emotional responses. Thus it is not the situation which makes us feel a certain way, but rather the beliefs we have when faced with that situation.

Counsellors can also use the *ABCDE Model* (see ***Cognitive Restructuring*** chapter) to teach clients how to first catch their automatic thoughts and then examine them to see how rational they are. For example in the case of Peter:

A Antecedent – smile on train
B Beliefs – "Everyone is laughing at me and thinking I'm a loser"
C Consequences – feeling anxious
D Disputation – Maybe the person who smiled at me was someone I used to work with, or had mistaken me for someone else
E (Alternative Explanation) – Just because someone smiled at me doesn't mean they are laughing at me.

Note also another important step that counsellors should reinforce with clients:
F Forging ahead - Once you have resolved the issue move on. Don't continue to keep going back over the situation time and time again. You can't change yesterday only tomorrow.

Problem solving

Teaching clients a structured way of solving problems is related to more positive treatment outcomes. Problem solving can also be used to facilitate other treatment strategies (e.g. working out how to overcome obstacles to practicing relaxation techniques).

The steps involved in problem solving are as follows:

- Orientation - step back from the problem.
- Define the problem - be specific.
- Brainstorm solutions - anything goes.
- Decision making - consider pros and cons of each solution. Choose a solution. Consider how to put the solution into action.
- Implementation - rehearse the strategy, evaluate its effectiveness and then try it out.

(See ***Problem Solving*** chapter for more details.)

Clients with cognitive damage may find problem solving a difficult exercise. These clients may require a lot of practice and simple, easy to follow information. For suggestions on techniques to use with cognitively impaired clients, refer to ***Cognitive Impairment***.

Goal setting

As well as goals related to their substance use, counsellors can also help clients to use goal setting as a strategy for treating symptoms of anxiety. For example, they could set a goal of keeping track on a week-by-week basis of their progress in therapy. An example is a goal of monitoring their use of relaxation techniques and how they feel as a result. This not only provides information regarding the utility of particular strategies but also allows clients to experience success, which can be an effective way of targeting their feelings of learned helplessness.

It is important that the goals are specific, achievable, short term, described in positive terms and negotiated (see ***Goal Setting*** tips).

These specific CBT strategies should be integrated with other components of treatment such as motivational interviewing, relapse prevention and management, pharmacotherapy etc. The Centre for Clinical Interventions (CCI) website (www.cci.health.wa.gov.au) also provides information and resources for the treatment of particular anxiety disorders (social anxiety, GAD, panic disorder) using CBT. These resources are designed for use by both professionals and clients and are relevant to the treatment of general symptoms of anxiety.

Due to the very high rates of PTSD among AOD populations, and the fact that the symptoms of this disorder can worsen following the cessation of substance use, counsellors are encouraged to be aware of how to respond appropriately to clients who present with symptoms of PTSD. For further information refer to the ***Sexual Abuse and other Trauma*** and ***Grounding*** chapters of this manual.

Anxiety - tip sheet

Many clients who experience difficulties with alcohol or drug use will concurrently be experiencing difficulties with anxiety.

Although there is a strong relationship between the experience of anxiety and AOD difficulties, the nature of this relationship can be difficult to tease apart.

Targeted treatment of anxiety symptoms is related to more positive treatment outcomes and reduced risk of relapse.

Research suggests that cognitive behavioural therapy is an effective way of treating co-occurring anxiety and AOD disorders.

The following CBT strategies can be used to target symptoms of anxiety:

- relaxation training;
- cognitive restructuring;
- grounding;
- goal setting; and
- problem solving.

These specific CBT strategies should be integrated with other components of treatment such as motivational interviewing, relapse prevention and management, pharmacotherapy etc.

Due to high rates of PTSD among AOD clients, counsellors should be familiar with how to appropriately respond clients who suffer from PTSD and are referred to the ***Sexual Abuse and other Trauma*** and ***Grounding*** chapters for assistance with this.

31. Sexual abuse and other trauma

There is a strong relationship between child sexual abuse (CSA) and AOD disorders. Rates of CSA in women in AOD treatment are estimated to be between 31% and 74% and in men these rates are estimated at around 16% (Swift et al 1996; Simpson & Miller 2002). In addition to sexual abuse, clients presenting for AOD treatment report greater levels of family and domestic violence, both in their family of origin and currently, than the general population.

Trauma exposure per se does not lead to increased AOD use. Rather, increased AOD use is only likely if PTSD symptoms develop from exposure to the trauma. The presence of PTSD symptoms indicates that the trauma is still affecting the person in the present. The literature indicates PTSD plays a causal role in the development of AOD disorders, with AOD being used to self-mediate PTSD symptoms.

The Diagnostic and Statistical Manual of Mental Disorders IV (DSM-IV text revision, American Psychiatric Association 2000) classifies PTSD symptoms into three groups:

1. Recurrent “re-experience” of the traumatic event, through nightmares, “flashbacks” and intrusive memories.
2. Persistent avoidance of thoughts, reminders or localities which are associated with the trauma, and a general numbing and lack of responsiveness.

3. Persistent symptoms of increased physiological arousal, including hypervigilance towards distressing cues, sleep difficulties, exaggerated startle response, increased anger and concentration difficulties.

These symptoms operate in a cycle, whereby intrusive memories of the trauma, accompanied by re-experiencing and hyperarousal symptoms are followed by suppression of memories and avoidance of reminders, usually accompanied by emotional numbing.

At least one third of clients in any AOD treatment setting can be expected to have PTSD. These rates tend to be higher in inpatient settings.

Najavits (2002) summarises a number of facts drawn from the literature about PTSD and AOD use.

- Clients say PTSD symptoms often trigger AOD use – they use drugs to cope with the symptoms.
- Ceasing AOD use does not resolve PTSD and can instead amplify PTSD symptoms.
- People with co-occurring PTSD and AOD disorders have a more severe clinical profile than those with only one disorder.
- Treatment outcomes for people with co-occurring PTSD and AOD disorders are worse than for those with one disorder.
- People with PTSD tend to have a lot of life problems such as other psychological disorders, interpersonal difficulties, medical problems, domestic violence, and homelessness that complicate the clinical picture and their treatment.
- Even though AOD use is seen as helpful in the short term of PTSD symptoms, some forms of AOD use can exacerbate PTSD symptoms in the longer term.

31.1 Recommended treatment approach

Given the considerable rates of sexual abuse, other trauma and PTSD in AOD treatment populations, it is important that clinicians are aware of this when undertaking an assessment. Once a therapeutic alliance has been developed between the clinician and the client, then clients can be asked whether they have experienced sexual abuse or other trauma, and whether it still affects them. This should be done in a sensitive manner during assessment, but not usually in the first sessions. It is important that clients are advised that they do not need to discuss these issues if they don't feel ready. Be aware that not just sexual abuse, but also physical, and emotional abuse creates feelings of shame, guilt and powerlessness. Feelings of shame associated with sexual abuse can be particularly intense for male clients. It is also important that counsellors do not question clients in too much depth about these experiences unless or until the clients have developed the skills to manage the intense negative affect likely to arise when talking about them.

As a result of the self medication role of AOD use for clients with co-occurring PTSD and AOD problems, both the PTSD and the drug use should be treated simultaneously. If this is not done, then when clients with PTSD who have no strategies to cope with their PTSD symptoms other than drug use attempt to detoxify from drugs, their PTSD symptoms and distress can escalate, resulting in relapse to cope with this. Similarly, although dealing with PTSD symptoms can decrease drug use for some, most clients need additional specific AOD relapse prevention strategies.

The treatment model recommended in the literature for conceptualising clinical work with clients with sexual abuse or other trauma and PTSD is a phased model. The model draws particularly on the work of Herman (1992), Briere (2002) and van der Kolk (2001). Phase 1 focuses on establishing safety and building client resources, and can be undertaken by all AOD counsellors with their clients. Phase 2

focuses on the trauma and should only be attempted by highly trained and experienced specialist clinicians. Many clients, particularly those who experienced multiples traumas and have AOD problems, are also unable to tolerate work that focuses on the trauma, and their treatment would just focus on phase 1 activities. Also important when working with clients who have experienced chronic interpersonal trauma is long, slowly paced therapy guided by the client and including the continual establishment of safety.

Phase 1

Phase 1, establishing safety, is usually the longest and most difficult stage of recovery, particularly for clients who experienced chronic childhood interpersonal trauma and who cope with the effect of this by using alcohol or drugs. For AOD clients it involves building their coping skills and resources to reduce their need to use drugs as a way of coping with their symptoms and distress, which then facilitates a reduction in their drug use. This phase focuses on the following.

- Establishing a therapeutic relationship.
- Making it clear that client can control the pace and topics covered in counselling – they have had experiences of powerlessness and need a sense of control to even start to feel safe in counselling.
- Making it clear that too much focus on the trauma is not a good thing until they have the skills to manage the associated distress – avoid asking questions to deepen exploration of the trauma and gently stop the client if they are talking about it and becoming distressed.
- Validating and normalising the experiences and reactions of the client by being empathic and genuine.
- Psychoeducation about PTSD (there are many handouts for clients available on the web).
- Exploration of the link between PTSD symptoms and a client's AOD use (motivational interviewing can be useful here, although it is important to consider the cost/benefit of further increasing client's psychological distress, so care is needed).
- Reducing AOD use (consider addiction pharmacotherapies and use AOD counselling interventions such as motivational interviewing, harm reduction and negotiated safety, goals setting, problem solving and relapse prevention).
- Reducing unsafe behaviours, thoughts and situations such as suicidal ideation and attempts, self harm, unsafe sex, staying in abusive relationships, living on the streets (use AOD counselling strategies such as motivational interviewing and relapse prevention as applied to the relevant behaviour or situation).
- Building client resources such skills to cope with trauma reactions and dissociation (use grounding strategies), affect management (helping clients to name emotions, introduce a 1-10 distress rating scale and advise clients when they reach 7/10 that they should take a break from whatever it is that is upsetting them, problem solving strategies that help them to calm down, teaching relaxation approaches – see note below).
- Developing healthy relationships (assist with assertion training, anger management training, communication skills).
- Over time, developing interests, going back to study or work.

Clients with PTSD react unpredictably and their thoughts can very easily turn to the trauma they have experienced. Therefore consider the following.

- Always stress to clients that they can refuse to try any strategy suggested in session and stop trying one if they feel uncomfortable.

- Always get feedback about client experiences of any strategies you suggest.

- When teaching relaxation strategies, make sure there is clear focus for the client's attention as with progressive muscle relaxation. Don't leave traumatised clients listening to whales or gentle forest sounds as they will tend to drift quickly back to traumatic memories.

For opioid using clients, opioid substitution treatments (methadone, buprenorphine) can be very helpful in continuing to provide the drug effect that helps contain PTSD symptoms allowing clients to reduce their other AOD use more quickly. Psychiatric medications, particularly some antidepressants, can also be useful.

Phase 2

Phase 2 focuses on the trauma. Referred to as "remembrance and mourning" by Herman (1992) it involves remembering and making sense of the trauma that was experienced. It involves exposure to memories of the trauma and the feelings associated with it and reprocessing of the traumatic material.

Although exposure treatment is considered the treatment of choice for PTSD from a single traumatic event, it is often contraindicated for people with PTSD from chronic childhood trauma and for people with AOD disorders (Foa et al 1999). Exposure treatments involve re-experiencing intense negative affect, which people with PTSD from chronic childhood trauma tend to manage in risky ways such as drug use, self harm, aggression, or suicide attempts, and which people with AOD disorders often manage by relapsing to drug use or dropping out of treatment (Marsh in press). It is therefore not appropriate for many AOD clients with a history of sexual abuse unless they have managed to attain sufficient stability during the safety stage of treatment. This phase of treatment should only be undertaken by clinicians trained to do this work, and only with clients who are able, and willing, to tolerate it.

A treatment resource for use by counsellors

A very useful resource for clinicians working with AOD clients who were sexually abused or experienced other trauma is a 25-topic cognitive behavioural manualised treatment for co-occurring PTSD and AOD disorder called "Seeking Safety" (Najavits 2002). The approach integrates AOD and PTSD treatment and focuses on phase 1 safety strategies to assist with affect regulation, containing and managing PTSD symptoms, managing interpersonal situations, and AOD relapse prevention. It does not include exposure, and is therefore suited for use by a broader range of counsellors than the treatments that include exposure. It includes a multitude of client handouts.

Other considerations

Marsh and Dale (2006) highlight the need for counsellors to be aware of the difficulties that may arise when attempting to gain the trust of clients who have a history of childhood sexual or physical abuse. When working with such clients it is recommended that counsellors be realistic in their expectations of both themselves and the client, and tailor treatment to take into account the client's emotional and cognitive capacity to engage in the tasks of therapy. Treatment for clients with AOD issues and sexual abuse is usually of necessity long term, and can require referral to clinicians trained in working with PTSD. At the same time, counsellors not trained in this area can still often provide valuable assistance to clients in terms of increasing their safety and stability.

Finally, clients who have experienced chronic interpersonal abuse often have intense transference reactions towards counsellor – both positive and negative. In turn, counsellors often have strong countertransference reactions to these clients, again either positive or negative. So that counselling does not become bogged down in playing out these issues at the expense of client progress, it is

essential that counsellors receive regular supervision and discuss their own and their client's reactions in the context of the therapeutic relationship.

Sexual abuse and other trauma – tip sheet

PTSD is common among survivors of sexual abuse and other trauma.

AOD problems are associated with the development of PTSD symptoms with AOD use usually providing a self-medication function.

PTSD and AOD problems can not be treated as discrete entities but need to be treated together.

When working with people who have been traumatised counsellors should consider the following.

- The need to assess and raise the issue of sexual abuse and other trauma with sensitivity once a therapeutic alliance has been formed.
- It may not be necessary to elicit extensive details of the trauma to understand the impact on the client.
- The importance of reassuring and normalising client reactions to the trauma.
- The importance of establishing, and continually re-establishing if need be, therapeutic and practical safety with the client.
- The importance of building client resources and coping strategies.
- Brief intervention is not indicated when working with clients who have trauma issues.
- Use Najavits (2002) "Seeking Safety" as a guide to assist traumatised clients with safety and stability
- Exposure treatments are not recommended for clients with PTSD from prolonged abuse or AOD disorders unless sufficient stability and coping skills are developed
- Referral to appropriate clinicians or services may be required.

32. Grief and loss

Issues of grief and loss are almost unavoidable when working in the AOD field. There are a myriad of different sources of grief and loss. The loss of a friend, partner or family member from the effects of AOD is one source of grief. Clients who have been traumatised by childhood abuse may experience feelings of grief and loss relating to the impact the abuse has had on their lives. The initiation of substance use may have been a coping mechanism to deal with grief or loss and therefore, the successful reduction of substance use necessitates the resolution of grief and loss issues.

Feelings of grief and loss may also arise from the cessation of drug use itself: grief over a life style that is lost, friends who are lost, and the stable constant embrace of the drug itself. Finally, many clients present with feelings of grief over a life with hopes and dreams that has been replaced with the drug using life.

Grief involves a series of reactions that can be grouped into four categories, emotional, psychological, physical and social.

Emotional

For most people the first feeling following a loss is one of shock, numbness and disbelief. They can't believe what has happened and often can't comprehend the facts. People's reactions at this stage can vary considerably, from withdrawal to laughing and joking in an inappropriate manner.

Following the initial shock and disbelief, people may find themselves vacillating between a range of confusing emotions including a sense of loss of control, anger, confusion, frustration, panic, guilt, hostility, fear, a desire to blame and a yearning for a reappearance of the deceased. It is normal for people to continue to vacillate between, and re-experience, these emotions over a long period of time. This shouldn't be taken as a sign of the client having failed to resolve their feelings and counsellors should endeavour to normalise this process for the client.

Psychological

The way that we think changes immensely during the grieving process. Typical cognitions experienced by bereaved people include disbelief, confusion, preoccupation with thinking about the deceased, sense of presence of the deceased, and hallucinations (in the first few weeks) (Worden, 2002). It is also common for people to experience difficulties with concentration or the processing of new information. Many people also find themselves questioning their religious, ethical and moral belief systems as well as facing existential issues such as the inevitability of their own death. Counsellors should encourage clients to explore these existential issues, as well as their changing religious, moral and ethical views.

Physical

Bereaved people commonly experience a number of physical reactions including sleep disturbance, appetite disturbance, lethargy, tiredness, reduced libido, gastro intestinal symptoms, muscular tension, headaches and nausea. Other common physical reactions include hollowness in the stomach, tightness in the chest or throat, oversensitivity to noise, breathlessness, and dry mouth. Bereaved clients may also experience symptoms of depersonalisation. For example, they may describe experiences such as walking down the street and feeling as though nothing is real, including themselves. Mimicking a reaction whereby the bereaved may develop symptoms similar to that from which the deceased died, can also occur. Counsellors need to reassure clients of the normality of these reactions and explore drug free strategies to help with sleep, relaxation and personal care.

Behavioural

During a normal reaction to grief people often experience changes in their patterns of behaviour. These include sleep and appetite disturbance, absentminded behaviour, dreams of the deceased, social withdrawal, avoidance of situations or objects that are reminders of the deceased, searching and calling (often subvocally), sighing, restlessness, hyperactivity, crying, carrying reminders of the deceased, visiting places associated with the deceased, and treasuring things that belonged to the deceased (Worden, 2002). Again, counsellors should attempt to normalise these behaviours for the client and explain to them the variety of behavioural changes that can be associated with the experience of grief and loss.

Social

Following a loss, the patterns of social interactions often change. Bereaved people often report feeling isolated because people with whom they previously had regular contact with appear to ignore them. It is likely that these people feel uncomfortable and ill equipped to face the subject of death.

32.1 Goals of grief counselling

Worden (2002) conceptualises the process of mourning as consisting of four tasks to be achieved. It is recommended that the goals of grief counselling should be to facilitate the completion of these four tasks. It is noted however, that the tasks of grief are to be engaged in flexibly, that is, it is not a requirement that each task be completed before moving on to the next task; often several tasks will be worked on at the same time; and often previous tasks will need to be revisited. The goals of grief counselling include the following.

Increasing acceptance of the reality of the loss

This process takes time and is facilitated by rituals such as the funeral. Counsellors can encourage clients to talk about the loss in detail (when? how? how did they hear? the funeral), and encourage visiting the gravesite.

Helping clients work through the pain and grief by dealing with both expressed and latent affect

This involves working through the range of feelings that might arise for clients, including sadness, loss, anger, anxiety, loneliness, guilt or relief. Encourage and help clients to identify and experience their feelings, including negative feelings about the deceased. This task may be difficult as people may try to avoid experiencing such feelings. Clients may need to be educated about the effect such avoidance can have on their feelings (ie exacerbation of the pain and grief). Counsellors should also be aware of the possibility that clients will be uncomfortable with grieving, and can attempt to ameliorate this by normalising the experience of grief.

Helping clients to overcome obstacles to readjusting to an environment that no longer includes the deceased

This task involves adjustments that are external (behaviours), internal (sense of self, cognitions), and spiritual (beliefs, values) in nature. Counsellors may find that problem solving is a useful technique to assist clients to overcome any obstacles they may experience when attempting to adjust to a life without their deceased. Given that grief can cloud one's judgements, it is also recommended that counsellors discourage clients from making any major life decisions or changes at this point.

Helping clients to find a way to remember the deceased and feel comfortable reinvesting in life

Reassure clients that moving on and engaging in new interests or relationships can be done in a way that does not detract from the love that is felt for the deceased. This can be facilitated by encouraging clients to reminisce, and by helping them to work through doubts about the initiation of new relationships or impulses to jump quickly into new relationships. Rituals can be useful for helping clients to cherish their memories of the deceased whilst also integrating their "changed relationship" into their daily lives.

32.2 General points when working with grief

While the following points are specific to bereaving people, they are appropriate to bear in mind when working with other grief and loss issues. Grief is universal, with common underlying themes across different sources.

- Grief is normal, natural and painful, and cannot be avoided.

- No two people will experience grief in the same way though there may be common elements. Thus it is important for counsellors to normalise a client's experience of grief reactions, particularly if the client perceives that these reactions indicate they are going mad (a common thought experienced by bereaved people).

- Bereaved people often appear distracted and preoccupied.

- Give people permission to grieve.

- Grief takes time to resolve, and people may need to retell the story of their loss many times over. There are no time lines for grief. People do not “get over” grief but learn to live with it.

- It is essential to facilitate clients talking about their feeling regarding a deceased person, not just the positive ones but also the negative ones as well. Unless both positive and negative feelings are processed, some clients will not adequately process the grief.

- Previous losses will affect the current situation. An individual’s reaction may seem inappropriate to the current loss, however it may be influenced by previously unresolved loss issues which may need to be talked about as well.

- Give the client your undivided attention. Actively listen, communicate empathy and unconditional positive regard.

- Try to avoid giving someone only a time limited commitment. Working through issues of grief is often long term.

- If you need to give information to someone who is bereaved, always give both verbal and written instruction. When someone is grieving it is often difficult for them to concentrate.

- Use the name of the deceased and use the word death. The use of euphemisms will not help soften the pain.

- People often need practical help as well as emotional support.

- Encourage clients to find an avenue to help them express their grief. Such avenues include:

  - talking;
  - writing (a letter, poem, stream of consciousness);
  - artistic expression (drawing, sculpting, painting);
  - physical expression (running, rowing, hitting a punching bag wearing gloves, walking, going to the gym);
  - emotional expression (screaming, crying, yelling);
  - relaxation; and
  - taking care of oneself.

- Encourage the client to find somewhere that they feel comfortable and safe before they try any of the above strategies, as well as trying to develop strategies of their own.

- Encourage clients to find a ritual in order to help them to move on. Counsellors should use clinical judgment as to the appropriateness of this intervention and ensure that the client is “ready” to move on.

- Encourage clients to seek social support. This may be in the way of friends, family, AA/NA and bereavement support groups.

- The first year, including the first Christmas, birthday, and indeed any anniversary can be particularly painful for people.

- Consider the well being of the whole family - partner, siblings and other generations.

- Continually assess the client's level of suicidal ideation. Suicide rates are elevated in grieving people, and the most dangerous time for suicide is thought to be two to three days after the funeral, and eight to twelve weeks after death, when most social supports tend to withdraw. (See chapter on ***Suicide Assessment and Management***).

- Continually assess the client's levels of depression. Should clinical depression develop and continue for a significant period of time after the loss with no indications of relief or improvement, specific interventions designed to alleviate the depression may be appropriate. (See chapter on ***Depression***.)

- Drug use tends to be actively condoned during the grieving process. People are often prescribed sleeping pills or antidepressants, or encouraged to have a drink. For those already struggling with substance use issues, it may be useful to book them into a residential service during this time which will allow access to more social support, professional support and constant monitoring by staff.

- Divorce rates following the death of a child are very high thus grieving parents should be encouraged to seek help together (such as both attending a parent bereavement support group if one is available or other forms of support groups or counselling).

- Be aware of any transference or countertransference issues that may arise. When working with bereaved people, counsellors are encouraged to work closely with their supervisor.

- Counsellors need to have worked through their own issues surrounding death and grief before attempting to work with grieving people.

- You can not take away someone else's pain. The best you can do is provide support, guidance and accompany them on their journey.

The above points are relevant to people suffering grief irrespective of its source (eg loss of drug, dreams, plans). This information can be used as a framework and adapted to suit the client and the source of his or her grief.

Due to the high suicide and overdose rates among AOD clients, it is important for counsellors to have a general understanding of the process that occurs when someone is found dead to enable them to support family members or to provide appropriate referrals if necessary. Counsellors should contact their local funeral service to find out about this process. In the Perth, Western Australia metropolitan area, when a person is found dead the police are called, who in turn call the coronial inquiries police. The coronial inquiries police investigate the scene and transport the body to the Coronial Pathology Centre at the Queen Elizabeth II Medical Centre. Parents or next of kin are contacted by the Coroners department, before being asked to make a formal identification. The family or next of kin contact a funeral director to initiate the funeral process. Families should be informed that all "accidental" deaths are investigated with the body being subject to an invasive post mortem. Families have the right to object to an invasive post mortem.

It is important for counsellors to be able to support families through this process, and refer family and friends to an appropriate counsellor or service if so desired. When working closely with grieving individuals, counsellor should have the support and guidance of a clinical supervisor experienced in the area. Assistance can also be provided by various funeral organisers or grief recovery centres, many of which can be found by searching the web.

32.3 Client death

It is normal for counsellor to be saddened and find themselves experiencing a sense of loss and grief following the death of a client. A short period of time off work, consultation and support from their supervisor and colleagues and perhaps more formal support from an Employee Assistance Program is encouraged. If counsellors wish to attend the funeral, they should be encouraged to do so but are reminded to maintain confidentiality. Counsellors should not attend the funeral if they believe it will upset family members.

Extreme prolonged grief reactions following the loss of a client are not normal. Counsellors are encouraged to seek professional help if they find they are experiencing many of the symptoms described earlier and are having difficulty getting over the loss of a client.

Grief and loss - tip sheet

- Grief can arise from a number of different sources, not just from the death of someone close.
- Grief is a normal, natural and painful process.
- No two people will experience grief in the same way.
- Avoid time limited counselling if possible as working through issues of grief is often long term.
- The first year including the first Christmas, birthday or any anniversary is particularly painful. However, there are no time lines for grief.
- Don’t judge others by your standards.
- Previous losses will affect the current situation.
- The story relating to the loss may need to be told several times.
- Facilitate the client talking about both their positive and negative feeling about a deceased person as not doing so can result in unresolved grief.
- Be open and client centred. Allow the client the freedom to talk about the loss, or about other issues, as they wish.
- If you need to give information to the bereaved, always give both verbal and written instruction.
- People often need practical help as well as emotional support.

Grief and loss - tip sheet (cont.)

- Encourage clients to find an avenue to help them express their grief. For example: talking, writing, artistic expression, physical expression, emotional expression, relaxation, taking care of themselves.
- Continually monitor levels of depression and suicidal ideation.
- The most dangerous times for suicide are considered to be 2-3 days after the funeral, and 8-12 weeks after the death.
- Drug use is actively condoned for grief. For people already struggling with substance use issues consider booking them into a residential service
- Due to high divorce rates, encourage parents grieving over the loss of a child to seek help together.
- Encourage clients to seek social support from support groups or family and friends.
- Be aware of any transference or countertransference issues that may arise and always work closely with your supervisor.
- You can not take away someone else's pain. The best you can do is give them support and guidance and accompany them on their journey.

33. Cognitive impairment

Cognitive impairment can result from a number of different causes. In addition to birth defects, people can sustain cognitive damage from head injuries (car accidents, fights and heavy falls) and the effects of AOD themselves. Long-term users of alcohol or methamphetamine are at particular risk of suffering impairment in cognitive functioning. The following areas of cognitive functioning are often observed to be impaired in people with a history of heavy, prolonged use of alcohol and methamphetamine.

Alcohol

- problem-solving;
- perceptual motor skills;
- non-verbal memory;
- visuospatial abilities;
- response inhibition;
- reasoning;
- planning abilities;
- memory recall;
- skill and information acquisition; and
- cognitive efficiency (focusing on relevant information while ignoring irrelevant information).

Methamphetamine

- attention and concentration;
- visual and verbal memory;
- information processing;
- problem solving;
- decision making;

- response inhibition;
- sequencing; and
- emotional processing.

Deficits in cognitive functioning can have significant deleterious effects on treatment progress and outcome. Therefore the assessment and recognition of cognitive damage needs to be considered early in treatment. Depending on the degree of severity of suspected cognitive damage, counsellors may wish to refer clients to a neuropsychologist or clinical psychologist with experience conducting neuropsychological assessments for further assessment. A diagnosis of cognitive impairment should only be made by a neurologist, neuropsychologist or clinical psychologist with experience in neuropsychology.

One of the difficulties with referring clients for assessment only when impaired cognitive functioning is obvious, however, is that more subtle cognitive functioning difficulties, which are often not readily apparent in many counselling interactions, can still have a significantly negative impact on treatment. For example, a client with impaired executive functioning (which is involved in making plans and carrying them out) might repeatedly agree to reduce drinking and complete homework tasks but simply not be sufficiently organised to do so. Behaviour such as this is often interpreted by counsellors as due to poor motivation. However the client might be very motivated but need some extra help to break tasks down, sequence them, and problem solve difficulties that might arise to enable them to put their agreements into action. With subtle cognitive impairments, it may only be as counselling progresses and the counsellor starts to notice some of the difficulties the client is having that impaired cognitive functioning might be suspected.

Where cognitive deficits are suspected or clearly present, counsellors are encouraged to tailor their intervention strategies to the client's abilities and ensure that counselling is delivered accordingly. Without consideration of a client's cognitive capabilities when designing a treatment plan, the efficacy of the interventions is likely to be limited.

Treatment for clients with cognitive impairment should have a strong behavioural focus. Counsellors should teach clients concrete skills to avoid high-risk situations, prevent relapse and maintain abstinence. Abstinence is often the most realistic goal than controlled drinking or reduced drug use. Where possible, the help of family or other support can be enlisted.

For improved outcomes however it is essential that counsellors accommodate for the neuropsychological impact of long-term substance use on the cognitive abilities when implementing treatment. Thus when working with clients who present with symptoms of cognitive impairment, or in whom cognitive impairment is suspected, a number of strategies can enhance the effectiveness of standard AOD cognitive behavioural interventions. Ideally particular strategies will be incorporated into treatment in response to cognitive difficulties in particular areas. However, unless a neuropsychological assessment has been completed and recommendations for specific treatment adaptations made, most counsellors will not necessarily be clear about the exact nature of the cognitive difficulties many clients are experiencing.

Therefore, although the strategies below are targeted to particular cognitive difficulties, counsellors may choose to try including them in treatment with drinkers and amphetamine users (and indeed users of other drugs) unless it becomes apparent that the client does not wish them to be included or is managing well without them. For example, counsellors can ask clients at the start of counselling how well they remember appointments. If they say they have difficulties, explore why this is and whether reminders are necessary. When discussing issues in session it can also be helpful to ask clients if they want to write down any particularly important points or between session tasks. Some clients will not do this as they know they have good memories, however others will think it a good idea.

The strategies listed below were suggested by Collins[16] (2007, personal communication) and should be integrated with traditional components of treatment (eg therapeutic alliance, assessment, motivational interview, goal setting, harm reduction, relapse prevention and management etc).

Verbal and visual memory problems:

- Remind client of appointments
- Keep appointments at regular times.
- Review important issues from previous session at the beginning of the next one to accommodate poor memory continuity across sessions.
- Limit the amount of content covered each session.
- Repeat key ideas.
- Provide instructions one at a time.
- Encourage clients to:
    - Write things down
    - Use memory aids (e.g. pair unusual visual images with words)
    - Develop routines

Attentional Problems

- Encourage focus of attention on important issues.
- Help with steps to explicitly encode important information.
    - Focus attention.
    - Repeat content.
- Problem solve with clients how they can minimise distraction in problem situations (e.g. go to a quiet place to think, shut the door, turn off the TV).

Information Processing (speed of understanding and linking information)

- Go slowly.
- Allow plenty of time for questions.
- Use lots of repetition and summarisation.
- Have clients repeat to you their understandings.

Executive Functioning (planning, problem solving, sequencing etc)

- Be more explicit when helping clients think issues through.
- Teach how to identify issues.

[16] Marjorie Collins (M.Clin.Psych; M.Neuropsych; PhD), Senior Lecturer, Psychology, Murdoch University

- Teach step-by-step problem solving.
- Help clients plan out everyday timetables when having trouble organising themselves.
- Have clients rehearse sequences in session.
- Encourage them to develop routines.
- To inhibit impulses use aids such as breathing, counting to 10 before acting, notes they keep with them before acting, signs around the house.

Cognitive impairment - tip sheet

- Long-term users of alcohol or methamphetamine are at particular risk of suffering impairment in cognitive functioning.
- Depending on the degree of severity of suspected cognitive damage, counsellors may wish to refer clients to a clinical or neuro psychologist for further assessment. The purpose of such a referral should be clear to both client and counsellor.
- To increase the likelihood of positive treatment outcomes, counsellors should ensure that intervention strategies are adapted to the client's abilities and endeavour to deliver counselling accordingly.
- Clients tend to respond better to more simple, straightforward and concrete behavioural type interventions.
- Abstinence is often a more realistic goal than controlled drinking or drug use.

34. Coerced clients

The issue of coerced clients is particularly pertinent to working with clients with alcohol and drug issues, especially given Western Australia's comprehensive diversion strategy. This includes diversion by police for first offenders, a range of court diversion options for repeat offenders including the drug court system and similar strategies nationally.

There are a number of different types of coerced clients such as those who are required to complete a treatment program by the judicial system, those referred in relation to child protection issues, individuals required to engage in treatment by their place of employment, and adolescents referred by parents or schools. Coercion may come from sources such the client's employer, partner, children, doctor or even landlord.

Issues of confidentiality, conflict of interest, working with resistance, and the appropriateness of harm reduction interventions are particularly important when working with this client group. A related issue concerns clarifying the question, "who is the client?".

Confidentiality is complicated when working with coerced clients. Difficulties can arise when a report is required upon the conclusion of therapy, for example when clients on a court order continue to use. To date there has been no systematic development of guidelines regarding confidentiality in such situations. Instead, confidentiality should be negotiated between all interested parties at the onset of any therapeutic enterprise.

For example, if a counsellor decides (or is required) to report a client's drug use to the relevant corrections officer, the counsellor needs to explain this to both the client and the corrections officer prior to the beginning of therapy. In line with this, counsellors also need to ensure that they are aware of the type of information that they may be required to give to a third party, such as the reporting requirements of the Ministry of Justice. Open communication regarding the boundaries of confidentiality needs to occur with all parties when working with coerced clients (including parents, schools, partners etc.) prior to engagement in treatment. Counsellors need to be honest with clients and not promise levels of confidentiality that can not be met.

Young people brought to treatment by their parents are often "coerced" in the sense that they don't want to be there. Parents of minors considered not sufficiently mature to give informed consent are legally entitled to information about their child's treatment. However, if the young person is considered to have the maturity to provide informed consent, then their wishes for confidentiality must be respected unless other legal constraints and obligations apply. This assessment is usually made around the age of 14 or 15. In all cases, it is essential that the limits of confidentially are explained clearly to the young person and the parents or guardians at the commencement of treatment. In most situations it is helpful to have parents involved in treating young people, and this should be managed and discussed in advance with the young person. For further information on working with young people, please refer to the chapters on ***Young People*** and ***Significant Others*** in this guide and the literature review.

To reduce the possibility of conflicts of interest between referring bodies and professional integrity, it is recommended that agency staff agree upon the purpose of therapy and boundaries of counselling. These discussions necessarily need to take into account the competing needs of various clients such as the victim of a drug-related offence, the general public, the client's family and the justice system. Thus, issues such as relapse management may need to be carefully considered in the context of inter-agency protocol as well as on a case-by-case basis.

Working with coerced clients often involves working with resistance. The initial encounter with coerced clients is essentially a conflict situation requiring mediation and negotiation skills. There are six steps to allow adoption of the role of negotiator or conflict manager (Barber 1991):

- clear the air;
- identify legitimate client interests;
- identify non-negotiable aspects of intervention;
- identify negotiable aspects of intervention;
- negotiate the case plan; and
- agree on criteria for progress.

Counsellors should "roll" with resistance and acknowledge it with the client, instead of working against it. It should be discussed with the client and not confronted or viewed as something "bad". Motivational interviewing is a useful technique for working with resistance. For example, the counsellor can ask the client to consider to good and not so good things about coming to counselling. Through use of these techniques, opportunities for change to occur may arise even when a client is coerced to attend treatment sessions.

Harm reduction also requires careful consideration. For some clients, the primary harm relating to drug use may be the re-imposition of a prison sentence. Depending upon the court ordered requirements, even low levels of illicit substance use may be associated with serious harm to the client. Likewise, when drug use is seriously affecting the ability to care for children or is associated with violence or other criminal behaviour, clinicians need to weigh up the harms of the drug using client against the harms to "indirect" clients. If appropriate, however the process of negotiating safer using practices may potentially strengthen the therapeutic relationship with the client (Marsh & Dale, 2006).

Coerced clients - tip sheet

- There are many types of coerced clients.
- Confidentiality should be negotiated between all interested parties prior to the onset of therapy.
- As a general guide, parents of children under the age of 16 can have access to information. Discuss the type of information to be disclosed to parents openly with both your client and the parents.
- Be aware of conflicts of interest between what the counsellor may perceive to be best for the client and what the referral body requires.
- Resistance is common among coerced clients. Adopt the role of negotiator or conflict manager. Follow the six steps:

    1. clear the air;
    2. identify legitimate client interests;
    3. identify non-negotiable aspects of intervention;
    4. identify negotiable aspects of intervention;
    5. negotiate the case plan; and
    6. agree on criteria for progress.

- Learn to "roll" with resistance. Accept, acknowledge and discuss the resistance with your client. Motivational interviewing is a useful technique for working with resistance.
- Where appropriate, consider harm reduction strategies and attempt to negotiate safer using strategies. Harm reduction options should be clarified with the statutory agency.

35. Incarcerated clients

Much has been written about the link between crime and alcohol and drug issues, and it has long been accepted that the one of the highest rates of drug use is found amongst the prison population. Consequently, it is becoming increasingly common for AOD treatment services to be involved with the prison system. Incarceration can provide a prime opportunity for intervention that otherwise may not be possible. Incarcerated clients can be difficult to work with, and an added difficulty may be encountered as counsellors work in a system not conducive to therapeutic change.

Confidentiality is an important issue when working with this client population (see chapter on ***Coerced Clients***). Counsellors need to be clear regarding to whom they should report their clients' activities and communicate this to their clients prior to therapy. Due to the restrictions when working in a prison, drug use may need to be discussed in a hypothetical sense. Alternatively, counsellors may find that clients are dishonest regarding their drug use activities.

Harm reduction is important when working with incarcerated clients. Reports indicate an extremely high incidence of sharing of injecting equipment (and consequently the transmission of Hepatitis C) whilst in prison, and high rates of overdose following release. Clients and counsellors need to work together on a plan of harm reduction strategies that the client is willing to implement.

Counsellors need to be aware of the debriefing and liaison process when incarcerated clients express suicidal ideation or are self harming. Counsellors have a duty of care to inform the centre psychologist and obtain increased support for the client.

Counsellors need to have a clear understanding of the policies and procedures relevant to working in prisons. This includes levels of command, to whom they should report, the type of information they should disclose and to whom, and having an overall knowledge of the general running of the prison.

Incarcerated clients - tip sheet

- Be clear regarding to whom you need to report your client's activities to. Make sure you communicate this to your clients prior to the onset of therapy.
- Be clear as to the limits of confidentiality and the nature of activities that will be reported to the relevant authorities. Again, clearly communicate this to your client prior to the onset of therapy.
- Harm reduction should be a focus of any intervention.
- Acknowledge resistance and negotiate the relationship accordingly.
- If a client is self harming and/or suicidal you have a duty of care to inform the centre psychologist.
- Have a clear understanding of prison policies and procedures, levels of command, who you need to report to, the type of information you need to disclose and to whom, as well as having an overall knowledge of the general running of the prison.

36. Significant others

There are a number of issues pertinent to working with partners, families and friends of the substance user. There are two levels of working with this group: working with them as clients in their own right; and working with them as part of an individual's treatment. Quite different issues arise as a result of the context with which one is working and these will be considered later in this chapter.

To work effectively with significant others in whatever capacity agencies and individual counsellors need a sound understanding of family sensitive practice. The assumptions of family sensitive practice outlined below are adapted from the principles listed by the Bouverie Centre Family Institute in Victoria (http://www.latrobe.edu.au/bouverie/mentalhealth/assumptions.html).

36.1 Assumptions of family sensitive practice

- Working in an open, respectful and collaborative fashion with families and clients is usually likely to promote and enhance clinical goals.
- Being open, respectful and collaborative is highly complex and does not always fit well with traditional clinical practices.
- AOD problems in a family have a similar effect to major trauma in the sense that trauma puts extreme pressure on clients and family members and on their relationships with each other.
- Blame, guilt, grief, shame and frustration are natural companions of the trauma of AOD problems and other major family difficulties in our culture.
- Families have needs in their own right and have a right to have their needs acknowledged.

- By and large, families and AOD clients have a personal and social intention mainly directed to personal and social survival rather than malevolence. That is, people usually do the best they can given their situation, history and personal style.
- Approaching families in a generous way, empathising with their hardship and acknowledging their strengths, will tend to generate good responses to clients and counsellors.
- The distinction between intention (which us usually good) and effect of action is important in understanding why clients and families, at times, act in extremely unhelpful ways.
- Establishing a trusting relationship with families puts counsellors in a better position to assist families to overcome crises and problems. This often means time efficiencies in the long term.
- On occasions when family members behave in destructive ways, an appreciation of the family situation can help counsellors address this destructiveness more effectively.
- It is important to understand the family sensitive principles and assumptions at a personal level in order to be able to make a professional commitment to them.

It is important to note that many adult clients do not want family members involved. There are many reasons for this including conflict with family members, no contact with family members, anger and hurt at neglect of abuse experienced as children from family members, or not wanting family members to know they have an AOD problem. Even in situations when the client does not want family members involved with them or you as their counsellor, family members should still be assisted to find support from other counsellors or other agencies.

36.2 Working with significant others as clients in their own right

Excessive AOD use is a cause of stress to families, partners and friends of problem AOD users. It is not uncommon for this client group to seek counselling for themselves in order to help them better cope with their family member's or friend's drug use. Heightened levels of anxiety and depression are common in these clients, and they often report feeling helpless and isolated. It is therefore important that they be provided with appropriate support. Goals and treatment plans for counselling should be negotiated. If the problem AOD user is in treatment with one counsellor, it is often appropriate for this support for families and friends to be provided by a different counsellor. This helps clinicians to avoid conflicts of interest and breaches of confidentiality. An exception to this is when the whole family is considered to be the client as in a treatment that has family therapy as a base, such as the Multidimensional Family Therapy (MDFT) approach (described in the next chapter ***Young People***).

Counsellors can assist the client to review their role as it relates to the problem AOD user as well as examining general life problems and developing ways to better cope with the problem drug use.

Significant others also often seek help with the aim of identifying ways to stop their family member or friend using alcohol or other drugs. Engaging the client with their presenting issue(s) is an important component in building a good therapeutic relationship. Once established, other options can be explored and different strategies introduced to the client. Finally, working with this group can offer an opportunity to provide accurate AOD information, which directly helps the client, and indirectly may assist the AOD user through dissemination of the information via the family or friends.

Copello and colleagues (2005) recommend the following five steps when working with a family member or partner who is living with someone with AOD-related problems. These steps aim to reduce the level of strain (physical and psychological symptoms) experienced by the family member or partner, and enhance their coping mechanisms.

- Give the family member or partner the opportunity to talk about the problem.

- Provide relevant information.

- Explore how the family member or partner responds to the person's substance use.

- Explore and enhance social support.
- Discuss the possibilities of onward referral for further specialist help.

36.3 Working with significant others as an adjunct to an client's AOD treatment

The inclusion of family members, partners and friends in treatment within a family system context is associated with positive treatment outcomes. Family centred practice in an AOD context should be oriented around four goals including the following.

1. To change AOD-related interactional patterns and develop interactions that support change in AOD using behaviour.
2. To help the family confront and resolve relationship conflicts without the client resorting to AOD use.
3. To help mend rifts in relationships that have been aggravated as a result of the AOD use.
4. To help the family or couple develop shared activities that are rewarding and do not involve AOD use.

Counsellors should be careful to avoid blame and should not highlight the AOD user as the problem.

Practice that is family centred does not require specialist family therapy training and can result in family members receiving the support they need in their own right and can also be beneficial to treatment outcomes for the drug user. However, if counsellors wish to engage in family therapy, specific skills and specialist training is required.

36.4 Confidentiality

It is not uncommon for family members, partners or friends to contact the counsellor working with the problem AOD user regarding the progress of the client. To acknowledge the presence of someone in therapy is a breach of confidentiality without prior consent to do so being obtained from the client. Any information regarding progress should be provided only with the agreement of the client and be in general terms. The exception to this is that parents of minors considered not sufficiently mature to give informed consent are legally entitled to information about their child's treatment. However, if the young person is considered to have the maturity to provide informed consent, then their wishes for confidentiality must be respected. This assessment is usually made around the age of 14 or 15.

Responding to family members, partners or friends who call for information when the client has not given consent is therefore quite tricky. An appropriate response is to express empathy regarding the request, but make it clear that you are unable to provide information without consent from a client. It is also appropriate to provide AOD information and basic support and general advice.

If the client has given permission for you to talk to family members, partners or friends, be circumspect in how much information you provide. It can be a good idea if the client is willing to bring significant others into a session with the client so they know what is discussed. It can also be important to clarify with your client what issues they are happy to have talked about with significant others and what they want kept confidential.

36.5 Some issues specific to parents

As the extent of drug use by young people has continued to grow and become more complex, and significantly more young people are living at home for longer than ever before, parents are at the front line struggling to cope with all the associated difficulties. Many of the clinical presentations exhibited by parents result from the stress experienced when a child is using drugs. Grief is another issue common to parents with a drug-using child. Not only the grief if a child a child dies, but also the grief of things not working out as planned and "lost dreams".

Parent levels of anxiety and grief should be acknowledged prior to providing advice and working on strategies to help them deal with the situation better. High levels of stress and anxiety and low level of self- or parent-efficacy may hamper a parent's reception to advice and self-confidence in effectively use the advice provided. Therefore, the initial aim of working with parents should be to lessen their levels of anxiety and depression and feelings of isolation, raise their self-awareness and increase their confidence in managing the situation. Appropriate interventions with parents can significantly decrease their levels of anxiety and depression and their feelings of isolation and helplessness and place them in a much stronger position to provide the necessary support to the young person.

Supporting parents in their parental role using a model of empowerment means the counsellor works alongside parents to achieve the agreed goals. Previous experiences (what has worked and what hasn't worked), the parent's value system and family norms should be taken into account when providing advice and information on strategies. Topics that can be explored with parents include the following.

- Knowledge of drugs and drug use issues.
- Strengthening parenting role and parent's confidence.
- Communication skills.
- Conflict resolution.
- Negotiating guidelines/boundaries.
- Issues of attachment and commitment to the drug-using child.
- Responding versus reacting.
- Remaining calm, consistent and credible.
- Accessing additional support (parent support groups, family therapy).
- Making time for self, other family members and friends.

Most importantly, working with parents should not be seen as difficult or onerous but viewed as enhancing the therapeutic endeavour and maximising positive outcome for young people and their families.

Significant others - tip sheet

There are two levels of working with significant others:

- working with parents, partners, families and friends as clients in their own right; and
- working with partners, families and friends as part of an individual client's AOD treatment.

AOD agencies and counsellors should have a sound understanding of family sensitive practice.

Working with parents, partners, families and friends as clients in their own right

- This group can be clients in their own right with individual goals and treatment plans.
- Although not the purpose of intervention, working with this group can provide an avenue for the problem substance user to seek assistance.
- Accurate alcohol and other drug information and support should be provided.

Working with partners, partners, families and friends as part of an individual client's AOD treatment

- Involving family members is associated with more positive treatment outcomes for the drug user than individual treatment.
- Never invite family and friends to participate in treatment with you as the counsellor without the expressed consent of your client.

Counselling should be oriented around (although not limited to) the following:

- Helping the family member or partner reduce their level of stress and anxiety.
- Helping develop interactions that encourage self responsibility and promote positive change in the AOD using behaviour.
- Assisting the family or partner to deal with conflict in relationships.
- Helping the family member or partner to develop coping strategies to minimise the negative impact of substance use on themselves and enhance their quality of life.

Confidentiality

- Family members, partners or friends may contact you regarding progress of a client. Client confidentiality needs to be respected. Any information should be provided only with the agreement of the client and be in general terms.
- If the client wants information given to significant others, it can be useful for this to occur in a session with the client present so they know what is discussed.
- Provide alcohol and other drug information and basic support at least.

Significant others - tip sheet (cont.)

Issues specific to parents

- Parent levels of anxiety, depression and grief should be acknowledged prior to providing advice and working on strategies to better manage the situation with their AOD using child. Concentrate initially on lessening anxiety and feelings of isolation, and increasing their confidence in managing their situation before moving on to strategies.

Interventions to assist parents to work with their AOD using children:

- providing knowledge of drugs and drug use issues;
- strengthening parenting role and parent's confidence;
- communication skills;
- conflict resolution skills;
- negotiating guidelines/boundaries;
- issues of attachment and commitment; and
- responding versus reacting.

37. Young people

Adolescence can be a difficult time for many young people as they make the transition from childhood to adulthood. To work effectively with young people counsellors and agencies need to understand the developmental issues that characterise adolescence, as well the risk and protective factors that are linked to problems the adolescent's development, and tailor their approach accordingly.

Developmental issues for young people

These developmental processes include the following.

- Adjusting to physical changes.
- Learning to understand and take responsibility for their sexuality.
- Working towards autonomy while maintaining an emotionally connected relationship with parents.
- Developing a sense of who they are, or personal identity.
- Developing social and working relationships.
- Choosing and making plans for their career.
- Being adventurous and experimental.
- Needing acceptance from their peers.
- Not thinking of the long term consequences of their actions.
- Taking risks.
- Feeling immortal.
- Being unpredictable in their moods and behaviour.
- Needing to rebel against the older generation in society.
- Learning about sexuality.
- Being excitable and restless.
- Finding it difficult to talk about feelings.

These developmental processes can make working with young people challenging, and many traditional counselling interventions in effective (Winters 1999). Winters argues that adolescents must be approached differently because of their unique developmental processes, physical differences, and differences in belief and value systems.

Risk and protective factors

Adolescent drug use occurs in the context of a range of developmental risk and protective factors, and it is these that need to be targeted in a multi-dimensional way in treatment. Risk factors can be grouped into individual, family, peer, school, neighbourhood/community, and societal factors, and these risk factors can influence and reinforce each other (Hawkins et al 1992). For example, parental psychological difficulties may be linked to insecure attachment of child to parent and associated with affect regulation problems for the child, unemployment and poverty, poor family management skills, difficulty managing the challenges of a teenager and hence a poor parent-child relationship. The adolescent might react to these difficulties by joining a more accepting drug using peer group and using drugs to rebel and belong and also to cope with emotional distress. Or a teenager with a reactive temperament may influence family relationships and management. For example if the adolescent reacts with intense anger when parents attempt to put boundaries in place, the parents might become chronically frustrated with the adolescent, be less consistent in boundaries to maintain family peace, resulting in less parental monitoring and control over the adolescent and allowing the adolescent more freedom to become involved with drug using peers. Higher numbers of risk factors are associated with a higher likelihood that an adolescent will develop a drug problem.

Protective factors occur in the same domains as risk factors. Protective factors involve connections to prosocial pursuits and relationships inside and outside the family. A good relationship with parents is particularly important as a buffer against the development of problems, and the emotional support provided by such a relationship can also reverse to course of negative peer influences once problems have begun to develop (Steinberg et al 1994).

Treatment approach

The literature provides increasing evidence that involving families in drug treatment, particularly with young people, is “best practice”, with research indicating that parents, if appropriately resourced, can positively impact on young people’s behaviour, including substance use (Liddle, 2004). In addition, because adolescent drug use and associated problems occur in the context of a range of risk and protective factors that influence the course of adolescent development, intervention needs to multidimensional, focussed on reducing risk factors and increasing protective factors across a number of domains.

Multidimensional family therapy

One multidimensional treatment approach for adolescent drug problems is Multidimensional Family Therapy (MDFT) (Liddle 2002). MDFT is a manualised approach that is rated in recent research as a scientifically proven effective evidence-based treatment for adolescent drug use. It is described by Liddle (2002: 228) as “a multicomponent, developmental-ecological treatment for adolescent drug abuse and related problems that seeks to reduce symptoms and enhance developmental functioning by facilitating change in several behavioural domains”.

MDFT is based on several evidence-based assumptions (Liddle 2002: 10):

- “The family is the primary context of healthy identity formation and ego development.
- Peer influence is contextual; it interacts with the buffering effects of family against the deviant peer subculture.
- Adolescents need to develop an interdependent rather than an emotionally separated relationship with their parents.”

MDFT assesses and targets adolescent functioning in six domains including drug use, identity development and autonomy, peers and peer influence, bonding to prosocial institutions, racial and cultural issues, and health and sexuality.

MDF includes a number of dimensions (Liddle 2002).

- Outcome orientation. The therapist focuses on the optimal and "good enough" outcomes from every aspect of the intervention. Outcome incorporates immediate, short term, intermediate and long term therapeutic goals. These goals encompass outcome from an individual clinical interaction such as a 5 minute phone call with a parent through to overall treatment goals.

- Process. This refers to a conceptualisation and plan of how particular therapeutic outcomes can be achieved.

- Development. This refers to the knowledge base from which clinicians work. To work effectively with families and adolescents clinicians need to understand normal adolescent development tasks and processes, and expected and normal changes in the adolescent-parent relationship.

- Problem behaviours. These are conceptualised as deviations from normal development, linked to a range of risk and protective factors. The risk and protective factors that form the context for problem behaviours are carefully assessed and targeted in treatment.

- Ecology, which refers to the multiple social ecologies or contexts within which an adolescent operates, such as the family, school and peer group. Assessment and facilitation of change is needed across all problem areas and will often involve working with other organisations such as school and justice.

- Psychotherapy. The psychotherapy approach in the MDFT approach is influenced by behavioural, client centred and AOD-specific counselling approaches. It can address a range of issues including the adolescent's AOD use, comorbid psychological difficulties and self esteem issues.

- Family therapy. Family involvement is central to an MDFT approach. MDFT has been influenced by several family therapy approaches including Structural-Strategic Family Therapy and Problem Solving Therapy. Family involvement is central.

- Treatment parameters. This refers to structural parameters such as number of sessions, where the sessions are held and so on. These parameters can be flexible and responsive to adolescent and family needs. The program is time limited, usually about 12 weeks, but can include intensive and varied forms of contact during that period.

MDFT treatment has three phases (Liddle 2002):

1. *Building the foundation.* This involves building therapeutic alliances and thoroughly assessing problem areas and potential areas of strength. Therapeutic relationships are developed with adolescents, parents, other family members, and other influential people such as school and justice staff as appropriate. Knowledge of normal adolescent development is used to devise appropriate therapeutic foci for each family member. It includes a counsellor seeing the adolescent and the parents separately.

   Engaging the adolescent involves demonstrating a genuine commitment to the adolescent's well being. This involves being non-judgemental and empathic, and helping them to articulate their feelings and thoughts about their life and family, and over time to express these to the family. The adolescent is also helped to articulate a different agenda from that of the parents. Engaging with the parents also involves being non-judgemental and empathic with their distress and often anger. Assessing and adjusting the emotional connection of the parents to the adolescent is usually the first issue to be approached, and over time parents are assisted to reconsider and define their parenting beliefs and approach in the context of being educated about adolescent development processes and needs.

2. *The working phase.* This phase aims to facilitate developmentally appropriate competence in all areas of the young person's life including individuals, family, peers, school etc. It includes teaching communication and problem solving, helping the young person to access resources outside the family, such as job training or further education, working with key themes such as adolescent and parent beliefs and behaviours that cause family problems, and working with past hurts and traumas in the adolescent's life and family experiences. Examples of parent beliefs that can be a focus of therapy include parental frustration, helplessness, fear of setting expectations, abdication, and sense of lack of competence. Examples of adolescent beliefs that can be a focus of therapy include entitlement, rejection of parental authority and hierarchy, hopelessness, or negative perceptions of parents. Working with past hurts and traumas in the adolescent's life and family experiences is important because if these can be discussed in therapy between adolescents and parents, and the hurt and anger expressed and responded to appropriately, it can remove obstacles to communication and problem solving with the family in the present.

3. *Sealing the changes and exit.* In this phase the focus is on acknowledging and cementing changes that have been made, and enabling the family to continue with progress and generalise new ideas and behaviours. Positive change is expected on many fronts such as the adolescent's drug use, school attendance, criminal involvement and relationships; and the family's ability to handle difficult situations and resolve problems.

Liddle (2002) notes that most therapists using the MDFT approach have at least psychology masters degrees in clinical work, need to have a systems-oriented family therapy background, and need to be prepared to work intensively with the adolescent and the family and engage in supervision.

Whether or not counsellors adopt the manualised MDFT approach, it is recommended the general principles and approaches inherent in the approach by included in all treatment with adolescents with substance use problems.

Specific issues to be addressed in adolescent AOD treatment

Consistent with the MDFT approach, a number of specific issues should always be incorporated into treatment with adolescents.

Taking a multidimensional and practical approach

Many young people entering alcohol and other drug treatment experience a number of difficulties including family, psychological, accommodation, legal, education and training, social and recreational issues. It is important that the counsellor addresses these with young people, and where appropriate links them to additional services.

Including family members

Family is central to positive adolescent development and positive family relationships are protective against problematic adolescent behaviour, including substance use. Note that although counsellors need training to conduct family therapy, training is not needed for counsellors work with many young people and their parents to enhance family functioning. Family therapy proper is likely to be necessary for more complex family situations, however, and so it is recommended that AOD treatment agencies ensure they have trained family therapists on staff, and offer family therapy training to as many staff members as possible.

Being flexible in approach

It is important that agencies and counsellors be creative and flexible in their approach to young people. Working with alternative mediums (such as art and music) and outside the traditional treatment setting (talking while playing pool, going to a coffee shop etc) are often important component of effective treatment with adolescents.

Providing practical and concrete strategies

For most young people, the most effective type of intervention involves providing them with concrete and practical coping strategies. Research supports the use of motivational interviewing, problem solving, relapse prevention, social skills training, anger management, and cognitive restructuring. Note that although process oriented psychotherapy is usually not appropriate due to the levels of chaos and confusion that mark adolescence, it can be effective as another component of counselling with some young people by the time they reach late adolescence.

Working with other agencies already involved with each client
In order to ensure commonality of approach, open communication via case discussions between all the agencies involved with the young person is essential. In the event that a case manager has not been assigned to the young person, a shared case management approach may be appropriate (see ***Case Management***).

Linking clients to ancillary services
Counsellors should link clients to additional medical, psychological or psychiatric services when required.

Using harm reduction strategies where appropriate
It is unrealistic to expect many young people to completely cease using all substances and engaging in other risk taking behaviours (such as driving at high speeds, promiscuity), at least initially. Given that young people are more likely to present with non-abstinence based treatment goals, it is important that counsellors include harm reduction strategies when working with this population.

Counsellor qualities
A number of counsellor qualities are important when working with young people. These include understanding the developmental processes of adolescence, having a sense of humour, maintaining consistent limits, relating at the level of youth, setting clear boundaries, allowing young people some freedom of choice and honesty.

Responding to psychological comorbidity
There is a high incidence of psychopathology and complex psychological difficulties among young substance users presenting for alcohol and other drug treatment, including mood disorders, conduct disorder, anxiety disorders, dissociative disorders, attention deficit hyperactivity disorder, schizophrenia and eating disorders. Late adolescence is also the most common time for a psychotic disorder (eg schizophrenia, bipolar disorder) to initially present, and it can be difficult to distinguish between symptoms of a psychiatric disorder and the symptoms of a drug induced psychosis.

Young people with co-existing psychological problems have less positive outcomes from traditional AOD treatment approaches than those without co-existing psychological difficulties, are also more likely to experience relapse following treatment for their substance use (Brown & Ramo 2006). This highlights the need to be vigilant at detecting co-occurring psychological problems, thus enabling effective therapeutic response to the client's array of symptoms, which may often require referral for psychiatric assessment and intervention, as well as more intensive treatment.

Confidentiality

In working with young people the limits of confidentiality are influenced by the context and nature of the treatment provided, and an assessment of the maturity of the young person and their ability to make informed decisions and give voluntary informed consent

Maturity is a professional judgement, and the young person's intelligence, ability to think logically and abstractly, and to think through situations and consider their implications should be considered in making this judgement. Most young people would be considered to be "mature minors" by the age of around 14 or 15. In this case there is no obligation to provide information to the parents unless other legal and reporting constraints operate, and confidentiality must be respected. In most circumstances,

however, it is helpful to have parents involved in treating young people, and this should be discussed with the young person at the outset of treatment and their consent for parental involvement sought.

When working with young people who are unable to give voluntary informed consent, clinicians must protect the minor's best interests and consider their responsibilities to inform the parents or guardian. Parents or guardians have a right to information about the treatment of such a young person, as their legal responsibility for the young person's interest takes precedence over the wishes of the young person. However, counsellors should explain these limits of confidentially to the young person and endeavour to gain their consent.

Young people - tip sheet

Intervention with young drug user should be based on an understanding of the developmental processes that characterise adolescence, along with a thorough assessment of the risk and protective factors which provide the context for the AOD use and related problems for the adolescent.

Research indicates that regardless of the family's relationship to the young person's problem, they always need to be involved in the solution, as treatment that does not include the family is less likely to be successful in the long run.

MDFT is an evidence-based treatment which has shown very good outcomes for adolescent AOD use and related problems. It is based on several evidence-based assumptions (Liddle 2002: 10):

- "The family is the primary context of healthy identity formation and ego development
- Peer influence is contextual; it interacts with the buffering effects of family against the deviant peer subculture.
- Adolescents need to develop an interdependent rather than an emotionally separated relationship with their parents."

MDFT adopts a multidimensional approach to treatment with interventions targeted across a range of areas according to client needs, and incorporates family therapy as a central intervention. Counsellors should be familiar with the MDFT approach and ensure they incorporate key principles and approaches into their work with adolescent drug users and their families.

Young people - tip sheet (cont.)

Effective treatment with young people should:

- be multidimensional and practical;
- include the family;
- be flexible in approach, using outreach services;
- providing practical and concrete strategies;
- include working with other agencies already involved with each client;
- include assessment of co-morbid mental health symptomatology and referral for psychiatric assessment as necessary;
- link clients to additional medical, psychological or psychiatric services when required; and
- include the appropriate negotiation of harm reduction strategies (see ***Harm Reduction***).

Important counsellor qualities include:

- having an understanding the developmental processes of adolescence;
- having a sense of humour;
- maintaining consistent limits;
- the ability to relate to young people and their parents;
- setting clear boundaries; and
- allowing young people some freedom of choice.

The limits of confidentiality as regards disclosing information to parents and guardians are influenced by assessment of maturity of the young person to provide informed consent and by the treatment being provided. In most situations it is helpful to have parental involvement, and this should be discussed with the young person at the start of treatment. Consent must be obtained from "mature minors" for parental involvement.

38. Child protection issues

Although problematic AOD use does not necessarily result in poor parenting, it is often a contributing factor to negative child outcomes, with children of parents with AOD problems at greater risk of developing emotional, behavioural or social problems. Although AOD use is commonly implicated in child abuse and neglect, it is rarely the only factor. Usually there is a picture in "at risk" families of multiple disadvantage often also including domestic violence, mental health problems, parents who experienced abuse or neglect as children, financial problems and/or housing problems (Dawe et al 2007).

As a result, when working with AOD using parents, counsellors must be equipped to:

- accurately assess and manage the potential risk of harm to a child in their AOD using client's care; and
- work in a multi-systemic manner with the parents to address other areas of difficulty that impact on their parenting capacities.

38.1 Assessment and management of child safety

Issues of childcare and risk to children should be raised gently in the context of a supportive therapeutic relationship. During the initial assessment counsellors should establish whether the client currently has children in their care, or with whom they have access visits. If a level of suspicion exists

as a result of the assessment interview, structured assessment instruments can be used to explore child safety in more detail.

The *Hearth Safety Assessment Tool* (Robinson & Camins 2001) is designed to help counsellors assess specific areas of risk and strengths to provide clinicians with an overall picture of the global level of the child's risk of harm in a drug using environment. This tool has not been subjected to reliability and validity studies, but is nevertheless widely used in AOD treatment services in Western Australia. There are two components to the assessment, the first of which explores the impact of AOD use on the parent's ability to respond to the needs of a child, and the second which assesses other factors that contribute to the safety of the child. When assessing risk, counsellors should consider the age of the child and the potential short and long term consequences of parent substance use. Short term consequences involve safety issues and the parent's ability to respond to the physical needs of the child. Long term consequences arise from the parent's ability to provide comfort, consistency and to be emotionally available. The Hearth instrument covers a number of important areas, but does not ask about violence in the relationship between the parents or towards the child, or about the child's potential exposure to risk from associates of the parents, which should always be examined. Training is required to use the tool.

Another instrument to assist with assessing parenting and child safety in the context of parental drug use that is freely available on the web, does not require training, covers a range of important areas including violence and exposure to potential risk, though has also not been evaluated for reliability and validity, is the *Risk Assessment Checklist for Parental Drug Use*[17]. This is an Australian instrument designed to assist clinicians and clients to make connections between drug use and parenting and to assist in identifying parenting problems and tracking improvements. It is freely available on the Drugnet website.

The Department of Health (2004) guidelines suggest that counsellors gather information from the following categories when assessing the safety of a child:

- Immediate risk is indicated if:
  - any physical abuse is present;
  - sexual abuse has been disclosed or evidenced;
  - threats or behaviours towards the child indicate a probable intent to harm the child;
  - the child has been left unsupervised or with irresponsible/unsafe adults;
  - the parent's ability to ensure the safety of a child is grossly impaired by their current level of intoxication;
  - the parent's behaviour is chaotic with escalating levels of unsafe substance use; or
  - increased risk is also indicated if the child is under 5 years of age.

- Managing immediate risk:
  - If the child is present at the time of assessment, delay the child from leaving the premises until consultation with a social worker and/or a referral to an appropriate child protection service has been made.
  - Record all relevant information and referral details in the client's file.

- Possible risk is indicated if:
  - the client's child is not engaged with any other services or other responsible adults who can monitor their safety (eg are not at child care centre, school or being cared for by other family members);
  - the child has a medical condition and/or disability;
  - there is evidence of inadequate housing, food, clothing or hygiene;
  - parent's mood/behaviour is unstable; or

[17] Available from Drugnet website: http://www.drugnet.bizland.com/assessment/checklis1.htm

    - increased risk is also indicated if the child is under 5 years of age.

- Managing possible risk:
    - Raise concerns with parent/s and advise them of counsellor's duty of care.
    - Document concerns.
    - Consult with social worker or medical consultant.
    - Encourage client to voluntarily engage with an appropriate child protection or parenting service to access support and services.
    - Continue to monitor the situation and if no improvement is noted or the situation escalates follow immediate risk management strategies.

It is suggested that counsellors complete the following safety checklist (taken from Department for Community Development 2006) when working with parents who have AOD difficulties:

- If a child has been injured, is the injury severe?
- Is the child very young?
- Does the child have special needs that may increase his/her vulnerability (eg disability)?
- Has the child disclosed any abuse or neglect?
- Has the parent or caregiver threatened to harm the child?
- Does an alleged perpetrator of abuse have continuing access to the child?
- Is there a history of family violence?

If the answer to more than one of these questions is "yes", it is recommended that counsellors seek advice from an appropriate child protection agency.

Counsellors should always seek the advice and support from supervisors and specialised colleagues (eg social workers) regarding risk assessments and treatment plans. Counsellors can also consult anonymously with Department for Child Protection regarding child protection and safety issues.

38.2 Interventions to improve parents' lives

Intervention with AOD using parents involves balancing child protection with interventions to improve parents' lives. It involves multisystemic interventions to:

- enhance the protection and care for children; and
- improve the quality of life for parents, by helping them with a range of issues as necessary (eg parenting skills, drug related problems, family discord, co-occurring psychological disorders, support systems, safety of the familial environment, housing, education, employment, and support systems).

Multisystemic interventions with AOD using parents can include interventions aimed at building parent resources better general functioning, interventions focused specifically on parenting, and interventions to decrease barriers to parents seeking help.

Interventions to build family resources include helping parents to:

- access AOD treatments;
- manage mental health and other personal problems and their parenting impact (eg counselling, education, referral for medication);
- manage daily stresses associated with economic disadvantage;
- seek and sustain support systems (family, social networks);
- access social services and community supports;
- deal with relationship conflict, anger and domestic violence (eg couples counselling);
- work on self protection or crime protection if at risk of assault; and

- access housing, employment or study.

Interventions focused on parenting can include:

- educating parents about how to provide children with a secure relationship characterised by sensitive and responsive care, as well as appropriate limits – see "Circle of Security" website for resources to assist http://www.circleofsecurity.org/downloads.html ;
- providing direct parenting assistance with practical issues – education, problem solving, behaviour management, how to talk to children about their drug use;
- building parenting confidence by focussing on parenting strengths (such as sense of responsibility to their children) as well as addressing parenting difficulties;
- linking parents with services that do family home visiting to assist with parenting;
- making it clear you want to help parents keep children, not the reverse, while clarifying duty of care; and
- framing parenting interventions as help not punishment.

Reducing barriers for AOD using parents accessing help includes interventions such as:

- building a solid therapeutic alliance;
- making transport and child care as accessible as possible;
- linking parents with services that will attend the home; and
- helping clients access treatment services that include children such as Sarana in WA for women with children.

Counsellors also need to be aware of the stigma associated with being a substance using parent accompanied by the pervasive fear about having their children taken away. These feelings often prevent substance using parents from accessing treatment services, which is likely to increase the level of risk to the children. Those parents who do enter treatment tend to be extremely defensive about issues surrounding childcare, making it difficult to assess accurately the level of risk to the child. This highlights need tor raise parenting issues very gently and in the context of a supportive therapeutic relationship. Clients who may have previously experienced mandated child protection interventions may present with feelings of inadequacy, anger, loss, and shame which may need to be addressed during treatment.

Counsellors often experience the management and treatment of AOD using parents as difficult and frustrating. They are therefore encouraged to monitor their own countertransference reactions to avoid ruptures in the therapeutic relationship.

When attempting to conduct an accurate risk assessment and design an appropriate treatment plan counsellors may encounter difficulties due to restrictions in terms of their mobility such that they do not get to see the children in the home. This may be compounded by the fact that many substance using parents may not be able, or willing, to present an accurate picture of the impact of their use and the consequences it has on children in their care. Therefore, counsellors are encouraged to employ strategies such as involving children at some point in the counselling process or involving the client's non using partner or other adult support can help to establish the child's situation. It may be necessary, particularly when there are young children, to refer the family to a service that has the capacity for home visits and intensive support. Such agencies in Western Australia include Attached (previously called Hearth, outpatient), Perth Women's Centre Pregnancy and Early Parenting Project (outpatient) and Saranna (residential). Referrals to more intensive services may also enable the complex issues often faced by families with substance using difficulties to be dealt with more effectively.

It is also important to consider he perspective of children living with parents who have AOD problems as this is often neglected. Dawe (2007) reviewed this limited research which indicates that children generally know about parental drug use earlier than the parents were aware of, do not say anything

about for fear of being rebuffed or separated from their parents, have fears for their parents' health and safety, have concerns about violence, and experience distress at concluding they come second to the drugs. She concluded that children need to be provided the opportunity to talk about their experiences and have some help to understand their parents' drug use in an age-appropriate manner.

Child protection issues – tip sheet

Intervention with AOD using parents involves balancing child protection with interventions to improve parents' lives. It involves:

- enhancing the protection and care for children by accurately assess and manage the potential risk of harm to a child in their client's care, and
- improving the quality of life for parents by working in a multi-systemic manner with the parents to address other areas of difficulty that impact on their parenting capacities.

Assessment and management of child safety

Issues of child care and risk to children should be raised gently in the context of a supportive therapeutic relationship.

Counsellors should make inquiries regarding the family unit and the children's welfare as a routine part of assessment.

Involving the children or a client's non using partner or other adult support at some point in the counselling process can help to establish the child's situation.

Counsellors should assess the potential risk of harm to a child when working with a drug AOD using parents. This can be done by exploring information from the following areas:

1. child's functioning;
2. parents' functioning; and
3. protective factors in the child's environment.

Assessment instruments such as the *Risk Assessment Checklist for Parental Drug Use*[18] or the *Hearth Safety Assessment Tool* may be useful if a level of suspicion exists.

If the risk is assessed to be either immediate or possible, appropriate management strategies should be implemented. Department for Child Protection can provide confidential consultation.

[18] Available from Drugnet website: http://www.drugnet.bizland.com/assessment/checklis1.htm

Child protection issues – tip sheet (cont.)

Interventions to improve parents' lives

In conjunction with the parent's substance use interventions a range of other issues often need to be addressed such as: parenting skills, drug related problems, family discord, co-occurring psychological disorders, support systems, safety of the familial environment, housing, education, employment, and support systems, and reducing barriers to treatment.

Children in AOD using families should be provided with opportunities to talk about and understand their experiences with their AOD using parents.

If it becomes necessary to involves Department for Child Protection or to refer the family to a service that has the capacity for home visits and intensive support, these interventions should be framed in positive terms as a way of providing help.

39. Women

There are a number of issues that counsellors need to consider when working with women in an AOD treatment context. These issues concern the notion that the life context in which harmful drug use is embedded is psychologically, physiologically and socially different for men and women.

Counsellors should be aware of the physiological differences between men and women which alter the effects and specific risks associated with drug use. While men tend to drink or use drugs in a more harmful fashion than women, women often experience physical effects of alcohol sooner than their male counterparts. For example, women drinkers develop liver cirrhosis more quickly than men, may suffer reproductive and sexual dysfunctions and are more likely to die from medical conditions related to alcohol use. Hence, it is important that counsellors working with women be well informed as to the specific risks associated with AOD use.

Society considers it much more unacceptable for women to have AOD problems, especially when the drug use is of an illegal nature. As a result women in AOD treatment may be more likely to suffer greater levels of shame, stigmatisation and powerlessness. All these issues need to be acknowledged and addressed during the course of treatment.

Depression, anxiety and somatic and personality disorders are particularly prevalent among women engaging in treatment. Additionally, women with substance use issues frequently present with difficulties relating to poor self-esteem and self image, comorbid eating disorders, and high rates of suicide attempts. Histories of sexual abuse and assault are also common in women with AOD problems and many women presenting for treatment also report having experienced higher levels of domestic violence than the general population both as children and adults.

Because of the high rates of trauma, usually perpetrated by men, experienced by female clients presenting for AOD treatment, it is imperative for treatment settings to be capable of providing an environment in which women feel safe. It is therefore important to offer women the option of a female counsellor, to offer information and/or referral regarding women only AOD services when appropriate, and for residential treatment services provide separate bedroom and bathroom facilities for women. Research also indicates that women perform better in "women only" groups, and should therefore ideally be offered this option if attending group therapy. There is also some evidence suggesting that women do better than men in self help groups, and that social support is essential to positive treatment outcomes. Therefore, where appropriate, treatment programs should link women to self-help and/or social support groups and expand their support networks. Treatment with female

clients is also more likely to be successful if any underlying issues (eg depression or anxiety) are treated directly, rather than treatment focusing primarily on drug use.

Finally, where possible, counsellors should also endeavour to provide access to childcare facilities and encourage parenting skills training if necessary.

Women - tip sheet

- Female clients should have the option of a female counsellor.
- Be sensitive in your assessment and handling of issues of sexual abuse and domestic violence.
- Treatment should focus on the underlying issues driving the AOD use as well as the AOD use itself.
- Where possible, women should have the option of women-only groups as this tends to improve outcome.
- Consider linking female clients into additional support services and groups as they tend to respond very well to engagement in support groups
- Pay attention to the full range of health (physical and emotional), justice, child care and welfare issues that women may be facing.

40. Pregnant women

While the issues relevant to working with women in general are also applicable to working with pregnant women, there are a number of issues specific to this population. Due to the health risks associated with drug use during pregnancy, it is important to facilitate client's engagement with appropriate medical personnel and obstetric services as early as possible in the pregnancy. It is also not appropriate for counsellors to recommend the sudden cessation of any drug use, especially methadone or other opioids, as withdrawals have the potential to cause miscarriage.

Counsellors also need to be aware of the increased levels of shame and stigmatisation that AOD using pregnant women may suffer. It may also be useful to offer interventions aimed at developing parenting skills to reduce the risk of heightened stress following the birth of the child.

Pregnant women - tip sheet

- Be aware of the increased levels of shame and stigmatisation that drug using pregnant women suffer.
- Always work from a model of empowerment when working with drug using pregnant women.
- DO NOT recommend the sudden cessation of any drug use, especially methadone or other opioids as withdrawals have the potential to cause miscarriage.
- Facilitate the client's engagement with appropriate medical personnel. If possible accompany them on their first visit.
- It is normal for pregnant women on methadone to have their dosage of methadone increased for the duration of the pregnancy.

41. Men

There is general agreement that men respond better to more concrete, action oriented treatment approaches. Therefore, cognitive behavioural techniques are recommended when working with men.

Due to the strong association between drug use (especially drinking) and violence, counsellors should explore with the client the consequences of anger and violence (including family violence). Specific skills training involving anger management strategies should be included where appropriate (see ***Anger Management***).

Physical, emotional and sexual abuse in male clients seeking alcohol and drug treatment is common. As with women, this creates feelings of shame, guilt and powerlessness, which are often compounded by the feelings associated with dependency. Counsellors need to be aware of these issues when working with men and consider referral to an appropriate service when necessary.

It is also important to consider the high rates of completed suicide among males as opposed to females. Men are much more likely to choose lethal means for suicide attempts and therefore, are much more likely to be successful. Counsellors should always explore suicidal ideation. For more information, counsellors are referred to the ***Assessment*** and ***Suicide Management*** chapters in this guide.

There is evidence to suggest that men perform better in mixed gender groups. Therefore, in order to respect the recommendations for working with women, it is recommended that men participate in mixed gender groups with women who also choose to be in mixed gender groups.

Men - tip sheet

- When initially engaged, men tend to respond better to a cognitive behavioural intervention style with emphasis on concrete and practical strategies. However, as therapy progresses do not be limited to this approach.
- Be sensitive in your assessment and handling of issues of past sexual or other abuse. Men tend to suffer even greater levels of shame from past abuse then women.
- Where appropriate encourage male clients to examine the consequences of anger, violence or domestic violence.
- Where appropriate include the development of anger management strategies and alternative coping strategies to alcohol and drug use.
- Be aware of the high rates of lethality of suicide attempts in men when conducting suicide assessments and always explore suicidal ideation.
- Where possible, include men in mixed gender groups with women who also choose to be in mixed gender groups.

42. Culturally and linguistically diverse people

Culturally and Linguistically Diverse (CLD) clients are thought to be under-represented in AOD treatment due to problems finding suitable services. However, it is unrealistic to expect that sufficient culture-specific AOD treatment services can be established in Australia. Instead, AOD counsellors and services should work from the principle that "the best treatment outcome for a CLD client is likely to come from collaboration between AOD treatment agencies and ethnospecific services" (DAMEC 2007).

Some of barriers to CLD clients and their families accessing AOD treatment include:

- Different expectations of treatment and difficulty clarifying these due to language barriers.
- Lack of familiarity with what AOD treatment services are available.
- Confusion about AOD dependence.
- Language difficulties which make participation in AOD treatment programs difficult.
- When clients are referred to a more culturally appropriate service (ethnospecific or bilingual such as a migrant resource centre), counsellors at such centres often do not have sufficient AOD knowledge.
- Wanting to seek treatment outside their own community for fear of the shame and stigma of being found out in their own community, yet fearing seeking help outside their community for fear of being judged.

DAMEC (2007) suggests several ways of improving treatment access for CLD clients:

- Manage expectations: explain that the client can request an interpreter, explain what is available in terms of treatment.

- Have an AOD worker conduct the initial assessment, with the aid of an interpreter if necessary. Having an AOD worker conduct the initial assessment is necessary as their expertise will be necessary for developing an appropriate treatment plan.

- If the client is then referred to an specific or bilingual service that does not specialise in AOD problems for ongoing treatment, the AOD service should provide support to the case worker working with the client.

- If an agency has a considerable number of clients of a particular ethnicity seeking AOD treatment, consider employing a bilingual worker who is trained or can be trained in AOD issues.

- Implement policies that promote collaboration between AOD workers and ethnospecific agencies and migrant resource centres.

Houseman (2003) notes the importance when working with CLD clients of understanding their AOD use in the context of their cultural base. She argues that gaining knowledge of their cultural base provides a context for understanding how they might be interpreting and feeling about their experiences with substance use and in AOD treatment, and helps the counsellor avoid making assumptions that may be wrong. Houseman suggests this involves gathering information about three aspects of clients' lives:

- Context of the migration: why the left their country of origin, how they got to Australia, their legal status, whether they have residency, any trauma experiences in the context of their country of origin or migrating to Australia.

- Subgroup membership: ethnicity, gender, sexual orientation, area in which they live, refugees or immigrants, religious affiliation.

- Degree of acculturation: *traditional* if the client adheres completely to beliefs values and behaviours of their country of origin; *bicultural* if they have a mix of new and old beliefs, values and behaviours; *acculturated* if the client has modified their old beliefs, values and behaviours in an attempt to adjust the new ones; *assimilated* if they have completely given up their old beliefs, values and behaviours and adopted those of the new country.

Be aware that clients from CLD backgrounds may place a much higher value on extended family than non-CLD clients if they come from a collectivist rather than individualist perspective. Individualism refers to the tendency of people in some cultures to value individual identity, rights and achievements over those of the group, and for people to be expected to look after themselves and their immediate family. Collectivism refers to the tendency of people in other cultures to value group identity and concerns over individual concerns, and for people to be integrated into strong, cohesive in groups, which provide them with protection in exchange for unwavering loyalty (Hofstede 1991).

When working with CLD clients who come from a collectivist perspective, counsellors need to be particularly oriented towards family sensitive practice (see ***Significant Others***), and when appropriate build a sensitive collaboration with families. Essentially family sensitive practice involves working in an open, respectful and collaborative fashion with families *if the primary client indicates they would like them to be involved*, and if the client does not want them involved, helping them to access support and counselling of their own.

It is also important to remember when working with refugees that many of them will have experienced trauma, loss, difficulties adjusting to the new culture, and disadvantage (Sowey, 2005). Helping clients

to place their AOD problems in the context of such experiences can help to reduce shame and increase self compassion.

Note also that the use of interpreters can be problematic. First, confidentiality needs to be carefully addressed. Second, feedback from CLD workers suggests that some CLD clients may be reluctant to use an interpreter in case the interpreter comes from their own community, and in case the interpreter is known to them, which can heighten shame. Third, some clients may be reluctant to disclose some things in front of an interpreter who is not a trained counsellor. Fourth, languages often can not be directly translated into English, and visa versa, which means that some the meaning of what is said by both client and counsellor may be lost when using an interpreter. Whenever an interpreter is used, counsellors should be conscious of using very clear and unambiguous language so as to avoid misunderstanding.

Culturally and linguistically diverse – tip sheet

Work from the principle that "the best treatment outcome for a CLD client is likely to come from collaboration between AOD treatment agencies and ethnospecific services" (DAMEC, 2007).

Be aware of potential difficulties for CLD clients seeking AOD treatment:

- Different expectations of treatment and difficulty clarifying these due to language barriers.
- Lack of familiarity with what AOD treatment services are available.
- Confusion about AOD dependence.
- Language difficulties which make participation in AOD treatment programs difficult.
- Counsellors at more culturally appropriate services often not having sufficient AOD knowledge.
- Shame and stigma which can make seeking treatment outside their own community more appealing.
- Shame and stigma which can lead to fear of seeking treatment from mainstream AOD services.

To make treatment more accessible and effective:

- Manage expectations: explain that the client can request an interpreter, explain what is available in terms of treatment.
- Have an AOD worker conduct the initial assessment (with the aid of an interpreter if necessary) as they have the expertise to develop an appropriate treatment plan.
- If the client is then referred to an specific or bilingual service that does not specialise in AOD problems for ongoing treatment, the AOD service should provide support to the case worker working with the client.
- If an agency has a considerable number of clients of a particular ethnicity seeking AOD treatment, consider employing a bilingual worker who is trained or can be trained in AOD issues.
- Implement policies that promote collaboration between AOD workers and ethnospecific agencies and migrant resource centres.

Understand the cultural base of the client's AOD use by the context of their migration, subgroup membership, and degree of acculturation.

Be aware of potential problems when thinking of using an interpreter, such as client concerns re confidentiality, the interpreter coming from their own community or being known to them, and difficulty translating some languages accurately.

Be aware of the potential need to include family members in treatment, particularly if the client comes from a collectivist perspective and wants family involvement.

43. Aboriginal people

Existing mainstream models of practice in the AOD field have overwhelmingly been developed within western systems of knowledge and may ignore an Aboriginal 'worldview'. Application of these models to working with Aboriginal people can be detrimental, to the extent that some approaches can directly undermine Aboriginal cultural ways of working resulting in Aboriginal people feeling disempowered as their cultural beliefs/values and family systems are ignored, misunderstood or disrespected. This can result in Aboriginal people disengaging from seeking support and treatment. In the past there have also been efforts to impose approaches from Indigenous people in other countries on Aboriginal Australians. This can also have devastating outcomes as it weakens Australian Aboriginal culture and often these approaches are embedded in western disease ideology which is very different to an Aboriginal concept of holistic health and well being.

Culturally secure ways of working

As a result of these concerns, AOD evidence based approaches that are central to Aboriginal ways of working have been developed. These new models, framed from within an Aboriginal cultural context and developed by Aboriginal people, appear to be more effective. These models are considered to be culturally secure in that they respect the legitimate rights, values and expectations of Aboriginal people and acknowledge the diversity within and between Aboriginal communities living in remote, regional and metropolitan areas. These models also:

- incorporate an Aboriginal holistic concept of health and well being;
- are grounded in an Aboriginal understanding of the historical factors, including traditional life, the impact of colonisation and the ongoing effects;
- aim to strengthen Aboriginal family systems of care, control and responsibility;
- address culturally secure approaches to harm reduction;
- work from within empowerment principles.

The concept of the spirit is also central to these new models. Casey and Keen (2006) at Drug and Alcohol Office in WA have developed a number of models and associated resources: Strong Spirit Strong Mind. In essence, Strong Spirit Strong Mind articulates the importance of strengthening our Inner Spirit to enhance good decision-making and support behavioural change, not only at an individual level but also at a collective level with family and community. This approach draws on work by Roe (2000) and should be considered as a way forward in our endeavours to address AOD related harm for Aboriginal Australians. The resource outlines how working with Inner Spirit can be applied in a therapeutic context and incorporates culturally secure Cognitive Behavioural Therapy (CBT) approaches. The models provide a framework for understanding the structure of traditional Aboriginal life, the implications of colonisation and the introduction of alcohol and other drugs, the effects of ongoing oppression and their continuing impact upon the lives of Aboriginal clients, their families and their communities.

It is important when working with Aboriginal clients that non-Aboriginal workers have an understanding of how these areas may impact on the client's life experiences and consider the underlying issues that often present with alcohol and other drug use problems. The Strong Spirit Strong Mind resource (Casey & Keen 2006) includes information about how to work with the client, family or community in culturally secure ways.

Considering how mainstream models apply to Aboriginal ways of working is also useful. Social Learning Theory (SLT) acknowledges that drug use is learned and that people learn to use drugs in the environment they live. This approach complements traditional Aboriginal ways of learning as Aboriginal people have always learnt from their elders, other family and community members on a day-to-day basis through observing, listening and trying it out. This was applied to all aspects of life and remains an on-going process today. Since colonisation Aboriginal people have been predisposed to hazardous and harmful patterns of AOD use by the broader Australian society. Today this

continues, however now the stronger influence is Aboriginal people learning hazardous and harmful patterns of AOD use from their own people. This is in keeping with traditional ways of learning, nevertheless has tragic consequences on the health and well being of Aboriginal people.

SLT also recognises that that people have reasons for using drugs, outcomes can be positive and negative, and multiple factors influence drug use. The complexity of interrelated physical, social, emotional, economic and environmental inequalities that contribute to and exacerbate AOD use Aboriginal people means that a range of culturally secure principles need to be incorporated into responses. The implications for agencies and AOD workers are:

- Opportunities for partnerships and collaboration with Aboriginal services and individuals should be pursued.

- Opportunities should be taken, within AOD agencies and other sectors, to build capacity for responding effectively to AOD problems in Aboriginal people and communities.

- Agencies should employ skilled Aboriginal people and provide them with training and resources to increase their effectiveness in contributing to the Aboriginal AOD area.

- Prior to working with Aboriginal clients Non-Aboriginal workers should participate in cultural awareness training

- When possible, non-Aboriginal workers should seek on-going cultural supervision workers working with Aboriginal clients.

- Aboriginal clients should be offered referral to or additional support from Aboriginal-specific AOD services where possible.

- Counsellors should be aware that the concept of family in Aboriginal culture includes immediate and extended family and relatives, and, with the permission of the client, include family members in the counselling as much as possible.

- A flexible approach is needed when working with Aboriginal clients, as family, community, and cultural obligations will often take precedence over appointments.

- Counsellors should be aware of the high levels of grief and loss that are a constant factor in the lives of many Aboriginal people, their families and communities

- Counsellors should be aware of the impact of intensely distressing levels of shame that many Aboriginal clients experience, this can become exacerbated when dealing with a Non-Aboriginal counsellor/worker.

- Cognitive behavioural approaches work well with Aboriginal people providing they are used in culturally secure ways

- AOD workers should consider using Strong Spirit Strong Mind (Casey & Keen 2006) as a model and resource when working Aboriginal people affected by AOD problems.

Aboriginal people - tip sheet

Use culturally secure ways of working with Aboriginal people, their families and communities.

Culturally secure ways of working respect the legitimate rights, values and expectations of Aboriginal people and acknowledge the diversity within and between Aboriginal communities living in remote, regional and metropolitan areas.

Culturally secure models of working:

- incorporate an Aboriginal holistic concept of health and well being;
- are grounded in an Aboriginal understanding of the historical factors, including traditional life, the impact of colonisation and the ongoing effects;
- aim to strengthen Aboriginal family systems of care, control and responsibility;
- address culturally secure approaches to harm reduction;
- work from within empowerment principles.

Social Learning Theory (SLT) should also be used to understand Aboriginal AOD use as it acknowledges that drug use is learned. This approach complements traditional Aboriginal ways of learning as Aboriginal people have always learnt from their elders, other family and community members on a day-to-day basis through observing, listening and trying it out.

The complexity of the factors contributing to AOD problems by Aboriginal people means that culturally secure responses need to occur at all levels of government, agencies and the community, and partnerships and collaboration between Aboriginal and non-Aboriginal agencies and individuals is essential.

Implications for ways of working with Aboriginal clients include the following considerations:

- Opportunities for partnerships and collaboration with Aboriginal services and individuals should be pursued.

- Opportunities should be taken, within AOD agencies and other sectors, to build capacity for responding effectively to AOD problems in Aboriginal people and communities.

- Agencies should employ skilled Aboriginal people and provide them with training and resources to increase their effectiveness in contributing to the Aboriginal AOD area.

- Prior to working with Aboriginal clients Non-Aboriginal workers should participate in cultural awareness training

- When possible, non-Aboriginal workers should seek on-going cultural supervision workers working with Aboriginal clients.

- Aboriginal clients should be offered referral to or additional support from Aboriginal-specific AOD services where possible.

Aboriginal people - tip sheet (cont.)

- Counsellors should be aware that the concept of family in Aboriginal culture includes immediate and extended family and relatives, and, with the permission of the client, include family members in the counselling as much as possible.

- A flexible approach is needed when working with Aboriginal clients, as family, community, and cultural obligations will often take precedence over appointments.

- Counsellors should be aware of the high levels of grief and loss that are a constant factor in the lives of many Aboriginal people, their families and communities

- Counsellors should be aware of the impact of intensely distressing levels of shame that many Aboriginal clients experience, this can become exacerbated when dealing with a Non-Aboriginal counsellor/worker.

- Cognitive behavioural approaches should be integrated into work with Aboriginal clients as they work well providing they are used in culturally secure ways.

- AOD workers should consider using Strong Spirit Strong Mind (Casey & Keen 2006) as a model and resource when working Aboriginal people affected by AOD problems. This is a culturally secure model with resources for workers that incorporates the importance of strengthening the Inner Spirit to enhance good decision-making and support behavioural change. It also demonstrates how these principles can be applied in a therapeutic context and incorporates culturally secure Cognitive Behavioural Therapy (CBT) approaches.

44. Confidentiality

Confidentiality refers to how information obtained in a professional relationship is treated Counsellors have an obligation to refrain from disclosing information received in confidence unless there is a sufficient and compelling reason to do so. Sufficient and compelling reasons include:

- disclosing information about clients during the course of supervision;
- if the client threatens to harm him or her self or someone else;
- if a child is currently ‘at risk’ of abuse or neglect; and
- if the counsellor or case notes are subpoenaed to court.

Counsellors should be honest regarding the limits of confidentiality prior to any therapeutic engagement and discourage clients from disclosing details of their illegal activities. Clients need to be aware that the counsellor will discuss the content of their sessions with their supervisor as part of the supervision process. When the counsellor works as part of a multidisciplinary team in an agency, the client also needs to know that important information about the client’s problems and progress will be shared with other treating team members.

Counsellors should be aware of confidentiality in communications with related professionals. Written informed consent should be obtained from the client in all instances prior to the sharing of information unless sharing the information is deemed necessary to prevent immediate risk to the client or another person. Counsellors should carefully consider the possible lack of confidentiality particularly when faxing, posting or emailing client information.

Confidentiality is limited for coerced clients where reporting client progress to a third party is required. These limits need to be carefully explained to clients at the onset of therapy.

Finally, counsellors should be aware that under the Commonwealth Freedom of Information Act (1982) and the Western Australian Freedom of Information Act (1992) clients can apply to have access to their own case notes and assessment information. When working with children 16 years and under, parents can legally apply for case information unless the young person is deemed to have the maturity to give informed consent (they are deemed to be a "mature minor" – see chapter on ***Young People***).

Confidentiality - tip sheet

Counsellors have an obligation to refrain from disclosing information received in confidence unless there is a sufficient and compelling reason to do so.

Sufficient and compelling reasons include:

- disclosing information about clients during the course of supervision;
- if the client threatens to harm her/ him self or someone else;
- if there is a child involved who is currently 'at risk' of abuse; and
- if the counsellor or case notes are subpoenaed to court.

You may also be required to disclose information regarding coerced clients, or clients who are minors.

Be honest regarding the limits of confidentiality prior to any therapeutic engagement.

Written informed consent should be obtained from clients prior to an agency (or counsellor) sharing any client related information with associated professionals or otherwise.

When sharing information about clients, counsellors should consider the possible lack of confidentiality when posting, faxing and emailing information.

Agencies need to be aware that under the Commonwealth and State Freedom of Information Act clients can apply to have access to their own case notes and assessment information.

45. Clinical supervision

Evidence based practice requires staff to integrate knowledge from the research and professional field as well as their own experiences, into their clinical practice. This process requires:

- a range of learning opportunities both on the job and off site to update skills and knowledge;
- effective and supportive supervision to build a climate of continuous learning and support;
- organisational structures which allow for reflective practice to integrate acquired knowledge and skills into the workplace; and
- the ability to use both successes and mistakes as learning opportunities.

There are various ways in which learning and development occurs via work. These include supervision, opportunistic learning, intentional on the job learning, use of job aids, attending training events, action learning, and using successes and mistakes to aid learning. Discussion of all these areas is included in the ***Supervision and Professional Development*** chapter in the literature review. Clinical supervision is the focus of this chapter.

Clinical supervision

Clinical supervision is an important aspect of any treatment service as it assists in the maintenance and improvement of counsellors' standards of practice. It involves exploration of the way that the

supervisee works with clients. It is regular, systematic and carries with it a responsibility to ensure quality of practice. Clinical supervision should occur regularly for all staff. For supervision to be most effective, both supervisor and supervisee should be familiar with common supervisory practices. On commencement of supervision role boundaries should be determined and goals identified. These should be reviewed over time. The aim of clinical supervision is to enhance the supervisee's ability to meet professional, personal and agency objectives.

Clinical supervision should facilitate a worker's ability to:

- work effectively with clients;
- be aware of and able to recognise more complex clients;
- be aware of their own reactions and responses to the client;
- be aware of transference (all thoughts, feelings and reactions that the client has to the counsellor based on the client's past experiences and relationships) and countertransference (thoughts, feelings and reactions that the counsellor projects onto the client based on the counsellor's past experiences and relationships);
- understand the dynamics of how they and the client interact;
- examine possible interventions and their consequences; and
- expand their ways of working.

The function of a clinical supervisor is to facilitate growth and development of the supervisee as a counsellor. A supervisor needs to be able to act as a mentor, even to quite experienced counsellors. A supervisor should promote team problem solving whilst also making clear that counsellors have primary responsibility for their clients' care. The supervision style should include a balance of support, feedback, problem solving and instruction.

Supervision is about enhancing the standards of practice. It involves the supervisor having sufficient trust in supervisees to allow them to make their own mistakes, while at the same time being able to guide and develop their practice.

What makes good supervision?

Good supervision consist of a clearly developed contract stating the purpose of supervision, expectations of the supervisor and supervisee. It should be developed via negotiation and mutual agreement. It should:

- contain the focus, content, methods and arrangements for supervision;
- be clearly stated and understood by both parties; and
- be renewed or revised at agreed intervals.

Once the structure for supervision has been set, other elements of good supervision include the following.

- A balance of support, feedback, problem solving and instruction.
- Clear open communication.
- Active listening and attending skills.
- Providing supervisees with an adequate mix of support, empathy and respect.
- Proactive agenda setting.
- Having clear professional boundaries.

- Providing clear and specific goals and expectations with appropriate timing.

- Being able to give and receive constructive and corrective feedback.

- Having knowledge and skills of the alcohol and drug arena and the process of supervision.

- Engaging in both teaching and conceptualising behaviours where appropriate.

- Stimulating supervisee self-reflection and self-examination.

- Understanding the dynamics of parallel process, also known as the mirroring process. This occurs when the supervisee reproduces in the supervisor some of the feelings that the client promotes in the supervisee. For example, a client trivialising drug use in counselling and then the supervisee trivialising the issue in supervision

- Being respectful of the supervisees' current levels of practice whilst also extending supervisees' work beyond their current capabilities.

Factors that have been identified as important in an effective supervision process are:

- level of comfort with a supervisor;
- level of congruence between the therapist and supervisor on interventions, goals, and strategies that could be utilised in psychotherapy with particular clients;
- rapport (ie openness, honesty, and respect);
- supervision that is consistent with a particular theoretical model.

The supervisor should tailor the level of supervision to the supervisee's current level of practice. Dryden and Thorne (1991) suggest that there are six styles of supervision, differentially appropriate for the level of the supervisee as follows.

- Reflection on the content of the counselling session.

- Exploration of the strategies and interventions used by the counsellor.

- Exploration of the counselling process and relationship.

- Focus on the counsellor's counter transference.

- Focus on the here and now process as a mirror or parallel of the there and then process. That is, the process issues occurring in supervision are likely to be a reflection of the process issues that occurred during therapy.

- Focus on the supervisor's countertransference.

As counsellors increase their levels of confidence, the style of supervision should move away from an analysis of the techniques used and content of the counselling sessions and towards examining issues of process in both the counselling and supervision sessions. Readers are referred to Dryden and Thorne (1991) for a more detailed discussion on supervision.

Obligations of the supervisee

Supervisees share half of the responsibility in terms of the effectiveness of clinical supervision. The responsibilities of the supervisee are to:

- help draw up a contract for supervision;
- be clear in their expectations of supervision;
- be clear and open in their communication with the supervisor;
- be conscious of, and clearly communicate, changing supervision needs;
- be honest in all interactions with the supervisor. Ensure that the supervisor gets an accurate picture of counselling sessions, as well as issues of countertransference;
- be honest about the process of supervision. If the supervisees needs are not being met, it is both their right and responsibility to voice this;
- be open to constructive feedback – this is one of the supervisor's jobs; and
- do any homework tasks as set by the supervisor.

Group or individual supervision?

Group supervision offers a number of additional advantages including the development of a team atmosphere, the greater pool of resources and skills (from the increased number of members of the group) and the greater level of support or counsellors. Counsellors should also have access to regular individual clinical supervision.

Recordings of counselling sessions and reviewing case notes in supervision

It is extremely useful for counsellors to record some counselling sessions. By either viewing (optimal) or listening to audio-recordings of counselling sessions counsellors can practise a form of self supervision by keeping track of their own progress and process and highlighting issues they may have missed the first time around.

Recordings of sessions are also an integral component of effective supervision as they provide the supervisor with an inside view into the counselling process. In the absence of recordings, the supervisor is totally dependent on the self-reporting of the supervisee. Self-reporting is likely to suffer from bias and is limited by the awareness and knowledge of supervisees. Supervisors need to have access to an insider's view.

Obtain written permission from the client to record sessions and play these to your supervisor. Make sure you describe the purposes of recording sessions to your client, and clearly explain that they have every right to refuse if they are not comfortable with the idea. A consent form should be signed by the client.

The supervisor should also periodically review case notes and reports. If the counsellor receives outside supervision (that is, obtains supervision away from the grounds of the agency) counsellors should photocopy the case notes and blank out any identifying information. Never remove confidential information from your agency with identifying details on it.

Clinical supervision - tip sheet

The aim of clinical supervision is to enhance the supervisee's ability to meet professional, personal and agency objectives.

Clinical supervision involves exploring in detail the way that the supervisee works with clients. It is regular, systematic and carries with it a responsibility to ensure quality of practice.

Clinical supervision has three functions:

- the managing or administrative function;
- the educative or teaching function; and
- the supportive or enabling function.

Supervision should facilitate workers ability to:

- become aware of and able to recognise more complex client issues;
- become aware of their own reactions and responses to clients;
- become aware of transference and countertransference issues;
- understand the dynamics of how they and the client interact;
- examine possible interventions and their consequences; and
- explore alternative ways of working.

The function of a supervisor is to facilitate growth and development of the supervisee as a counsellor. A supervisor needs to be able to act as a mentor, even to quite experienced counsellors.

Supervision is not therapy.

A supervisor guides and encourages the supervisee to develop their own hypotheses and directions for working with particular clients.

What makes good supervision tip sheet

Supervision should involve the development of a contract stating the purpose of supervision and the expectations of the supervisee and supervisor. It should:

- contain the focus, content, methods and arrangements for supervision;
- be clearly stated and understood by both parties; and
- be renewed or revised at agreed intervals.

Factors that have been identified as important in an effective supervision process are:

- level of comfort with a supervisor;
- level of congruence between the therapist and supervisor on interventions, goals, and strategies that could be utilised in psychotherapy with particular clients;
- rapport (ie openness, honesty, and respect);
- supervision that is consistent with a particular theoretical model.

What makes good supervision tip sheet (cont.)

Other elements of good supervision include the following.

- A balance of support, feedback, problem solving and instruction.
- Clear open communication.
- Active listening and attending skills.
- Provision of an adequate mix of support, empathy and respect.
- Proactive agenda setting.
- Provision of clear and specific goals and expectations with appropriate timing.
- Having clear professional boundaries.
- Being able to give and receive constructive feedback.
- Stimulating supervisee self-reflection and self-examination.
- Having knowledge and skills of the alcohol and drug arena and the process of supervision.
- The engagement of both teaching and conceptualising behaviours where appropriate.
- Understanding the dynamics of parallel process.

The supervisor should be more experienced than the supervisee.

The supervisor should recognise the supervisee's current level of practice and tailor the level of supervision accordingly.

The supervisor should have access to recorded sessions (with the client's written permission) to review with the supervisee.

On occasion, the supervisor should review case notes and client reports, always ensuring that confidentiality is protected, however.

Supervision should occur at regular intervals.

Responsibilities of the supervisee - tip sheet

The supervisee shares half of the responsibility in terms of the effectiveness of supervision.

Specific responsibilities include the following.

- Help draw up a contract for supervision.
- Be clear in your expectations of the supervision.
- Be clear and open in your communication with your supervisor.
- Be conscious of, and clearly communicate, changing supervision needs.
- Be honest - ensure that your supervisor gets an accurate picture of counselling sessions, as well as issues of countertransference.
- Be honest about the process of supervision. If your needs aren't being met tell your supervisor.
- Be open to constructive feedback.
- Do any homework tasks as set by your supervisor.

46. Stress and burnout

Stress

There are a number of different sources of stress in the workplace. These include wondering whether you:

- are making a difference;
- have the necessary competencies to do your job;
- are valued in your workplace;
- are being adequately remunerated; or
- have a sense of control, influence and a stake in the workplace where you are able to act instead of just reacting to events around you.

Issues such as distressing outcomes for clients, conflict in the workplace, unsympathetic management, lack of support for further training, lack of clinical supervision, job uncertainty and lack of collegiality also add to stress in the workplace. As stress is unique and personal, all of these issues affect different people in different ways. It is important to be aware of the things that you experience as stressful at work.

Coping strategies include the following.

- Physical self care: eating well, sleeping well, doing exercise.
- Emotional self care: ensuring opportunities to talk and debrief.
- Professional self care: by maintaining adequate support, clinical supervision and professional development.

Burnout

Burnout is a form of strain. Strain occurs when the experience of stress is intense and prolonged and coping strategies prove ineffective. When workers experience strain they may resign, become physically ill or experience burnout. Burnout is particularly important in the counselling profession as it seriously affects the counsellor's ability to continue to deliver a quality service. Burned out counsellors may feel emotionally exhausted, lose their human touch with clients and become cynical about the power of their work.

Stress and burnout tip sheet

There are a number of different sources of stress in the workplace. These include wondering whether you:

- are making a difference;
- have the necessary competencies to do your job;
- are valued in your workplace;
- are being adequately remunerated; or
- have a sense of control, influence and a stake in the workplace where you are able to act instead of just reacting to events around you.

Other potential sources of stress include:

- conflict in the workplace;
- unsympathetic management;
- lack of support for further training;
- lack of clinical supervision; and
- job uncertainty and lack of collegiality.

Remember that stress is unique and personal.

Important strategies for coping with stress include:

- Physical self care: eating well, sleeping well, doing exercise.
- Emotional self care: ensuring opportunities to talk and debrief.
- Professional self care: by maintaining adequate support, clinical supervision and professional development. .

When stress is intense and prolonged people experience strain, in which case they may resign, become physically ill, or experience burnout.

Burned out health professionals may feel emotionally exhausted. They may lose their human touch with clients and become cynical about the power of their work.

47. Best practice outcome performance indicators

Core performance indicators involve changes in scores on measures of a number of key areas of client functioning from the beginning to the end of treatment, and at follow up at 1 and 3 months following treatment (where possible). The assessment of client satisfaction is also a core performance indicator.

Core performance indicators, which should be reported for all clients, are as follows:

- reduction in alcohol and/or other drug use;
- reduction in overdose risk and blood borne disease risk behaviours;
- improvement in social functioning;
- improvement in physical health;
- improvement in psychological adjustment;
- reduction in criminal behaviour;
- client satisfaction assessment; and

- engagement in treatment and treatment completion.

As mentioned in ***Initial engagement and assessment***, there are standardised questionnaires that do not take very long to complete that assess a number of these areas such as the Opiate Treatment Index (Darke et al 1992a) and the Maudsley Addiction Profile (Marsden et al, 1998) which are both freely available on the web, and the Client Satisfaction Questionnaire (Larsen et al 1979) which is included in Appendix 3. Even simple rating scales are better than nothing if getting clients to complete questionnaires is felt to be too difficult. For instance clients and counsellors can simply rate progress in each area on a scale from 1 (much worse than at the start of counselling) to 5 (much better than at the start of counselling). Treatment engagement and completion can be assessed by examining the number of clients who drop out of treatment within the first few sessions, and by the number who agree to a certain period of treatment and terminate prematurely.

Performance indicators of agency functioning are also important. Agency performance indicators should reflect those at which expectations are directed for ensuring high quality service standards (see ***Ensuring High Quality Standards*** in the Literature Review). There should be quality improvement process in place at each agency, in which staff are involved, which ensures the development, maintenance, review and revision of clear policies, procedures and practices developed around:

- intake and referral of clients;
- evidence based treatment;
- consumer focused practice;
- staff development, support and supervision;
- client records;
- risk management;
- organisational governance and management; and
- agency and client rights and responsibilities.

Appendices

Appendix 1: Assessment of suicide risk

Appendix 2: Mental State Examination

Appendix 3: Client Satisfaction Questionnaire

Appendix 4: Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) scale

Appendix 5: Objective Opioid Withdrawal Scale (OOWS) and Subjective Opioid Withdrawal Scale (SOWS)

Appendix 6: Benzodiazepine Withdrawal Assessment Scale

Appendix 7: Amphetamine Cessation Symptom Assessment (ACSA) Scale

Appendix 8: Cannabis Withdrawal Assessment Scale

Appendix 9: Depression, Anxiety, Stress Scale

Appendix 10: Psychosis screener

Appendix 11: Goal setting worksheet – for clients

Appendix 12: Problem solving practice sheet – for clients

Appendix 13: Relapse prevention worksheet – for clients

Appendix 14: Common thinking errors – for clients

Appendix 15: Breathing retraining – for clients

Appendix 16: Progressive muscle relaxation – for clients

Appendix 17: Creating an imaginary sanctuary – for clients

Appendix 18: Grounding – for clients

Appendix 19: Bill of rights – for clients

Appendix 20: Coming off methamphetamine – for clients

Appendix 1: Assessment of Suicide Risk

Next Step Drug and Alcohol Service, August 2007

SUICIDE RISK ASSESSMENT

Name ……..Date of Birth……
Date …….

1.Previous History of suicidal behaviour (Include self harm, risk taking behaviour)

2. Current Psycho-Social Stressors (Loss, disappointment, homeless, legal, relationship etc.).

3. Hopelessness (Future plans, motivation for treatment)

4. Current Suicidal Ideation (Intensity, frequency, plans, intent)

5. Protective Factors (Family, friends, other services, religious moral beliefs).

6. Symptomatic Presentation (Mood state, agitation, intoxication, impulsiveness etc)

SUICIDE RISK ASSESSMENT

Name ……..Date of Birth……

Assessment of Risk (See attached Form for a description of each risk level)

Risk Level: Non Existent Mild Moderate Severe Extreme
[----------I----------I----------I----------I----------]

Type of risk: Baseline (usual level of risk) [ ]
Acute (higher than usual) [ ]

Summary/Comments

Management Plan (Dependent on level of risk and supports available)

Discussed with who? (e.g., supervisor, colleague, manager)

What Action is to be taken?

Client:

Clinician:

Who else is involved in the client's safety? ……..

What is their role? …….

Have they been informed of the management plan? ……

Date to be reviewed with Supervisor/Clinical Team:

Date of assessment:

Clinician:…….. Signature: …….

Guide to rating severity of suicidal risk
(adapted from Rudd et al 2001)

1. ***Non Existent*** – no identifiable suicidal ideation

2. ***Mild*** – suicidal ideation of limited frequency, intensity and duration. No identifiable plans, no intent (i.e., subjective or objective), mild dysphoria/symptomatology, good self control (i.e., subjective or objective), few risk factors and identifiable protective factors

3. ***Moderate*** – frequent suicidal ideation with limited intensity and duration, some specific plans, no intent (i.e., subjective or objective), limited dysphoria/symptomatology, some risk factors present, identifiable protective factors.

4. ***Severe*** – Frequent, intense and enduring suicidal ideation. Specific plans, no subjective intent but some objective markers of intent (e.g., choice of lethal method(s), method is available/accessible, some limited preparatory behaviour), evidence of impaired self-control (i.e., subjective and/or objective), severe dysphoria/symptomatology, multiple risk factors present, few if any protective factors

5. ***Extreme*** – Frequent, intense, enduring suicidal ideation, specific plans, clear subjective and objective intent, impaired self control (i.e., subjective and objective), severe dysphoria/symptomatology, many risk factors, no protective factors.

Appendix 2: Mental State Examination

http://www.prisonmentalhealth.org/downloads/professional_resources/09-1_mental_state_exam.doc

July 2007

Mental State Examination form

Appearance and behaviour: Physical appearance? Reaction to situation?

Speech: Rate, volume and quantity of information?

Mood and affect: Mood? Affect?

Form of thought: Amount and rate of thought? Continuity of ideas?

Thought content: Delusions? Suicidal thoughts? Other?

Perception: Hallucinations? Other perceptual disturbances?

Sensorium and cognitions: Level of consciousness? Memory? Orientation? Concentration? Abstract thoughts?

Insight

OVERVIEW OF THE MENTAL STATE EXAMINATION (MSE)

1. Appearance and behaviour
Appearance eg grooming, hygiene, clothing, hair, nails, other significant features
Attitude to situation and examiner eg hostile, withdrawn, seductive
Motor behaviour eg slowed down, restless, tremors, bizarre (include description)

2. Speech
Rate eg slow, pressured (very rapid), monotonous
Volume eg loud, quiet, slurred
Quantity of information eg restricted amount of spontaneous speech

3. Mood and affect
Mood eg depressed, euphoric, suspicious, labile - (alternating between extremes)
Affect eg restricted, flattened (absence of emotional expression) inappropriate

4. Form of thought
Amount of thought and rate of production eg hesitant thinking, vague, flight of ideas
Continuity of ideas - refers to logical order of the flow of ideas
Disturbance in language or meaning eg uses words that don't exist or word salad

5. Content of thought
Delusions (particular problems arise from delusions of persecution, poisoning)
Suicidal thoughts, plans or intent
Other - eg obsessions, compulsions, hypochondriacal preoccupations

6. Perception
Hallucinations relating to sounds heard, visions, smells, tastes, tactile or somatic sensations. Note in particular any command hallucinations. Does the patient think that he or she may act upon these?
Other perceptual disturbances (derealisation, depersonalisation, heightened/dulled perception)

7. Sensorium and cognition
Level of consciousness eg abnormal drowsiness, delirium, clouding of consciousness
Memory: immediate, recent, remote
Orientation: time, place, person
Concentration: ask the individual to subtract serial 7s from 100
Abstract thinking

8. Insight
Extent of individual's awareness of problem. Compliance with treatment.

The Mental State Examination is designed to obtain information about specific aspects of the individual's mental experiences and behaviour at the time of the interview. The MSE may also be used if the clinician feels that an individual under his or her care may be experiencing a relapse of illness. This book does not attempt to explain how to carry out a mental state examination. None-the-less, the following general guidance can be given:

- The mental state exam form provides a structure that encourages the examiner to record his or her observations of the patient. The form is often filled in after the conversation with the patient has been completed.

- The actual conversation that the examiner has with the patient, while carrying out these observations, should not consist of a series of direct questions. More than a few direct questions turns the conversation into an interrogation and may be counter-productive.

- Mental state examinations are normally carried out where the person examined is distressed. The first part of the conversation must indicate that the examiner understands that the patient is distressed and that the reasons for the distress will be listened to sympathetically.

- Whether the conversation is exploring the patient's history or present distress, it is about topics that are meaningful and personal to the patient (their story). The patient needs to understand that the purpose of the exercise is for help to be arranged for him or her by the person carrying out the examination.

- An atmosphere must be created that will encourage the patient to feel free to share his/her inner feelings, and be able to talk without fear of being criticised or judged. Privacy is of great importance in creating this atmosphere and so is confidentiality. The limits of confidentiality should be explained to the patient.

- If the patient is reluctant to discuss his or her feelings and thoughts, direct questions are not likely to produce further results. Indirect probes may help, for example - "If you could have three wishes granted right now, what would they be?' Most patients will respond to this kind of indirect, open-ended question and provide the examiner with conversational points which can be explored further. "Why's that?" is a useful further question to keep the conversation going when blocks occur.

- Where possible, mental state examinations are better carried out over two or three interviews rather than all at once. Except in an acute emergency (for example, where it is thought that the patient may be harbouring ideas of serious violence) where persistence will be necessary, the most important outcome of any mental state examination is that, at the end, the examiner has a better idea of what the patient is thinking and feeling and the patient trusts the examiner and is willing to continue the conversation at a later date.

Appendix 3: Client Satisfaction Questionnaire (CSQ8)

Larsen DL, Attkisson CC, Nguyen TD (1979). 'Assessment of client/patient satisfaction: Development of a general scale'. Evaluation and Program Planning, 2: 197-207.

Reprinting with permission from C.C. Attkisson (1991). The CSQ was developed by C.C. Attkisson et alcohol at the University of California, San Francisco, Department of Psychiatry. Use for non-profit research and evaluation purposes is permitted. All other uses by prior permission and user fee, without exception.

The CSQ-8 is a paper and pencil, self completion questionnaire and takes about 5 minutes to complete.

Scoring: Scores are summed across items, once items 2, 4, 5, and 8 are reverse scored.
Total scores range from 8 to 32, with the higher number indicating greater Satisfaction.

Client Satisfaction Questionnaire

Please help us improve our program by answering some questions about the Services you have received. We are interested in your honest opinion, whether they are positive or negative. Please answer all of the questions. We also welcome your comments and suggestions. Thank you very much, we really appreciate your help.

CIRCLE YOUR ANSWER

1. How would you rate the quality of service you received ?

4	3	2	1
Excellent	Good	Fair	Poor

2. Did you get the kind of service you wanted ?

4	3	2	1
No, definitely not	No, not really	Yes, generally	Yes, definitely

3. To what extent has our program met your needs ?

4	3	2	1
Almost all of my needs have been met	Most of my needs have been met	Only a few of my needs have been met	None of my needs have been met

4. If a friend were in need of similar help, would you recommend our program to him or her ?

4	3	2	1
No, definitely not	No, not really	Yes, generally	Yes, definitely

5. How satisfied are you with the amount of help you have received ?

4	3	2	1
Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Very satisfied

6. Have the services you received helped you to deal more effectively with your problems ?

4	3	2	1
Yes, they helped a great deal	Yes, they helped somewhat	No, they really didn't help	No, they seemed to make things worse

7. In an overall, general sense, how satisfied are you with the service you have received ?

4	3	2	1
Very satisfied	Mostly satisfied	Indifferent or mildly dissatisfied	Quite dissatisfied

8. If you were to seek help again, would you come back to our program ?

4	3	2	1
No, definitely	No, I don't think so	Yes, I think so	Yes, definitely

Appendix 4:
Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) scale

Metcalfe P, Sobers M, Dewey M. (1995). The Windsor Clinic Alcohol Withdrawal Assessment Scale (WCAWAS): investigation of factors associated with complicated withdrawals. *Alcohol*, *30*(3):367-372.

Note: the WCAWAS is a revised version of the CIWA-Ar scale and is usually referred to simply as the CIWA-Ar as has been done here.

Scoring

A score of 8 or more indicates significant withdrawal symptoms and the need for medication. A score of 15+ indicates severe withdrawals with impending risk of confusion and seizures - medical attention should be immediately sought.

Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) scale

Patient _____Date _____Time_____

NAUSEA AND VOMITING — Ask "Do you feel sick to your stomach? Have you vomited?" Observation.

0 no nausea and no vomiting
1 mild nausea with no vomiting
2
3
4 intermittent nausea with dry heaves
5
6
7 constant nausea, frequent dry heaves and vomiting

TREMOR — Arms extended and fingers spread apart. Observation.

0 no tremor
1 not visible, but can be felt fingertip to fingertip
2
3
4 moderate, with patient's arms extended
5
6
7 severe, even with arms not extended

PAROXYSMAL SWEATS — Observation.

0 no sweat visible
1 barely perceptible sweating, palms moist
2
3
4 beads of sweat obvious on forehead
5
6
7 drenching sweats

ANXIETY — Ask "Do you feel nervous?" Observation.

0 no anxiety, at ease
1 mildly anxious
2
3
4 moderately anxious, or guarded, so anxiety is inferred
5
6
7 equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

AGITATION — Observation.

0 normal activity
1 somewhat more than normal activity
2
3
4 moderately fidgety and restless
5
6
7 paces back and forth during most of the interview, or constantly thrashes about

TACTILE DISTURBANCES — Ask "Have you any itching, pins and needles sensations, burning sensations, numbness or do you feel bugs crawling on or under your skin?" Observation.

0 none
1 very mild itching, pins and needles, burning or numbness
2 mild itching, pins and needles, burning or numbness
3 moderate itching, pins and needles, burning or numbness
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

AUDITORY DISTURBANCES — Ask "Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?" Observation.

0 not present
1 very mild harshness or ability to frighten
2 mild harshness or ability to frighten
3 moderate harshness or ability to frighten
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

VISUAL DISTURBANCES — Ask "Does the light appear to be too bright? Is its colour different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?" Observation.

0 not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

HEADACHE, FULLNESS IN HEAD — Ask "Does your head feel different? Does it feel as if there is a band around your head?" Do not rate for dizziness or lightheadedness. Otherwise, rate severity.

0 not present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe

ORIENTATION AND CLOUDING OF SENSORIUM — Ask "What day is this? Where are you? Who am I?"

0 oriented and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disoriented for date by no more than 2 calendar days
3 disoriented for date by more than 2 calendar days
4 disoriented for place and/or person

Total CIWA-Ar score: _____

Rater's initials: _____

Maximum possible score: 67

Appendix 5: Objective Opioid Withdrawal Scale (OOWS)

Subjective Opioid Withdrawal Scale (SOWS)

Handelsman, L., Cochrane, K. J., Aronson, M. J. *et al.* (1987) Two New Rating Scales for Opiate Withdrawal, *American Journal of Alcohol Abuse*, 13, 293-308.

OOWS: Range 0-13
SOWS: Range 0-64.

OBJECTIVE OPIOID WITHDRAWAL SCALE (OOWS)

Name …… Date …… Time ……

OBSERVE THE PATIENT DURING A
5 MINUTE OBSERVATION PERIOD
THEN INDICATE A SCORE FOR EACH OF THE OPIOID WITHDRAWAL SIGNS LISTED BELOW (ITEMS 1-13). ADD THE SCORES FOR EACH ITEM TO OBTAIN THE TOTAL SCORE

	SIGN	MEASURES		SCORE
1	Yawning	0 = no yawns	1 = ≥ 1 yawn	
2	Rhinorrhoea (runny nose)	0 = < 3 sniffs	1 = ≥ 3 sniffs	
3	Piloerection (goose bumps - observe arm)	0 = absent	1 = present	
4	Perspiration	0 = absent	1 = present	
5	Lacrimation (runny eyes)	0 = absent	1 = present	
6	Tremor (hands)	0 = absent	1 = present	
7	Mydriasis (large pupils)	0 = absent	1 = ≥ 3 mm	
8	Hot and Cold flushes	0 = absent	1 = shivering / huddling for warmth	
9	Restlessness	0 = absent	1 = frequent shifts of position	
10	Vomiting	0 = absent	1 = present	
11	Muscle twitches	0 = absent	1 = present	
12	Abdominal cramps	0 = absent	1 = Holding stomach	
13	Anxiety	0 = absent	1 = mild - severe	
	TOTAL SCORE			

Range 0-13

THE SUBJECTIVE OPIATE WITHDRAWAL SCALE (SOWS)

Name …… Date …… Time ……

		PLEASE SCORE EACH OF THE 16 ITEMS BELOW ACCORDING TO HOW YOU FEEL NOW (CIRCLE ONE NUMBER)				
	SYMPTOM	NOT AT ALL	A LITTLE	MODERATELY	QUITE A BIT	EXTREMELY
1	I feel anxious	0	1	2	3	4
2	I feel like yawning	0	1	2	3	4
3	I am perspiring	0	1	2	3	4
4	My eyes are teary	0	1	2	3	4
5	My nose is running	0	1	2	3	4
6	I have goosebumps	0	1	2	3	4
7	I am shaking	0	1	2	3	4
8	I have hot flushes	0	1	2	3	4
9	I have cold flushes	0	1	2	3	4
10	My bones and muscles ache	0	1	2	3	4
11	I feel restless	0	1	2	3	4
12	I feel nauseous	0	1	2	3	4
13	I feel like vomiting	0	1	2	3	4
14	My muscles twitch	0	1	2	3	4
15	I have stomach cramps	0	1	2	3	4
16	I feel like using now	0	1	2	3	4

Range 0-64

Appendix 6: Benzodiazepine Withdrawal Assessment Scale

McGregor C, Machin A, White J, M. (2003). In-patient benzodiazepine withdrawal: comparison of fixed and symptom-triggered taper methods. *Drug and Alcohol Review*, *22*:175-180.

BENZODIAZEPINE WITHDRAWAL ASSESSMENT SCALE

These questions refer to how the client is feeling right now at the present moment

1. Anxiety Arms extended, elbows slightly flexed and fingers spread *0 No anxiety – at ease* *1 Mild* *4 Moderately anxious or guarded so anxiety is inferred* *7 Equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions*	***4. Headache*** Ask 'Do you have a headache or feeling of fullness in the head?' *0 No headache* *1 Mild* *4 Moderate* *7 Severe*
2. Restlessness/ Agitation Ask 'Do you feel more restless or agitated than you are normally?' *0 Normal activity* *1 Somewhat more than normal activity* *4 Moderately fidgety or restless* *7 Unable to sit or stand still*	***5. Concentration*** Ask 'Do you have any difficulty concentrating?' *0 No difficulty concentrating* *1 Mild* *4 Moderate* *7 Severe*
6. Palpitations *Ask 'Are you aware of your heart racing in your chest?'* *0 No palpitations* 1 Mild palpitations 4 Moderate awareness of heartbeat 7 Aware of heart racing constantly	***7. Appetite*** *Ask 'Have you noticed any change in your appetite?'* 0 No loss of appetite *1 Slight loss* 4 Moderate loss 7 Complete loss of appetite, unable to eat at all

Sleep **(0800 observations only – not to be included in total score)** *Ask ' How did you sleep last night?'* 0 Sufficient sleep 1 Some sleep 4 Moderate/restless sleep 7 No sleep

Appendix 7: Amphetamine Cessation Symptom Assessment (ACSA) Scale

McGregor, C., Srisurapanont, M., Mitchell, A., Longo, M. C., Cahill, S., & White, J. M. (In press). Psychometric evaluation of the Amphetamine Cessation Symptom Assessment (ACSA). Journal of Substance Abuse Treatment, Accepted 23rd May, 2007.

Scale range 0–64

AMPHETAMINE CESSATION SYMPTOM ASSESSMENT (ACSA) SCALE

Date …….…… Name ……..……..

QUESTIONS REFER TO THE PAST 24 HOURS ONLY		***PLEASE CIRCLE ONE RESPONSE TO EACH QUESTION***				
1	**Have you had difficulty concentrating? (eg on reading, conversation, tasks, or making**	*Not at all*	*A little*	*Moderately*	*Quite a lot*	*Extremely*
2	**Have you been sleeping (or wanting to sleep) a lot?**	*Not at all*	*A little*	*Moderately*	*Quite a lot*	*Extremely*
3	**Have you been tense?**	*Not at all*	*A little*	*Moderately*	*Quite a lot*	*Extremely*
4	**Have you had vivid, unpleasant dreams?**	*Not at all*	*A little*	*Moderately*	*Quite a lot*	*Extremely*
5	**Have you felt irritable?**	*Not at all*	*A little*	*Moderately*	*Quite a lot*	*Extremely*
6	**Have you been tired?**	*Not at all*	*A little*	*Moderately*	*Quite a lot*	*Extremely*
7	**Have you been agitated?**	*Not at all*	*A little*	*Moderately*	*Quite a lot*	*Extremely*
8	**Have you felt that life is not worth living?**	*Not at all*	*A little*	*Moderately*	*Quite a lot*	*Extremely*
9	**How active have you been compared to your usual level of activity?**	*Usual level of activity*	*A little less active*	*Moderately less active*	*Quite a lot less active*	*No activities at all*
10	**Have you felt anxious?**	*Not at all*	*A little*	*Moderately*	*Quite a lot*	*Extremely*
11	**Have you lost interest in things or no longer take pleasure in**	*Not at all*	*A little*	*Moderately*	*Quite a lot*	*Extremely*
12	**Have you found it difficult to trust other people?**	*Not at all*	*A little*	*Moderately*	*Quite a lot*	*Extremely*
13	**Have you felt sad?**	*Not at all*	*A little*	*Moderately*	*Quite a lot*	*Extremely*
14	**Have you felt as if your movements were slow?**	*Not at all*	*A little*	*Moderately*	*Quite a lot*	*Extremely*
15	**In the past 24 hours, how much of the TIME have you been craving for amphetamines?**	*None of the time*	*A little of the time*	*Moderate amount of the time*	*Quite a lot of the time*	*All of the time*
16	**How STRONG has your craving for amphetamines been?**	*No craving*	*A little*	*Moderately*	*Quite a lot*	*Extremely*

Scale range 0–64

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Appendix 8: Cannabis Withdrawal Assessment Scale

Budney AJ. (2006). Are specific dependence criteria necessary for different substances: how can research on cannabis inform this issue? *Addiction, 101* Suppl 1:125-133.

Government of South Australia
Southern Adelaide Health Service

DRUG & ALCOHOL SERVICES SOUTH AUSTRALIA

(Label)
SURNAME: .....
GIVEN NAMES: .....
DOB: ..... /...../ ..... SEX M☐ F☐
REG NO: .....

Photo

Cannabis Withdrawal Scale (CWS)

BD OBSERVATIONS

Date															
Time															
Temperature															
Pulse															
Respiration Rate															
Blood Pressure															
Pupil Size and Reaction															
Sclera (red Y/N)															
Weight (daily) - Morning															

PLEASE SCORE EACH ITEM BELOW ACCORDING TO HOW YOU FEEL **NOW**

0=NONE **1=MILD** **2=MODERATE** **3=SEVERE**

1	Shakiness/Tremulousness														
2	Depressed Mood														
3	Decreased Appetite														
4	Nausea														
5	Irritability														
6	Sleep Difficulty														
7	Sweating														
8	Craving to Smoke Marijuana														
9	Restlessness														
10	Nervousness/Anxiety														
11	Increased Aggression														
12	Headaches														
13	Stomach Pains														
14	Strange/Wild Dreams														
15	Increased Anger														
16	Other (list)														
	TOTAL SCORE														

Appendix 9: Depression, Anxiety and Stress Scale (DASS)

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

The DASS can be used to clarify the locus of emotional disturbance as part of a clinical assessment. It assesses the severity of the *core* symptoms of depression, anxiety and stress. Clinically depressed, anxious or stressed persons may exhibit additional symptoms that tend to be common to two or all three of the conditions, such as sleep, appetite, and sexual disturbances. These disturbances are not assessed by the DASS and need to be further enquired about. Additionally, suicidal ideation is not assessed by the DASS and should be further enquired about.

DASS	*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 myself getting upset by quite trivial things	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 (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
5	I just couldn't seem to get going	0	1	2	3
6	I tended to over-react to situations	0	1	2	3
7	I had a feeling of shakiness (eg, legs going to give way)	0	1	2	3
8	I found it difficult to relax	0	1	2	3
9	I found myself in situations that made me so anxious I was most relieved when they ended	0	1	2	3
10	I felt that I had nothing to look forward to	0	1	2	3
11	I found myself getting upset rather easily	0	1	2	3
12	I felt that I was using a lot of nervous energy	0	1	2	3
13	I felt sad and depressed	0	1	2	3
14	I found myself getting impatient when I was delayed in any way (eg, lifts, traffic lights, being kept waiting)	0	1	2	3
15	I had a feeling of faintness	0	1	2	3
16	I felt that I had lost interest in just about everything	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 perspired noticeably (eg, hands sweaty) in the absence of high temperatures or physical exertion	0	1	2	3
20	I felt scared without any good reason	0	1	2	3
21	I felt that life wasn't worthwhile	0	1	2	3

Reminder of rating scale:

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

22	I found it hard to wind down	0	1	2	3
23	I had difficulty in swallowing	0	1	2	3
24	I couldn't seem to get any enjoyment out of the things I did	0	1	2	3
25	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)	0	1	2	3
26	I felt down-hearted and blue	0	1	2	3
27	I found that I was very irritable	0	1	2	3
28	I felt I was close to panic	0	1	2	3
29	I found it hard to calm down after something upset me	0	1	2	3
30	I feared that I would be "thrown" by some trivial but unfamiliar task	0	1	2	3
31	I was unable to become enthusiastic about anything	0	1	2	3
32	I found it difficult to tolerate interruptions to what I was doing	0	1	2	3
33	I was in a state of nervous tension	0	1	2	3
34	I felt I was pretty worthless	0	1	2	3
35	I was intolerant of anything that kept me from getting on with what I was doing	0	1	2	3
36	I felt terrified	0	1	2	3
37	I could see nothing in the future to be hopeful about	0	1	2	3
38	I felt that life was meaningless	0	1	2	3
39	I found myself getting agitated	0	1	2	3
40	I was worried about situations in which I might panic and make a fool of myself	0	1	2	3
41	I experienced trembling (eg, in the hands)	0	1	2	3
42	I found it difficult to work up the initiative to do things	0	1	2	3

DASS	Scoring Template
	S A D A D S A S A D S S D S A D D S A A D

Apply template to both sides of sheet and sum scores for each scale.

Appendix 10: Psychosis screener

From Jablensky A, McGrath JH, Castele D, Gureje O, Evans M. et al (2000). Psychotic disorders in urban areas: an overview of the study on low prevalence disorders. *Australian and New Zealand Journal of Psychiatry, 34*: 221-236.

Scoring
A positive screen for psychosis is indicated by:

- At least 2 out of items 1-6 items positive
- Positive to item 6 ‘definitely’ to item 7

Psychosis screener

1. Delusional mood

    (a) Has the person felt something strange, unexplainable was going on?

    (b) If yes, was this so strange others would find it very hard to believe?

2. Grandiose delusions

    (a) Has the person ever believed they have special powers, talents that most people lack?

    (b) If yes, do they belong to a group that has special powers?

3. Delusions of reference/persecution

    (a) Has the person ever felt people were too interested in them?

    (b) If yes, did they feel harm might come to them?

4. Delusions of control

    (a) Has the person ever felt thoughts were directly interfered with, controlled by others?

    (b) If yes, did this happen in a way others would find hard to believe, e.g., telepathy

5. Hallucinosis

    Has the person ever heard voices or had visions when there was no-one around?

6. Diagnosis of psychosis

    Has the person ever been prescribed antipsychotic medication, diagnosed as psychotic by a doctor?

7. Using clinical judgement, is this person psychotic or has this person ever been psychotic?

    0 = definitely not
    1 = possibly
    2 = definitely

Appendix 11: Goal setting worksheet - for clients

I am going to.....

The most important reasons I want to achieve this goal are...

Things that may stop me achieving this goal are....

Things that I can do to overcome these dangers are...

The ways other people can help me are (name the person and how they can help)...

I will start achieving this goal by...

I will know when I have achieved this goal because...

Appendix 12: Problem solving practice sheet - for clients

What exactly is the problem?
Stand back from the problem and imagine that you are advising a friend. Write it down:

Brainstorm solutions
Male a list of all possible solutions, even silly one.

Look at your list of brainstormed solutions and cross any that immediately appear silly or impossible. With the remaining list imagine the possible short and long term consequences of each option. Which strategies are possible? Which are likely to be possible? Write down your three favourite solutions:

1.
2.
3.

Implementation
What do you need to do in order to implement the solution? Rehearse the strategy and consider whether it worked, or could be employed.

Appendix 13: Relapse prevention work sheet - for clients

High risk situations
High-risk situations involve those situations where you find it particularly difficult not to drink or use drugs. High-risk situations include your emotions, thoughts, places, events and people. For example:

"I was starting a new job and I just didn't want to stuff it up. I was so anxious about it and I didn't know what was expected of me."
"It was my birthday and one of my mates bought me some scotch as a present. It was to celebrate. I couldn't say know."

Jot down your possible high-risk situations.

Feelings
This includes good and bad moods and boredom. For example:

"I just got a job, so I had to celebrate."
"I was just walking down the street and these cops came up and started hassling me. I was just so stressed out, I couldn't cope, so I used."

Jot down your high-risk feelings.

Thoughts
Your thoughts are those things that say to yourself that make you want to use. For example:

"I am nothing but a no good junkie. I'll never be able to give up."
"It's just one taste. One taste won't hurt, I deserve just one more taste."

Jot down your high-risk thoughts.

People

This includes anyone that when you hang around them, makes you want to use. It could include your parents, mates, parole officer etc. For example:

- hanging around with your using mates; and
- hanging around with people who stress you out.

Jot down your high-risk people.

Places
For example:

- places where you used to use;
- places where other people are using;
- suburbs where your old dealers live; and
- places where you used to score.

Jot down your high-risk places.

My reasons for change

Appendix 14: Common incorrect beliefs - guide for clients[19]

All or none thinking
"If I fail one test, I am a total failure."

Mental filter
Interpreting events based on what has happened in the past
"I can't trust men, they only let you down."

Overgeneralisation
Expecting that just because something has happened once it always will.
"I tried to give up once before but relapse. I will never be able to give up."

Catastrophising
Exaggerating the impact of events - Imagining the worst case scenario
"I am never going to find somewhere to live. I am homeless and am going to starve to death."

Mistaking feelings for facts
Often people get confused between feelings and facts.
"I feel like a failure, so therefore I am a failure."

Should statements
Living in the world of the shoulds, oughts and musts.
"I must give up heroin."

Personalising
Often people blame themselves for any unpleasant event and take to much responsibility for others feelings and behaviours
"It's all my fault, I must have done something wrong."

Discounting positive experiences
People often discount positive things that happen
"I stayed clean because I didn't run into any of my using mates."

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[19] Adapted from Beck, J. 1995, *Cognitive therapy, Basics and beyond,* New York: The Guildford Press.

and

Jarvis, T., Tebbutt, J., & Mattick, R. 1995, *Treatment approaches for alcohol and drug dependence,* John Wiley & Sons, Chichester, UK.

Appendix 15: Breathing retraining - guide for clients

Shallow, rapid breathing goes hand in hand with feelings of anxiety, stress and panic.

First, learn to recognise the difference between shallow breathing and abdominal breathing.

Increase the rapidity of your breathing. Place your hand gently on your abdomen and feel how shallow and rapid your breathing is. Then increase the rapidity of your breathing. This is shallow breathing.

Next practice abdominal breathing. Follow the instructions below.

- Place one hand on your abdomen right beneath your rib cage.
- Inhale deeply and slowly, thinking of send the air as low and deep into your lungs as possible. If you are breathing from your abdomen you should feel your hand rise.
- When you have taken a full breath pause before exhaling through your nose or mouth. As you exhale imagine all of the tension draining out of your body.
- Do ten slow abdominal breaths. Breathe in slowly counting to four, before exhaling also to the count of four. Repeat this cycle ten times.

Practice this for between 10 and 20 minutes per day. This will help to reduce your overall level of tension and also provide you with a strategy that you can use in anxiety provoking situations, or other high risk situations when you are tempted to relapse.

Appendix 16:
Progressive muscle relaxation - guide for clients[20]

Progressive muscle relaxation involves tensing and relaxing different muscle groups in succession.

Before starting make sure you are sitting in a quiet and comfortable place.

When tensing a particular muscle group, do so strongly and hold the tension for 10 seconds.

Concentrate on the feelings in your body and on the feelings of tension and release.

When relaxing muscles feel the tension draining out of your body and enjoy the sensation of relaxation for 15 seconds.

Isolate each muscle group at a time, allowing the other muscle groups to remain relaxed.

The process:

1. Take three deep abdominal breaths, exhaling slowly each time, imagining the tension draining out of your body.

2. Clench your fists. Hold for ten seconds (counsellors may want to count to ten slowly), before releasing and feeling the tension drain out of your body (for 15 seconds).

3. Tighten your biceps by drawing your forearms up toward your shoulders and make a muscle with both arms. Hold, then relax.

4. Tighten your triceps (the muscles underneath your upper arms) - by holding out your arms in front of you and locking your elbows. Hold, then relax.

5. Tense the muscles in your forehead by raising your eyebrows as high as you can. Hold, then relax.

6. Tense the muscles around your eyes by clenching your eyelids shut. Hold, then relax. Imagine sensations of deep relaxation spreading all over your eyes.

7. Tighten your jaws by opening your mouth so widely that you stretch the muscles around the hinges of your jaw. Hold, then relax

8. Tighten the muscles in the back of your neck by pulling your head way back, as if you were going to touch your head to your back. Hold, then relax.

9. Take deep breaths and focus on the weight of your head sinking into whatever surface it is resting on.

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[20] Instructions taken from Bourne, E.J. 1995, *The anxiety and phobia workbook*, New Harbinger Publications, California.

10. Tighten your shoulders as if you are going to touch your ears. Hold, then relax.

11. Tighten the muscles in your shoulder blades, by pushing your shoulder blades back. Hold then relax.

12. Tighten the muscles of your chest by taking in a deep breath. Hold, then relax.

13. Tighten your stomach muscles by sucking your stomach in. Hold, then relax.

14. Tighten your lower back by arching it up (don't do this if you have back pain). Hold, then relax.

15. Tighten your buttocks by pulling them together. Hold, then relax.

16. Squeeze the muscles in your thighs. Hold, then relax.

17. Tighten your calf muscles by pulling your toes towards you. Hold, then relax.

18. Tighten your feet by curling them downwards. Hold, then relax.

19. Mentally scan your body for any left over tension. If any, muscle group remains tense repeat the exercise for those muscle groups.

20. Now imagine a wave of relaxation spreading over your body.

Appendix 17:
Creating an imaginary safe place – guide for clients

This involves remembering or imagining scene that you find particularly safe and peaceful. The scene needs to be as real as possible. Useful things to consider in making your safe place as real as possible include the following.

How did you get there?

What does it smell like?

How warm is it?

How does the air feel against you skin?

What does the atmosphere smell like?

What can you see around you?

What can you hear?

Appendix 18: Grounding – guide for clients[21]

Grounding involves detaching yourself from emotional pain by focussing on the outside world rather than what's going on inside you. It is useful for extreme emotional pain.

Examples of mental grounding:

- Describe objects in your environment in detail using all your senses.
- Describe an every day activity, such as eating or driving to work, in detail.
- Use imagery. For example hop on a cloud and float away from your pain, float away in a bubble, change the TV channel to one not showing pain.
- Use a grounding statement. "I am Jo, I am 23 years old, I am safe here, today is….
- Say the alphabet slowly.
- Think of something funny.

Examples of physical grounding:

- Run cool or warm water over your hands.
- Press your heels into the floor.
- Touch objects around you as you say their name.
- Jump up and down.
- Change your posture to a more upright one.
- Stretch.
- As you breathe say "in", "out" as you inhale and exhale; or on the exhale say "calm" or "easy" or "safe".

Examples of soothing grounding:

- Rub nice smelling hand cream slowly into hands and arms and notice the feel and smell.
- Say encouraging statements to yourself such as "You're okay, you'll get through this".
- Think of favourites of any kind of object (e.g. cars) or animal.
- Think of a place where you felt calm and peaceful, describe where you were, what was around you and what you were doing.
- Plan something nice for yourself such as a bath or a good meal.
- Think of things you look forward to doing in the next few days.

Suggestion to make grounding work well:

- Practice the strategies.
- Have a list of best grounding strategies somewhere handy to remind you to use them: e.g. a note in a diary, a note stuck in the car or on the fridge.
- Start doing grounding exercises early in a distress cycle.
- Rate your distress levels before and after grounding, so you can tell which strategies work best.

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[21] Based on Najavits, L. 2002, *Seeking safety: A treatment manual for PTSD and substance abuse*, The Guildford Press, New York. Handout: "Using grounding to detach from emotional pain".

Appendix 19: Bill of Rights – handout for clients[22]

Everybody has the right to:

- Make mistakes.
- Change their mind.
- Offer no reasons or excuses for their behaviour.
- Make their own decisions.
- Not to have to work out solutions for other people's problems.
- Criticise in a constructive and helpful manner.
- Say 'no' without feeling guilty.
- Tell someone that they do not understand their position or else 'do not care'.
- Not have to depend on others for approval.
- Express feelings and opinions.
- Be listened to by others.
- Disagree with others.
- Have different needs wants and wishes from other people.

[22] Some of the information above is adapted from Jarvis et al. (1995). *Treatment Approaches for Alcohol and Drug Dependence*. Chichester: John Wiley:ch. 7

Appendix 20:
Coming off methamphetamine – handout for clients

- Ensure your environment is safe and low stress

- Surround yourself with supportive, non-irritating, non-authoritarian people who can provide reassurance without being overly intrusive

- Find strategies that will help you:
    - Cope with mood swings
    - Cope with strange thoughts
    - Cope with cravings
    - Improve sleep

- Eat healthy food

- Do some exercise daily

- Use relaxation techniques

- Structure your days

- Concentrate only on the immediate future

- Identify high risk situations

- Break goals up into small bits

- Don't start working through distressing past incidents until feeling more robust and stable.