

# **Evidence Based Practice Indicators for Alcohol and Other Drug Interventions: Summary**

**2<sup>nd</sup> 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 School 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 *Summary of the evidence based practice indicators for alcohol and other drug interventions* informs contracts for service as well as service delivery in Western Australian agencies.

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

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# 1. General counselling approach

As part of the general counselling approach, counsellors should consider the following.

- Supportive and empathic counselling is a sound base.
- Counselling is a joint approach between the counsellor and client with treatment plans negotiated by and agreed upon by both parties.
- Therapeutic orientation is not as important as the therapeutic relationship.
- Therapeutic relationship is the most active ingredient in change.
- Terminating counselling should be dealt with sensitively as clients often experience distress at such an important relationship ending.
- Professional development is an important aspect of general counselling.

General counselling should include the following.

- Linking clients with appropriate services whilst client is still engaged.
- Anticipating and developing strategies with the client to cope with difficulties before they arise.
- Specific evidenced based interventions where appropriate (eg goal setting, motivational interview, problems solving etc).
- Focus on positive internal and external resources and successes as well as problems and disabilities.
- Where appropriate, involve a key supportive other to improve the possibility of behavioural change outside the therapeutic environment.

The counselling approach adopted with a particular client should be 'evidence-based' and hence reflect an integration of:

- best existing research evidence;
- clinical wisdom and expertise; and
- client circumstances, needs and expectations.

# 2. Program content

Counsellors need to look at the wider context of clients' lives, and when working at an individual level should include a range of techniques. Specific cognitive behavioural therapy interventions should be included as follows.

- *Goal Setting* gives therapy a direction, provides a standard by which progress can be reviewed and gives clients concrete evidence of their improvement.
- *Motivational interviewing and decision making* are useful strategies for those clients with ambivalence about changing their behaviour. This is done by encouraging the client to consider the good and not so good aspects about drug use.
- *Problem solving* using a variety of techniques such as verbal instruction, written information and skill rehearsal.
- *Relapse prevention and management strategies* encompass cognitive behavioural strategies that provide clients with skills and the confidence to avoid and deal with any lapses. This often involves exploration of high risk situations, mood, thoughts, places, people, situations, and events.

Counsellors should not be limited to cognitive behavioural approaches, particularly with clients with more complex problems, and where possible should integrate interpersonal process work with other approaches.

Program content should:

- address non drug use difficulties or issues raised in the assessment process where appropriate;

- respect treatment matching information and evidence based practice in regard to population groups, but be flexible enough to incorporate the needs of the individual and their goals; and
- link clients to other social services and support networks (such as medical services, housing assistance, parenting classes, employment and recreation services) when required. Agencies should have the necessary pathway and partnerships established.

Non residential and residential treatment services should have a program that includes:

- individual and group therapy;
- stress management;
- social, occupational and assertiveness skills training;
- relapse prevention and management; and
- exploration of harm reduction strategies.

### **3. Assessment**

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 enables treatment evaluation and research.

To enable research and evaluation across AOD services, treatment agencies should use the same core standardised assessment instruments.

#### **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, 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; 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.

### **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.

## **4. Treatment matching**

The fundamental purpose of assessment should be to match the individual client to the appropriate treatment intervention. In treatment matching the following factors need to be considered:

- severity of dependence;
- cognitive functioning'
- life problems;
- client motivation and choice;
- gender, age and cultural issues; and
- support networks.

When matching clients to the appropriate treatment intervention, the following is recommended:

- Clients with a higher degree of dependence should be encouraged to engage in more intensive programs that help to develop a social network not supportive of drinking or drug using.
- Clients with higher levels of alcohol dependence are likely to do better with treatment focused on abstinence rather than controlled drinking.
- Residential treatment programs are more strongly indicated for clients with a lack of stable housing or primary relationships, and those clients with a support network supportive of continued using.
- If a client has a support base encouraging continued drinking or drug using, it is recommended that they consider attending at least three sessions of AA/NA in order to assess its appropriateness.
- Clients with high levels of anger respond better to motivational enhancement treatment.
- Core cognitive behavioural AOD treatment approaches should be adapted to be more behavioural to take account of particular cognitive deficits.
- Methadone maintenance and buprenorphine (Subutex<sup>1</sup>, Suboxone<sup>2</sup>) treatments have been found to be effective for long term users with severe opiate dependence.
- Naltrexone maintenance treatment has been found to be effective for clients highly motivated for abstinence and for those who have networks supportive of ceasing use.
- Counselling interventions should be appropriate to the client's stage of change.

## 5. Treatment plans

Treatment plans should always be devised and documented in case notes.

Treatment plans should be:

- well developed, articulated, written, detailed and clear;
- jointly negotiated between the counsellor and client;
- directly derived from 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:

- 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*).

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<sup>1</sup> SUBUTEX® Reckitt Benckiser.

<sup>2</sup> SUBOXONE® Reckitt Benckiser.

## 6. Goals of intervention

Goals should be negotiated and:

- client directed;
- respectful of client's stage of change;
- clear;
- stated in positive terms;
- realistic and achievable; and
- overall treatment goals to be broken down into their smallest components.

Goals should include:

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

## 7. Harm reduction

Harm reduction strategies are appropriate for clients who continue to use AOD, or who are likely to relapse. Strategies aim to reduce the problems associated with AOD use, such as:

- overdose (eg avoid mixing drugs, using alone etc);
- family violence (eg not to use when you are feeling angry or aggressive, sobering up shelters or to have an escape plan for potential victims of family violence etc);
- driving under the influence of alcohol and other drugs (eg think about alternative methods of transport etc); and
- blood borne viruses (eg use clean injecting equipment etc).

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

- understanding the functions and problems of drug use;
- potential drug AOD harms can fall into categories such as: problems of intoxication, problems of regular use and problems of dependence or 'liver, lover, livelihood, law'; and
- potential risks of polydrug use and the interactions of different drugs.

Motivational interviewing should be used to explore any factors constraining clients' implementation of harm reduction strategies and to reduce any ambivalence around safer using.

## 8. Case management

All clients should be case managed as this provides a holistic approach to client care.

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

Case managers are not expected to provide all aspects of client care, but instead to refer to and facilitate client engagement with other agencies as appropriate.

When adopting a case management approach, it is recommended the counsellor:

- 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; and
- evaluate services provided to clients.

Effective primary and combined case management should involve the following:

- clear and open communication between the professionals involved;
- clarification of the requirements and boundaries of each specialist, which includes what will be communicated to and by the case manager (or team);
- knowledge of other professionals involved and the nature of their involvement in the case;
- a contract (written or verbal) outlining the expectations and boundaries of service provision, methods for ensuring continuity of services during staff turnover, clear lines of authority and control over various aspects of the case management process, a formal record of agencies' agreements and responsibilities; and
- keeping the client informed regarding their case management plan.

## **9. Information and advisory services**

It is important that agencies and counsellors possess information and resources that are up to date and objective. Specific information services need to be readily accessible and attuned to the individual needs of the person using the service.

## **10. Follow up**

Follow up can provide useful support for the client as well as information regarding treatment efficacy, effective components of treatment and relapse rates. It is recommended that the following be considered.

- Despite the difficulties of following up many drug using clients, follow up be conducted.
- Follow up should be arranged within one to three months at the conclusion of treatment.
- Preference should be given to face to face (individual or group) or telephone contact, however, even written contact has benefit.
- The importance of, and format for, follow up procedures should be explained to clients prior to discharge. Clients should be given the option to participate in follow up.
- The follow up session should be scheduled prior to the client leaving the program.
- 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.

## 11. 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 intervention is recommended for clients with:

- a low to moderate dependence on alcohol;
- a dependence on nicotine; or
- a low to moderate dependence on cannabis.

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

- advice on how to reduce drug use or drinking to a safer level;
- the 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.

## 12. Withdrawal management

Withdrawal is the process whereby the body gets used to functioning without a particular drug.

Medication regimes are well established for assisting withdrawal from most drugs of dependence, and medications for symptomatic relief can be for drugs with no established medication regimes.

Withdrawals from significant dependence on alcohol and benzodiazepines can be dangerous and potentially life threatening unless managed with medication. Withdrawal from significant dependence on these drugs should therefore always be under medical supervision.

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

Specialist inpatient withdrawal is most appropriate when:

- 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 withdraw as an outpatient have been unsuccessful;
- there is a lack of social support; or
- the client is pregnant.

Outpatient withdrawal is most appropriate when:

- 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; and
- the client is strongly motivated for abstinence.

Clients and support people should be provided with information about what to expect from withdrawal prior to engaging in the process, and be assisted to develop a plan to cope with the process. Booklets for clients are available.

For outpatient withdrawal, ensure significant others are also informed of what to expect and are given some help regarding how to cope. Home withdrawal services can assist in many cases.

When there is dependence on more than one drug, withdrawal should occur from one drug at a time.

Ideally withdrawal should be a gateway to further treatment, including a link to ongoing treatment services or relapse prevention pharmacotherapies.

Non using significant others should be engaged as supports.

Pregnant women should be referred to a specialist drug and alcohol service and be linked with obstetric service as withdrawal from some drugs places the pregnancy at risk, and withdrawal should usually occur in a specialist inpatient setting.

### **13. Therapeutic communities**

TC treatment is associated with reduced drug use and criminality even two years post treatment, significantly improved psychological and physical health, and trends to increased involvement in work, education and training.

TC treatment should be considered for clients who:

- engage in high risk AOD use;
- have long AOD use histories;
- are significantly cognitively impaired;
- are homeless;
- have social and living environments not supportive of abstinence;
- have insufficient education or work skills to earn a living; and
- are motivated for abstinence.

Therapeutic community programs should be broad based and include:

- introductory programs to prepare clients;
- individual and group counselling;
- the facilitation of access to medical facilities;
- employment, education and skills training;
- life skills training (cooking, budgeting etc) ;
- entry into non drug using community groups and activities of interest, psychiatric facilities and legal services (where appropriate);
- a reintegration program; and
- well coordinated aftercare services.

They should also consider including additional elements as appropriate for individual clients such as:

- parenting training;
- treatment for psychological disorders;
- family involvement; and
- culture-specific variations.

## **14. 12-Step self help groups**

12-Step groups such as AA and NA can be helpful and lead to better treatment outcomes. Therefore:

- all counsellors should be familiar with 12 Step groups in their area and should facilitate referrals for clients where appropriate;
- irrespective of the theoretical orientation of the agency or its counsellors, 12 Step groups should be considered as an option for support for some clients; and
- all clients with inadequate non substance using social support networks, or with high levels of dependence, should be made aware of AA and/or NA, and if they are willing to consider the goal of abstinence they should be encouraged to attend for at least three visits.

## **15. Sobering up centres**

Sobering up centres provide a safe, care oriented environment in which persons found drunk in public may sober up, thereby reducing the risk of harm to themselves or others and diverting them from police lock ups.

Sobering up centres should:

- provide a safe place where an intoxicated person may receive care and respite until the effects of the substances consumed has dissipated;
- offer clients a shower, clean bed, laundering of clothes (worn by the person at admission), and regular observations to ensure that the client is sobering up safely;
- provide clients with a link to further treatment and other health and welfare services when there is an opportunity to do so;
- have the support of local police and other community patrols and health, welfare and community groups for effective operation; and
- be established following a community development process, whereby all local key stakeholders are consulted and included.

The following is recommended for staff of sobering up centres:

- Training in first aid, including recognition of medical conditions requiring hospital referral, management of intoxicated people, critical incidents and in procedures associated with observation; and
- The ability to recognise symptoms of a severe withdrawal syndrome and access medical services if required.

## **16. Pharmacotherapies for dependence**

### **16.1 Opioid dependence**

Pharmacotherapies for opiate dependence should not be seen as stand alone treatments but used in conjunction with other treatment components such as counselling.

Clients with 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 neonatal abstinence syndrome is milder than that associated with methadone.

### **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.

## 16.2 Alcohol dependence

Pharmacotherapies for alcohol dependence should not be seen as stand alone treatments but used in conjunction with other treatment components such as counselling.

Clients with alcohol 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.

### 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.

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.

### 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.

## 17. Methamphetamine

When working with clients using methamphetamine the following is recommended.

- As intoxicated and withdrawing amphetamine users can present with potentially violent and aggressive behaviour counsellors should be trained in how to respond to challenging behaviour.
- Given that psychotic symptoms are more likely to be present and persistent in clients with long-term methamphetamine use, it is recommended that these clients be screened for psychotic

disturbances

- Methamphetamine withdrawal can be inpatient or outpatient, depending on the client's medical, psychiatric and social functioning. It does not necessarily entail medication, but may involve medication with benzodiazepines, antidepressants or antipsychotics.
- 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.
- Heavy, prolonged methamphetamine use is associated with cognitive deficits which hold significant implications for the content, process and outcome of counselling. 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.

## **18. Clients with complex issues**

Clients with complex issues are common in alcohol and other drug treatment. When working with this client group it is recommended that:

- greater attention is paid to personal and social issues beyond drug using per se; and
- a case management approach be integrated into the client's treatment, ensuring referral to and liaison with appropriate services, including medical and psychiatric practitioners and social welfare agencies.

## **19. Co-occurring mental health issues**

Co-occurring psychological disorders are common in clients presenting for AOD treatment. When working with this client group, counsellors should consider the following.

- Clients presenting for alcohol and drug treatment may exhibit any one of a range of disorders along this continuum, ranging from the less severe (mild anxiety disorders) to the more severe (psychotic disorders).
- It is often difficult to establish the causal connection between substance abuse and psychological disorders.
- Psychiatric intervention should be sought for those clients with more complex co-existing psychiatric disorders.
- Liaison with appropriately trained medical and allied health personnel and mental health service providers should occur.

## **20. Depression**

Although there is a strong relationship between the experience of depression and AOD difficulties, the relationship is complicated and causality can be difficult to establish.

Counsellors should endeavour to target symptoms of depression during treatment to avoid the risk of relapse.

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.

## **21. Anxiety**

Although there is a strong relationship between the experience of anxiety and AOD difficulties, the relationship is complicated and causality can be difficult to establish.

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 respond to AOD clients who suffer from PTSD.

## **22. Sexual abuse and other trauma**

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.

## **23. Cognitive impairment**

When working with clients who are cognitively impaired counsellors should consider the following.

- Long term heavy use of some commonly used drugs, particularly alcohol and methamphetamine, can lead to cognitive impairment.
- Cognitive impairment is associated with poorer treatment outcome
- Cognitive impairment is often not obvious upon presentation, yet can still significantly impact on treatment progress and outcome
- Depending on the degree of severity of suspected cognitive damage, counsellors may wish to refer clients to a clinical or neuropsychologist for further assessment. The purpose of such a referral should be clear to the client and the counsellor.
- Interventions should be adapted as appropriate for people with cognitive deficits. In general simple and straightforward behavioural type interventions are most appropriate for people with cognitive damage.
- Abstinence is often a more realistic goal than controlled drinking or reduced drug use.

## **24. Coerced clients**

The literature indicates similar outcomes are achieved with coerced clients and “voluntary” clients.

When working with coerced clients attention should be given to the following:

- awareness of potential conflicts between what they perceive to be best for the client and what the referral body requires;
- ensuring clarity regarding the limits of confidentiality and the nature of activities that will be reported to the third party, and to communicating this to clients prior to the onset of counselling;
- recognition of legitimate client interests as well as the negotiable and non negotiable aspects of interventions is the basis for negotiating a case plan and agreed criteria for progression;

- acknowledging resistance and negotiating the therapeutic relationship accordingly; and
- including harm reduction as a strong focus of any intervention and clarifying harm reduction options with the statutory agency.

## **25. Incarcerated clients**

As for working with coerced clients, when working with incarcerated clients attention should be given to the following.

- awareness of potential conflicts between what they perceive to be best for the client and what the referral body requires;
- ensuring clarity regarding the limits of confidentiality and the nature of activities that will be reported to the third party, and to communicating this to clients prior to the onset of counselling;
- recognition of legitimate client interests as well as the negotiable and non negotiable aspects of interventions is the basis for negotiating a case plan and agreed criteria for progression;
- acknowledging resistance and negotiating the therapeutic relationship accordingly; and
- including harm reduction as a strong focus of any intervention and clarifying harm reduction options with the incarcerating agency.

## **26. Significant others**

Significant others (parents, partners, families and friends) can be included:

- as clients in their own right; and
- as part of an individual client's AOD treatment.

AOD agencies and counsellors should have a sound understanding of family sensitive practice.

### ***Working with significant others as clients in their own right***

- Parents, partners, families and friends 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 AOD user to seek assistance.
- Accurate AOD information and support should be provided to this group.

### ***Working with significant others 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.
- It is often appropriate for significant others to be seen by a counsellor who is not seeing the problem AOD user.
- Counsellors need to be clear about client confidentiality as significant others often seek information regarding the progress of the client.

Counselling should be oriented around (although not limited to) the following:

- assisting the family member to reduce their level of stress and anxiety;
- helping develop interactions that encourage self responsibility and promote positive change in the drinking/drug use behaviour;
- assisting the family member to deal with conflict in relationships; and

- helping the family member develop coping strategies to minimise the negative impact of the substance use on themselves and enhance their quality of life;

When working with parents, anxiety, depression and grief should be acknowledged prior to providing advice and working on child/parent strategies. Interventions should initially concentrate on reducing anxiety and feelings of isolation, and increasing confidence in managing their situation.

Once these issues have been addressed, work on child/parent strategies can commence. Specific strategies should include:

- 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;
- 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; and
- behavioural contracts.

## 27. Young people

Agencies and counsellors should work from an understanding of the developmental processes that characterise adolescence, and from a thorough assessment of the risk and protective factors which provide the context for the AOD use and related problems.

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.

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:

- 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.

## 28. Child protection

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
- helping improve 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](#)<sup>3</sup> 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.

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<sup>3</sup> Available from Drugnet website: <http://www.drugnet.bizland.com/assessment/checklis1.htm>

## **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 involve 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.

## **29. Women**

When working with women it is recommended that:

- the option of a female counsellor be available;
- counsellors are sensitive in assessment and handling of issues of sexual abuse and domestic violence;
- women are linked to support groups and additional support services as this improves outcome;
- where possible, women are enabled to participate in women-only groups as this tends to improve outcome;
- where possible, women only groups should be incorporated as part of a group program;
- programs pay attention to the full range of health (physical and emotional), justice and welfare issues that women may be facing;
- treatment services assist with the provision of child care where needed; and
- women are offered separate bedroom and bathroom facilities in residential services with mixed gender services.

## **30. Pregnant women**

When working with pregnant women it is recommended that:

- counsellors remain cognisant of the increased levels of shame and stigmatisation that drug using pregnant women suffer;
- counsellors not encourage the sudden cessation of any drug use, especially methadone, as withdrawals can endanger the pregnancy; and
- counsellors need to facilitate client's engagement with appropriate medical personnel and referral to appropriate antenatal services.

## **31. Men**

When initially engaged in a therapeutic relationship, men generally respond well to a cognitive behavioural intervention style. However, treatment should not be limited to this approach.

When working with men the following is recommended that:

- counsellors are sensitive in their assessment of issues of past sexual or other abuse;
- counsellors be aware of the lethality of male suicide attempts and always explore suicidal ideation;
- where appropriate, men are encouraged to examine consequences of anger, violence, or domestic violence;
- where appropriate, anger management strategies are incorporated in the intervention;

- men are encouraged to examine alternative coping skills to alcohol and other drug use; utilisation of cognitive behavioural strategies is recommended; and
- where possible, men are included in mixed gender groups with women who also choose to be in mixed gender groups.

## **32. Culturally and linguistically diverse**

When working with people who are culturally and linguistically diverse the following is recommended.

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 service (ethnospecific or bilingual such as a migrant resource centre) not having sufficient AOD knowledge; and
- 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.

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 a 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 b 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.

## **33. Aboriginal people**

Only culturally secure ways of working should be used when 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.

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.

## **34. Confidentiality**

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 themselves 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 also consider the following in relation to confidentiality.

- Counsellors may also be required to disclose information regarding coerced clients, or clients who are minors.
- Counsellors should 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.
- 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.

## **35. Supervision and professional development**

Supervision and professional development is an important aspect of any treatment service as it assists in the maintenance and improvement of counsellors' standard of practice.

Supervision and professional development can include both self directed and agency facilitated learning. Individual and whole of agency approaches should complement each other. This includes:

- intentional on the job learning, including regular clinical supervision for all counselling staff by experienced clinicians, peer supervision and coaching where appropriate and possible, scheduled time for presentations and case discussions etc;
- supervision in the form of line management to educate staff in agency requirements and manage performance;
- incorporation of action learning and coaching methodologies;
- tailored professional development and training to suit the individual and group needs of staff, and is followed up with workplace integration;
- on the job learning and resources, such as videos, journals, web sites and books that are easily accessible by staff who have scheduled time for this purpose;
- opportunistic learning such as case discussions, informal dissemination of new information and impromptu presentations are features of a learning workplace;
- using successes and mistakes as learning opportunities; and
- acknowledging and making explicit individual and agency gains from the professional development program.

## **36. Ensuring service quality**

Quality improvement programs involve a continuous process development, review, implementation and modification of policies and procedures to improve clinical practices.

Staff are encouraged to be centrally involved in all aspects of the process.

The development of policies and procedures involves wide consultation within and outside the agency, including with consumers.

AOD agencies should be involved in a quality improvement program.

## **37. 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.

For AOD treatment evaluation purposes, there is general agreement about a number of key domains of client functioning for standardised assessment. These domains include:

- alcohol and drug use: quantity and frequency, level of dependence;
- blood borne virus risk exposure and behaviour;
- general health;

- social functioning;
- psychological functioning;
- criminality;
- engagement in treatment and treatment completion; and
- client satisfaction with treatment.

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 Service Quality*). There should be a 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.