



Government of **Western Australia**  
Mental Health Commission

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# Counselling guidelines: Alcohol and other drug issues

**Fourth Edition 2019**

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## Abbreviations and acronyms

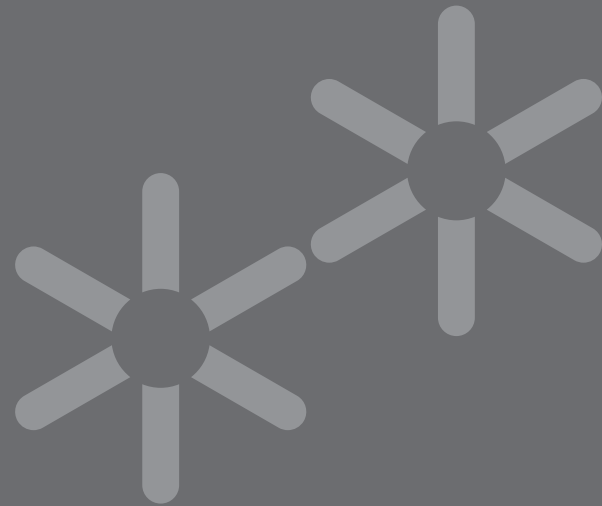
5As	Ask, Assess, Advise, Assist and Arrange [model]
ABS	Australian Bureau of Statistics
ACE	Adverse childhood experience
ACE-R	Addenbrooke's Cognitive Examination-Revised
ACSA	Amphetamine Cessation Symptom Assessment Scale
ACT	Acceptance and commitment therapy / Australian Capital Territory
ADF	Alcohol and Drug Foundation
ADHD	Attention deficit hyperactivity disorder
AIDS	Acquired immunodeficiency syndrome
AIHW	Australian Institute of Health and Welfare
AIVL	Australian Injecting and Illicit Drug Users League
AOD	Alcohol and other drug
ASSIST	Alcohol, Smoking, and Substance Involvement Screening Test
ATS	Amphetamine-type stimulants
AUDIT	Alcohol Use Disorders Identification Test
BAC	Blood alcohol concentration
BBV	Blood-borne virus
BI	Brief intervention
BMI	Brief motivational interview
CALD	Culturally and linguistically diverse
CBT	Cognitive behaviour therapy
CF	Compassion fatigue
CI	Cognitive impairment
CIWA-Ar	Clinical Institute Withdrawal Assessment Scale – Alcohol, revised
CIWA-B	Clinical Institute Withdrawal Assessment Scale – Benzodiazepines
CNCP	Chronic non-cancer pain
CNS	Central nervous system
COWS	Clinical Opiate Withdrawal Scale
CPR	Cardiopulmonary resuscitation
CPFS	Child Protection and Family Support [WA]
CPOP	Community Program for Opioid Pharmacotherapy [WA]
CRT	Cognitive rehabilitation therapies
CSAT	Center for Substance Abuse Treatment [USA]
DAMEC	Drug and Alcohol Multicultural Education Centre
DARN	Desire, ability, reason, and need
DASS	Depression Anxiety Stress Scale
DAST	Drug Abuse Screening Test
DSM	Diagnostic and Statistical Manual of Mental Disorders
EARS	Elaboration, affirming, reflecting and summarising
EPE	Elicit-provide-elicited
FARE	Foundation for Alcohol Research and Education
FASD	Fetal alcohol spectrum disorder
FIT	Feedback-informed treatment
FRAMES	Feedback, Responsibility, Advice, Menu, Empathy and Self-efficacy [model]
GABA	Gamma-aminobutyric acid

GAD	Generalised anxiety disorder
GMT	Goal management training
GP	General practitioner
HIV	Human immunodeficiency virus
ICD	International Classification of Diseases
ICD 11	International Classification of Diseases 11
LGBTI	Lesbian, gay, bisexual, transgendered and intersex
MDD	Major depressive disorder
MDFT	Multidimensional family therapy
MDMA	Methylenedioxymethamphetamine [ecstasy]
MHC	Mental Health Commission [WA]
MoCA	Montreal Cognitive Assessment
MI	Motivational interviewing
MSE	Mental State Examination
NADA	Network of Alcohol and Other Drug Agencies
NCETA	National Centre for Education and Training on Addiction
NRT	Nicotine replacement therapy
NSEP	Needle Syringe Exchange Program
NSP	Needle Syringe Program
NSW	New South Wales
OARS	Open questions, affirmations, reflections and summaries
OBI	Opportunistic brief intervention
OWL	Older Wiser Lifestyles [Program]
PCL	PTSD Checklist
PDD	Persistent depressive disorder
PFA	Psychological first aid
PTSD	Post-traumatic stress disorder
RC	Recovery capital
SAD	Social anxiety disorder
SAMHSA	Substance Abuse and Mental Health Services Administration [USA]
SBIRT	Screening, Brief Intervention, and Referral to Treatment
SOWS-Gossop	Short Opiate Withdrawal Scale
SRS	Session Rating Scale
STI	Sexually transmitted infection
STS	Secondary traumatic stress
SUD	Substance use disorder
TGA	Therapeutic Goods Administration
UK	United Kingdom
VBI	Very brief intervention
VPTG	Vicarious posttraumatic growth
VT	Vicarious trauma
WOW	Ways of Working with Aboriginal people [Program]
WA	Western Australia
WHO	World Health Organization

# 1

## Section One: Setting the scene

- 1 Introduction
- 2 Principles of effective treatment
- 3 Ingredients of effective treatment
- 4 Best practice outcome performance indicators





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# 1. Introduction

## Development of the fourth edition

The Counselling guidelines: Alcohol and other drug issues were first published in 2000, and written by Ali Dale and Ali Marsh (Curtin University, School of Psychology, and the Drug and Alcohol Office). The second edition was revised by Ali Marsh (Curtin University of Technology, School of Psychology, and the Drug and Alcohol Office) and Laura Willis (Curtin University School of Psychology). The third edition was revised by Ali Marsh (Drug and Alcohol Office) and Stephanie O'Toole (University of Western Australia) with advice and editing by Sue Helfgott (Drug and Alcohol Office) and the addition of two chapters by other authors.

This fourth edition was developed following consultation with the alcohol and other drug (AOD) sector through an electronic survey, consultation meetings and a focus group. New chapters were added, including Counselling using technology, Older people, and other chapters were expanded, such as the chapter on gender, which is now Gender and sexual diversity.

Some chapters from the previous edition were not included in this edition. Most notably, the decision was made not to include specific drug-related chapters or a chapter on prevention. The reason was that there is a range of excellent evidence-based easily-accessible resources available on drugs and prevention, some of which are listed in Appendix 1. Some types of drugs, such as emerging psychoactive substances, are changing rapidly, with current information at risk of becoming quickly out of date.

This edition was also influenced by current issues in the AOD sector, such as the need to respond to clients with multiple complex needs including trauma and co-occurring mental health conditions; rising opioid overdose rates and the availability of naloxone; the changing meaning of recovery in the AOD sector; an ageing population; and the use of technology in counselling. The changes are consistent with the priorities outlined in *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025: Better Choices. Better Lives*, such as recovery-oriented practice and the need to work in a more holistic and integrated way. Other policy documents which influenced this edition include the *National Alcohol and Other Drug Workforce Development Strategy 2015-2018* and the *Western Australian Mental Health, Alcohol and Other Drug Workforce Strategic Framework: 2018-2025*, which both acknowledge the need to build the capacity of the AOD sector to respond to co-occurring issues and older people who use AOD.

This edition of the Counselling guidelines is consistent with the definition of harm reduction in the *National Drug Strategy 2017-2026*: “reducing the adverse health, social and economic consequences of the use of drugs, for the user, their families and the wider community” (Department of Health, 2017, p. 1). The Counselling guidelines addresses the priority populations outlined in the National Drug Strategy.

The previous edition was updated to include current research and evidence-informed practice. The revised chapters underwent expert review. The reviewers are recognised on the Acknowledgements page.

References are located at the end of each chapter. As in the previous edition, appendices are located at the end of the *Counselling guidelines*. The appendices contain forms and other resources that can be used with clients.

This edition is divided into six sections, as follows.

- **Setting the scene:** includes the Introduction, which outlines the process undertaken to develop the *Counselling guidelines*, and their purpose. It provides overarching concepts covered in the chapters Principles of effective treatment and Ingredients of effective treatment.
- **Professional practice:** incorporates essential elements of professional counselling practice, including chapters on Confidentiality, Case notes, Clinical supervision, Case management, Stress and burnout and Secondary traumatic stress, compassion fatigue and vicarious trauma.
- **AOD knowledge and skills:** includes chapters with information specific to AOD issues, including Managing intoxicated clients, Withdrawal management and Pharmacotherapies for AOD dependence.

- **Assessment and treatment planning:** includes chapters on Treatment planning, Assessment, Recovery, Case formulation and other key processes that inform assessment and treatment planning.
- **Counselling interventions:** includes chapters on strategies and interventions that counsellors can use when working with clients with AOD-related issues. Chapters include Motivational interviewing, Problem-solving, Goal-setting, Harm reduction, Relapse prevention and management, and a range of other strategies that are effective in working with people who use AOD.
- **Working with specific issues:** clients often present with co-occurring conditions which can have a significant impact on their AOD use. The chapters in this section include Co-occurring AOD and depression, Co-occurring trauma issues, Gender and sexual diversity, Pain management for dependent clients, Aboriginal clients, their families and communities, AOD use and pregnancy, and Child protection and parenting issues.

## Purpose of the guidelines

This edition of the *Counselling guidelines* explores the key skills needed to work with individuals who have AOD-related issues. The *Counselling guidelines* assumes the reader has a basic understanding of the development of AOD issues and already possesses basic counselling skills.

The *Counselling guidelines* can be used by counsellors and other workers in the specialist AOD sector and other sectors such as mental health, health, human and community services. Managers, supervisors and counsellors are encouraged to use this resource as a reference, an educational tool and as an aid to quality management and professional supervision.

While the *Counselling guidelines* provides an overview of skills and knowledge for working with clients who use AOD, it is not a substitute for counsellors' own deeper exploration of topics. Ongoing further reading and professional development is strongly recommended.

## Feedback welcome

If you would like to provide feedback on the fourth edition of the *Counselling guidelines: alcohol and other drug issues*, please contact Workforce Development, Mental Health Commission (MHC) via email at [AOD.training@mhc.wa.gov.au](mailto:AOD.training@mhc.wa.gov.au) or phone on (08) 6553 0560.

## References

Department of Health. (2017). *National Drug Strategy 2017-2026*. Canberra, ACT: Commonwealth of Australia.

Intergovernmental Committee on Drugs. (2014). *National Alcohol and Other Drug Workforce Development Strategy 2015-2018: A Sub-strategy of the National Drug Strategy 2010-15*. Retrieved from <http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/naodwds2015-18>

Mental Health Commission, Western Australia (MHC). (2015). *Western Australian Mental Health, Alcohol and Other Drug Services Plan 2015-2025: Better Choices. Better Lives*. Perth, Western Australia: Author.

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## 2. Principles of effective treatment

AOD treatment has been researched extensively and its efficacy and effectiveness are well established. Treatment reduces AOD use, improves health, reduces criminal activity, and improves wellbeing and community participation (Ritter et al., 2014). The principles of effective treatment listed below are adapted from the National Institute on Drug Abuse's 'Principles of Drug Addiction Treatment' (2013), and the Victorian Alcohol and Drug Treatment Principles (State of Victoria, Department of Health, 2013).

- Substance dependence is a complex but treatable condition that affects brain function and influences behaviour. These changes can persist long after drug use ceases, which might account for the long-lasting risk of relapse. While lapse and relapse are common but not inevitable features of changing AOD-using behaviours, they can also offer valuable learning opportunities for consumers.
- All service providers must adhere to the highest ethical standards.
- No single treatment approach is appropriate for everyone. Treatment options should include a variety of evidence-based and evidence-informed biopsychosocial approaches, interventions and modalities oriented towards people's recovery (see chapter on **Recovery**). A responsive service system requires a range of approaches to meet people's diverse needs. Treatment should build on each person's own strengths, resilience and resources.
- Treatment needs to be readily available. Because people using AOD tend to be ambivalent about entering treatment, it is important that services are available for them when they are ready for treatment. Earlier access to treatment is associated with more positive outcomes.
- Treatment system needs to be visible, accessible from multiple points of entry and available in a timely manner. Treatment should be provided equitably and without prejudice to diverse populations (e.g. Aboriginal and Torres Strait Islander peoples; culturally and linguistically diverse (CALD) communities; women/parents with young children; people with disabilities; people with diverse sexual orientations; people engaged in the corrective services system) and in diverse locations (e.g. metropolitan, rural and remote).
- Family members and people who are significant to the client need to be engaged in the treatment process (with the client's approval). AOD treatment also needs to address the needs of family members (including dependent children) and significant others.
- Consumers and families should experience treatment as welcoming, accepting, non-judgmental and responsive.
- Effective treatment attends to the multiple needs of the individual, not just his or her AOD use issues. Effective treatment addresses medical, psychological, social, vocational and legal issues in addition to the AOD use. This approach is person-centred and supports people to be active and equal participants and partners in their treatment planning, taking into account their age, gender, family, significant others, cultural circumstances and any other needs.
- Remaining in treatment for an adequate period of time is critical. The optimal length of time in treatment varies from person to person and lapse or relapse is common. Successful treatment often involves multiple episodes of treatment over a long period of time. Programs should include active strategies to engage and retain clients in treatment, as well as aftercare follow-up and support, and re-entry as needed.
- Medications are an important element of treatment for many clients, especially when combined with counselling and other behavioural therapies. Medications can include addiction pharmacotherapies (e.g. methadone) or medications for psychological issues such as anxiety or depression.
- An individual's treatment plan must be continually assessed and modified as necessary to ensure that it meets their changing needs. As such, treatment systems should articulate clear care pathways; deliver early intervention, prevention and harm reduction; involve treatment of appropriate mix and duration; and include post-treatment follow-up. Abstinence from alcohol, tobacco or other drugs is not the only goal that many individuals seek to achieve through treatment.

- Many individuals with AOD issues also have co-occurring mental health issues. Therefore, clients presenting with either AOD or mental health issues should be assessed and treated for both. Treatment should include the use of medications as appropriate.
- The experiential knowledge of AOD consumers (including clients) and their family members should inform all levels of the AOD treatment system, including policy development, service planning, service development and delivery, and continuous quality improvement. The value of experiential knowledge must be acknowledged and supported within organisations and programs.
- Withdrawal management (medically assisted and non-medically assisted) may only be the first stage of AOD treatment and by itself does little to change long-term drug dependence. Clients should be encouraged to continue drug treatment following withdrawal. Interventions, beginning at initial intake, can improve treatment engagement and outcomes.
- Counselling – individual and/or group – and other behavioural therapies are the most common forms of AOD treatment. They vary in their focus and include basic addiction counselling strategies (e.g. motivational interventions, relapse prevention and management) as well as strategies to teach problem-solving, to assist with developing better relationships and developing alternative non-drug rewards and activities. Group therapy and peer support programs can also help maintain AOD use changes.
- Treatment does not need to be voluntary to be effective. Sanctions or enticements from family, employment settings and/or the criminal justice system can significantly increase treatment entry, retention rates and the ultimate success of drug treatment interventions. While there are situations where treatment is mandated, choice and motivation should still have a fundamental role.
- As lapses during treatment for AOD use occur, drug use during treatment should be monitored. Monitoring can assist clients in their efforts to change and can also provide an early indication of a return to past patterns of drug use, signalling a possible need to adjust the treatment plan.
- Treatment programs should discuss and support clients wanting to be screened for the presence of human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), hepatitis B and C, tuberculosis and other infectious diseases. They should also provide targeted harm reduction counselling to help clients modify or change behaviours that place them at risk of contracting or spreading infectious diseases.
- AOD policy and practice must be informed by a robust evidence base. The timely transfer of knowledge between research and practice is a critical enabler of evidence-informed policy and practice. Resource allocation which supports sector innovation and evaluation is encouraged to complement the existing evidence base.
- Service providers should ensure that trauma-informed policies are embedded in all aspects of service provision. Many AOD-using clients have significant trauma histories and policies need to be enacted to reduce the risk of re-traumatisation within services. All staff should be trained in trauma-informed care and practice.

## References

- National Institute on Drug Abuse. (2013). *Principles of drug addiction treatment: A research-based guide* (3rd ed.). Washington, DC: U.S. Department of Health and Human Services. Retrieved from <http://www.drugabuse.gov/publications/principles-drug-addiction-treatment>
- Ritter, A., Berends, L., Chalmers, J., Hull, P., Lancaster, K., & Gomez, M. (2014). *New horizons: The review of alcohol and other drug treatment in Australia*. Sydney, NSW: National Drug and Alcohol Research Centre.
- State of Victoria, Department of Health. (2013). *Victorian alcohol and drug treatment principles*. Melbourne, VIC: Author.

### 3. Ingredients of effective treatment

This chapter provides a brief overview of issues central to effective AOD counselling. These include:

- developing a strong therapeutic alliance
- assessment, case conceptualisation and treatment planning
- effective case management
- specific interventions responding to co-occurring issues
- terminating treatment sensitively
- professional development and supervision.

#### A strong therapeutic alliance

The general psychotherapy and the addiction literature highlight the importance of the therapeutic alliance to treatment outcome (e.g. Andrews, 2001; Ardito & Rabellino, 2011; Meier, Barrowclough, & Donmall, 2005). In particular:

- the strength of the therapeutic alliance is consistently predictive of positive outcomes, including engagement and retention of clients in treatment
- the link between alliance and outcome is independent of the type of treatment used, and the alliance is dependent upon the interaction between client and counsellor.

A sound therapeutic relationship is the foundation of successful intervention and enables communication of respect, understanding, warmth, acceptance, commitment to change and a corrective interpersonal experience (Teyber, 2006). 'Corrective interpersonal experience' means that the counsellor responds to the client in empathic and helpful ways that are different from previous hurtful experiences they have had with others, which may include their family of origin. A sound therapeutic relationship is collaborative, with counsellor and client working as partners to help the client achieve their goals.

Counsellors' qualities affect the therapeutic alliance. Therapist qualities and techniques found to make a positive contribution to the therapeutic alliance (Ackerman & Hilsenroth, 2003, p. 28) are listed below.

Personal attributes:

- |               |               |              |           |
|---------------|---------------|--------------|-----------|
| • flexible    | • respectful  | • interested | • warm    |
| • experienced | • trustworthy | • alert      | • open    |
| • honest      | • confident   | • friendly   | • curious |

Techniques:

- |               |   |                                     |
|---------------|---|-------------------------------------|
| • exploration | • use of notes about past therapy success | • affirmation                       |
| • depth       | • accurate interpretation                 | • understanding                     |
| • reflection  | • facilitation of expression of affect    | • attendance to client's experience |
| • support     | • active listening                        |                                     |

Other tips for improving the therapeutic alliance (adapted from Macneil, Hasty, Evans, Redlich, & Berk, 2009) are:

- tailor interventions to the client's readiness for change
- ask about previous treatment experiences, positive and negative, to guide counselling
- see the whole person: explore their strengths as well as their challenges
- understand how the client sees their issues and experiences, as these will form the basis for goals the client will be comfortable with
- avoid labels where possible; instead, use language that captures a shared understanding of the client's situation
- encourage realistic hope and optimism – a client needs to expect the treatment will be effective to be able to engage, but providing false hope will damage the alliance
- care about your clients – "let the patient matter to you" (Yalom, 2002, p. 28)

- within clear and reasonable limits, be available to clients
- mend therapeutic ruptures, as they can be a signal of discord in the therapeutic alliance (Miller & Rollnick, 2013)
- put in the effort needed to manage the ongoing therapeutic relationship.

Client factors also influence the therapeutic alliance and its outcomes, including the degree to which clients are open about their issues and personal information and the client's willingness to undertake tasks (Macneil et al., 2009).

## Assessment, case conceptualisation and treatment planning

Assessment, case formulation and treatment planning are central to developing an understanding of the client's issues and how best to address them.

- Assessment refers to the process of identifying the client's presenting issues and gaining an understanding of how they fit with their history and current circumstances (see chapter on **Assessment**).
- Case formulation involves using a theoretical framework to integrate the information gathered from an assessment into an explanation of how the client's presenting issues are caused and maintained. Central to a good case formulation is developing a clear understanding of the meaning and functionality of the client's AOD use. A clear case formulation indicates the causal and maintaining factors that a treatment plan must address to help the client resolve their presenting issues (see chapter on **Case formulation**).
- Treatment planning entails developing a written plan of the services and resources that the client will be assisted to access so they can address the factors that maintain their AOD issues. A treatment plan should include strategies to address AOD issues, such as counselling or perhaps referral for withdrawal or long-term rehabilitation, and strategies to address issues in other areas of a person's life such as psychological, social, health, legal, accommodation and financial issues. In more recent times, feedback-informed treatment (FIT) has accrued a significant body of evidence supporting its utilisation in the counselling field. Through FIT, clinicians gather real-time input from clients through structured yet flexible measures that identify what is and is not working in therapy, and how to better meet clients' needs (Prescott, Maeschalck, & Miller, 2017) (see chapter on **Treatment planning**).

## Effective case management

Case management involves the coordination of resources and services to help clients to overcome their AOD issues. Case management prolongs treatment retention and increases clients' use of community-based services, quality of life and treatment satisfaction (Vanderplasschen et al., 2007). When clients have complex needs, the counsellor's primary role may initially be that of a case manager, linking the client to appropriate welfare, legal and social services. Adopting this role can strengthen the therapeutic relationship and help the client to develop the life circumstances that will give them the best chance at success (see chapter on **Case management**).

## Specific interventions

Counselling works, as evidence in the general psychotherapy and the addiction literature shows. However, there is no evidence that any particular theoretical approaches to counselling are better than others. Wampold and Imel (2015) suggest that "when counseling approaches are directly compared on their effectiveness, no approach has emerged as being more efficacious than any other" (p. 272). From this perspective, counselling consists of matching clients to a theoretical model/rationale that both the counsellor and client agree upon, focusing on building the relationship (alliance), developing client expectations, and applying interventions that are consistent with the agreed-upon rationale. However, some theoretical approaches, such as cognitive behaviour therapy (CBT) and interpersonal therapy, have been more thoroughly researched and have a better evidence base.



All theoretical orientations to counselling advocate the use of techniques that play a small but important role in successful intervention. Counselling techniques strengthen the client's expectations of change by heightening the credibility of counselling, and providing a rationale and strategies for change, which can diminish the client's sense of hopelessness and increase thoughts of positive outcomes (Lewis, 2017).

In considering what approach to adopt with a client, counsellors should be guided by the:

- best existing research evidence
- clinical wisdom and expertise
- client circumstances, needs and expectations (Gambrill, 1999).

## Addressing co-occurring issues

Many AOD clients present with diagnosable mental health disorders that may interfere with AOD treatment progress. Many clients also present with symptoms of mental health disorders such as anxiety or depression, but do not meet criteria for a diagnosable disorder. These mental health symptoms can impact on client functioning and AOD treatment progress and outcome (Sterling et al., 2011). Therefore, it is important that counsellors are alert for symptoms of mental health disorders and that they help clients with these issues. Depending upon the severity of the mental health issues, counsellors should consider integrating strategies to address them into their AOD counselling and/or referring clients for medication or specialised psychological services. Some strategies to help clients with mental health issues are covered in later chapters in this guide (see chapters on **Co-occurring AOD and depressive disorders**, **Co-occurring AOD and anxiety**, **Co-occurring trauma issues**, **Anger management**, **Mindfulness**).

## Managing termination

Recognising the importance of the counselling relationship also raises the issue that counselling relationships end. As with working with other painful client themes, issues and emotions that arise for clients in ending longer-term counselling relationships need to be responded to with empathy, and often with exploration of their similarities to and differences from past experiences.

Essentially, the key principles of ending a counselling relationship are (Teyber, 2006):

- letting clients know about the ending well in advance (4–5 weeks if possible)
- inviting clients to express and explore both positive and negative feelings about ending and responding non-defensively to those feelings by reacting with empathy and acceptance
- exploring with clients the meaning that the end has for them and for the counsellor.

When a client is nearing completion of a counselling program, it can be helpful to spread the final few sessions out over a longer period of time so as to gradually reduce the frequency of contact. However, if a counsellor is leaving the service and referring the client to another counsellor, spreading out the final sessions is usually not appropriate.

It is important to review and highlight clients' improvements, how they've achieved these changes and what they can do to maintain them or to deal with lapses, as well as the client's strengths. Clients should also be encouraged to recontact the agency (or clinician if appropriate) in future if necessary (and if agency policy permits).

Norcross, Zimmerman, Greenberg, and Swift (2017) developed a useful checklist for workers in the ending phase of the therapeutic relationship – see Appendix 2.

## Professional development and supervision

Finally, professional development is an important aspect of general counselling. Continuous reflective practice, supervisory support and other professional development methods are associated with better outcomes (see chapter on **Clinical supervision**).

## Ingredients of effective treatment – tip sheet

Effective AOD counselling requires:

- a strong therapeutic alliance
- assessment, case conceptualisation and treatment planning
- effective case management
- specific interventions where appropriate
- feedback-informed treatment
- responding to co-occurring issues
- terminating treatment sensitively
- professional development and supervision for clinicians.

## References

- Ackerman, S. J., & Hilsenroth, M. J. (2003). A review of therapist characteristics and techniques positively impacting on the therapeutic alliance. *Clinical Psychology Review, 23*(1), 1–33. [https://doi.org/10.1016/S0272-7358\(02\)00146-0](https://doi.org/10.1016/S0272-7358(02)00146-0)
- Andrews, H. (2001). Back to basics: Psychotherapy is an interpersonal process. *Australian Psychologist, 36*(2), 107–114. <https://doi.org/10.1080/00050060108259642>
- Ardito, R. B., & Rabellino, D. (2011). Therapeutic alliance and outcome of psychotherapy: historical excursus, measurements, and prospects for research. *Frontiers in Psychology, 2*(270). doi: 10.3389/fpsyg.2011.00270
- Gambrill, E. (1999). Evidence-based clinical behaviour analysis, evidence-based medicine and the Cochrane collaboration. *Journal of Behaviour Therapy and Experimental Psychiatry, 30*(1), 1–14. [https://doi.org/10.1016/S0005-7916\(98\)00035-4](https://doi.org/10.1016/S0005-7916(98)00035-4)
- Lewis, D. (2017). *Can I be helped? The prospects for change in me and my depression: A thematic analysis of pre-therapy expectations* (Doctoral dissertation). Retrieved from <http://eprints.uwe.ac.uk/30737>
- Macneil, C. A., Hasty, M. K., Evans, M., Redlich, C., & Berk, M. (2009). The therapeutic alliance: Is it necessary or sufficient to engender positive outcomes? *Acta Neuropsychiatrica, 21*(2), 95–98. <https://doi.org/10.1111/j.1601-5215.2009.00372.x>
- Meier, P. S., Barrowclough, C., & Donmall, M. C. (2005). The role of the therapeutic alliance in the treatment of substance misuse: a critical review of the literature. *Addiction, 100*(3), 304–316. doi: 10.1111/j.1360-0443.2004.00935.x
- Miller, W., & Rollnick, S. (2013). *Motivational interviewing: helping people change* (3rd ed.). New York, NY: Guilford Press.
- Norcross, J. C., Zimmerman, B. E., Greenberg, R. P., & Swift, J. K. (2017). Do all therapists do that when saying goodbye? A study of commonalities in termination behaviors. *Psychotherapy, 54*(1), 66-75. <http://dx.doi.org/10.1037/pst0000097>
- Prescott, D. S., Maeschalck, C. L., & Miller, S. D. (Eds.). (2017). *Feedback-informed treatment in clinical practice: Reaching for excellence*. Washington, DC: American Psychological Association.
- Sterling, S., Chi, F., & Hinman, A. (2011). Integrating care for people with co-occurring alcohol and other drug, medical, and mental health conditions. *Alcohol Research & Health, 33*(4), 338-349. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3625993/pdf/arh-33-4-338.pdf>
- Teyber, E. (2006). *Interpersonal process in psychotherapy* (5th ed.). Belmont, CA: Brooks/Cole.
- Vanderplasschen, W., Wolf, J., Rapp, R. C., & Broekaert, R. (2007). Effectiveness of different models of case management for substance-abusing populations. *Journal of Psychoactive Drugs, 39*(1), 81–95. doi: 10.1080/02791072.2007.10399867
- Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work* (2nd ed.). New York, NY: Routledge.
- Yalom, I. (2002). *The gift of therapy: Reflections on being a therapist*. London, United Kingdom: Piatkus Books.



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## 4. Best practice outcome performance indicators

An essential part of evidence-based practice is quantifying the changes that clients make in relation to their presenting problems. Core performance indicators involve measuring changes in key areas of client functioning from the beginning to the end of treatment and at one and three months after treatment (if possible). Assessment of client satisfaction is also a core performance indicator.

Core performance indicators, which should be reported for all AOD clients, cover the following areas:

- AOD issues – use and associated issues
- co-occurring mental health conditions
- general wellbeing
- client satisfaction with treatment
- engagement in treatment and treatment completion.

Examples of screening tools to assess the first four core performance indicators listed above are given in the chapter on **Assessment**. In addition, Deady (2009) reviewed other assessment tools. Many agencies use simple rating scales in which clients and counsellors can 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 attendance of scheduled appointments and dropout. Some clients will attend all scheduled appointments and complete treatment; others may drop out of treatment within the first few sessions or agree to a certain period of treatment and terminate prematurely.

### Feedback-informed treatment

Feedback-informed treatment is:

*...a Pantheoretical approach for evaluating and improving the quality and effectiveness of behavioural health services. It involves routinely and formally soliciting feedback from consumers regarding the therapeutic alliance and outcome of care and using the resulting information to inform and tailor service delivery.*

(International Center for Clinical Excellence, 2012)

The Outcome Rating Scale (ORS) and the Session Rating Scale (SRS) are provided at Appendix 9. They are very brief, easy to use FIT measures that are designed to monitor client wellbeing and the quality of the therapeutic alliance; however, they cannot be administered in isolation. Clinicians need to create a therapeutic relationship and environment that supports feedback, and enable clients to feel free to rate their experience of the service. It is important that they do not fear retribution and that their feedback will actually be used to inform the nature and the quality of the service for all users.

## Agency performance indicators

Performance indicators of agency functioning are also important. Agency performance indicators should reflect the agency's goals in order to ensure high-quality service standards. Quality improvement programs are available for agencies to define performance expectations, assess agency functioning, and develop and implement plans to improve agency functioning. The outcome of this process is continuous development, review, implementation, and modification of clinical policies and practices.

Counsellors should be involved in the quality improvement process and provide feedback on the 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
- agency and client rights and responsibilities.

## References

Deady, M. (2009). *A review of screening, assessment and outcome measures for drug and alcohol settings*. Retrieved from [https://www.nada.org.au/wp-content/uploads/2017/01/review\\_of\\_measures\\_09.pdf](https://www.nada.org.au/wp-content/uploads/2017/01/review_of_measures_09.pdf)

International Center for Clinical Excellence. (2012). *Manual 2. Feedback-informed clinical work: The basics*. Retrieved from [http://fit-elearning.myoutcomes.com/Content/docs/Manual\\_2.pdf](http://fit-elearning.myoutcomes.com/Content/docs/Manual_2.pdf)

# 2

## Section Two: Professional practice

- 5 Confidentiality
- 6 Case notes
- 7 Waitlist management and follow-up
- 8 Working with significant others
- 9 Clinical supervision
- 10 Stress and burnout
- 11 Secondary traumatic stress, compassion fatigue, and vicarious trauma
- 12 De-escalating aggressive behaviours
- 13 Critical incidents
- 14 Case management

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## 5. Confidentiality

Confidentiality refers to how information obtained in a professional relationship is treated. There is no such thing as absolute confidentiality in counselling relationships. Counselling relationships are confidential, but not privileged like lawyer–client relationships (i.e. information shared with a counsellor can be obtained legally). Counsellors should familiarise themselves with their agency’s confidentiality policies and procedures.

Counsellors have an obligation to maintain confidentiality by refraining 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 supervision or case management reviews
- the client threatening to harm themselves or someone else
- a child being at risk of abuse or neglect
- disclosure of a serious crime
- a court issuing a subpoena for the records relating to the client.

Extra care should be taken to maintain confidentiality in small communities or when working with Aboriginal and CALD people, as confidentiality can be harder to maintain when small pieces of information can inadvertently identify clients to others.

Counsellors should be honest regarding the limits of confidentiality prior to any therapeutic engagement (Psychotherapy and Counselling Federation of Australia, 2017). If a client engages in illegal activities that are not associated with serious safety risk to the client or another person, it can be useful to discourage the client from disclosing specific details.

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 issues 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 it is deemed necessary to prevent immediate risk to the client or another person. Counsellors should be particularly careful about confidentiality when sharing client information.

Confidentiality is limited for mandated clients where reporting client progress to a third party is required, for example drug court. These limits need to be carefully explained to clients at the beginning of the counselling relationship (see chapters on **Coerced clients** and **Working with clients referred by the justice system**).

Involving families and significant others in treatment is associated with positive treatment outcomes (Manuel, Houck, & Moyers, 2012). Clinicians and clients can often feel that involving families in treatment can create tensions about confidentiality, but if approached sensitively and with the right parameters in place to maintain confidentiality, clients and families or significant others can benefit greatly from this approach. In family-inclusive practice, clients need to consent to giving specific information to family members, and this should be reviewed after each counselling session. Families or significant others also need to understand the kinds of information about the client that can and cannot be discussed (see chapter on **Working with significant others**).

Finally, counsellors should be aware that under freedom of information and privacy legislation, clients can apply for access to their own records (see chapter on **Case notes**). When working with children aged 16 years and under, parents can legally apply for client information unless the young person is deemed to be a mature minor, that is, they have the maturity to give informed consent (see chapter on **Young people**).

## Confidentiality – tip sheet

There is no such thing as absolute confidentiality in counselling relationships. Counselling relationships are confidential, but not privileged like lawyer–client relationships

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:

- disclosure of information about clients during supervision or case management
- the client threatening to self-harm or harm someone else
- disclosure of a serious crime, such as murder
- a child involved being at risk of abuse
- court issuing a subpoena for the client’s records.

Counsellors may also be required to disclose information regarding mandated clients or clients who are minors.

Extra care should be taken to maintain confidentiality in small communities or when working with Aboriginal or CALD people. Counsellors should ensure that they discuss the limits of confidentiality with the client at the beginning of their contact.

If approached well and with the right parameters in place to maintain confidentiality, clients and families or significant others can benefit greatly from a family-inclusive practice approach without confidentiality being breached. Written informed consent should be obtained from clients before an agency or counsellor shares any client-related information with associated professionals.

When sharing information about clients, counsellors should consider threats to confidentiality when posting, faxing and emailing information. Agencies need to be aware that clients can apply for access to their own case notes and assessment information under Commonwealth and State Freedom of Information Acts.

## References

- Manuel, J. K., Houck, J. M., & Moyers, T. B. (2012). The impact of significant others in motivational enhancement therapy: Findings from Project MATCH. *Behavioural and Cognitive Psychotherapy*, 40(3), 297–312. doi: 10.1017/S1352465811000592
- Psychotherapy and Counselling Federation of Australia. (2017). Code of ethics. Retrieved from <http://www.pacfa.org.au/wp-content/uploads/2017/11/PACFA-Code-of-Ethics-2017.pdf>

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## 6. Case notes

Case notes generally refer to the chronological record of interactions, observations and actions relating to a particular client. Case notes are the agency record of client engagement and provide evidence of the client's progress and type of treatment or services offered and the rationale for such treatment or services. Case notes are legal documents and are part of the service provider's duty of care to the client. Counsellors should be familiar with their agency's policies and procedures about case notes, storage of client records, and managing requests for access to client records.

Poorly written case notes can result in workers relying on memory, guessing or not really knowing what has occurred. This can result in errors and poorly informed decision-making, putting the client, the worker and the agency at risk.

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. This might be verbalised as follows:

*As part of our counselling I am required to keep some case notes. What this means is that during and after each session I take some basic notes about what we discussed and did during the session. This helps us to keep track of where we are up to and helps us review what we are doing 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 them. They will not be released to anyone else without your permission. The only exception to that is if they get subpoenaed, which means I am legally bound to release them. That generally only happens if there is a court case. I am careful about what I record and only record the most important information. If you would like to read your case notes, please discuss this with me.*

This explanation will vary according to agency policies and procedures and relevant legislation. When clients ask to see their case notes, allow them to see the ones you have written but not those of other staff without first seeking their permission. If a client wishes to have a copy of their whole file, most agencies have procedures for clients 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.

Case notes are confidential within the limits of confidentiality (see chapter on **Confidentiality**) and should always be stored in a locked cabinet, filing system or drawer when not being used.

### Elements of good case notes

Case notes are a useful tool for the client, counsellor and other staff. They can assist with review, planning and accountability, and help workers and clients identify what has been helpful or otherwise in their sessions. For example, reviewing past sessions with a client may help them to appreciate their progress over time. Case notes can also be used as a part of reflective practice in clinical supervision. They also assist colleagues to follow up with clients in a worker's absence.

Case notes should be objective, accurate, concise and avoid judgements or value statements about the client. Case notes should be written using a third-person perspective, using formal objective language to refer to the client and others. For example, the client should be described as 'the client', or by their name; the author of the case notes could be written as 'the counsellor', or 'the author'. Avoid using pronouns such as 'we', 'you', 'he', 'she', 'they' and 'I'. Information recorded in case notes should be related to what you can observe and what the client reports. Any opinion contained in case notes should be qualified with relevant background information, facts, theory or research (Australian Association of Social Workers, 2016).

#### **Example**

*The client is in withdrawal.* This is an opinion without any rationale.

*Based on the client's report of nausea, sweating and tremor, the client appears to be experiencing mild withdrawal symptoms. This is an opinion with information about why the opinion has been formed, consistent with clinical knowledge.*

Case notes should include a record of all contact with a client, including appointments which the client attends or cancels, the service cancels, and emails, phone calls and other information related to the client's engagement with the service.

Case notes are best written immediately or within one or two working days after client contact and recorded in clear, easy to read, specific, concise and objective language. Acronyms, slang, emoticons and jargon should be avoided. Some organisations may have a list of approved abbreviations.

Notes should be handwritten in pen (preferably black), or typed, dated and the time of contact noted, and each page should be signed and include the worker's name and role. A line should be drawn through spaces between case notes. Case notes which go over more than one page should be noted as a continuation of a previous page (e.g. by writing the date and 'continued' at the top). Each page should have the client's identifying details on it (e.g. first name, surname, record number, date of birth); this helps avoid errors such as writing notes in the wrong client's file.

Avoid recording unnecessary information in case notes; information should be relevant to the client's contact with the agency. For example, it is usually inappropriate to record a third person's full name – their relationship to the client is usually sufficient. This does not apply to other workers whom you or the client contact in relation to the client.

Correction fluid should not be used; instead, strike through, initial and date mistakes. If you make an alteration or addition to an original set of notes, a new entry should be made. The date, time and author of the original entry should be noted in the new entry, and it should include an explanation as to why the original case note required amendment.

**Example**

*Amendment to case note dated 25/02/2018, 10am, written by J. Smith due to incorrect noting of client's GP name. Client advised GP's name is Doctor James Watson, not Doctor John Watson as was documented.*

It is important not to 'diagnose' clients in your case notes unless you are specifically trained to do so (e.g. if you are a doctor, psychiatrist or clinical psychologist). If the client has been diagnosed with a mental health disorder or psychological condition by someone qualified to do so, it is appropriate to record this information, clearly stating how this information was obtained.

**Example**

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

Diagnoses can be unhelpful if they are misunderstood, and some may be stigmatising to the client. In some circumstances it can be more helpful to describe the symptoms that the person reports or displays rather than the diagnosis. It is important to record the origin of the information in the notes.

**Example**

*Betty explained that she feels irritable and low in mood when withdrawing from amphetamines. Doctor Jones, Consultant Psychiatrist at James Street Mental Health Centre, stated that Betty was diagnosed with schizophrenia in Graylands hospital in 1978.*

If a client expresses suicidal ideation, or appears to be a risk to themselves or another person, it is important to record all of the steps taken to explore the issue and ensure client safety. In such situations, consult with your supervisor or colleagues 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 10 (10 being definitely wanting to die and one being just a fleeting thought with no intent behind it), how much she wishes to commit suicide, she reported that the ideation was only about a one out of 10. Betty was willing to establish a safety plan to use if the suicidal thoughts increased in intensity. As part of this plan, I supplied Betty with emergency telephone contact numbers.*

For further information about recording case notes, see the *Alcohol and Other Drugs Assessment Form Clinician's Guide* (Mental Health Commission [MHC], 2018)<sup>1</sup> (also see chapter on **Suicide assessment and management**).

1 Available from the WANADA website [http://wanada.org.au/index.php?option=com\\_docman&view=document&layout=default&alias=13-alcohol-and-other-drug-assessment-clinicians-booklet&category\\_slug=resources-for-the-alcohol-and-other-drug-aod-sector&Itemid=265](http://wanada.org.au/index.php?option=com_docman&view=document&layout=default&alias=13-alcohol-and-other-drug-assessment-clinicians-booklet&category_slug=resources-for-the-alcohol-and-other-drug-aod-sector&Itemid=265)



## Case notes and the law

Organisations generally have policies and procedures that cover legal issues such as requests for case notes. It is important that workers are familiar with these policies and procedures.

In Western Australia, clients have a right to apply to see their files under the Commonwealth *Freedom of Information Act 1982* (for access from a Commonwealth Government agency) and their relevant state freedom of information act (for access from a state government agency). Note that some non-government agencies are also subject to freedom of information legislation if they are acting as an agent of a government. Non-government or private sector organisations are subject to the Commonwealth *Privacy Act 1988*, which gives members of the public rights to access information about themselves. Clients have the right to view their personal records unless there are specific legal exemptions, even if the counsellor or agency does not wish them to. Legislation may vary across jurisdictions.

Any written information may be subpoenaed and required as evidence in a court case during and after the client's contact with the counsellor and agency. The author may also be subpoenaed and required to appear in court for cross-examination about the content of the notes. Subpoenas, the Freedom of Information Act and the Privacy Act can apply to other client information the counsellor and the agency might keep, including emails and diaries.

In Western Australian government organisations, the *State Records Act 2000* applies to any record of business activity, however recorded. For this reason, all information related to the client's engagement with the service should be included in the client's file. Client's files should only be disposed of according to the agency's retention and disposal schedule.

## Critical Incident reports

In the event of a critical incident it is important to record the following factual information in the case notes:

- when it occurred (date and time)
- where it occurred
- what happened (observations, not opinions)
- who was involved and who was present
- in the event of an injury, the individual's condition beforehand and afterwards
- what action staff took
- the name, position and agency of the person to whom it was reported.

Most agencies have policies and procedures for recording information about critical incidents. See the chapter on **Critical incidents** for further information.

## Recording information about liaison

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

- client consent to exchange information. This should be recorded in the notes as well as the release of information forms (or similar). Note that client consent to exchange or release information should be time limited (e.g. 6–12 months) and specific, noting what information was exchanged, why, and with whom (see chapter on **Confidentiality**)
- who supplied the information (name, title, agency, position in the agency, relationship to the client)
- how the information was supplied (letter, in person, fax, email, phone)
- what action (if any) is planned as a result of the liaison, who is responsible for its implementation, and when it should be completed
- whether your client (and/or the agency or others) are at risk and what steps should be taken to minimise that risk.

Avoid transporting case files or client notes whenever possible to reduce the risk of breaching confidentiality (e.g. if your car or house is burgled). If supervision arrangements or agency liaison requires you to transport client notes, use a locked briefcase or take de-identified photocopies of the original documents. They should be stored in a locked drawer or cupboard when off site and not in use and should not be left in a car unattended.



## Models for writing case notes

Models provide a framework for recording information that can assist with writing case notes (Cameron & Murray, 2012). Two common models are as follows:

- S** – Subjective – what the client says
- O** – Objective – what is clinically observed
- A** – Assessment – analysis of the issues, explanations, theories
- P** – Plan – what follow-up is intended, interventions, actions, goals

### **Examples**

*Betty advised that she had not been sleeping due to withdrawal symptoms, including tremors, sweating and palpitations, which she states are due to decreasing her benzodiazepines. (Subjective)*

*Observed a slight tremor in Betty's hands, as well as some sweat on her face and neck. (Objective)*

*Betty may be experiencing withdrawal symptoms since she decreased her benzodiazepine dose. (Assessment)*

*Plan: make an appointment with Betty's GP, Dr Watson, as soon as possible for review. (Plan)*

- D** – Data – Information from the session – current issues, signs and symptoms, current interventions, concerns, etc.
- A** – Assessment – analysis of the issues, explanations, theories
- P** – Plan – intended follow-up, interventions, actions, goals

### **Examples**

*Betty advised that she had not been sleeping due to withdrawal symptoms, including tremors, sweating and palpitations, which she states are due to decreasing her benzodiazepines. Observed a slight tremor in Betty's hands, as well as some sweat on her face and neck. (Data)*

*Betty may be experiencing withdrawal symptoms since she decreased her benzodiazepine dose. (Assessment)*

*Plan: make an appointment with Betty's GP, Dr Watson, as soon as possible for review. (Plan)*

## Case notes – tip sheet

Case notes can assist with review, planning and tracking client progress.

Case notes communicate what has occurred to other workers in the agency.

Counsellors and other workers have a duty of care to maintain accurate records of their interactions with clients.

Clients should be informed about the presence and purpose of client files, where they are stored, who has access to them and why files are maintained.

Case notes should be kept confidential and stored in a locked cabinet, filing system or drawer.

In general, clients have a legal right to access their records.

Client records may be subpoenaed and required as evidence in court.

Avoid transporting case files or client notes where possible. This runs the risk of breaching confidentiality.

Good case notes have the following qualities:

- written in black pen
- clearly written/legible
- free of jargon and acronyms
- written as soon as possible after client contact
- concise
- easily read
- formal, objective language
- record ALL information related to the client's contact with the agency.

Models provide a framework for recording information that can guide the writing of case notes. Two common models are SOAP and DAP.

**S** – Subjective

**O** – Objective

**A** – Assessment

**P** – Plan

**D** – Data

**A** – Action

**P** – Plan

## References

Australian Association of Social Workers. (2016). Ethical guideline – case note recording. Retrieved from <https://www.aasw.asn.au/document/item/2356>

Cameron, J., & Murray, J. (2012). *Take note! A practical guide to writing case notes: The complete reference guide for alcohol and other drug clinicians and managers*. Fitzroy, VIC: Turning Point Alcohol and Drug Centre.

Mental Health Commission, Western Australia (MHC). (2018). *Alcohol and other drugs assessment: Clinician's guide and assessment form*. Perth, WA: Author.

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## 7. Waitlist management and follow-up

It is standard practice for services to use a waitlist system for managing the volume of people requesting treatment. However, people seeking treatment of the AOD use will often ring services when in crisis and motivation for treatment can be difficult to maintain during the waiting period for an appointment. In addition, some people will present with a more urgent need for treatment and different treatment priorities than others. Thus, effective waitlist management is important. Further, the practice of following up with clients who have missed appointments and client who have exited treatment can allow clients to re-engage with the service. Follow-up is also an important element of evidence-based practice, providing useful information about treatment efficacy, effective components of treatment and relapse rates.

### Waitlist management

Many services have a waitlist management policy or procedure. Following referral, people requesting a service generally undergo an initial assessment and their treatment needs and priorities are discussed in a clinical intake or allocations meeting. Decisions about waitlisting clients often relate to the needs of priority groups, a client's level of risk and existing supports, and the capacity of the service or program. Counsellors should ensure these issues are considered in waitlist management strategies. For example, waitlisted clients who are pregnant or at risk of overdose should be seen at the earliest opportunity. The waitlist should be reviewed frequently to ensure that any changes in clients' situations are taken into account and to ensure that no client waits longer than the assigned period.

Being on a waitlist is perceived as a barrier among clients seeking treatment (Lubman et al., 2014) and the longer the waiting period, the less likely clients are to follow through with the appointment (Redko, Rapp, & Carlson, 2006). Clients who have been added to the waitlist for counselling are more likely to attend their initial appointment if they have had contact with the service while on the waitlist (Guitar, 2017). In scheduling an initial appointment, encourage the client to receive automated appointment reminders from the service as there is evidence that text message reminders, as well as letters and personalised phone calls, substantially improve attendance (Downer, Meara, & Da Costa, 2005). Some clients might not answer unfamiliar telephone numbers. It can be useful to have a conversation with clients about this, and encourage them to store the service number in their phones.

Services can implement strategies that encourage waitlisted clients to engage in interim treatment while they wait for their appointment. Strategies such as waitlist groups, interim phone contact, and referral to a telephone counselling service can help waitlisted clients maintain motivation for face-to face counselling.

### Follow-up

Assertive attempts to re-engage the client should be made when clients do not attend an initial or scheduled appointment. This is particularly beneficial for clients who lack strong family or social support (Lubman et al., 2014). Following up with clients can be difficult; however, the practice has great utility. Clients generally perceive appropriate follow-up as "welcome and beneficial" (Lubman et al., 2014, p. xiv). Clients who fail to attend appointments are more likely to perceive barriers to attending (Collins, Santamaria, & Clayton, 2003). Follow-up with clients who miss appointments can include helping them to address barriers to attendance and brief interventions (BIs) over the phone to boost their motivation (National Treatment Agency for Substance Misuse, 2009). Follow-up can also provide a forum for brief intervention (BI) 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 increase the client's likelihood of re-engaging in treatment should the need arise (Lubman et al., 2014).

It is recommended that clients are contacted for short-term follow-up between one and three months after treatment (Lubman et al., 2014). For clients coming to the end of their treatment, the importance and possible format of follow-up should be explained before their final session. Follow-up appointments, either face-to-face or telephone, can be scheduled prior to the client exiting the service. Follow-up can take many forms. Face-to-face or telephone follow-up primarily consist of re-establishing rapport, discussion 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 procedures should address the individual client's needs regarding continued support, re-engagement with the service (if necessary), or referral to another service or relevant self-help groups.

### Waitlist management and follow-up – tip sheet

Providing support for clients who are on waitlists for counselling increases the likelihood of them engaging in treatment.

Strategies such as waitlist groups, interim phone contact, and referral to a telephone counselling service can help waitlisted clients maintain motivation for face-to-face counselling.

Follow-up with clients who miss counselling appointments can include helping them to address barriers to attending and (BIs) over the phone to boost their motivation.

It is recommended that clients who have been in treatment, regardless of whether they have relapsed, are followed up between one and three months after treatment.

The importance and format of follow-up procedures should be explained to the client before their final session.

Preference should be given to face-to-face or telephone contact, but written contact can be beneficial. Face-to-face or telephone sessions should be scheduled with the client before discharge from treatment.

Follow-up gives clients a sense of care and commitment and enables valuable feedback about treatment efficacy.

Follow-up procedures should offer continued support, re-engagement with the service (if necessary), or referral to another service or relevant self-help groups.

### References

- Collins, J., Santamaria, N., & Clayton, L. (2003). Why outpatients fail to attend their scheduled appointment: A prospective comparison of differences between attenders and non-attenders. *Australian Health Review*, 26(1), 52-63. Retrieved from <https://pdfs.semanticscholar.org/e042/1641882d821203108d75a3803d7fc5670c59.pdf>
- Downer, S. R., Meara, J. G., & Da Costa, A. C. (2005). Use of SMS text messaging to improve outpatient attendance. *Medical Journal of Australia*, 183(7), 366-368. Retrieved from [https://www.mja.com.au/system/files/issues/183\\_07\\_031005/dow10816\\_fm.pdf](https://www.mja.com.au/system/files/issues/183_07_031005/dow10816_fm.pdf)
- Guitar, N. A. (2017). Why can't patients last the wait? Decreasing substance abuse treatment waiting list attrition. *University of Western Ontario Medical Journal*, 86(2), 40-41. Retrieved from [http://www.uwomj.com/wp-content/uploads/2017/12/vol86no2\\_15.pdf](http://www.uwomj.com/wp-content/uploads/2017/12/vol86no2_15.pdf)
- Lubman, D., Manning, V., Best, D., Berends, L., Mugavin, J., Lloyd, B., ... Room, R. (2014). *A study of patient pathways in alcohol and other drug treatment*. Fitzroy, VIC: Turning Point.
- National Treatment Agency for Substance Misuse. (2009). *Towards successful treatment completion: A good practice guide*. London, United Kingdom: Author.
- Redko, C., Rapp, R. C., & Carlson, R. G. (2006). Waiting time as a barrier to treatment entry: Perceptions of substance users. *Journal of Drug Issues*, 36(4), 831-852. doi:10.1177/002204260603600404.

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## 8. Working with significant others

It is widely accepted that people's AOD use causes stress to their family members and friends, and that AOD users' significant others may also need support. It is also apparent that significant others can be instrumental in facilitating treatment engagement for the person with AOD issues and that their involvement can improve treatment outcomes (Orford et al., 2005). Even simple interventions with significant others, such as the provision of self-help materials, can significantly improve their coping skills, levels of stress, and the outcome for the client with AOD use issues (Velleman et al., 2011). It is recommended that, with the client's permission, significant others are given the option of being involved in the treatment process.

Helfgott (2009) outlined a number of important reasons why significant others should be involved in the client's treatment:

- to assess the needs of significant other(s) and provide counselling and support accordingly
- to determine the function of the AOD use within the family or social network
- to assess how significant others may initiate or maintain the AOD use issues
- to explore general life issues and stressors
- to assess the quality of the relationship between the person with AOD use issues and the significant other(s).

Counsellors may be required to work with significant others as part of the client's treatment plan or as clients in their own right. Various issues arise as a result of the context of the working relationship, and these are considered below.

To work effectively with significant others, agencies and individual counsellors need a sound understanding of family-inclusive practice. The assumptions of family-inclusive practice outlined below are adapted from the principles and assumptions listed by the Bouverie Centre Family Institute in Victoria.<sup>2</sup>

### Assumptions of family-inclusive 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 and mental health issues 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 and mental health issues and other major family difficulties in our culture.
- Families have needs in their own right and have a right to have their needs acknowledged.
- 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 facilitate a therapeutic alliance.
- The distinction between the intention (which is usually good) and the effect of an action is important in understanding why clients and families sometimes inadvertently act in unhelpful ways.
- Establishing a trusting relationship with families improves counsellors' ability to assist families to overcome crises and issues. This often means time efficiencies in the long term.
- 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 principles and assumptions of family-inclusive practice in order to commit to them professionally.

<sup>2</sup> See [www.bouverie.org.au](http://www.bouverie.org.au)

It is important to note that many adult clients do not want family members involved. There are many reasons for this, including conflict or no contact with family members, anger and hurt at neglect or abuse experienced in childhood, or not wanting family members to know they have an AOD issue. Even when the client does not want family members involved, family members should still be assisted to find support from other counsellors or agencies.

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

Excessive AOD use is a cause of stress to families, partners and friends of people who have AOD-related issues. Common stressors include worry about the individual's health and the impact of the drug use on other family members, financial strain, incidents, crises, violence and social isolation (Copello, 2011). It is common for this client group to independently seek counselling to help them better cope with their family member's or friend's AOD use. Heightened levels of anxiety and depression are common in these clients and they often report feeling helpless and isolated; therefore, it is important that they are given appropriate support. Goals and treatment plans for counselling should be negotiated. If the person using AOD is in treatment with one counsellor, it is often appropriate that support for families and friends be provided by another different counsellor. This helps clinicians to avoid conflicts of interest and breaches of confidentiality. An exception is when the whole family is considered to be the client, as in a treatment that has family therapy as a base, such as multidimensional family therapy (MDFT; see Liddle et al., 2001) approach (see chapter on *Young people*).

Counsellors can assist the significant other to review their role as it relates to the person who is using AOD, as well as to examine general life issues and develop better ways to cope with their AOD use.

Significant others often seek help with the aim of identifying ways to stop their family member or friend using alcohol or other drugs. Engaging the significant other (client) with their presenting issue(s) is an important component of building a good therapeutic relationship. Once established, other options can be explored and strategies introduced to the client. Finally, working with this group enables provision of accurate AOD information, which directly helps the significant other and may indirectly assist the person using AOD through dissemination of the information via family or friends.

A useful heuristic to recall in working with significant others is the 'stress-strain-coping-support' model (Orford, Templeton, Velleman, & Copello, 2005). Accordingly, the following five steps aim to reduce the family's or partner's level of strain, both physical and psychological, and enhance their coping mechanisms (Orford et al., 2005):

- give the family member or partner the opportunity to talk
- provide relevant information
- explore how the family or partner responds to the person's substance use
- explore and enhance social support
- discuss the possibilities of onward referral for further specialist help.

Copello (2011) outlined additional approaches that can be helpful in working with significant others. In particular, it may be useful to discuss the process of motivation and change, help the significant other to identify relapse cycles, encourage the pursuit of activities that do not involve AOD use, and discuss goal-setting and problem-solving.

Overall, it is important to give the family members or partner the opportunity to talk about the issue and to respond empathically to their concerns. Give significant others information, explore their current coping skills, and help them to develop support (Copello, 2011). It may also be necessary to discuss onward referral for further specialist help.

## Working with significant others as an adjunct to a 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 (Copello, 2011). Family-centred practice in an AOD context should be oriented around the following four goals:

- to change AOD-related interactional patterns and develop interactions that support change in AOD using behaviour
- to help the family confront and resolve relationship conflicts without the client resorting to AOD use
- to help mend rifts in relationships that have been aggravated as a result of the AOD use
- 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 refer to either the person using AOD or the significant other as the cause of the problem.

Family-centred practice does not require specialist family therapy training. It can give family members the support they need and can improve treatment outcomes for the drug user. However, if counsellors wish to engage in family therapy, specific skills and specialist training are required.

## Confidentiality

It is common for family members, partners or friends to contact the counsellor working with the person using AOD to ask about the progress of the client. To acknowledge that a client is in treatment is a breach of confidentiality unless prior consent is obtained. Information about progress should only be provided with the agreement of the client, and should be in general terms. The exception to this is that parents of minors considered insufficiently 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 desire for confidentiality must be respected. This assessment is usually made around the age of 14 or 15 years (see chapter on **Young people**).

Responding to family members, partners or friends who call for information when the client has not given consent can be tricky. It is important to express empathy regarding the request, but clarify that you cannot provide information without the client's consent. It is appropriate, however, to provide AOD information and basic support and general advice. Counsellors should also ensure that confidentiality does not become a barrier to expressing concern and empathy for the family members and the difficult issues and emotions that they are experiencing. It is important to revisit consent with the client as family situations and relationships can change over time and the client may choose to provide consent at a later date.

If the client has given permission for you to talk to family members, partners or friends, ensure that you are 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 for you and your client to agree on the issues they are happy for you to discuss with significant others and those they want to remain confidential.

## Some issues specific to parents

AOD can be complex, and as significantly more young people are living at home for longer periods, parents are often left struggling to cope with their child's AOD use issues. Many of the clinical presentations exhibited by parents result from the stress experienced when a child is using drugs. Parents often report feeling shock and disbelief, isolation, anger, fear, guilt and shame when they become aware of their child's AOD issues (Parent Drug Information Service, 2006). Grief is also common, not just from the death of a child, but also from stressful or lost relationships, or things not working out as planned and 'lost dreams' for their child.

Parents' emotional reactions to their child's drug use should be acknowledged prior to providing advice and working on strategies to help them manage the situation better. For example, emphasise that grieving is a normal reaction in response to the child not living the life that the parent had hoped for them (Parent Drug Information Service, 2015). High levels of stress and anxiety and low levels of self-efficacy may reduce parents' openness to advice and self-confidence in effectively using 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.

Parents can find information and guidance in many resources. For example, the Parent and Family Drug Support Line's Parent and Family Information and Support Pack is freely available at [www.mhc.wa.gov.au](http://www.mhc.wa.gov.au).



Information and strategies to explore with parents include the following:

- knowledge of AOD and AOD use issues
- strengthening parenting role and parents' confidence
- communication skills
- conflict resolution
- negotiating guidelines/boundaries
- issues of attachment and commitment to the AOD-using child
- responding versus reacting
- remaining calm, consistent and credible
- accessing additional support (parent support groups, family therapy)
- making time for self
- reaching out for support from other family members and friends
- importance of not trying to 'fix the issue'.

Working with parents should be seen as a positive way of enhancing the therapeutic process and maximising the positive outcome for young people and their families.

## Working with 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
- 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-inclusive 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 person using AOD to seek assistance.
- Provide significant others with accurate AOD information, help them to explore the impact of the AOD-related behaviour on their own health and wellbeing, explore their coping skills, and help them to enhance available social support.

### **Working with parents, 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 person using AOD 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 include:

- helping the family member or partner to reduce their levels 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 AOD use on themselves and enhance their quality of life.



## Confidentiality

- Family members, partners or friends may contact you to ask about the progress of a client. Client confidentiality needs to be respected.
- Information should only be provided to family members with the consent of the client, and then only in general terms. These agreements should be reviewed periodically so that information provision reflects changes in family relationships and sources of support.
- 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 AOD information and basic support at a minimum.

## Issues specific to parents

- Parents' levels of anxiety, depression and grief should be acknowledged before providing advice and working on strategies to better manage the situation with their AOD using child.
- Concentrate initially on lessening parental 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 should include the following:

- information on alcohol or other drugs and related issues
- strengthening the parenting role and the parent's confidence
- improving communication skills
- improving conflict resolution skills
- negotiating guidelines/boundaries
- discussing issues of attachment and commitment
- responding rather than reacting.

## References

- Copello, A. G. (2011). The family perspective. In D. B. Cooper (Ed.), *Responding in mental health – substance use* (pp. 6-15). London, United Kingdom: Radcliffe Publishing.
- Helfgott, S. (2009). Counselling significant others. In S. Helfgott & S. Allsop (Eds.), *Helping change: The drug and alcohol counsellors' training program*. Perth, WA: Drug and Alcohol Office, Government of Western Australia.
- Liddle, H. A., Dakof, G. A., Parker, K., Diamon, G. S., Barrett, K., & Tejada, M. (2001). Multidimensional family therapy for adolescent drug abuse: Results of a randomized clinical trial. *American Journal of Alcohol and Drug Abuse, 27*(4), 651-688. doi:10.1081/ADA-100107661
- Orford, J., Natera, G., Copello, A., Atkinson, C., Mora, J., Velleman, R., ... Walley, G. (2005). *Coping with alcohol and drug problems: The experience of family members in three contrasting cultures*. East Sussex, United Kingdom: Routledge.
- Orford, J., Templeton, L., Velleman, R., & Copello, A. (2005). Family members of relatives with alcohol, drug and gambling problems: A set of standardized questionnaires for assessing stress, coping and strain. *Addiction, 100*, 1611-1624. doi:10.1111/j.1360-0443.2005.01178.x
- Parent Drug Information Service. (2015). *Parents and Family Information and Support Pack*. Retrieved from <https://www.mhc.wa.gov.au/media/1676/pfds-parent-and-family-info-pack.pdf>
- Velleman, R., Orford, J., Templeton, L., Copello, A., Patel, A., Moore, L., ... Godfrey, C. (2011). 12-month follow-up after brief interventions in primary care for family members affected by the substance misuse problem of a close relative. *Addiction Research and Theory, 19*(4), 362-374. <https://doi.org/10.3109/16066359.2011.564691>

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## 9. Clinical supervision

Clinical supervision is a vitally important aspect of an AOD treatment service. It assists in the maintenance and continuous improvement of counsellors' standards of best practice through exploration of the way that the supervisee works with clients.

The National Research Centre on Alcohol and Other Drugs ([NCETA] 2005) defined clinical supervision as being:

*... directed at developing less experienced worker's clinical practice skills through the provision of support and guidance from a more experienced supervisor. The clinical supervision relationship is characterised by regular, systematic and detailed exploration of a supervisee's work with clients or patients. Clinical supervision is usually a collaboration between an experienced practitioner and one or more less experienced practitioners. It can also involve two practitioners of equal seniority and breadth of experience. (p. 2)*

The function of clinical supervision, therefore, is to facilitate the growth and development of the supervisee as a counsellor. Proctor (1988) summarised the three main functions of supervision in counselling as being normative, formative, and restorative:

- normative – issues of professional standards, such as case management
- formative – the development of the supervisee's knowledge and clinical skills
- restorative – support through debriefing and emotional processing.

It is important to note that clinical supervision does not focus on administrative or managerial goals (NCETA, 2005). It does, however, ensure that the supervisee achieves best practice standards (Hart, 1982). Ideally, operational managers will not conduct clinical supervision, but resource constraints mean some managers may perform both roles. It is very important that both parties are comfortable with this arrangement and that clear distinctions are made about the different functions, when they occur, and do not blend both functions into one meeting time (NCETA, 2005).

The focus of clinical supervision is the learning of the supervisee. Carroll (2010) outlined the content and process of supervision as follows:

*The what-is-being-learned of supervision is anything to do with the work: theory, skills, induction into a profession, professional savvy and wisdom, skills and competencies, self-awareness, ethical awareness and sensitivity, ability to use intuition, and that array of knowledge, skills, attitudes, values, and mind-sets that go to make up the professional in whatever profession. The methods used by supervisors to facilitate learning are many, ranging from teaching, training, and instruction through to role-play, skills development, self-awareness, feedback, challenge, insight, parallel process, and sharing their own experience.*

*The acid test of how effective supervision is simple: what are you (the supervisee) doing differently now that you were not doing before supervision? What have you learned from the past hour in supervision with me? What shifts have taken place in the supervision room that have been transferred to your work? (p. 1)*

Learning occurs via the supervisor facilitating the reflection of the supervisee on their practice. Clinical supervision should facilitate a worker's ability to:

- work effectively with clients
- be aware of and able to recognise more complex client issues
- be aware of their own reactions and responses to clients
- 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
- expand their ways of working.

A useful framework which can be used to guide supervision is the 'after action review' (Carroll, 2010). This framework can help to build the supervisee's reflective capacity and includes the following kinds of questions in relation to the supervisee's client work:

- What were my overall aims with the client last session?
- What actually occurred in counselling the client and why did I do it that way?
- What went well in counselling the client and why?
- What went less well or even badly and why?
- What have I learned from evaluating what happened?
- What will I do differently next session as a result of this learning from past sessions?

## Common barriers to supervision

The implementation of sound clinical supervision practice can suffer from various barriers, including a lack of understanding about its value, goals and how to do it (NCETA, 2005). For example:

- managers may not understand the benefits
- supervisors may not be trained and/or experienced
- supervision policies and procedures may not have not been well articulated and/or written
- confusion about the difference between clinical and managerial supervision may exist
- a lack of shared understanding of concepts and terminology used in supervision may exist
- there may be inadequate resources allocated to supervision
- counsellors may experience difficulty in obtaining regular supervision.

Effective supervision is essential for good clinical practice and worker wellbeing. It is important that services address and resolve any barriers to adequate supervision.

## What makes effective supervision?

Ellis et al. (2014) outlined the criteria they believe are necessary for minimally adequate clinical supervision across disciplines. They stated that a supervisor should:

- possess relevant credentials (as defined by the supervisor's discipline/profession)
- possess appropriate knowledge and skills for clinical supervision as well as an awareness of their limitations
- use a supervision contract or obtain consent
- provide a minimum of one hour of face-to-face individual supervision per week
- monitor supervisee's work via observation and reviews
- provide fair, respectful, honest, ongoing and formal evaluative feedback
- proactively support the supervisee's professional growth, development and welfare
- be conscious of attending to multicultural and diversity issues in supervision
- maintain confidentiality (as appropriate)
- be aware of boundary issues and the power imbalance between the supervisor and supervisee and the effects this can have on the supervisory relationship.

At the heart of effective supervision is the quality of the relationship between supervisor and supervisee (Milne, 2009). The following factors have been identified as important for an effective supervision relationship (Bernard & Goodyear, 2009):

- collaboration between supervisor and supervisee
- mutual understanding of the supervision process
- rapport between supervisor and supervisee (i.e. openness, honesty, and respect).

Within the supervisory relationship, it is important that the clinical supervisor maintains appropriate boundaries. Stephen Power (2006) suggested the supervisor should ensure that:

- supervisees only discuss anything that is directly relevant to the supervisee's clinical work, either in general or specifically regarding clients/colleagues
- supervision does not become a friendly chat or gossip
- the supervisor never acts as a therapist, counsellor, agony aunt or line manager.

At the beginning of the supervisory relationship, critical process issues such as confidentiality and its limits, the definition of supervision, and procedures for disputes and grievances need to be established. This will increase the likelihood of developing a sound supervisory relationship and minimise misunderstandings and inappropriate expectations (NCETA, 2005).

Supervisees also need to be prepared in order to get the most out of the supervision process. Supervisors need to ensure that supervisees understand:

- why supervision is needed
- what to expect
- the supervisor and supervisee characteristics that enhance supervision
- the importance of work-related goals
- how to contribute to planning supervision sessions
- the range of training and observations techniques that may be used
- procedures for resolving disputes with their supervisor
- that different forms of supervision are available (e.g. peer, group, remote) (NCETA, 2005).

Another essential element of effective supervision is a clearly developed contract. This contract should state the purpose of supervision as well as the expectations of the supervisor and supervisee. It should be developed via negotiation and mutual agreement, and:

- contain the focus, content, methods and arrangements for supervision
- be clearly stated and understood by both parties
- be renewed or revised at agreed intervals.

Howard (1997) suggested a 12-item supervision contract checklist which includes:

- the purpose of supervision – the supervisor and supervisee need to establish a shared understanding
- a professional disclosure statement – this provides the supervisor and supervisee with an opportunity to learn about each other's professional experiences
- practical issues such as where, when, frequency, review dates, etc. – ideally these details will be negotiated between the supervisor and supervisee
- the supervisee's goals – what does the supervisee hope to achieve (goals) from clinical supervision?
- the methods used to support learning and how the effectiveness of supervision will be evaluated – the methods should be discussed in an open and collaborative manner with the supervisee and how supervision is evaluated must be negotiated
- accountability and responsibility of both the supervisor and the supervisee – any codes of practice/ethics must be discussed
- confidentiality and documentation – the extent and limitations of confidentiality must be clarified by the supervisor and what information will be recorded and why should be negotiated with the supervisee
- dual relationships – ideally clinical supervision should be provided by someone other than a line manager however if this situation is unavoidable, appropriate boundaries for the supervisory relationship must be clarified
- a statement of agreement/contract – the commitments for both the supervisor and the supervisee need to be highlighted.

The content of effective AOD clinical supervision may include:

- topics – for example, evidence-based AOD interventions; co-occurring presentations
- competencies – for example, generic counselling skills, biopsychosocial assessment skills, case planning and management skills, the ability to implement evidence-based CBT, BIs, MI, confidential and ethical practice, closure skills
- issues – for example cross-cultural concerns; worker burnout
- goals – the worker identifies learning goals which are negotiated with the supervisor, SMART (specific, measurable, achievable/agreed upon, realistic and time-based), recorded and contracted (NCETA, 2005).

Video or audio recordings of sessions are 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. It is helpful for supervisors to have access to an insider's view. Recording sessions also allows counsellors to 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.

Written permission (a signed consent form) needs to be obtained from the client in order to record sessions for the purposes of the counsellor's clinical supervision. The client must understand the purpose of these recordings and be told that they have the right to refuse to have a session recorded.

The supervisor should also periodically review case notes and reports. If the counsellor receives external supervision from a clinical supervision in another service, counsellors should photocopy the case notes and blank out any identifying information. Confidential information that contains identifying details should never be removed from an agency (see chapter on **Confidentiality**).

## Inadequate or harmful supervision

A clinical supervisor holds an evaluative, hierarchical position in which the supervisee's professional career is in their hands. The supervision relationship therefore is an inextricably vulnerable one for the supervisee, and they are at risk of harm if the supervisor were to act in a harmful or unethical manner (Bernard & Goodyear, 2014).

Ellis et al. (2014) examined the issue of inadequate and harmful supervision. They defined inadequate clinical supervision as occurring when:

*... the supervisor is unable, or unwilling, to meet the criteria for minimally adequate supervision, to enhance the professional functioning of the supervisee, to monitor the quality of the professional services offered to the supervisee's clients, or to serve as a gatekeeper to the profession. (p. 439)*

In their study of 363 supervisees, Ellis et al. (2014) found that 93% were currently receiving inadequate supervision (based on their criteria for minimally adequate clinical supervision, above). This was primarily due to 39.7% of supervisors failing to observe or properly monitor supervisee sessions and 54.2% failing to use a supervision consent form or contract.

Harmful supervision was defined as any supervision practice that results in trauma, psychological, emotional and/or physical harm to the supervisee. Ellis et al. (2014) found that 35.3% of the supervisee sample was currently receiving harmful supervision and that over half of all the supervisees had experienced harmful supervision at some time in their career.

## Group supervision

Group supervision can offer an alternative or additional forum for clinical supervision. Individual supervision offers more depth and focus on opportunities for highlighting an individual counsellor's strengths and working on areas for improvement. Group supervision benefits include the development of a supportive team atmosphere, a greater pool of resources and skills, and exposure to an increased number of client cases (Ogren, Boethius, & Sundin, 2014).

Bernard & Goodyear (2009) described group supervision as:

*... the regular meeting of a group of supervisees (a) with a designated supervisor or supervisors, (b) to monitor the quality of their work, and (c) to further their understanding of themselves as clinicians, of the clients with whom they work, and of service delivery in general. These supervisees are aided in achieving these goals by their supervisor(s) and by their feedback from and interactions with each other. (p. 244)*

Group supervision places high demands on the group supervisor's knowledge and skills. Group supervisors need to have knowledge and understanding of organisational issues, be experienced in small group dynamics, and be able to handle supervisor and leader roles simultaneously (Ogren et al., 2014). Andersson (2008) cautioned that "... not all individual supervisors have had sufficient training in group work, and hence may not be suited for group supervision, regardless of how good they may be as dyadic supervisors" (p. 39).

Group supervision can also present some disadvantages. These include logistical challenges faced in setting up a group meeting time and suitable place; the fact that some supervisees may experience increased anxiety in a group setting; and urgent cases may not get the necessary attention. If the group is not cohesive, supervisees may be less inclined to participate actively and disclose details of the counselling sessions openly and honestly (Mastoras & Andrews, 2011). Furthermore, there are individual differences in the perceived benefits of group supervision (Mastoras & Andrews, 2011).

## Individual or group supervision?

According to the Center for Substance Abuse Treatment ([CSAT] 2009) the decision to use either individual or group supervision, or a combination of both, can be made by considering the following issues.

For the supervisee:

- What are the learning goals for the supervisee?
- What is the supervisee's current level of experience and professional development?
- What is the learning style of the supervisee?

For the supervisor:

- What are the supervisor's goals for the supervisee?
- What is the supervisor's theoretical orientation?
- What is the supervisor's learning goals for the supervisory process?

In order to choose whether to use an individual or group approach to clinical supervision, taking into account issues such as time constraints, the function of supervision needs to be clearly identified. For example, a well-functioning, supportive team may benefit from group supervision. However, if specific skill development or other individually focussed additional attention is required, then one-to-one supervision would be recommended (CSAT, 2009).

### Clinical supervision – tip sheet

Clinical supervision facilitates the professional growth, development and learning of the supervisee. It ensures that best practice standards are attained and maintained for the benefit of the service's clients.

Effective supervision ensures that the supervisor and supervisee undertake normative, formative and restorative tasks and meet their responsibilities.

Effective supervision requires:

- mutual understanding of the supervision process
- a supportive, collaborative working relationship
- maintenance of appropriate boundaries
- a supervision contract or consent form.

Effective supervision covers the following areas:

- topics – e.g. evidence-based AOD interventions
- competencies – e.g. AOD assessment skills
- issues – e.g. worker self-care
- goals – e.g. supervisee's professional learning goals.

It is important that services address and resolve any barriers to adequate supervision that may exist.

The clinical supervisor and the service must ensure that the supervisee is protected from inadequate or harmful supervision.

Group supervision may provide some additional benefits to individual supervision, but it also has some disadvantages.

Factors such as the function of supervision as well as practical issues need to be taken into consideration when deciding whether individual or group supervision is recommended.



## References

- Andersson, L. (2008). Psychodynamic supervision in a group setting: Benefits and limitations. *Psychotherapy in Australia*, 14(2), 36-41. Retrieved from [http://www.psychotherapy.com.au/fileadmin/site\\_files/pdfs/GroupSupervision1.pdf](http://www.psychotherapy.com.au/fileadmin/site_files/pdfs/GroupSupervision1.pdf)
- Bernard, J. M., & Goodyear, R. K. (2009). *Fundamentals of clinical supervision* (4th ed.). Upper Saddle River, NJ: Pearson Education.
- Bernard, J. M., & Goodyear, R. K. (2014). *Fundamentals of clinical supervision* (5th ed.). Boston, MA: Pearson.
- Carroll, M. (2010). Supervision: Critical reflection for transforming learning (Part 2). *The Clinical Supervisor*, 29, 1-19. doi: 10.1080/07325221003730301
- Center for Substance Abuse Treatment (CSAT). (2009). *Clinical Supervision and Professional Development of the Substance Abuse Counselor* (Treatment Improvement Protocol (TIP) Series 52). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Ellis, M. V., Berger, L., Hanus, A. E., Ayala, E. E., Swords, B. A., & Siembor, M. (2014). Inadequate and harmful clinical supervision: Testing a revised framework and assessing occurrence. *The Counselling Psychologist*, 42(4), 434-472. <http://dx.doi.org/10.1177/0011000013508656>
- Hart, G.M. (1982). *The process of clinical supervision*. Baltimore, MD: University Park Press.
- Howard, F. M. (1997). Supervision. In H. Love & W. Whittaker (Eds.), *Practice issues for clinical and applied psychologists in New Zealand*. Wellington, NZ: The New Zealand Psychological Society.
- Mastoras, S. M., & Andrews, J. J. (2011). The supervisee experience of group supervision: Implications for research and practice. *Training and Education in Professional Psychology*, 5(2), 102-111. doi: 10.1037/a0023567
- Milne, D. (2009). *Evidence-based clinical supervision: Principles and practice*. Chichester, United Kingdom: UPS Blackwell.
- National Centre for Education and Training on Addiction (NCETA). (2005). *Clinical supervision resource kit for the alcohol and other drugs field*. Adelaide, SA: Author.
- Ogren, M., Boethius, S. V., & Sundin, E. (2014). Challenges and possibilities in group supervision. In C. Watkins & D. Milne (Eds.), *The Wiley international handbook of clinical supervision* (1st ed., pp. 648-669). Retrieved from <http://mastor.cl/blog/wp-content/uploads/2016/09/C.-Edward-Watkins-Jr.-Derek-L.-Milne-The-Wiley-International-Handbook-of-Clinical-Supervision-Wiley-Blackwell-2014.pdf>
- Proctor, B. (1988). A co-operative exercise in accountability. In M. Marken & M. Payne (Eds.), *Enabling and ensuring: supervision in practice*. Leicester, United Kingdom: National Youth Agency.
- Power, S. (2006). Boundaries and responsibilities in clinical supervision. In J. Driscoll (Ed.), *Practising clinical supervision: A reflective approach for healthcare professionals* (2nd ed., pp. 53-71). Cambridge, United Kingdom: Bailliere Tindall, Elsevier Ltd.

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## 10. Stress and burnout

### Stress

A manageable level of stress in the workplace is normal and can be motivating. There are various sources of stress in the workplace, the most common of which are workload and time pressures. Other common sources of stress include concerns about:

- making a difference
- having the necessary competencies to do the job effectively
- whether staff are valued in the workplace
- adequate remuneration.

Issues such as distressing outcomes for clients, conflict in the workplace, feeling unsupported by management, a lack of support for further training and 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.

Working in the AOD sector can be a very rewarding experience. Sources of job satisfaction and reward for workers include:

- the opportunity to help and work directly with people
- feeling their work makes a valuable contribution to society
- the opportunity for growth and development on personal and professional levels (Skinner & Roche, 2005).

On the other hand, there is increasing recognition that workers in the health and human services fields often experience high levels of work-related demands and stressors, and are therefore particularly vulnerable to stress, burnout or vicarious trauma (Ewer, Teesson, Sannibale, Roche, & Mills, 2015). This is particularly pertinent to workers who work directly with clients (have an active caseload) (Best, Savic, & Daley, 2016).

Many Aboriginal AOD workers have a heavier burden and experience a greater range of stressors and pressures in their work roles than non-Aboriginal AOD workers. The work that Aboriginal AOD workers undertake is often complex and demanding, and can entail very personally relevant issues (Gleadle et al., 2010), including:

- loss and grief
- trauma
- stigma
- social disruption.

### Burnout

Burnout is a term used to describe the experience of long-term strain and exhaustion as a result of chronic work stressors (Maslach & Leiter, 2016). Burnout tends to occur when the experience of stress is intense and prolonged and coping strategies prove ineffective. The following workplace factors increase the risk of burnout (Maslach & Leiter, 2016):

- excessive workload and time pressure
- role conflict (conflicting job demands that have to be met)
- role ambiguity (uncertainty about the roles and responsibilities of a job)
- lack of social support from co-workers and supervisors
- lack of feedback about performance
- lack of control or involvement in decision-making.



The experience of burnout has three recognised dimensions (Maslach & Leiter, 2016):

- physical and emotional exhaustion
- cynicism and detachment from the job
- a sense of inefficacy.

Exhaustion refers to the impact of chronic work-related stress, which may lead to feeling over-extended and emotionally and physically drained. The cynicism component of burnout refers to a negative view towards work, or the workplace in general, and can be associated with a detached response or depersonalisation at work. This is a particular concern when working in the AOD or health-related sectors, as workers who experience burnout may feel that they have lost their human touch with clients and become cynical about their profession. Finally, the reduced efficacy aspect of burnout refers to feelings of incompetence or lacking a sense of achievement. This is also of concern for AOD workers given the high rates of relapse among clients.

Burnout is associated with job dissatisfaction and workers who experience burnout are more likely to be absent from work or resign (Tziner, Rabenu, Radomski, & Belkin, 2015). Burnout is also associated with negative stress-related physical health outcomes. Burnout is a particularly important issue in the AOD sector as it seriously affects workers' ability to continue to deliver a quality service. Workers may feel emotionally exhausted, become cynical about their work, feel detached from clients and ineffective in their ability to help. This can have an obvious negative impact on the therapeutic alliance.

Prevention of burnout is paramount to ensure retention of staff and worker wellbeing (Morse, Salyers, Rollins, Monroe-DeVita, & Pfahler, 2012) and support from co-workers and clinical supervision is critical in this regard (Maguire, Grellier, & Clayton, 2012). If staff feel concerned about the level of work-related stress that they are experiencing, or if they start to feel cynical, detached or ineffective at work, they should raise this issue with a supervisor and make arrangements for support. Workers generally have access to free employee assistance programs which they can access should they experience work-related burnout or other issues which contribute to work stress.

## **Coping with stress and preventing burnout**

Coping strategies to manage stress and prevent burnout are critical in AOD counselling. Active coping has been associated with reduced levels of stress and reduced likelihood of burnout (Garrosa & Moreno-Jiménez, 2013).

Active coping strategies include the following:

- physical self-care: eating well, sleeping well, exercising, allocating time for relaxation and leisure activities
- emotional self-care: taking opportunities to talk and debrief
- professional self-care: maintaining adequate support, clinical supervision, professional development, time management, and addressing any concerns about work demands, unfairness or inequity.

Engagement in the workplace and appreciation of the value of the work can reduce the risk of burnout, particularly among AOD workers (Vilardaga et al., 2011). It is important for AOD workers to have realistic expectations about client outcomes and to recognise the value of providing evidence-based treatment to clients.

## Stress and burnout – tip sheet

There are multiple sources of stress in the workplace. The most common sources of stress are workload and time pressures. Other sources of stress include:

- concerns about making a difference in a role
- concerns about doing a job effectively
- concerns about whether staff are valued and adequately remunerated
- distressing outcomes for clients
- conflict in the workplace
- feeling unsupported by management
- lack of support for training and clinical supervision
- job uncertainty
- lack of collegiality.

Burnout is a term used to describe the experience of long-term strain and exhaustion. It is a response to work overload when stress is intense and prolonged and coping strategies prove ineffective. Burnout has three components:

- physical and emotional exhaustion from stress
- cynicism and detachment from work
- a sense of inefficacy.

Burnout is a particular concern among counsellors because it seriously affects the ability to provide a quality service. Counsellors who experience burnout may become exhausted, detached from clients, and feel ineffective and cynical about their profession.

Aboriginal AOD workers may experience a greater range of stressors and pressures in their work roles than non-Aboriginal AOD workers.

Workplace risk factors that have been associated with burnout include:

- excessive workload and time pressure
- role conflict from incompatible job demands
- role ambiguity due to unclear goals
- lack of support from co-workers and supervisors
- lack of feedback about performance
- lack of control and involvement in decision-making.

If staff feel concerned about their risk of burnout, they should raise this issue with a supervisor and make arrangements for support, including the use of employee assistance programs where available. Management of stress and prevention of burnout is critical among AOD counsellors. Active coping strategies include the following:

- physical self-care: eating well, sleeping well, exercising, relaxation and leisure activities
- emotional self-care: taking opportunities to talk and debrief
- professional self-care: maintaining adequate support, clinical supervision, professional development, time-management, and addressing concerns about work demands, unfairness or inequity.

## References

- Best, D., Savic, M., & Daley, P. (2016). The well-being of alcohol and other drug counsellors in Australia: Strengths, risks, and implications. *Alcoholism Treatment Quarterly*, 34(2), 223-232. <https://doi.org/10.1080/07347324.2016.1148514>
- Ewer, P. L., Teesson, M., Sannibale, C., Roche, A., & Mills, K. L. (2015). The prevalence and correlates of secondary traumatic stress among alcohol and other drug workers in Australia. *Drug and Alcohol Review*, 34(3), 252-258. doi:10.1111/dar.12204
- Garrosa, E., & Moreno-Jiménez, B. (2013). Burnout and active coping with emotional resilience. In S. Bährer-Kohler (Ed.), *Burnout for Experts* (pp. 201-221). Boston, MA: Springer.
- Gleadle, F., Freeman, T., Duraisingam, V., Roche, A., Battams, S., Marshall, B., ... Weetra, D. (2010). *Indigenous alcohol and drug workforce challenges: A literature review of issues related to Indigenous AOD workers' wellbeing, stress and burnout*. Adelaide, SA: National Centre for Education and Training on Addiction.
- Maguire, N., Grellier, B., & Clayton, K. (2012). The impact of CBT training and supervision on burnout, confidence and negative beliefs in a staff group working with homeless people. *Housing, Care and Support*, 15, 177-185.
- Maslach, C., & Leiter, M. P. (2016). Understanding the burnout experience: Recent research and its implications for psychiatry. *World Psychiatry*, 15(2), 103-111. doi:10.1002/wps.20311
- Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. *Administration and Policy in Mental Health and Mental Health Services Research*, 39(5), 341-352. doi:10.1007/s10488-011-0352-1
- Skinner, N., & Roche, A. M. (2005). *Stress and burnout: A prevention handbook for the alcohol and other drugs workforce*. Adelaide, SA: National Centre for Education and Training on Addiction.
- Tziner, A., Rabenu, E., Radomski, R., & Belkin, A. (2015). Work stress and turnover intentions among hospital physicians: The mediating role of burnout and work satisfaction. *Journal of Work and Organizational Psychology*, 31(3), 207-213. <https://doi.org/10.1016/j.rpto.2015.05.001>
- Vilardaga, R., Luoma, J., Hayes, S., Pistorello, J., Levin, M., Hildenbrandt, M., & Bond, F. (2011). Burnout among the addiction counseling workforce: The differential roles of mindfulness and values based processes and work-site factors. *Journal of Substance Abuse Treatment*, 40(4), 323-335. doi: 10.1016/j.jsat.2010.11.015

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# 11. Secondary traumatic stress, compassion fatigue, and vicarious trauma

Undertaking work with traumatised clients can be a rewarding experience, but it can also be challenging and emotional. Secondary traumatic stress (STS), compassion fatigue (CF) and vicarious trauma (VT) are terms used in the literature to describe possible negative emotional consequences of working with traumatised clients – of knowing about or being directly exposed to the effects of another person’s suffering (Huggard, Law, & Newcombe, 2017).

It is important to note that not every health professional who works with traumatised clients will develop STS, CF or VT, and experiencing indirect traumatisation such as VT does not reflect the worker’s level of competence. It is an effect of working with survivors of trauma and is considered a normal adaption to the ongoing exposure to client’s traumatic stories (Pearlman & Saakvitne, 1995). However, if a worker develops STS, CF or VT it may impair their therapeutic effectiveness and cause changes in their personal life. It is therefore vital that workers are supported to participate in activities to counter and manage any negative effects of STS, CF and VT.

## Secondary traumatic stress

Figley (1995, 2002) described STS as the natural emotional and behavioural consequence of indirectly knowing about trauma from the client’s stories, coupled with the desire to help and the associated feelings of stress. STS has features similar to post-traumatic stress disorder (PTSD) in that it manifests in three symptom clusters: intrusive thoughts (e.g. imagery relating to the client’s trauma), psychological arousal, and avoidance responses.

## Compassion fatigue

Compassion fatigue and STS are similar in meaning and often used interchangeably (Figley, 1995; Salston & Figley, 2003; Stamm, 1995). Figley (1995) refers to CF as a profound sense of cognitive, emotional, and spiritual exhaustion which may be expressed as anger, apathy, depression and ineffectiveness. Over time, CF could result in workers losing their ability to work empathically and objectively, and if they begin to react by protecting themselves from their client’s traumatic stories, they risk becoming less therapeutically effective (Figley, 2002).

## Vicarious trauma

Vicarious trauma has also been described as “... the negative transformation in the helper that results from empathic engagement with trauma survivors and their trauma material, combined with a commitment and responsibility to help them” (Pearlman & Caringi, 2009, p. 202). The difference between STS, CF and VT is that whereas STS and CF focus on workers’ responses such as experiencing intrusive thoughts and avoiding stimuli that may trigger memories or hyperarousal (jumpiness), VT focuses on long-term changes in a worker’s core beliefs about issues such as safety, trust and intimacy (McCann & Pearlman, 1990).

The possible symptoms of VT listed below are drawn from Pearlman and Caringi (2009) and Pearlman and Saakvitne (1995).

- Difficulty in:
  - managing emotions aroused in response to a client’s trauma stories
  - managing feelings
  - feeling stable and consistent
  - making decisions
- Somatic issues – experiencing intense thoughts, feelings and behaviours associated with physical symptoms (e.g. pain, fatigue) that interfere with daily life
- PTSD symptoms such as intrusive imagery (repeated flashbacks, nightmares, memories of the events clients have described)

- Alterations in personal frame of reference, including negative changes in views on spirituality, identity and the world
- Disruptions in interpersonal relationships and professional life as a result of a sense of loss of safety, trust, control, intimacy and self-esteem
- Acute stress disorder, depression or anxiety
- Loss of meaning and hope
- Difficulty with boundary management.

## STS, CF and VT in the AOD sector

Ewer, Teesson, Sannibale, Roche, and Mills (2014) noted that:

*Over recent years, there has been growing recognition of the high prevalence of trauma exposure and post traumatic stress disorder (PTSD) among clients of alcohol and other drug (AOD) services. Trauma exposure is almost universal in this population and up to two-thirds of clients have current PTSD. (p. 252)*

Ewer and colleagues conducted an anonymous web-based survey of 412 Australian AOD workers and identified an STS prevalence rate of 19.9%. STS was associated with a worker having higher caseloads of traumatised clients, less time in clinical supervision, and high levels of stress and anxiety. They also found that less than two thirds of workers with STS reported having ever received trauma training.

In 2017, Huggard and colleagues conducted a systematic review of literature on the presence of VT, CF and STS in AOD clinicians. They found that although these terms were used to describe the emotional consequences for a broad range of health professionals working with traumatised clients, little information related directly to the impact on AOD workers. They noted that the reviewed literature demonstrated that AOD workers were at risk of experiencing STS and CF, but VT was not discussed. Huggard et al. (2017) speculated that the absence of literature relating to VT in the AOD field was indicative of limited awareness about VT in this sector.

## Strategies to manage and prevent STS, CF and VT

General personal and professional self-care strategies for workers include:

- recognising and acknowledging the risk of VT
- developing self-awareness
- using effective coping strategies and self-care practices
- developing a plan to engage in regular wellness activities
- maintaining a balance between work, play and rest to encourage healthy functioning
- seeking healing activities and connecting to spiritual needs
- seeking personal growth opportunities
- seeking effective supervision
- maintaining professional connections
- avoiding isolation
- participating in activities such as journalling, personal counselling, meditation, and seeking emotional support from significant others in order to reconnect with and manage emotions.

Organisational strategies include:

- providing a comfortable, relaxed work atmosphere that promotes self-care
- providing continuing professional development and regular in-service training to increase understanding of VT, encourage self-awareness and highlight risk factors
- considering caseload and work conditions as well as support for individual staff strategies
- supporting peer supervision to decrease isolation and increase worker empathy, compassion, ethical debriefing, and encourage counsellors to express reactions to clients (e.g. countertransference), and reaffirm confidence in clinical skills
- ensuring supervision which supports reflective practice, debriefing and professional development (see chapter on **Clinical supervision**).

(Trippany, White Kress, & Wilcoxon, 2004)

## Vicarious post-traumatic growth

“With so much literature focusing on the negative impact of working with trauma survivors, it is important that adequate attention is also paid to the positive consequences of such work” (Manning-Jones, Terte, & Stephens, 2015, p. 135).

Saakvitne and Pearlman (1996) argued that VT may present opportunities for personal and spiritual growth through the use of adaptive self-care and coping strategies. Vicarious posttraumatic growth (VPTG) is the term used in the literature to refer to the positive changes that can develop as a result of indirect traumatic exposure (Arnold, Calhoun, Tedeschi, & Cann, 2005).

Manning-Jones et al. (2015) conducted a systematic literature review of VPTG. They found that, similar to the way clients can experience post-traumatic growth following a traumatic event, workers who have experienced indirect trauma exposure can experience VPTG. However, they also noted subtle differences. Direct trauma survivors often talk about a sense of increased personal strength, whereas workers report a more abstract sense of people’s general resilience in the face of adversity. Direct trauma survivors also frequently describe experiencing personal spiritual growth, in contrast to workers, who recognise more broadly that spiritual beliefs can be a useful healing tool. Other aspects of growth were unique to VPTG including the worker’s ability to make a difference in trauma survivor’s lives, acknowledgement of the value and importance of the work, and growth in professional skills. Overall, the review showed that workers with VPTG experienced increased competency, realisation of the value and importance of their work, and that they could make a difference in client’s lives.

## Factors that facilitate VPTG

Manning-Jones et al. (2015) also examined evidence about psychological, cognitive, behavioural, interpersonal and external factors that could assist the development of VPTG (they noted considerable inconsistency in the 28 articles they reviewed). They categorised the factors studied in the literature as follows.

Cognitive and psychological factors:

- empathic engagement
- optimism and positive affect
- negative affect (possibly reflecting the fact that a worker must first experience VT exposure before being able to develop VPTG)
- a sense of satisfaction, competence and value in their work
- compassion satisfaction – the positive feelings derived from helping others.

Behavioural factors:

- engaging in active and conscious self-care, coping strategies. For example, exercise, healthy eating, having a hobby, prayer, spiritual and religious activities, personal therapy.

Interpersonal factors:

- social support from peers
- supervision
- witnessing posttraumatic growth in clients.

External factors:

- time: with the ability to process and find meaning, a worker’s initial levels of distress can decrease and be replaced by personal growth.

## Secondary traumatic stress, compassion fatigue and vicarious trauma – tip sheet

Secondary traumatic stress, CF and VT are all terms used to describe the negative effects of working with clients and their experiences of trauma. STS and CF are similar and often used interchangeably. Workers with STS may experience symptoms and behaviours similar to PTSD, including intrusive thoughts, psychological arousal and avoidance responses. Cognitive, emotional and spiritual exhaustion are associated with CF. VT describes changes to a worker's inner thoughts and core beliefs. Although the literature relating to workers' experience of indirect trauma in the AOD field concludes there is a risk of developing STS and CF, it does not mention VT, indicating limited awareness of this concept.

Experiencing VT is not related to worker competency, but rather is a natural consequence of working with traumatised clients. However, VT can be minimised and managed.

### General personal and professional self-care strategies that can help to minimise VT

Secondary traumatic stress, CF and VT can be prevented and managed. It is important for workers to be aware of their own reactions when working with traumatised clients, make a conscious effort to connect with others such as peers and colleagues, and maintain a balance between personal and professional lives, with a focus on self-care activities.

### Agency strategies that can help to minimise VT

Agencies can assist to minimise VT by providing supportive workplaces that encourage staff self-care, provide ongoing professional development opportunities and regular supervision, as well as considering caseloads and related work conditions.

### Vicarious posttraumatic growth

Positive changes can occur in workers when they engage with clients' traumatic material. Workers may gain an appreciation of people's resilience, a greater sense of competency and growth in professional skills, and realise the value and importance of their work and the possibility of making a difference in their client's lives.

## References

- Arnold, D., Calhoun, L. G., Tedeschi, R., & Cann, A. (2005). Vicarious posttraumatic growth in psychotherapy. *Journal of Humanistic Psychology, 45*(2), 239-263. <https://doi.org/10.1177/0022167805274729>
- Ewer, P. L., Teesson, M., Sannibale, C., Roche, A., & Mills, K. (2014). The prevalence and correlates of secondary traumatic stress among alcohol and other drug (AOD) workers in Australia. *Drug and Alcohol Review, 34*(3), 252-258. doi: 10.1111/dar.12204.
- Figley, C. R. (1995). Systemic traumatization: Secondary traumatic stress disorder in family therapists. In R. Mikesell, D. Lusterman, & S. McDaniel (Eds.), *Integrating family therapy: Handbook of family psychology and systems theory* (pp. 571-581). Washington, DC: American Psychology Association.
- Figley, C. R. (2002). Compassion fatigue: Psychotherapists' chronic lack of self care. *Journal of Clinical Psychology, 58*(11), 1433-1441. doi: 10.1002/jclp.10090
- Huggard, P., Law, J., & Newcombe, D. (2017). A systematic review exploring the presence of vicarious trauma, compassion fatigue, and secondary traumatic stress in alcohol and other drug clinicians. *Australasian Journal of Disaster and Trauma Studies, 21*(2), 65-72. Retrieved from [https://www.massey.ac.nz/~trauma/issues/2017-2/AJDTS\\_21\\_2\\_Huggard.pdf](https://www.massey.ac.nz/~trauma/issues/2017-2/AJDTS_21_2_Huggard.pdf)
- Manning-Jones, S., de Terte, I., & Stephens, C. (2015). Vicarious posttraumatic growth: A systematic literature review. *International Journal of Wellbeing, 5*(2), 125-139. doi: 10.5502/ijw.v5i2.8
- McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*(1), 131-149. <https://doi.org/10.1002/jts.2490030110>
- Pearlman, L. A., & Caringi, J. (2009). Living and working self-reflectively to address vicarious trauma. In C. A. Courtois & J. D. Ford (Eds.), *Treating complex traumatic disorders: An evidence-based guide* (pp. 202-224). New York, NY: Guilford Press.
- Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York, NY: W. W. Norton & Company.
- Salston, M. D., & Figley, C. R. (2003). Secondary traumatic stress effects of working with survivors of criminal victimization. *Journal of Traumatic Stress, 16*(2), 167-174. doi: 10.1023/A:1022899207206
- Stamm, B. H. (Ed.). (1995). *Secondary traumatic stress: Self-care issues for clinicians, researchers, and educators*. Lutherville, MD: Sidran Press.
- Trippany, R. L., White Kress, V. E., & Wilcoxon, S. A. (2004). Preventing vicarious trauma: What counselors should know when working with trauma survivors. *Journal of Counseling & Development, 82*, 31-37. doi: 10.1002/j.1556-6678.2004.tb00283.x.



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## 12. De-escalating aggressive behaviours

Aggression can be defined as a behaviour or action that causes harm, hurt or injury to another person (National Institute for Health and Care Excellence [NICE], 2015). Aggressive behaviour is more than anger or antagonism; it involves some verbal attack or intimidation that is harmful or offensive to the person involved. Aggressive behaviour that includes physical violence can involve harm to individuals or damage to personal or public property (NSW Ombudsman, 2014).

Issues relating to anger and aggression are common in AOD services and should be managed carefully. Episodes of aggression are usually triggered by a particular event or set of circumstances that led the client to feel threatened or frustrated. Anger and aggression may occur regardless of whether a person has a co-occurring mental health condition.

Clients may have impaired impulse control or a history of trauma which can manifest as aggression due to emotional regulation issues (Rasche et al., 2016; Salo, Ursu, Buonocore, Leamon, & Carter, 2009) (see chapters on **Anger management** and **Co-occurring trauma issues**). Clients may also be intoxicated, frustrated or overwhelmed by multiple stressors.

If a client becomes aggressive, threatening or violent, it is important that workers respond in accordance with the policies and procedures specific to their service. It is also important for workers to know how to respond to challenging behaviour, including physical threats or actual violence, in their work with clients.

Signs that a client could become aggressive include:

- appearance: intoxicated, dishevelled or dirty, bloodstained, bizarre, carrying anything that could be used as a weapon
- physical activity: restless or agitated, pacing, standing up frequently, clenching of jaw or fists, hostile facial expressions with sustained eye contact, entering off-limits areas uninvited
- mood: angry, irritable, anxious, tense, distressed, difficulty controlling emotions
- speech: loud, swearing or threatening, sarcastic, slurred
- workers' reactions: fear, anxiety, unease, frustration, anger.

(NSW Department of Health, 2007)

### Managing safety with an aggressive client

If a client is aggressive, avoid escalating the situation. Soften your body language, verbal language and approach, maintaining a non-threatening manner and response. Attempt to reduce stimuli and move the client (if safe to do so) to an area without an audience, or remove other clients from the area.

If a client or other person is aggressive, consider your personal safety as well as the safety of the client and others. Prior to entering a counselling room with a client, assess their level of aggression. If you are concerned about the risk, do not confine yourself to a room alone with the client. Ideally, try to speak to them in a public place and remain in view of another member of staff. If you deem it safe to enter a counselling room with a client displaying aggressive behaviour, either leave the door open or ensure that both of you have an easy exit from the room. Ensure that you have access to help, such as a telephone, emergency button, a duress alarm, someone within hearing range or have a prearranged 'code word' to discretely signal that help is required. If you are enlisting the help of other people, request that they stand at the periphery as crowding may escalate the situation (Marel et al., 2016). It is also important to consider that the presence of a friend or family member might help to calm an aggressive client (Marel et al., 2016).

## De-escalation strategies when communicating with an aggressive client

The following strategies can be employed whilst waiting for assistance to arrive:

- Assess the person's behaviours and the level of risk. If you are concerned about the level of risk, do not confine yourself with or be alone with the person. For example, ensure all parties can exit easily and safely
- ensure personal safety if a person becomes aggressive (e.g. carry a duress alarm)
- reduce environmental stimuli as much as possible. For example, take the person to a quieter environment and reduce light, noise and human traffic (if it is safe to do so or remove other people from the area if more appropriate)
- have one person approach the client and take control of the situation (with support close by if needed)
- approach from the front of the person so they don't get startled
- be respectful of the person's personal space – stay at least two metres away
- approach the person slowly and convey a sense of confidence
- keep language simple and speak calmly and clearly, maintaining a non-threatening tone of voice
- convey messages of help; (e.g. how can I help you feel safe?)
- attempt to establish rapport and emphasise cooperation
- offer and negotiate realistic options
- allow the person to express their concerns and acknowledge them
- acknowledge the issue, validate the person's feelings and empathise with them (e.g. I can hear that you feel angry and frustrated right now)
- indicate possible alternatives to alleviate the anger-provoking situation (e.g. I want to understand what is going on for you and how we can sort it out)
- if you are enlisting the support of other people, ask them to stand nearby to observe and support, but not to overcrowd the person
- sometimes asking a friend or family member to talk to the person or assist can be helpful as they may know what approaches have been helpful in the past.

Unhelpful approaches which may escalate the situation include:

- confrontation and arguments
- dismissing delusional thoughts. Remember, the issue is real for the client
- taking the person's comments or behaviour personally.

(Jenner & Lee, 2008; MHC, 2017; NICE, 2015)

If engaging with the client is deemed too risky (i.e. the client has a weapon, is intimidating or threatening or is not responding to de-escalation), consider calling security or police for assistance. **Always follow your agency's policies and procedures.**

Responding to an aggressive client can be traumatic for a worker and other witnesses. After an aggressive incident, ensure those involved, including witnesses, have access to support and an opportunity to debrief (see chapter on **Critical incidents**).

After any interaction with an aggressive client, workers need to follow their agency's incident reporting procedure and any other post-incident processes. Always remember to prioritise self-care.

## De-escalating aggressive behaviours – tip sheet

### DO:

- stay calm and keep your emotions in check
- adopt a passive and non-threatening body posture (e.g. hands by your side with empty palms facing forward, body at a 45-degree angle to the aggressor)
- be aware of tone of voice and body language
- let the client air their feelings and acknowledge them
- ask open-ended questions to keep a dialogue going
- be flexible (within reason)
- use the space for self-protection (position yourself close to the exit, don't crowd the client)
- structure the work environment to ensure safety (e.g. have safety mechanisms in place such as alarms and remove items that can be used as potential weapons)
- make sure other clients are out of harm's way
- exit the situation if it is dangerous
- call security or police for assistance if necessary.

### AVOID:

- challenging or threatening the client
- saying things that will escalate the aggression
- yelling, even if the client is yelling at you
- turning your back on the client
- rushing the client
- arguing with the client
- dismissing verbal threats or warnings of violence
- trying to disarm a person with a weapon.

Note: If a client becomes aggressive, threatening or violent, it is important for workers to respond in accordance with the policies and procedures specific to their service.

## References

- Jenner, L., & Lee, N. (2008). *Responding to challenging situations related to the use of psychostimulants: A practical guide for frontline workers*. Canberra, ACT: Department of Health and Ageing. Retrieved from [http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/07FF9B0DE1B39D7ECA25764D0080C854/\\$File/chall.pdf](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/07FF9B0DE1B39D7ECA25764D0080C854/$File/chall.pdf)
- Marel, C., Mills, K.L., Kingston, R., Gournay, K., Deady, M., Kay-Lambkin, F., Baker, A., & Teesson, M. (2016). *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*. Sydney, NSW: National Drug and Alcohol Research Centre. Retrieved from <https://comorbidityguidelines.org.au/>
- Mental Health Commission, Western Australia (MHC). (2017). *Recognising and responding to amphetamine intoxication/toxicity and opioid overdose: a guide for first responders*. Perth: WA: Author.
- National Institute for Health and Care Excellence (NICE). (2015). *Violence and aggression: Short-term management in mental health, health and community settings*. Retrieved from <https://www.nice.org.uk/guidance/ng10>
- NSW Department of Health. (2007). *Mental health reference resource for drug and alcohol workers*. Sydney, NSW: Author.
- NSW Ombudsman. (2014). *Model Guidelines - Managing and responding to threats, aggressive behaviour and violence from members of the public*. Retrieved from <https://www.ombo.nsw.gov.au/news-and-publications/publications/guidelines/state-and-local-government/model-guidelines-managing-and-responding-to-threats,-aggressive-behaviour-and-violence-from-members-of-the-public>
- Rasche, K., Dudeck, M., Otte, S., Klingner, S., Vasic, N. & Streb, J. (2016). Factors influencing the pathway from trauma to aggression: A current review of behavioral studies. *Neurology, Psychiatry and Brain Research*, 22(2), 75-80. <https://doi.org/10.1016/j.npbr.2016.01.009>
- Salo, R., Ursu, S., Buonocore, M., Leamon, M., & Carter, C. (2009). Impaired prefrontal cortical function and disrupted adaptive cognitive control in methamphetamine abusers: A functional magnetic resonance imaging study. *Biological Psychiatry*, 65(8), 706–709. doi: 10.1016/j.biopsych.2008.11.026.

## 13. Critical incidents

*Critical incidents are sudden unexpected events that can be perceived as psychologically or physically threatening, such as verbal threats or physical assaults. Suicide, overdose or sudden death of a client can also be considered critical incidents. 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.*

(Marsh, O'Toole, Dale, Willis, & Helfgott, 2013, p. 86)

Critical incidents can affect both workers and organisations (DeFraia, 2015). Following a critical incident, some people may find it extremely difficult to function normally in the workplace. As with exposure to other potentially traumatising events, people's reactions may vary based on the following:

- nature and severity of the event(s) they experience
- experience with previous distressing events
- access to supports
- physical health
- personal and family history of mental health issues
- cultural background and traditions
- age (World Health Organization [WHO], War Trauma Foundation and World Vision International, 2011)
- workplace stressors and organisational culture (DeFraia, 2015; Gouweloos-Trines et al., 2017).

Note that agencies will have policies and procedures in place to manage critical incidents. It is important that counsellors are familiar with their workplace policy and procedure in responding to critical incidents. The information that follows highlights some key principles of recovery from critical incidents.

The literature suggests that formal interventions, such as critical incident stress management, can impair recovery. There is evidence that group debriefing sessions may actually increase the risk of PTSD and permanently distort the participants' memories of the event (Paterson, Whittle, & Kemp, 2015). Group debriefing is unlikely to have a preventative benefit beyond an informal social interaction, and people who are formally debriefed may be less inclined to utilise social supports (Deville & Annab, 2008). As outlined below, social support is an important factor in the aftermath of a crisis situation. Consequently, it is strongly recommended that debriefing is offered on an individual basis after a critical incident.

### Psychological first aid

Psychological first aid (PFA) is an approach to helping people affected by an emergency, disaster or traumatic event, and includes basic principles of support to promote natural recovery (Australian Red Cross & Australian Psychological Society, 2013). It is based on the understanding that people affected by traumatic events will experience a range of reactions which may interfere with their ability to cope. The objective of PFA is to promote safety, calm, connectedness, self and group efficacy, and hope.

It is important to remember that not everyone involved in a crisis will need PFA. The WHO et al. (2011) advise that PFA should not be forced upon people who do not want it. However, PFA should be easily accessible to those who may want support following an incident.

According to the WHO et al. (2011), the action principles of PFA are as follows:

#### 1. Look

- check for safety
- check for urgent needs
- check for serious distress.

#### 2. Listen

- approach people who may need support
- ask about people's needs and concerns
- listen to people, help them feel calm.

#### 3. Link

- help people to address basic needs
- help to cope with issues
- give information
- connect people with social and emotional supports.

The WHO et al. (2011) suggests PFA should be offered with the following ethical principles in mind:

- be honest and genuine
- respect people's right to make their own decisions
- respect privacy and confidentiality
- explain limits of confidentiality
- keep an 'open door'
- take into account gender, power, culture, age, etc.
- act only in the person's best interests
- avoid making promises you can't keep.

Support is very important after a critical incident. Workers recover from critical incidents when they feel supported by management and colleagues. Receiving time off to recover from stressful incidents at work is a form of support that appears to be beneficial for workers' wellbeing (Gouweloos-Trines et al., 2017). Workers who have been affected by the suicide of a client benefit from open communication in the workplace, peer supports, space to grieve, as well as opportunities to reflect on what occurred and learn from it (Finlayson & Simmonds, 2017).

## Offering support to others

Support is not counselling or therapy. All workers in an agency can be involved in offering support. When offering support, consider 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 other feelings personally
- be interested in the person, not just the situation
- be supportive in a practical way (e.g. 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. Share ideas on what you think would help, or what has worked for you and others you know, but respect their choices
- it is not helpful to 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 responds to the situation or incident
- don't expect to always have the answers to questions, or to be able to fix the person's issues.

(MHC, 2018)

If the worker who experienced the critical incident continues to have difficulties such as excessive anxiety, insomnia, withdrawing from others, or talking repeatedly about the event, more intensive intervention may be required. This may include counselling, for example through an employee assistance scheme, or in some cases long-term therapy.

## Documenting critical incidents

In the event of a critical incident it is important to record the following factual information in the case notes:

- when it occurred (date and time)
- where it occurred
- what happened (observations, not opinions)
- who was involved in the incident and who was present
- in the event of an injury, the individual's condition beforehand and afterwards
- what action staff took
- the name, position and agency of the person to whom the incident was reported.

## Self-care

It is important for counsellors to apply self-care strategies if involved in a critical incident. Self-care strategies may include:

- being aware of one's own reactions in highly stressful or distressing situations
- requesting supervision and support from colleagues
- limiting alcohol or other drug use
- accepting stress reactions as 'normal'
- exercise
- adequate rest and sleep
- relaxation and meditation.

Also see the chapter on ***Stress and burnout***.

### Critical incidents – tip sheet

Critical incidents are sudden unexpected events that are perceived as threatening, either psychologically or physically, such as verbal threats or physical assaults, client suicide or sudden death. People react differently to stressful events; there is no right or wrong way to respond to a critical incident.

Counsellors should be familiar with their agency's policy and procedures related to critical incidents.

Formal debriefing interventions may impair recovery. It is clear from the literature that social support can reduce the impact of a traumatic event. Following a critical incident, it is important that those affected receive practical and immediate support. Encourage utilisation of available primary supports, such as a partner or close friend. In addition, a co-worker may offer informal support and assistance (see below).

Psychological first aid is an approach aimed at fostering normal recovery following a traumatic event. The approach is non-intrusive and aims to build upon available social supports and coping skills.

Important principles in managing a critical incident include:

- do not assume that someone who has experienced a critical incident will be traumatised
- avoid labelling normal reactions, such as shock or stress, as 'symptoms'
- avoid being intrusive or assuming that a colleague will want to talk about it in the workplace.

It is important that counsellors apply self-care strategies if involved in a critical incident.

## Guidelines for offering support

Social 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, consider the following:

- 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 (e.g. 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. Share ideas on what you think would help, or what has worked for you and others you know, but respect their choices
- 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 responds to the situation or incident
- don't expect to always have the answers to questions, or to be able to fix the person's issues
- know your limits. Be aware of any ongoing negative changes in behaviour, declining emotional condition, or other reactions that indicate the person may need professional help
- if you find the person who experienced the critical incident continues to have difficulties, more intensive intervention, such as formal counselling or therapy, may be required.

Document the incident: when and where it occurred, what happened, who was present and their involvement, whether there were injuries, actions taken, and to whom it was reported.

## References

- Australian Red Cross & Australian Psychological Society. (2013). *Psychological first aid: An Australian guide to supporting people affected by disaster*. Carlton, VIC: Author.
- DeFraia, G. S. (2015). Psychological trauma in the workplace: Variation of incident severity among industry settings and between recurring vs isolated incidents. *The International Journal of Occupational and Environmental Medicine*, 6(3), 155-168. doi: 10.15171/ijoem.2015.545
- Devilly, G. J., & Annab, R. (2008). A randomised controlled trial of group debriefing. *Journal of Behavior Therapy and Experimental Psychiatry*, 39(1), 42-56. doi: 10.1016/j.jbtep.2006.09.003
- Finlayson, M., & Simmonds, J. (2017). Workplace responses and psychologists' needs following client suicide. *OMEGA - Journal of Death and Dying*. doi: 10.1177/0030222817709693
- Gouweloos-Trines, J., Tyler, M. P., Giummarra, M. J., Kassam-Adams, N., Landolt, M. A., Kleber, R. J., & Alisic, E. (2017). Perceived support at work after critical incidents and its relation to psychological distress: A survey among prehospital providers. *Emergency Medicine Journal*, 34(12), 816-822. doi: 10.1136/emered-2017-206584
- Marsh, A., O'Toole, S., Dale, A., Willis, L., & Helfgott, S. (2013). *Counselling guidelines: Alcohol and other drug issues* (3rd ed.). Perth, WA: Drug and Alcohol Office.
- Mental Health Commission, Western Australia (MHC). (2018). *Crisis referral tool: For AOD services*. Perth, WA: Author. Retrieved from <https://www.mhc.wa.gov.au/media/2422/crisis-referral-tool-2018.pdf>.
- Paterson, H. M., Whittle, K., & Kemp, R. I. (2015). Detrimental effects of post-incident debriefing on memory and psychological responses. *Journal of Police and Criminal Psychology*, 30(1), 27-37. doi: 10.1007/s11896-014-9141-6
- World Health Organization, War Trauma Foundation, & World Vision International. (2011). *Psychological first aid: guide for fieldworkers*. Retrieved from [http://apps.who.int/iris/bitstream/handle/10665/44615/9789241548205\\_eng.pdf;jsessionid=B709CA1C10223B94BAFCA9561E9CF147?sequence=1](http://apps.who.int/iris/bitstream/handle/10665/44615/9789241548205_eng.pdf;jsessionid=B709CA1C10223B94BAFCA9561E9CF147?sequence=1)



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## 14. Case management

Case management is a collaborative, integrated and coordinated approach to the acquisition and delivery of services and provision of supportive care. It is intended to meet individual or family needs in order to increase their functioning and living in the community (Vanderplasschen, Rapp, Wolf, & Broekaert, 2004). The primary difference between case management and therapy is that case management focuses on assisting the client to obtain resources, while therapy focuses on facilitating intra- and interpersonal change. Case management and therapy are not mutually exclusive; generally both are required for addressing the needs of complex clients (Center for Substance Abuse Treatment (CSAT), 2000). Case management models include assertive community treatment, broker or generalist, clinical, rehabilitation and strengths-based (Rapp, Van Den Noortgate, Broekaert, & Vanderplasschen, 2014).

Case management is a particularly useful approach to clients with complex issues, or where services are fragmented or hard to access (CSAT, 2000; Savic, Best, Manning, & Lubman, 2017). People who present to services with AOD issues often have a range of psychosocial needs that impact on their AOD use, such as accommodation, employment, relationships, health and legal issues. Failing to address these co-occurring issues may exacerbate the client's AOD use and result in treatment drop-out. Indeed, evidence-based treatments for clients with AOD issues do not focus exclusively on the substance use; they also aim to address other psychosocial issues and improve the client's quality of life (Miller et al., 2011).

The aims of a case management approach are to increase the likelihood that clients receive specialist assistance where needed and to facilitate retention in treatment. Where case management involves regular face-to-face contact between the client and case manager, it is effective in increasing clients' use of community-based services, improving quality of life, increasing client satisfaction and prolonging treatment retention (Joo & Huber, 2015; Penzenstadler, Machado, Thorens, Zullino, & Khazaal, 2017; Rapp et al., 2014). Retention in treatment, in turn, has been consistently associated with better treatment outcomes among AOD-using populations (Rapp et al., 2014).

The core elements of AOD case management are:

- assessment of the client's health, social and emotional needs
- planning, facilitation and coordination of appropriate services
- monitoring to ensure the client is receiving the services
- 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. Case managers assist clients to identify and work towards their goals (see chapter on **Goal-setting**), participate in case reviews and discussions, and participate in supervision. The range of activities of case managers is often limited by agency guidelines and the client load they are expected to carry.

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

The broad principles of case management are that it:

- offers the client a single point of contact with health and social services
- is client-centred and driven by the client's needs
- involves advocacy
- is community based
- is pragmatic
- is anticipatory
- is flexible
- is culturally sensitive.

(CSAT, 2000)

In Australia the most common forms of case management are primary and shared case management.

## Primary case management

Primary (or single-agency) case management involves one case manager who personally establishes separate relationships with other professionals or services as required. These services and professionals may be located within the same agency, for example a multidisciplinary team, or at external agencies. The case manager retains full and autonomous control over the case and is responsible only to the parent agency (CSAT, 2000).

For example, a mental health case manager working with a clinically depressed mother of two who is using cannabis may refer the client to an AOD counsellor for help with drug-related issues, a psychiatrist for treatment of the depression, and a child protection agency to assist with child protection and parenting issues. The mental health case manager in this example is responsible for the overall coordination of services and ensuring that the client's overall needs are met.

## Shared case management

Shared (or interagency) case management involves several professionals who work collaboratively to coordinate services to respond to multiple and complex client needs (Savic et al., 2017). Case management may be shared across a single agency (e.g. a mobile assertive treatment team) or may occur across multiple agencies as either a formal or informal arrangement. There is some evidence to suggest that this model of case management is associated with higher client satisfaction, perhaps because it enables the prompt availability of a team of professionals who can help to address the client's needs (Day et al., 2011). 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.

Whether a primary or shared case management model is used, interagency cooperation is essential for effective case management (Marel et al., 2016). For example, a mental health service and an AOD treatment service may work together to meet the needs of a client experiencing amphetamine psychosis. The mental health service may address the mental health issues via medication and periodic admissions, and the AOD service might provide ongoing counselling for relapse prevention and management. Ideally the two services would communicate and share information on client progress, barriers to progress, aims of treatment and short-term goals. This open communication ensures the client receives a coordinated and complementary overall service from both agencies.

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

Important contributors to a high standard of structured case management and service coordination are:

- continuity of services during staff turnover
- clear lines of authority and control over all aspects of the case management process
- a formal record of agreements and responsibilities among agencies
- accountability of all agencies involved.

Whether a primary or shared model is used, interagency cooperation and good communication are essential for effective case management (Marel et al., 2016). Case management is most effective when the required services are accessible and when the case manager forms a strong working relationship with the client and follows a structured approach that includes time allocated to functions such as goal-setting, client advocacy and service coordination (Miller et al., 2011).

## Case management – tip sheet

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

Case management is client-centred and involves advocacy to meet the client's needs. It 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 primary difference between case management and therapy is that case management focuses on assisting the client to obtain resources, while therapy focuses on facilitating intra- and interpersonal change. Case management and therapy are generally both required for addressing the needs of complex clients.

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. Shared case management involves several professionals working collaboratively as a team.

Case managers should:

- work with the client to identify treatment and service needs
- assist clients to identify and work towards their goals
- obtain written informed consent from the client prior to sharing any client-related information with other service providers
- locate service options
- link clients with appropriate services
- monitor clients' progress in treatment
- evaluate services provided to clients
- advocate for the client as necessary
- participate in client case reviews and supervision.

Effective case management involves:

- clear and open communication between professionals
- 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
- a contract (written or verbal) that outlines the expectations and boundaries of service provision.

## References

- Center for Substance Abuse Treatment (CSAT). (2000). *Comprehensive case management for substance abuse treatment* (Treatment Improvement Protocol (TIP) Series No. 27). Retrieved from <https://store.samhsa.gov/shin/content/SMA15-4215/SMA15-4215.pdf>
- Day, C. A., Demirkol, A., Tynan, M., Curry, K., Hines, S., Lintzeris, N., & Haber, P. S. (2011). Individual versus team-based case-management for clients of opioid treatment services: An initial evaluation of what clients prefer. *Drug & Alcohol Review, 31*(4), 499-506. doi: 10.1111/j.1465-3362.2011.00347.x
- Joo, J. Y., & Huber, D. L. (2015). Community-based case management effectiveness in populations that abuse substances. *International Nursing Review, 62*(4), 536-546. doi: 10.1111/inr.12201
- Marel, C., Mills, K.L., Kingston, R., Gournay, K., Deady, M., Kay-Lambkin, F., Baker, A., & Teesson, M. (2016). *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*. Sydney, NSW: Centre of Research Excellence in Mental Health and Substance Use. Retrieved from <https://comorbidityguidelines.org.au/>
- Miller, W. R., Forcehimes, A. A., Zweben, A., & McLellan, A. T. (2011). *Treating addiction. A guide for professionals*. New York, NY: The Guilford Press
- Penzenstadler, L., Machado, A., Thorens, G., Zullino, D., & Khazaal, Y. (2017). Effect of case management interventions for patients with substance use disorders: A systematic review. *Frontiers in Psychiatry, 8* (51). doi: 10.3389/fpsy.2017.00051
- Rapp, R. C., Van Den Noortgate, W., Broekaert, E., & Vanderplasschen, W. (2014). The efficacy of case management with persons who have substance abuse problems: A three-level meta-analysis of outcomes. *Journal of Consulting and Clinical Psychology, 82*(4), 605-618. doi: 10.1037/a0036750
- Savic, M., Best, D., Manning, V., & Lubman, D. I. (2017). Strategies to facilitate integrated care for people with alcohol and other drug problems: A systematic review. *Substance Abuse Treatment, Prevention, and Policy, 12*(1), 19. doi: 10.1186/s13011-017-0104-7
- Vanderplasschen, W., Rapp, R. C., Wolf, J. R., & Broekaert, E. (2004). The development and implementation of case management for substance use disorders in North America and Europe. *Psychiatric Services, 55*(8), 913-922. doi: 10.1176/appi.ps.55.8.913

# 3

## Section Three: AOD Knowledge And Skills

- 15 Managing intoxicated clients
- 16 Withdrawal management
- 17 Pharmacotherapies for AOD dependence
- 18 Recovery
- 19 Stages of change

## 15. Managing intoxicated clients

It is likely that a counsellor working with people who use AODs will at some stage have to respond to a client who is intoxicated. Basic life support training or more comprehensive first aid training is recommended for counsellors working directly with AOD using clients. It is important that counsellors are aware of their agency's policy and procedures relating to intoxicated clients.

Intoxication is normally a transient state that follows the administration of psychoactive substances, and manifests as disturbances in levels of consciousness, cognition, perception, affect, behaviour or other psychophysiological functions (WHO, 2018). Intoxication can result from deliberate self-poisoning, accidental ingestion and intentional intoxication with alcohol and/or other drugs (Saunders et al., 2016). Symptoms of intoxication can range in severity from mild changes in behaviours and mental state through to life-threatening overdose (Donroe & Tetrault, 2017); this is normally determined by the quantity (or purity) of a drug that is taken.

A risk assessment should be undertaken with clients who present as intoxicated, especially those who present as severely intoxicated, as they may require medical assistance or be at risk to themselves or others. Factors to consider in a risk assessment include:

- the individual's level of dependency
- medical history (e.g. diabetes, epilepsy, head injury)
- AOD use history
- risk factors (e.g. overdose, suicide attempts, trauma history)
- AOD and other substance/s taken, including dose, route of administration, time taken
- likely and possible worst-case scenarios and ways to prevent these occurring.

(Saunders et al., 2016)

The client's presenting symptoms will vary depending on the nature of the drug/s taken, along with individual and environmental factors. Clients who are intoxicated with alcohol or benzodiazepine may present as disinhibited, have impaired memory and concentration, be sedated, have slurred speech and be emotionally labile<sup>3</sup>. Clients who are intoxicated with opioids may present similarly in terms of sedation, but also have slowed breathing, drowsiness and constricted or 'pinned' pupils (Donroe & Tetrault, 2017). If affected by stimulants, clients will present with increased physical and mental activity which can result in agitation and irritability (MHC, 2017).

Clients may also become verbally and/or physically abusive to counsellors, staff or other clients (see chapter on **De-escalating Aggressive Behaviours**). Counsellors should enlist the assistance of other staff if they believe the person is likely to become aggressive. If the client is aggressive, the counsellor should follow their agency's critical incident policy and procedures (see chapter on **Critical Incidents**).

Clients may be intoxicated by AOD that cause visual or perceptual distortions or may be experiencing symptoms of psychosis, including paranoia, delusions (of grandiosity, control and persecution), misperceptions and hallucinations. When clients are exhibiting symptoms of psychosis, explore whether the symptoms are transient, episodic or prolonged and assess whether the client has any insight into their symptoms. It will be important to reassess the client's mental state when they are not intoxicated.

It is important to note that medical conditions can present similarly to intoxication. For example, traumatic brain injury symptoms can include slurred speech and impaired balance. If a client requires immediate medical attention, call triple zero (000) and ask for an ambulance.

<sup>3</sup> An emotionally labile client may present with rapid and exaggerated mood changes, displaying strong emotions. These emotions may not suit the situation, or may be expressed much more strongly than the situation dictates.

## Toxicity and overdose

Severe amphetamine intoxication can quickly lead to toxicity, which is a medical emergency. Signs and symptoms of severe amphetamine intoxication can include:

- rapid breathing
- overheating
- severe persistent headache
- rapid pulse
- increased physical strength (due to increased adrenaline)
- intense headache
- jaw clenching
- uncoordinated movements
- body stiffness and rigid limbs
- psychomotor agitation – inability to stay still.

(Jenner & Lee, 2008)

Clients experiencing toxicity are at high risk of the following:

- chest pain
- fever
- difficulty breathing
- heart attack
- stroke
- psychotic features (hallucinations, severe paranoia, delusions or thought disorder)
- seizures
- uncontrolled hypertension (high blood pressure).

(MHC, 2017)

When a person experiences opioid overdose, they show one or more of the following signs or symptoms:

- blue lips, toenails and fingernails due to lack of oxygen. If the person has dark skin the inside of the mouth or eyelid will appear blue/grey in colour and not pink
- very slow and shallow breathing or not breathing at all. If they have been nodding off, this may not be particularly noticeable
- snoring or gurgling sound (similar to sleep apnoea)
- no response to touch or voice (calling their name).

(MHC, 2017)

In the event of an overdose situation follow first aid protocols (DRSABCD: Danger – Response – Send for help – Airway – Breathing – CPR [cardiopulmonary resuscitation] – Defibrillator), call an ambulance and refer to agency policy and procedures for medical emergencies. If your agency or the client has access to naloxone, administer it according to instructions.

## Client appointments

If the client is not severely intoxicated or impaired, it may be beneficial to have a shortened session to acknowledge the fact that the client has made an effort to attend the appointment (Glidden-Tracey, 2009). Some clients will continually attend sessions under the influence of AOD. It is important that counsellors establish boundaries concerning 'acceptable' levels of intoxication. This will depend on the agency's policy, the client, the goal of therapy and the client's behaviour while intoxicated.

If a client presents in a severely intoxicated state, it is suggested that the counsellor see the client briefly, explain that little is likely to be achieved in the session because of the level of intoxication, and reschedule the appointment. Try to reach an agreement that the client will be less intoxicated for the next session. In addition, depending on the client's behaviour and appearance, the counsellor may need to arrange medical attention for the client or an alternative means of transport home if possible (Glidden-Tracey, 2009); this may include contacting a friend or family member (with the client's permission). Counsellors should also consider their duty of care to their client's safety.

## Approaching intoxicated clients

It is important for counsellors to approach clients in a non-judgemental way, while maintaining the safety of the client, staff and any onlookers. Some general guidelines for approaching intoxicated clients are as follows:

- ensure your own safety if a person becomes aggressive
- reduce environmental stimuli as much as possible. For example, take the person to a quieter environment and reduce light, noise and human traffic
- use one person to approach and take control of the situation (with support close by if needed)
- approach from the front or side of the person so they don't get surprised
- be respectful of the client's personal space, try to give the client a 'bubble' of two metres
- approach the client slowly and with a sense of confidence
- keep language simple and speak calmly and clearly
- convey the message that you are there to assist by asking, "how can I help you?"
- avoid confrontation and arguments – this can often escalate behaviour
- allow the client to express any concerns and acknowledge them
- encourage the client to regulate their breathing with slow deep breaths
- take the client to a cool place, and encourage them to remove heavy or restrictive clothing if necessary
- if the client appears to be very hot, consider offering a cool, wet towel or compress on the back of the neck to cool them down. Usually overheating is related to amphetamine toxicity
- do not dismiss delusional thoughts; remember they are real for the client
- if possible, attempt to delay more use of alcohol or other drugs
- if the client has consumed amphetamines or ecstasy, encourage them to maintain their fluid intake by having regular small sips of water.

(MHC, 2017)

### Managing intoxicated clients – tip sheet

A risk assessment should be undertaken with intoxicated clients, especially those who present as severely intoxicated, as they may require medical assistance or pose a risk to themselves or others. Factors to consider in a risk assessment include:

- individual (medical history, drug history, risk factors)
- AOD and other substance/s taken, including dose, route of administration, time taken
- likely and worst-case scenarios and ways to prevent these occurring.

It is important for counsellors to approach clients in a non-judgemental way, while maintaining the safety of the client, staff and onlookers. Counsellors should enlist the assistance of other staff if they are concerned about the client's or other people's safety.

Severe intoxication can lead to overdose or toxicity, both of which are medical emergencies. Basic life support training or more comprehensive first aid training is recommended for counsellors working with clients who use AOD.

Some medical conditions can present similarly to intoxication. For example, traumatic brain injury symptoms can include slurred speech and impaired balance.



General guidelines for responding to intoxicated clients include:

- ensure your own safety if a client becomes aggressive
- reduce environmental stimuli as much as possible. For example, take the client to a quieter environment and reduce light, noise and human traffic
- use one person to approach and take control of the situation (with support close by if needed).
- approach from the front or side of the client so they don't get surprised
- be respectful of the client's personal space, approach to two metres distance
- approach the client slowly and with a sense of confidence
- keep language simple and speak calmly and clearly
- convey the message that you are there to assist by asking, "how can I help you?"
- avoid confrontation and arguments as this can often escalate behaviour
- allow the client to express any concerns and acknowledge them
- encourage the client to regulate their breathing with slow deep breaths
- take the client to a cool place, and encourage them to remove heavy or restrictive clothing if necessary
- if the client appears to be very hot, consider offering a cool, wet towel or compress on the back of the neck to cool them down. Usually overheating is related to amphetamine toxicity.
- do not dismiss delusional thoughts; remember it is real for them
- if possible, attempt to delay more use of alcohol or other drugs
- if the client has consumed amphetamines or ecstasy, encourage them to maintain their fluid intake by having regular small sips of water.

If the client is not severely intoxicated or impaired, it may be beneficial to have a shortened session to acknowledge the fact that the client has made an effort to attend the appointment. It is suggested that the counsellor see the client briefly, explain that little is likely to be achieved in the session because of the level of intoxication, and suggest that the appointment is rescheduled.

## References

- Donroe, J. H., & Tetrault, J. M. (2017). Recognizing and caring for the intoxicated patient in an outpatient clinic. *Medical Clinics of North America*, 101(3), 573-586. <https://doi.org/10.1016/j.mcna.2016.12.012>
- Glidden-Tracey, C. E. (2009). *Counseling and therapy with clients who abuse alcohol or other drugs*. Mahwah, NJ: Lawrence Erlbaum Associates.
- Jenner, L., & Lee, N. (2008). *Responding to challenging situations related to the use of psychostimulants: A practical guide for frontline workers*. Canberra, ACT: Department of Health and Ageing. Retrieved from [http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/07FF9B0DE1B39D7ECA25764D0080C854/\\$File/chall.pdf](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/publishing.nsf/Content/07FF9B0DE1B39D7ECA25764D0080C854/$File/chall.pdf)
- Mental Health Commission, Western Australia (MHC). (2017). *Recognising and responding to amphetamine intoxication/toxicity and opioid overdose: A guide for first responders*. Perth, WA: Author.
- Saunders, J., Conigrave, K., Latt, N., Nutt, D., Marshall, J., Ling, W., & Higuchi, S. (2016). *Addiction medicine* (2nd ed.). Oxford, United Kingdom: Oxford Medical Publications.
- World Health Organization (WHO). (2018). Management of substance abuse: Intoxication. Retrieved from [http://www.who.int/substance\\_abuse/terminology/acute\\_intox/en/](http://www.who.int/substance_abuse/terminology/acute_intox/en/)

## 16. Withdrawal management

Withdrawal from AOD dependence entails the reversal of neuroadaptation<sup>4</sup> (Manning et al., 2018). Withdrawal occurs as the experience of physical and psychological reactions as the person adjusts to the drug's absence from the body. Additionally, social factors can play a significant part in a person's withdrawal; therefore withdrawal management encompasses strategies which address the biopsychosocial elements of withdrawal. The degree to which each of these elements affects the person's AOD use will influence the experience of withdrawal (Manning et al., 2018). Supportive care and client choice are central to successful withdrawal.

Withdrawal from AODs can be managed in various settings depending on the level of medical care required. A stable client with mild dependence can be managed as an outpatient by a general practitioner (GP) or home-based withdrawal service.

Home-based or outpatient withdrawal is most suitable when:

- the client is not severely dependent
- previous withdrawal has not been complicated (e.g. no history of seizures, delirium, or psychosis)
- there are no significant complicating medical or mental health issues
- there is no significant polydrug use
- the person has a supportive home environment
- a non-using carer is present to provide support, monitor progress and control medications
- the client is strongly motivated for abstinence.

It is important to ensure that clients attempting home-based withdrawal are aware of when they should seek medical assistance, and where to access such assistance (including after hours) (Duong, Vytialingam, & O'Regan, 2018).

Clients requiring low to medium medical care can be managed in an inpatient withdrawal unit setting. However, those with unstable comorbid conditions, for example acute psychosis and delirium tremens requiring high levels of medical care, will likely require hospitalisation (Duong et al., 2018). Medication is often used to help manage withdrawal symptoms, complications and co-occurring medical conditions. Medically supervised withdrawal is especially important for people who are dependent upon alcohol or benzodiazepines, as both can result in life-threatening complications.

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 (e.g. a history of seizures, delirium, or psychosis)
- there is polydrug dependence
- previous attempts to withdraw as an outpatient have been unsuccessful
- there is a lack of social support
- the client is pregnant

(Duong et al., 2018)

<sup>4</sup> Neuroadaptation refers to the changes in the brain's neurons associated with both tolerance and the appearance of a withdrawal syndrome (World Health Organization, 2018).

## Assessment

Assessment prior to the client undertaking withdrawal is essential and should address the following issues:

- motivation for withdrawal and readiness to change
- whether the client has considered other treatment options, for example opioid substitution treatment for clients dependent on opioids
- a post-withdrawal plan – ideally this should be completed prior to commencing the withdrawal process
- previous withdrawal experience, including outcomes or complications from previous withdrawals
- history and pattern of AOD use including route of administration, frequency and time of last use
- degree of dependence as indicated by impaired control, social impairment, risky use and physiological indicators of dependence
- harm related to AOD use, including social, physical, economic and legal harms
- polysubstance use
- risk of relapse
- physical examination
- mental health including suicide risk assessment
- current medications, allergies or previous adverse reactions.

(Duong et al., 2018)

Pregnant women should always be referred to specialist AOD services and linked with antenatal obstetric services. Withdrawal management should usually occur as an inpatient, because some withdrawal symptoms can place the foetus at risk (Manning et al., 2018).

Regardless of the setting in which withdrawal management occurs, the primary aim is to achieve the client's goals in relation to their drug use and ensure their safety (Queensland Health, 2012). An additional goal of withdrawal management is to build the therapeutic alliance with the aim of increasing the likelihood that the person will engage in further treatment (CSAT, 2006). An underlying principle of withdrawal management is that – while withdrawal may present an opportunity for lasting abstinence – clients should not be discouraged from accessing withdrawal services because they are considered to lack commitment to long-term abstinence (Frei et al., 2012).

Clients should be provided with education and support throughout the withdrawal process as a part of holistic care (Frei et al., 2012). During the withdrawal process clients can be encouraged to consider strategies to help them cope with the period after withdrawal, reduce future harms, and prevent and manage relapse (Queensland Health, 2012).

Clients can be fearful of withdrawal and have concerns about the setting, physical consequences, medication and the prospect of an abstinent future. They should be encouraged to talk about their concerns and to participate actively in making informed decisions about the withdrawal process. Providing information about what to expect and helping the client to develop a plan to cope with withdrawal usually reduces their fears. Clients are unlikely to recall all of the information discussed so they should also be provided with written information (Marsh, O'Toole, Dale, Willis, & Helfgott, 2013).

It is advisable for counsellors to explore psychosocial issues that may present barriers to undertaking withdrawal. This can include having the care of young children, cultural issues (see chapters on **Culturally and linguistically diverse people** and **Aboriginal clients, their families and communities**), unstable housing, and a history of trauma (see chapter on **Co-occurring trauma issues**).

## Withdrawal from specific substances

A summary of withdrawal onset, duration and clinical features is shown in the table below. This table is followed by a brief summary of withdrawal information relating to the more commonly used AODs.

**Table 1: Overview of AOD withdrawal<sup>5</sup>**

Drug	Onset	Duration	Signs and symptoms
<b>Alcohol</b>	Depending on blood alcohol concentration (BAC), 6–24 hours after last drink and up to 48 hours	3–7 days (up to 14 days in severe withdrawal)	Mild - moderate: anxiety; sweating; nausea; vomiting; tremors; abdominal cramps; diarrhoea; insomnia; craving; increased blood pressure, heart-rate and temperature; headache; tachycardia  Severe: seizures; confusion; perceptual distortions; profuse sweating; disorientation; hallucinations; delirium tremens.
<b>Benzodiazepines</b>	1–10 days, depending on the half-life of the drug	3-6 weeks or more	Mild - moderate: Anxiety; headache; insomnia; muscle aching, twitching and cramping; nausea; vomiting; diarrhoea; perceptual changes; palpitations; feelings of unreality; depersonalisation  Severe: seizures; agitation; confusion; psychosis
<b>Opioids</b>	Withdrawal from short-acting opioids e.g. heroin and morphine can begin within 24 hours.  Longer-acting opioids e.g. methadone and buprenorphine can commence within (36-72 hours after last dose)	Heroin withdrawal typically peaks quickly (day 3), with more severe symptoms, subsiding fully within a week. Methadone and buprenorphine withdrawal result in a more protracted withdrawal, with a less abrupt peak and longer duration of symptoms	Runny eyes and nose; sneezing; sweating; agitation; irritability; loss of appetite; craving, abdominal cramps; diarrhoea; anxiety; irritability; disturbed sleep; fatigue; joint and muscle aches; nausea; vomiting; disturbed mood
<b>Cannabis</b>	1–2 days of last use	Acute phase: 2–6 days, subsiding after 2–3 weeks  May persist for months	Craving, anger, aggression, irritability, anxiety, nervousness, decreased appetite, weight loss, restlessness, sleep disturbances, chills, depressed mood, shakiness, sweating

<sup>5</sup> Adapted from Manning et al. (2018)

Drug	Onset	Duration	Signs and symptoms
<b>Nicotine</b>	4–12 hours	Peaks days 2–7 and continues in attenuated form for 2–4 weeks	Craving, irritability, anger, anxiety, sadness, restlessness, sleep disturbance, increased hunger, sore throat, headache, and difficulty concentrating
<b>Stimulants<sup>6</sup></b>	Crash phase: within hours of last use.  Withdrawal: 1–4 days after last use	Acute phase: initial 2–4 days (“crash”) followed by a further 10 to 14 days  A further period lasting from several weeks up to several months may be experienced	Initially exhaustion, fatigue, hunger, and fluctuating mood, followed by strong cravings to use drugs, sleep difficulty, agitation, low mood (dysphoria)  Later symptoms may include dysphoria, anhedonia, mood fluctuations, and ongoing sleep difficulties

For detailed information on withdrawal management, see the following:

Duong, T., Vytialingham, T., & O’Regan, R. (2018). *A brief guide to the management of alcohol and other drug withdrawal*. Perth, WA: Mental Health Commission, Western Australia.

Manning et al. (2018). *Alcohol and other Drug Withdrawal: Practice Guidelines* (3rd ed.). Richmond, Vic: Turning Point.

## Alcohol

Screening of clients with a reliable and validated screening tool, such as the AUDIT-C (the 3-item version of the Alcohol Use Disorders Identification Test), can indicate whether clients require further assessment for alcohol dependence and the risk of withdrawal symptoms. A comprehensive assessment, such as the one outlined in the assessment section of this chapter, should be undertaken before withdrawal is commenced. Withdrawal symptom severity can be assessed using the Clinical Institute Withdrawal Assessment Scale – Alcohol, revised (CIWA-Ar – see Appendix 3).

A person who is physically dependent on alcohol may develop withdrawal symptoms when their BAC is less than 0.1%. The consumption of approximately 24 standard drinks per day is required to keep a BAC above 0.1% (Quigley, Christmass, Vytialingham, Helfgott, & Stone, 2018). The onset of withdrawal begins 6–24 hours after the last alcoholic drink. Most clients will have symptoms for two to three days. However, some clients may experience increased severity of symptoms during the first 48–72 hours (Quigley et al., 2018).

Mild and severe symptoms of alcohol withdrawal are described in Table 1 above.

Alcohol withdrawal seizures are experienced by 2–5% of people who are alcohol dependent, typically within 6–48 hours after the cessation of drinking. A history of alcohol withdrawal seizures predicts an increased risk of experiencing seizures during subsequent alcohol withdrawals, as does concurrent benzodiazepine dependence, epilepsy or head injury (Duong et al., 2018; Manning et al., 2018; Quigley et al., 2018; Saunders et al., 2016). Benzodiazepines may be prescribed for a short duration to manage withdrawal symptoms.

Delirium tremens, or alcohol withdrawal delirium, is a severe form of alcohol withdrawal that involves a marked tremor, hyperactivity, extreme agitation, disorientation, hallucinations and clouding of sensorium<sup>7</sup>. The onset typically occurs 48–96 hours after the last drink, and affects approximately 5% of people withdrawing from alcohol without treatment (Saunders et al., 2016). Delirium tremens has a 1–4% mortality rate if left untreated (Quigley et al., 2018).

Patients at risk of severe withdrawal should be advised to continue drinking until they can be reviewed by a doctor (Duong et al., 2018).

<sup>6</sup> Includes amphetamine-type stimulants, MDMA (ecstasy) and cocaine.

<sup>7</sup> A disturbance of the parts of the brain that receive, process and interpret sensory stimuli, where the client can’t think clearly and is not fully aware of their immediate environment.

Alcohol withdrawal can be complicated by Wernicke's encephalopathy, an acute brain injury caused by thiamine (vitamin B1) deficiency. Wernicke's encephalopathy can cause confusion, an unsteady gait (ataxia), involuntary eye movement (nystagmus) and/or paralysis or weakness of the eye muscles (ophthalmoplegia), hypotension, hypertension and coma. Wernicke's encephalopathy can be initially reversed with large doses of thiamine. However, if left untreated it can become a permanent brain injury in the form of Korsakoff's syndrome. Korsakoff's syndrome is characterised by severe and permanent anterograde<sup>8</sup> and retrograde memory loss, including the inability to form new short-term memories and confabulation. Wernicke-Korsakoff syndrome occurs when acute Wernicke's encephalopathy is left untreated and Korsakoff's syndrome develops ( Duong et al., 2018; Manning et al., 2018).

For more detailed information on the assessment and treatment of alcohol withdrawal, see:

Quigley, A., Christmass, M., Vytialinga, R., Helfgott, S., & Stone, J. (2018). *A brief guide to the assessment and treatment of alcohol dependence*. Perth, WA: Mental Health Commission, Western Australia.

## Benzodiazepines

Approximately 50% of people who are prescribed benzodiazepines for more than four weeks will develop dependence (Soyka, 2017). Benzodiazepines are often used with other psychoactive substances, and when combined with other depressants such as opioids or alcohol, present an increased risk for fatal overdose (Duong et al., 2018).

The onset of withdrawal from benzodiazepines is variable and dependent on factors including dose, half-life, duration of use, benzodiazepine type and the individual's susceptibility (Manning et al., 2018). Withdrawal from short-acting benzodiazepines such as alprazolam can commence within 24 hours after the last dose, whereas for long-acting benzodiazepines such as diazepam withdrawal may commence up to three days after the last dose. Withdrawal from short-acting benzodiazepines may have more severe symptoms than withdrawal from those with a longer half-life. Other factors that contribute to the symptoms of withdrawal include other AOD use; history of seizures, anxiety, depression or trauma; and sharp reduction in benzodiazepine dose used (Manning et al., 2018).

It is important that the client's history of benzodiazepine use is understood, as it will determine whether a reducing regime of benzodiazepines is required to manage withdrawal and avoid complications such as seizures. While most withdrawals can be managed in a community setting, clients should be reviewed by a doctor before and throughout the withdrawal process.

Symptoms of benzodiazepine withdrawal are described in Table 1 above. Approximately 15% of clients will experience a protracted withdrawal which includes symptoms of anxiety, depression, insomnia, irritability, muscle aches and constipation (Manning et al., 2018). Approximately 1–2% of clients who withdraw from benzodiazepines experience seizures, and in rare cases these seizures cause death (Saunders et al., 2016).

Benzodiazepine withdrawal symptoms can be subjectively monitored using a scale like the Clinical Institute Withdrawal Assessment Scale – Benzodiazepines (CIWA-B; see Appendix 4). However, the CIWA-B has not been extensively evaluated for its psychometric properties (Manning et al., 2018).

Generally benzodiazepine withdrawal is treated with a reducing regimen of benzodiazepines, first converting the client's usual dose of benzodiazepines to a diazepam-equivalent dose, then decreasing the dosage over time. A long-acting benzodiazepine, such as diazepam, is preferred in order to avoid the cycles of intoxication and withdrawal that would ensue through use of short-acting medications. Longer-acting medication allows for stability in blood concentrations which in turn minimises the blood level peaks and troughs. Peaks may result in intoxication, which reinforces overuse behaviour; troughs result in withdrawal which leads to behaviours directed at avoiding withdrawal (i.e. further benzodiazepine use). While rates of dose reduction are often quoted, it is also important to involve the client when discussing and setting reduction goals. This decreasing regimen requires frequent client feedback on their withdrawal symptoms and is tapered individually to suit the clients' needs. Reducing regimens work best when coupled with psychological support (Manning et al., 2018; Saunders et al., 2016).

<sup>8</sup> Anterograde memory relates to the storage and retention of new information. Retrograde memory loss relates to the storage and retention of information from the past.



## Opioids

Withdrawal from opioids is uncomfortable, but not life-threatening (Schuckit, 2016) and can generally be undertaken in the community or in an inpatient setting. Withdrawal from opioids results in flu-like symptoms, which are described in Table 1.

The severity and duration of withdrawal from opioids depends on the opioid being used. Withdrawal from short-acting opioids like heroin usually begins 6–24 hours after last use and lasts 4–7 days, with withdrawal symptoms peaking 24–48 hours after last use. With longer-acting opioids such as methadone or buprenorphine, withdrawal may begin 36–72 hours after last use and last up to several weeks (Duong et al., 2018).

Subjective and objective scales are available for the measurement of opioid withdrawal. Subjective withdrawal scales are reportedly more sensitive to withdrawal symptoms than objective scales (Manning et al., 2018). The Short Opiate Withdrawal Scale (SOWS-Gossop) is a validated 10-item scale for rating and monitoring the severity of opioid withdrawal (Gossop, 1990; Vernon et al., 2016); see Appendix 5. The Clinical Opiate Withdrawal Scale (COWS), an objective scale, is also shown in Appendix 5.

Buprenorphine may be prescribed to assist clients by reducing the intensity of their withdrawal symptoms without significant sedation. Clonidine may be prescribed if there is a risk of precipitated withdrawal, but does not help to reduce cravings (Duong et al., 2018).

Without opioid substitution therapy, opioid withdrawal in the first trimester of pregnancy increases the risk of miscarriage. Opioid withdrawal in the third trimester of pregnancy increases the risk of foetal distress and foetal death (Duong et al., 2018). Buprenorphine tends to be associated with better neonatal growth outcomes than methadone.

People who withdraw from opioids are at significant risk of opioid overdose due to reduced tolerance. This can occur within a few days of ceasing opioid use. While exploring the possibility of relapse with a client who is planning withdrawal is essential, it is also strongly recommended that overdose prevention and management is discussed, including naloxone. Naloxone is an opioid antagonist which reverses opioid overdose (World Health Organization, 2014). Naloxone can also be prescribed by a doctor or purchased as an over-the-counter pharmacy-only medication. Take-home naloxone programs operate in Western Australia. Clients should be given information about naloxone and overdose prevention, and their significant others should receive the same information (MHC, 2017b). Counsellors can use the Naloxone Brief Education Tool to conduct brief education about opioid overdose and naloxone with their clients (MHC, 2017a, 2017b). The Naloxone Brief Education Tool is shown in Appendix 6.

## Amphetamine-type stimulants

In these guidelines, the term amphetamine-type stimulants (ATS) refers to amphetamine, methamphetamine, dexamphetamine, methylphenidate (Ritalin) and methylenedioxymethamphetamine (MDMA, or ecstasy). ATS dependence disproportionately affects vulnerable populations, including Aboriginal and Torres Strait Islander people, some gender and sexually diverse people, younger people, those in regional and remote areas, and people who are street-present (Manning et al., 2018). While withdrawal from ATS can generally be undertaken in a home-based setting, some people who use ATS can have complex presentations which warrant inpatient withdrawal.

ATS withdrawal begins after the 'crash' phase of the 'run–crash' cycle of psychostimulant use (Pead, Lintzeris, & Churchill, 1996). The run phase occurs whilst the client is using ATS; this is followed by a crash 12–24 hours after last use that lasts 2–4 days. During the crash phase, the client will feel fatigued, may wish to sleep a lot, and experience emotional fluctuations or low mood, increased hunger, generalised aches and pains, anxiety and mild cravings (Duong et al., 2018).

Prior to experiencing withdrawal, the client may have a preliminary residual toxicity phase during which the effects of ATS continue. This may persist for 1–3 days with longer-acting drugs such as amphetamines, and can include agitation, hyperactivity, paranoia and psychotic symptoms such as hallucinations and delusions (Saunders et al., 2016). More complex withdrawal symptoms or complications may occur several days later, when another assessment should be undertaken (Manning et al., 2018).

Saunders et al. (2016) argues that the withdrawal syndrome from ATS typically has two phases. In the initial phase the client will experience an extreme version of the symptoms of the crash phase. During the initial acute withdrawal phase for ATS, clients may experience a generally low mood, which may lead to depression and anhedonia, an extreme lack of energy (anergia), insomnia or hypersomnia, increased appetite, physical and



mental fatigue or weariness, and cravings (Saunders et al., 2016). This acute phase can peak during the first 1–3 days for a short-acting drug like cocaine, and decrease in a linear fashion over 7–10 days. Withdrawal symptoms for longer-acting drugs like amphetamines may not peak for up to 10 days and decrease over 2–3 weeks.

The second phase of withdrawal is a delayed or 'extinction' phase which commences after the acute symptoms of withdrawal pass (Saunders et al., 2016). This phase can last 6–10 weeks and is characterised by fluctuations in mood and energy, fatigue, low mood, anxiety, irritability and disturbed sleep. Cravings may persist for several months.

Whilst anhedonia is an issue for many people who withdraw from AOD, it can be significant for people who withdraw from ATS and can impact on a client's likelihood of relapse (Leventhal et al., 2008, 2010; Rusyniak, 2011). Clients should be made aware of the likelihood of experiencing anhedonia, changes in mood and disturbed sleep over a prolonged time as a result of ATS withdrawal so their feelings are normalised and validated.

The Amphetamine Cessation Symptom Assessment Scale (ACSA) is a 16-item self-report scale which can be used to determine the subjective severity of withdrawal symptoms (McGregor et al., 2005, 2008). The ACSA is shown in Appendix 7.

## Cannabis

Chronic use of cannabis is associated with dependence; cognitive impairment (CI), affecting memory, attention, organisation and the ability to process complex information; and respiratory problems including bronchitis and mouth and lung cancers. Cannabis is often mixed with tobacco, which contributes to respiratory problems. Heavy, long-term cannabis use can be associated with psychotic symptoms such as visual and auditory hallucinations, anxiety and paranoia (Duong et al., 2018).

Withdrawal from cannabis is not life-threatening and generally can be managed in a home-based or outpatient setting (Saunders et al., 2016). However, inpatient withdrawal can be considered if repeated attempts at home-based withdrawal have been unsuccessful, or the client has significant co-occurring mental health conditions or is using large amounts of alcohol or other drugs (Duong et al., 2018).

Common symptoms of cannabis withdrawal are described in Table 1. Less common are chills and sweats, depressed mood, stomach pain and shakiness (Duong et al., 2018). The severity of cannabis withdrawal symptoms depends on method of ingestion, potency, quantity used, co-occurring mental health conditions, and polydrug (including tobacco) dependence (Manning et al., 2018).

The withdrawal syndrome associated with cannabis usually lasts for 1–2 weeks. In some cases withdrawal can last for several weeks. Most symptoms commence 1–2 days after last use, and peak at 6–8 days (Saunders et al., 2016). During withdrawal any underlying psychiatric symptoms may become noticeable (Duong et al., 2018; Manning et al., 2018). Clients who are withdrawing from cannabis may also wish to withdraw from nicotine at the same time since the two are often consumed together.

The Cannabis Withdrawal Scale (Allsop, Norberg, Copeland, Fu, & Budney, 2011) provides a score for cannabis withdrawal symptom severity and functional impairment related to cannabis withdrawal. Research has shown that the Cannabis Withdrawal Scale has some validity and reliability, but additional research is required for full validity (Allsop et al., 2012). The scale can be self-completed or clinician administered. The Cannabis Withdrawal Scale is provided in Appendix 8.

## Nicotine

A very high proportion of clients who access AOD services smoke tobacco (Kelly et al., 2012). One study has found that 65% of clients engaged in AOD treatment in Australia are interested in quitting, but their attempts to quit are less successful than those of people who are not engaged in AOD treatment (Manning et al., 2018).

Clients undergoing withdrawal for other substances may see it as an opportunity to quit smoking, particularly as many services are now smoke-free. Some clients are reluctant to withdraw from nicotine in addition to other substances due to concerns that it will jeopardise the withdrawal process or remove a coping strategy. However, research shows that concurrent treatment for nicotine and other drug dependence improves treatment outcomes (Mendelsohn & Wodak, 2016). Clients may also seek to withdraw only from nicotine.

The symptoms of nicotine withdrawal are noted in Table 1. Nicotine withdrawal generally commences 4–12 hours after last ingestion and peaks after 2–7 days, with withdrawal lasting 2–4 weeks. The psychological cravings may persist much longer, so relapse prevention and management is essential (Manning et al., 2018).

Some clients may choose nicotine replacement therapy (NRT) to manage withdrawal symptoms. NRT is now widely available in pharmacies and some inpatient withdrawal services offer it to clients. It is not recommended for clients with significant cardiac or vascular problems or those who are sensitive or allergic to nicotine (Manning et al., 2018). However, the relative risk of continued cigarette smoking for individuals with significant cardiovascular disease must be weighed against the risk of NRT. NRT should be discussed with the client, as both a means to manage the severity of withdrawal symptoms and a harm reduction strategy in the event of a relapse. The current approach to NRT is to offer it in sustained release form (e.g. a patch); combined with a product that provides nicotine immediately (e.g. gum, spray). NRT is most successful when combined with counselling (Manning et al., 2018).

Several medications exist for nicotine dependence. Research is currently being undertaken into the feasibility, safety and efficacy of electronic nicotine devices as a harm reduction approach to stopping smoking (Manning et al., 2018).

Nicotine can alter the metabolism of certain medications, including antipsychotics such as olanzapine and clozapine, and some antidepressants including fluvoxamine and mirtazapine. Clients on these medications will need further medical assessment (Manning et al., 2018).

## Supportive counselling

Counselling sessions with a client who is in the process of withdrawal should focus on providing support and reassurance. Counselling should aim to encourage the client throughout the process and alleviate their fears and concerns. Help the client to learn or use coping skills, such as relaxation and grounding strategies, in order to manage withdrawal symptoms. In addition, discuss ways to minimise environmental stress during and after the withdrawal. Due to the chronic-relapsing nature of AOD dependence, counselling should also focus on relapse prevention and management, as well as harm reduction strategies (see chapters on **Relapse prevention and management and Harm reduction**).

For more detailed information on assisting clients with withdrawal, see:

Manning et al. (2018). *Alcohol and other Drug Withdrawal: Practice Guidelines* (3rd ed.). Richmond, Vic: Turning Point.

### Withdrawal management – tip sheet

Withdrawal from AOD dependence entails the reversal of neuroadaptation. Withdrawal occurs as the experience of physical and psychological reactions as the person adjusts to the absence of the drug. Additionally, social factors can play a significant part in a person's withdrawal; therefore, withdrawal management encompasses strategies which address the biopsychosocial elements of withdrawal.

The severity of withdrawal depends upon:

- the type of drug(s) used
- the severity of dependence and tolerance
- co-occurring medical and mental health conditions
- past history of withdrawal
- psychosocial factors
- reasons and motivation for abstinence.

Withdrawal may be managed at home as an outpatient or in a residential setting and may include medication, depending on the severity of dependence and client choice.

In general, inpatient withdrawal is recommended when:

- withdrawal symptoms are likely to be moderate to severe
- there are complicating medical, psychological or psychiatric issues
- there have been previous complicated withdrawals (e.g. a history of seizures, delirium, or psychosis)
- the client has polydrug dependence
- previous attempts to withdraw as an outpatient have been unsuccessful
- social support is poor or absent.

Pregnant women should be referred to a specialist AOD service or obstetric service as withdrawal from some drugs places the pregnancy at risk.

When a client is ready to discuss withdrawal, assist the client by:

- discussing the options available and what to expect
- exploring their motivation
- exploring possible barriers to withdrawal
- encouraging them to express any concerns or fears about withdrawal
- assisting with problem-solving barriers and self-support strategies
- encouraging the engagement of non-drug-using significant others and provide information subject to client consent
- discussing relapse as a reality and exploring relapse prevention and management
- supporting appropriate referral to a service or GP for withdrawal management.

Ensure that clients attempting home-based withdrawal are aware of when they should seek medical assistance, and where to get such assistance (including after hours).

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.

Specific issues of note related to alcohol, benzodiazepines, opioids and amphetamine-type stimulants are listed below.

## **Alcohol**

- Chronic heavy alcohol consumption, past severe withdrawal symptoms, and concomitant substance use and medical or psychiatric conditions increase the risk of severe withdrawal.
- Severe withdrawal symptoms can include seizures and may be life-threatening.
- 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.
- Clients should always be linked with a medical practitioner as medication is often needed to manage withdrawal safely.

## **Benzodiazepines**

- Sudden cessation of use of benzodiazepines can be associated with serious health consequences such as seizures, 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.
- A medical practitioner should always assist with managing withdrawal from benzodiazepines.

## **Opioids**

- Opioid withdrawal is not life-threatening and is generally treated with medication for symptomatic relief.
- Opioid withdrawal should not be encouraged during pregnancy; buprenorphine or methadone maintenance is recommended instead.
- The risk of overdose due to decreased tolerance should be discussed with the client.
- The counsellor should also discuss overdose prevention and management, including the use of naloxone and assist the client to obtain naloxone.

## **Amphetamine-type stimulants**

- Withdrawal can be managed in an inpatient or outpatient setting.
- Clients should be made aware of the likelihood of experiencing anhedonia, changes in mood and disturbed sleep over a prolonged time as a result of ATS withdrawal and have their feelings normalised and validated.

## References

- Allsop, D. J., Copeland, J., Norberg, M. M., Fu, S., Molnar, A., Lewis, J., & Budney, A. J. (2012). Quantifying the clinical significance of cannabis withdrawal. *PLoS ONE*, 7(9), e44864. doi: 10.1371/journal.pone.0044864
- Allsop, D. J., Norberg, M. M., Copeland, J., Fu, S., & Budney, A. J. (2011). The Cannabis Withdrawal Scale development: Patterns and predictors of cannabis withdrawal and distress. *Drug and Alcohol Dependence*, 119(1), 123-129. <https://doi.org/10.1016/j.drugalcdep.2011.06.003>
- Brett, J., & Murnion, B. (2015). Management of benzodiazepine misuse and dependence. *Australian Prescriber*, 38(5), 152-155. doi: 10.18773/austprescr.2015.055
- Busto, U. E., Sykora, K., & Sellers, E. M. (1989). A clinical scale to assess benzodiazepine withdrawal. *Journal of Clinical Psychopharmacology*, 9(6), 412-416.
- Center for Substance Abuse Treatment. (2006). *Detoxification and substance abuse treatment. Treatment Improvement Protocol (TIP)*. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Duong, T., Vytialingam, R., & O'Regan, R. (2018). *A brief guide to the management of alcohol and other drug withdrawal*. Perth, WA: Mental Health Commission, Western Australia.
- Frei, M., Berends, L., Kenny, P., Swan, A., Jenner, L., Hunter, B., & Mugavin, J. (2012). *Alcohol and other drug withdrawal: Practice guidelines*. Fitzroy, VIC: Turning Point Alcohol and Drug Centre. Retrieved from <http://www.turningpoint.org.au/Media-Centre/centrepubs/GetFile.axd?oid=22d5bd3f-876a-4ba2-acb1-ba94c4f4a5b4>.
- Gossop, M. (1990). The development of a short opiate withdrawal scale (SOWS). *Addictive Behaviors*, 15(5), 487-490. [https://doi.org/10.1016/0306-4603\(90\)90036-W](https://doi.org/10.1016/0306-4603(90)90036-W)
- Kelly, P. J., Baker, A. I., Deane, F. P., Kay-Iambkin, F. J., Bonevski, B., & Tregarthen, J. (2012). Prevalence of smoking and other health risk factors in people attending residential substance abuse treatment. *Drug and Alcohol Review*, 31(5), 638-644. doi: 10.1111/j.1465-3362.2012.00465.x
- Leventhal, A. M., Brightman, M., Ameringer, K. J., Greenberg, J., Mickens, L., Ray, L. A., ... Sussman, S. (2010). Anhedonia associated with stimulant use and dependence in a population-based sample of American adults. *Experimental and Clinical Psychopharmacology*, 18(6), 562-569. <http://dx.doi.org/10.1037/a0021964>
- Leventhal, A. M., Kahler, C. W., Ray, L. A., Stone, K., Young, D., Chelminski, I., & Zimmerman, M. (2008). Anhedonia and amotivation in psychiatric outpatients with fully remitted stimulant use disorder. *The American Journal on Addictions*, 17(3), 218-223. doi: 10.1080/10550490802019774
- Manning, V., Arunogiri, S., Frie, M., Ridley, K., Mroz, K., Campbell, S., & Lubman, D. (2018). *Alcohol and other drug withdrawal: practice guidelines* (3rd ed.). Richmond, VIC: Turning Point.
- Marsh, A., O'Toole, S., Dale, A., Willis, L., & Helfgott, S. (2013). *Counselling guidelines: Alcohol and other drug issues* (3rd ed.). Perth, WA: Drug and Alcohol Office.
- McGregor, C., Srisurapanont, M., Jittiwutikarn, J., Laobhripatr, S., Wongtan, T., & White, J. M. (2005). The nature, time course and severity of methamphetamine withdrawal. *Addiction*, 100(9), 1320-1329. doi: 10.1111/j.1360-0443.2005.01160.x
- McGregor, C., Srisurapanont, M., Mitchell, A., Longo, M. C., Cahill, S., & White, J. M. (2008). Psychometric evaluation of the Amphetamine Cessation Symptom Assessment. *Journal of Substance Abuse Treatment*, 34(4), 443-449. doi: 10.1016/j.jsat.2007.05.007
- Mendelsohn, C., & Wodak, A. (2016). Smoking cessation in people with alcohol and other drug problems. *Australian Family Physician*, 45(8), 569-573. Retrieved from <https://www.racgp.org.au/download/Documents/AFP/2016/August/afp-august-clinical-mendelsohn.pdf>
- Mental Health Commission, Western Australia (MHC). (2017a). *Brief education tool: Recognising and responding to opioid overdose*. Perth: WA: Author.
- Mental Health Commission, Western Australia (MHC). (2017b). *Recognising and responding to amphetamine intoxication/toxicity and opioid overdose: A guide for first responders*. Perth: WA: Author.
- Pead, J., Lintzeris, N., & Churchill, A. (1996). *From go to whoa: Amphetamines and analogues. The trainer's package for health professionals*. Canberra, ACT: Commonwealth Department of Human Services and Health.
- Queensland Health. (2012). *Queensland Alcohol and Drug Withdrawal Clinical Practice Guidelines - Queensland Health*. Herston, QLD: Author. Retrieved from <https://www.health.qld.gov.au/clinical-practice/guidelines-procedures/medicines/drugs-of-dependence?a=167070>.
- Quigley, A., Christmass, M., Vytialingam, R., Helfgott, S., & Stone, J. (2018). *A brief guide to the assessment and treatment of alcohol dependence*. Perth, WA: Mental Health Commission, Western Australia.
- Rusyniak, D. E. (2011). Neurologic manifestations of chronic methamphetamine abuse. *Neurologic Clinics*, 29(3), 641-655. <https://doi.org/10.1016/j.ncl.2011.05.004>
- Saunders, J., Conigrave, K., Latt, N., Nutt, D., Marshall, J., Ling, W., & Higuchi, S. (2016). *Addiction Medicine* (2nd ed.). Oxford, United Kingdom: Oxford Medical Publications.
- Schuckit, M. A. (2016). Treatment of opioid-use disorders. *New England Journal of Medicine*, 375(4), 357-368. doi: 10.1056/NEJMra1604339
- Soyka, M. (2017). Treatment of benzodiazepine dependence. *New England Journal of Medicine*, 376(12), 1147-1157. doi: 10.1056/NEJMra1611832
- Vernon, M. K., Reinders, S., Mannix, S., Gullo, K., Gorodetzky, C. W., & Clinch, T. (2016). Psychometric evaluation of the 10-item Short Opiate Withdrawal Scale-Gossop (SOWS-Gossop) in patients undergoing opioid detoxification. *Addictive Behaviors*, 60, 109-116. <https://doi.org/10.1016/j.addbeh.2016.03.028>
- World Health Organization (WHO). (2014). *Community management of opioid overdose*. Geneva, Switzerland: Author. Retrieved from [http://apps.who.int/iris/bitstream/handle/10665/137462/9789241548816\\_eng.pdf?sequence=1](http://apps.who.int/iris/bitstream/handle/10665/137462/9789241548816_eng.pdf?sequence=1)
- World Health Organization (WHO). (2018). *Lexicon of alcohol and drug terms published by the World Health Organization*. Retrieved from [http://www.who.int/substance\\_abuse/terminology/who\\_lexicon/en/](http://www.who.int/substance_abuse/terminology/who_lexicon/en/)

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## 17. Pharmacotherapies for AOD dependence

Pharmacotherapies for AOD dependence should not be seen as standalone treatments; their optimal use is in conjunction with other psychosocial interventions. Counsellors need a basic understanding of pharmacotherapies for AOD dependence so they can inform clients of relevant pharmacotherapy options and refer them to a doctor for further discussion and prescribing if desired.

Methadone and buprenorphine, which are opioids, can only be prescribed for the treatment of opioid dependence in Western Australia by medical practitioners who have undergone a training program to become approved prescribers under the Community Program for Opioid Pharmacotherapy (CPOP). Any medical practitioner can prescribe other AOD pharmacotherapies.

### Pharmacotherapies for opioid dependence

Pharmacotherapies for opioid dependence generally fall into two categories: agonists and antagonists.

**Agonists** (e.g. methadone, buprenorphine): These drugs produce effects similar to those of the opioid drug of dependence. Treatment with agonist drugs is often referred to as substitution treatment. They have a longer duration of action than the drugs of dependence, thereby delaying the onset of opioid withdrawal and reducing frequency of use, and hence reducing drug-related disruptions to daily life. Opioid substitution treatment also aims to remove the need to engage in criminal or risky activities to obtain illegal drugs (e.g. prostitution, stealing and dealing), and thereby promotes lifestyle change.

The aims of substitution treatment are to:

- reduce and/or cease illegal drug use
- improve physical and mental health
- reduce risk of opioid overdose
- reduce social costs of illicit opioid use
- reduce sharing of injecting equipment and hence transmission of blood-borne viruses (BBVs)
- motivate and support clients to reach their positive lifestyle goals, including cessation of criminal activity, attainment of employment, stable accommodation and positive relationships.

(Drug and Alcohol Office, 2014)

Once a stable dose is achieved, and if the client is not using other drugs (particularly depressant drugs such as benzodiazepines, alcohol or other opioids), opioid agonist medication is not associated with increased risk of accidents when driving or operating machinery.

Clients tend to have better outcomes if they remain on a substitution treatment until their lifestyle has stabilised, which usually takes 1–2 years. Many clients choose to remain on a substitution treatment for longer than this and others for a shorter time. To cease treatment, the dose should be very slowly decreased over a period of months or longer.

**Antagonists.** These drugs block the effect of opioids so that opioid use produces no euphoric effects and there is no incentive to take them. Naltrexone and naloxone are opioid antagonists.

### Methadone

Methadone is a long-acting synthetic opioid with a mean half-life (how long it takes for half the dose to be eliminated from the bloodstream) of 25 hours. It is usually administered in liquid form. Methadone activates opioid receptors and prevents heroin withdrawal symptoms. In turn, this reduces both the desire to use heroin and the euphoric effect if heroin is used in conjunction with methadone.

The initial aim of methadone treatment is to reach a maintenance dose (i.e. stable levels in the blood), but there can be a longer-term goal of abstinence. The risk of overdose death is increased during induction onto treatment, and clients need to be inducted slowly and monitored regularly during this period. Once the dose is stabilised (taking anywhere from 2 to 8 weeks) the risk of death from overdose is considerably lower than the risk of ongoing



heroin use. Withdrawal symptoms from methadone usually last longer, but are less intense than withdrawal symptoms from heroin.

Clients describe more sedation, opioid-like effects and impact on cognition with methadone than buprenorphine.

Methadone is taken orally under supervision on a daily basis. Methadone dosing can be supervised in a medical setting or a dispensing pharmacy authorised under the CPOP. Unsupervised doses (also called 'takeaways') may be prescribed once certain program stability features are attained.

## **Buprenorphine**

Buprenorphine (Subutex™, Suboxone®) is an opioid analgesic with partial agonist effects and high receptor affinity (meaning it displaces other opioids from the receptors). Its action is similar to that of full agonist drugs such as methadone and heroin, except that increases in dose have progressively less effect as receptor sites become saturated. The partial agonist effect of buprenorphine means that its respiratory depressant effect reaches a ceiling and the addition of more opioids causes no further significant respiratory depression. This makes it safer in terms of overdose risk than methadone when additional opioids are used. However, buprenorphine does not protect against overdose when combined with other depressant drugs such as benzodiazepines or alcohol.

High receptor affinity means that buprenorphine displaces other opioids from the receptors. This can result in precipitated withdrawal for people highly dependent on opioids if the buprenorphine is taken too soon after the last dose of a full opioid agonist (e.g. methadone, heroin). Buprenorphine has a longer duration of effect than methadone, and at high doses the effect is sufficiently prolonged to enable alternate day dosing.

In Australia buprenorphine is usually administered in the form of Suboxone®, a combination of buprenorphine and naloxone, which comes in the form of a sublingual film or tablet. Naloxone is an opioid antagonist that precipitates withdrawal in opioid-dependent people. It is not well absorbed when swallowed, but is active when injected. Naloxone is combined with buprenorphine in Suboxone® to discourage clients injecting. Another sublingual form of buprenorphine, Subutex™, does not contain naloxone and is less frequently used.

The reduced sedation, opioid effects, and impact on cognition that clients report with buprenorphine in comparison to methadone make it suitable for many clients. Following gradual dose tapering over a prolonged period (usually well over 6 months), withdrawal symptoms from cessation of long-term buprenorphine treatment typically emerge 3–5 days after the last dose and may persist for several weeks. Withdrawal symptoms may be milder than those for other opioids, including heroin and methadone. However, some individuals experience prolonged dysphoria associated with physical discomfort which may persist for many months.

Buprenorphine maintenance treatment is effective at retaining opioid-dependent clients in treatment. Medium or high doses (> 12mg) also reduce heroin use. 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.

## **Naltrexone**

Naltrexone is an opioid antagonist that displaces opioids from the receptors in the brain and has no opioid effect. When taken by opioid-dependent people, naltrexone will precipitate opioid withdrawal. When opioids are taken in the presence of naltrexone, they have no euphoric effect. Clients need to withdraw from opioids prior to starting naltrexone or withdrawal will be precipitated. Naltrexone is long-acting and has minimal side effects for most people, though some clients report headaches, sedation or nausea.

Naltrexone is listed in Australia as a Schedule 4 drug (prescription only). In the form of oral tablets, it has Therapeutic Goods Administration (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.

Acceptability and retention in treatment is much lower for oral naltrexone than for methadone or buprenorphine. Higher retention and completion rates, and reduced opioid use and criminal behaviour, are found for clients who are highly motivated to cease using and remain abstinent. In general people who are stable and have a non-AOD-using supportive environment are more likely to achieve positive treatment outcomes, as with all forms of treatment.

Oral naltrexone is associated with increased risk of fatal overdose should the tablets be ceased and heroin used, due to markedly reduced tolerance. Clients must be made aware of the increased risk of overdose in the event of a lapse.

Naltrexone should be used cautiously for clients with major mental health issues, renal problems and multiple drug dependence.

A few service providers have been able to obtain and utilise implantable (or 'depo') forms of naltrexone under the TGA Special Access Scheme, which allows the use of unapproved therapeutic goods for people for whom death is otherwise likely.

Research is still being undertaken to establish the effectiveness of naltrexone implants. Larney et al. (2014) suggested that the evidence on safety, efficacy, and effectiveness of naltrexone implants for treatment of opioid dependence was scanty and of poor quality, and had little clinical use in settings where effective treatments were already available.

The limited availability of naltrexone implants and their restricted approval means options for removal of the implant are also limited. Data is limited regarding the use of naltrexone during pregnancy (North Metropolitan Health Service, n.d.).

## **Pregnancy and breastfeeding (pharmacotherapies for opioid dependency)**

For clients who are pregnant and dependent on opioids, opioid substitution treatment with methadone or buprenorphine is the preferred approach (Gowing, Ali, Dunlop, Farrell, & Lintzeris, 2014; Zedler et al., 2016). Both methadone and buprenorphine have been proven to be safe. Any potential benefits of reducing or stopping opioid use must be carefully weighed against the risk of relapse to the mother and foetus, and the risks to the foetus associated with withdrawal. Withdrawal from opioids in the first trimester of pregnancy increases the risk of miscarriage, and in the third trimester it increased the risk of foetal distress and premature labour (Gowing et al., 2014).

Subutex™ is the preferred preparation of buprenorphine, as the effects of long-term exposure to low levels of naloxone on the developing foetus are unknown (see chapter on **AOD use during pregnancy**).

## **Pharmacotherapies for alcohol dependence**

Common pharmacotherapies for alcohol dependence include naltrexone, acamproste and disulfiram. A recent review of the role of pharmacotherapies for alcohol relapse prevention recommended that a pharmacotherapy – either acamprosate or naltrexone – should be offered to all alcohol-dependent clients and to all non-dependent clients with alcohol issues if they have not benefited from psychosocial interventions (Lingford-Hughes et al., 2012).

### **Naltrexone**

Naltrexone blocks the functioning of the endogenous opioid system in the brain, which appears to be linked to the rewarding effects of alcohol and other impulse control disorders such as pathological gambling. As a result, naltrexone appears to reduce the pleasurable effects from alcohol consumption and hence reduces heavy drinking should a lapse occur. Naltrexone can be used as needed when cravings occur or when a client is facing a potentially heavy-drinking situation. There is no evidence that it prolongs abstinence.

Naltrexone is taken orally. It is safe to take while clients are still drinking; the most common side-effects are headache and nausea, and sedation is reported occasionally. Naltrexone should be taken for at least 4–6 months, but may be taken for as long as deemed helpful by the individual and their treating clinicians.

### **Acamprosate**

Acamprosate (Campral®) works by aiding the restoration of neurotransmitter imbalance resulting from long-term alcohol use. It is through this system that acamprosate is hypothesised to reduce post-acute withdrawal symptoms that may lead to a return to drinking. It supports abstinence and can reduce heavy drinking during relapse. It should be started during withdrawal and can be prescribed for 3–12 months after ceasing treatment for optimal benefit.

Acamprosate is taken three times a day with food, a regime that some clients can struggle to maintain. It is usually well tolerated; the most common side effect is gastrointestinal disturbance (nausea, diarrhoea).



## Disulfiram

Disulfiram (Antabuse®) alters the metabolism of alcohol and causes acetaldehyde to accumulate in the body when alcohol is consumed, resulting in flushing, nausea and palpitations. This deters people from drinking. These symptoms can have potentially severe health consequences, so disulfiram is used with caution. It can only be started once a client has been alcohol-free for 24 hours, and there can be a reaction with alcohol for up to 7 days after stopping it.

Disulfiram appears to be effective if clients are motivated to become abstinent and administration is supervised. As disulfiram is not supported under the Pharmaceutical Benefits Scheme, the cost of approximately \$65 to \$90 per month can be a deterrent to use.

## Baclofen

Baclofen is a stereoselective gamma-aminobutyric acid (GABA) receptor agonist. It has been used since the 1920s to control spasticity. Much of alcohol's acute effects on the central nervous system (CNS) are mediated by its stimulation of the GABA system, which is neuro-inhibitory.

In animals, baclofen reduces alcohol's reinforcing, rewarding, stimulating and motivational properties (Duke et al., 2014; Maccioni et al., 2009). It has been shown to reduce the risk of relapse in high-risk drinkers (Addolorato et al., 2000, 2007; Flannery et al., 2004; Leggio et al., 2012), and seems most suited to patients who have more chronic and severe disease and a history of regular high-dose drinking, including those with advanced liver disease (Leggio et al., 2012). It is primarily aimed at drinkers seeking to maintain abstinence but is not approved for this indication in Australia.

Baclofen is highly toxic and can cause overdose if used in conjunction with other CNS depressants or in high doses by itself (Rolland, Simon, & Franchitto, 2018). Patients with a history of overdose or other substance use, as well as those with a history of psychotic illness or renal insufficiency, should be made aware of these risks and offered harm reduction advice.

## Pharmacotherapies for other drugs of dependence

### Benzodiazepines

Benzodiazepine dependence is usually treated by transferring the client from a short to a long-acting benzodiazepine and gradually reducing the dose. Sudden cessation of a high dose of benzodiazepine is dangerous as clients can experience withdrawal-related seizures. Maintenance prescribing of benzodiazepines for illicit drug users is not recommended, though reducing a dose to a therapeutic level can be helpful (Lingford-Hughes et al., 2012).

### Amphetamines

There are no medications approved for treating methamphetamine dependence in Australia (Lee & Jenner, 2014). The most recent review involved 39 studies of 18 potential pharmacotherapies. Dexamphetamine, modafinil, bupropion, naltrexone and methylphenidate were identified as medications with some promise. Predominantly high-quality double-blind placebo-controlled randomised controlled trials are discussed below (Christmass, 2017).

Dexamphetamine in variable doses (60–110mg) was not effective in reducing methamphetamine use. Benefits included reduced craving and withdrawal symptoms, improved retention, better engagement in counselling and improved physical health (Christmass, 2017).

Modafinil is a wakefulness-promoting agent approved for treating narcolepsy, shift-work sleep disorder and obstructive sleep apnoea. Modafinil in 200mg or 400mg doses did not reduce methamphetamine use in three trials (Anderson et al., 2012; Heinzerling et al., 2010; Shearer et al., 2009). Longer abstinence and better retention were found within the most compliant group in another study but this did not involve comparison with placebo (Christmass, 2017).

Bupropion is an antidepressant and smoking cessation aid. Two trials found bupropion reduced methamphetamine use for individuals with low baseline consumption (e.g. 18 days/month) (Heinzerling et al., 2014). While other studies have found that bupropion did not significantly increase abstinence in methamphetamine-dependent participants, compared to placebo (Anderson et al., 2015).

Naltrexone is a non-selective opioid receptor antagonist and is thought to impair amphetamine-mediated dopamine release. One trial demonstrated that naltrexone reduced methamphetamine use and cravings (Jayaram-Lindstrom et al., 2008). The researchers also found naltrexone inhibited subjective reinforcing effects of amphetamine during a single administration.

Methylphenidate inhibits dopamine and norepinephrine reuptake and is approved for treatment of attention deficit hyperactivity disorder (ADHD) in Australia. One trial showed methylphenidate was effective in reducing methamphetamine use (Tiihonen et al., 2007) but this was not replicated in a later study (Miles et al., 2013).

Mirtazapine has unique antidepressant activity. As an antagonist it increases norepinephrine secretion; there is no norepinephrine reuptake effect. Mirtazapine was found to reduce methamphetamine use in men who have sex with men (Colfax et al., 2011).

Some benefits have been observed with the medications outlined above. However, consistent findings in large-scale trials are needed before any pharmacotherapy can be advocated. Evidence is even more limited for other medications studied for their possible use in methamphetamine dependence.

## Cannabis

Early-stage evidence for a cannabis pharmacotherapy is promising. Preliminary data from a pilot study suggest that N-acetylcysteine (NAC) may reduce cannabis use in adolescents with cannabis use disorders. Further research is needed in this area (Hammond, 2016).

## Nicotine

Pharmacotherapies for nicotine dependence include forms of NRT (gum, lozenges and patches), varenicline and bupropion (Lingford-Hughes et al., 2012).

## Pharmacotherapies for AOD dependence – tip sheet

Pharmacotherapies should not be seen as standalone treatments. Their optimal use is in conjunction with other psychosocial interventions for most drugs of dependence.

### Pharmacotherapies for opioid dependence

Pharmacotherapies for opioid dependence fall into two categories:

- Agonists: These drugs produce similar opioid-like effects to the drug of dependence but have lower risks. Treatment with agonist drugs is often referred to as substitution treatment. Agonists include methadone and buprenorphine.
- Antagonists: These drugs block the effect of opioids so that opioid use produces no euphoric effects and there is no incentive to take them. Naltrexone and naloxone are opioid antagonists.

#### Methadone

- Methadone is a long-acting synthetic opioid.
- Clients describe more sedation, opioid-like effects and impact on cognition with methadone than buprenorphine. This can be useful for clients experiencing psychological distress.

#### Buprenorphine

- Buprenorphine (Subutex™, Suboxone®) is a very long-acting 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 reduced sedation, opioid effects, and impact on cognition clients report with buprenorphine in comparison to methadone make it suitable for many clients.

## Naltrexone

- Naltrexone is an opioid antagonist that displaces opioids from the receptors in the brain and has no opioid effect. Opioids taken in the presence of naltrexone have no euphoric effect.
- Acceptability and retention in treatment is much lower for oral naltrexone than for methadone or buprenorphine. Naltrexone is best suited to clients who are highly motivated to become abstinent.
- Oral naltrexone is associated with increased risk of fatal overdose should the tablets be ceased and heroin used, due to markedly reduced tolerance.
- A few service providers have been able to obtain and utilise implantable (depo) forms of naltrexone under the TGA Special Access Scheme, which allows the use of unapproved therapeutic goods for people for whom death is otherwise likely.
- Research is still being undertaken to establish the effectiveness of naltrexone implants. Larney and colleagues (2014) suggested that evidence on safety, efficacy, and effectiveness of naltrexone implants for treatment of opioid dependence was scarce and of poor quality, and had little clinical use in settings where effective treatments were already available.
- Due to the limited availability of naltrexone implants and their restricted approval, options for removal of the implant are also limited. Data is limited regarding the use of naltrexone during pregnancy.

## Pharmacotherapies for alcohol dependence

### Naltrexone

- Naltrexone blocks the functioning of the endogenous opioid system in the brain, and thus appears to reduce the pleasurable effects of alcohol consumption and reduces heavy drinking should a lapse occur. It can therefore be used as needed when cravings occur or when a client is facing a potentially heavy-drinking situation.
- There is little evidence that naltrexone prolongs abstinence.

### Acamprosate

- Acamprosate (Campral®) normalises alcohol-induced abnormalities in neurotransmission.
- It increases abstinence and most reviews find that it can reduce heavy drinking during relapse.

### Disulfiram (Antabuse®)

- Disulfiram alters the metabolism of alcohol and causes acetaldehyde to accumulate in the body when alcohol is consumed. Symptoms are flushing, nausea and palpitations. They can be dangerous, so disulfiram is used with caution.
- Disulfiram appears to be effective if clients are motivated to become abstinent and administration is supervised.

### Baclofen

- In animals, baclofen reduces alcohol's reinforcing, rewarding, stimulating and motivational properties and has been shown to reduce the risk of relapse in high-risk drinkers. Baclofen seems most suited to patients who have more chronic and severe disease and a history of regular high-dose drinking, including those with advanced liver disease. It is primarily aimed at drinkers seeking to maintain abstinence but is not approved for this indication in Australia.
- Either acamprosate or naltrexone should be offered to all alcohol-dependent clients and to all non-dependent clients with alcohol issues if they have not benefited from psychosocial interventions.

## Pharmacotherapies for other drugs of dependence

Benzodiazepine dependence is usually treated by transferring the client from a short to a long-acting benzodiazepine and gradually reducing the dose.

No medications for treating methamphetamine dependence are approved in Australia. However, dexamphetamine, modafinil, bupropion, naltrexone and methylphenidate have been identified as medications with some promise.

Early-stage evidence for a cannabis pharmacotherapy is promising. Preliminary data from a pilot study suggest that N-acetylcysteine (NAC) may reduce cannabis use in adolescents with cannabis use disorders. Further research is needed in this area.

Pharmacotherapies for nicotine dependence include forms of NRT (gum, lozenges and patches), varenicline and bupropion.

## References

- Addolorato, G., Caputo, F., Capristo, E., Colombo, G., Gessa, G. L., & Gasbarrini, G. (2000). Ability of baclofen in reducing alcohol craving and intake: II--Preliminary clinical evidence. *Alcoholism: Clinical & Experimental Research*, 24, 67-71. <https://doi.org/10.1111/j.1530-0277.2000.tb04555.x>
- Addolorato, G., Leggio, L., Ferrulli, A., Cardone, S., Vonghia, L., & Mirijello, A. (2007). Effectiveness and safety of baclofen for maintenance of alcohol abstinence in alcohol-dependent patients with liver cirrhosis: Randomised, double-blind controlled study. *The Lancet*, 370(9603), 1915-1922. [https://doi.org/10.1016/S0140-6736\(07\)61814-5](https://doi.org/10.1016/S0140-6736(07)61814-5)
- Anderson, A. L., Li, S. H., Biswas, K., McSherry, F., Holmes, T., Iturriaga, E., & Elkashef, A. M. (2012). Modafinil for the treatment of methamphetamine dependence. *Drug and Alcohol Dependence*, 120(1-3), 135-141. <https://doi.org/10.1016/j.drugalcdep.2011.07.007>
- Anderson, A. L., Li, S. H., Markova, D., Holmes, T. H., Chiang, N., Kahn, R., ... Elkashef, A. M. (2015). Bupropion for the treatment of methamphetamine dependence in non-daily users: A randomized, double-blind, placebo-controlled trial. *Drug and Alcohol Dependence*, 150, 170-174. doi: 10.1016/j.drugalcdep.2015.01.036
- Christmass, M. (2017). The crystal methamphetamine problem in Western Australia: Pilot project of a stimulant use disorder outpatient treatment clinic. Perth, WA: Next Step, East Metropolitan Community Alcohol and Drug Service and Mental Health Commission, Western Australia.
- Colfax, G. N., Santos, G. M., Das, M., Santos, D. M., Matheson, T., Gasper, J., ... & Vittinghoff, E. (2011). Mirtazapine to reduce methamphetamine use: A randomized controlled trial. *Archives of General Psychiatry*, 68(11), 1168-1175. doi: 10.1001/archgenpsychiatry.2011.124
- Drug and Alcohol Office. (2014). *Community Program for Opioid Pharmacotherapy (CPOP) - clinical policies and procedures for the use of methadone and buprenorphine in the treatment of opioid dependence*. Retrieved from <https://www.mhc.wa.gov.au/media/1614/wa-clinical-policies-and-procedures-for-the-use-of-methadone.pdf>
- Duke, A. N., Kaminski, B. J., & Weerts, E. M. (2014). Baclofen effects on alcohol seeking, self-administration and extinction of seeking responses in a within-session design in baboons. *Addiction Biology*, 19(1), 16-26. doi: 10.1111/j.1369-1600.2012.00448.x
- Flannery, B. A., Garbutt, J. C., Cody, M. W., Renn, W., Grace, K., Osborne, M., ... Trivette, A. (2004). Baclofen for alcohol dependence: A preliminary open-label study. *Alcoholism: Clinical & Experimental Research*, 28(10), 1517-1523. <https://doi.org/10.1097/01.ALC.0000141640.48924.14>
- Gowing, L., Ali, R., Dunlop, A., Farrell, M., & Lintzeris, N. (2014). *National Guidelines for medication-assisted treatment of opioid dependence*. Retrieved from [http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/AD14DA97D8EE00E8CA257CD1001E0E5D/\\$File/National\\_Guidelines\\_2014.pdf](http://www.nationaldrugstrategy.gov.au/internet/drugstrategy/Publishing.nsf/content/AD14DA97D8EE00E8CA257CD1001E0E5D/$File/National_Guidelines_2014.pdf)
- Hammond, C. J. (2016). The role of pharmacotherapy in the treatment of adolescent substance use disorders. *Child and Adolescent Psychiatric Clinics of North America*, 25(4), 685-711. doi: 10.1016/j.chc.2016.05.004
- Heinzerling, K. G., Swanson, A. N., Kim, S., Cederblom, L., Moe, A., Ling, W., & Shoptaw, S. (2010). Randomized, double-blind, placebo-controlled trial of modafinil for the treatment of methamphetamine dependence. *Drug and Alcohol Dependence*, 109(1-3), 20-29. <https://doi.org/10.1016/j.drugalcdep.2009.11.023>
- Heinzerling, K. G., Swanson, A. N., Hall, T. M., Yi, Y., Wu, Y., & Shoptaw, S. J. (2014). Randomized, placebo-controlled trial of bupropion in methamphetamine-dependent participants with less than daily methamphetamine use. *Addiction*, 109(11), 1878-1886. doi: 10.1111/add.1263
- Jayaram-Lindstrom, N., Hammarberg, A., Beck, O., & Franck, J. (2008). Naltrexone for the treatment of amphetamine dependence: A randomized, placebo-controlled trial. *American Journal of Psychiatry*, 165(11), 1442-1448. doi: 10.1176/appi.ajp.2008.08020304
- Larney, S., Gowing, L., Mattick, R. P., Farrell, M., Hall, W., & Degenhardt, L. (2014). A systematic review and meta-analysis of naltrexone implants for the treatment of opioid dependence. *Drug and Alcohol Review*, 33(2), 115-128. doi: 10.1111/dar.12095
- Lee, N. K., & Jenner, L. (2014). *Medication treatment options for amphetamine-type stimulant users*. Retrieved from <http://www.atoda.org.au/wp-content/uploads/rp29-medication-treatment-options.pdf>.

- Leggio, L., Ferrulli, A., Zambon, A., Caputo, F., Kenna, G. A., Swift, R. M., & Addolorato, G. (2012). Baclofen promotes alcohol abstinence in alcohol dependent cirrhotic patients with hepatitis C virus (HCV) infection. *Addictive Behaviors*, *37*(4), 561-564. doi: 10.1016/j.addbeh.2011.12.010
- Lingford-Hughes, A., Welch, S., Peters, L., & Nutt, D.J. (2012). BAP update guidelines: Evidence-based guidelines for the pharmacological management of substance abuse, harmful use, addiction and comorbidity: recommendations from BAP. *Journal of Psychopharmacology*, *26*(7), 899–952. doi: 10.1177/0269881112444324
- Maccioni, P., Carai, M. A., Kaupmann, K., Guery, S., Froestl, W., Leite-Morris, K. A., ... Colombo, G. (2009). Reduction of alcohol's reinforcing and motivational properties by the positive allosteric modulator of the GABA(B) receptor, BHF177, in alcohol-preferring rats. *Alcoholism: Clinical & Experimental Research*, *33*(10), 1749-1756. doi: 10.1111/j.1530-0277.2009.01012.x
- Miles, S. W., Sheridan, J., Russell, B., Kydd, R., Wheeler, A., Walters, C., ... Tiihonen, J. (2013). Extended-release methylphenidate for treatment of amphetamine/methamphetamine dependence: A randomized, double-blind, placebo-controlled trial. *Addiction*, *108*(7), 1279-1286. doi: 10.1111/add.12109
- North Metropolitan Health Service. (n.d.). Maternal medical/substance use – Clinical practice guideline. Retrieved from <https://www.kemh.health.wa.gov.au/~media/Files/Hospitals/WNHS/For%20health%20professionals/Clinical%20guidelines/NEOPN/WNHS.NEOPN.MaternalMedicationSubstanceUse.pdf>
- Rolland, B., Simon, N., & Franchitto, N. (2018). Safety challenges of using high dose baclofen for alcohol use disorder: A focused review. *Frontiers in Psychiatry*, *9*(367). doi: 10.3389/fpsy.2018.00367
- Shearer, J., Darke, S., Rodgers, C., Slade, T., van Beek, I., Lewis, J., ... Wodak, A. (2009). A double-blind, placebo-controlled trial of modafinil (200 mg/day) for methamphetamine dependence. *Addiction*, *104*(2), 224-233. doi: 10.1111/j.1360-0443.2008.02437.x
- Tiihonen, J., Kuoppasalmi, K., Fohr, J., Tuomola, P., Kuikanmaki, O., Vormaa, H., & Meririnne, E. (2007). A comparison of aripiprazole, methylphenidate, and placebo for amphetamine dependence. *American Journal of Psychiatry*, *164*(1), 160-162. doi: 10.1176/ajp.2007.164.1.160
- Zedler, B. K., Mann, A. L., Kim, M. M., Amick, H. R., Joyce, A. R., Murrelle, E. L., & Jones, H. E. (2016). Buprenorphine compared with methadone to treat pregnant women with opioid use disorder: A systematic review and meta-analysis of safety in the mother, fetus and child. *Addiction*, *111*(12), 2115–2128. doi: 10.1111/add.13462

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## 18. Recovery<sup>9</sup>

Over the last decade or so, there has been a move towards 'recovery-oriented systems of care' in both AOD and mental health service systems, first in the United States (Gaumond & Whitter, 2009), then the United Kingdom (Home Office, 2012) and more recently in Australia (Anex, 2012). This reflects a paradigmatic shift in approaches to treatment, driven by a recovery movement that is underpinned by increased advocacy and knowledge around the lived experience of people in recovery, aiming to support multiple and self-defined pathways to recovery (White, 2007).

These system reforms reflected a shift in the understanding of recovery, from professionally-led definitions focused on objective features that could be seen and measured, to first-person perspectives based on subjective experiences of improvements in quality of life, creating initial tension and debate (Beckwith, Bliuc & Best, 2016). Beckwith and colleagues (2016) argue that this tension has centred on who 'owns' the definition of recovery, thus who gets to say when someone is in recovery and what the pathway through recovery should look like. While it has been noted that traditional notions of recovery that focused heavily on abstinence did not reflect the lived experience of recovery for everyone (Helfgott & Allsop, 2009), first-person definitions that aimed to empower people to define their own recovery – the sense that 'you are in recovery if you say you are' (Valentine, 2011) – were initially criticised as being based on principles rather than evidence, with no agreement on what 'recovery' means in practice (Best et al., 2010). The challenge then has been to apply those principles in a meaningful and practical way.

Ideally, a useful and meaningful definition of recovery would integrate both personal and clinical perspectives (Slade, 2009; White, 2007), respecting the individual needs and understanding of people in recovery and their families – what Slade (2009) called 'personal recovery' – whilst acknowledging the needs of workers and the service system to capture and measure objective improvements that indicated effective treatment – what Slade (2009) called 'clinical recovery'.

Initial definitions of recovery therefore varied between jurisdictions, yet all agreed that recovery is a process that extends beyond changing or ceasing AOD use. This is reflected in the UK Drug Policy Commission's definition of AOD recovery, for example:

*Recovery from problematic substance use is a process that involves not only achieving control over drug use, but also involves improved health and wellbeing and building a new life, including family and social relationships, education, voluntary activities and employment. (UK Drug Policy Commission, 2012, p.14.)*

Such definitions highlight the holistic nature of recovery, with a broader focus on improvement across all domains of an individual's life – not just AOD use. A person's recovery need not encompass all these elements though. The overall aim of a recovery-oriented system is to support the person in recovery in choosing for themselves their own unique recovery pathway, ultimately increasing their quality of life. It is client-centred, strengths-oriented, and takes a whole-person view of recovery (Australian Government Department of Health, 2013; Sheedy & Whitter, 2009).

To conceptualise recovery in practice, much research has been conducted with a strong focus on the perspective of people in recovery.

Overall, findings have confirmed of the need to focus on increasing strengths and resources, rather than focusing solely on reducing pathology, as this has a greater impact on a positive recovery trajectory (White & Cloud, 2008). It might therefore be helpful to think about recovery in terms of these two aspects. Kelly and Hoepfner (2015) operationalise recovery as a process involving a reduction in addiction severity, including the various biopsychosocial harms associated with AOD use, alongside an increase in 'recovery capital', resources that can be mobilised to initiate recovery and increase overall quality of life. It is interesting to note that only 'physical capital' (one domain of recovery capital, including such tangible aspects as physical health, housing, and finances) is related to addiction severity (Burns & Marks, 2013), while recovery capital as a whole (which also comprises resilience, hope, positive sense of self, practical skills, social connections and support, and community engagement, for example) contributes to overall quality of life (e.g. Groshkova, Best & White, 2013; Mawson et al., 2015).

<sup>9</sup> This chapter was written with significant input from Melinda Beckwith, Eastern Health Clinical School, Monash University.



The other significant finding from recovery research is that social influences, support, and connections are important and necessary resources in sustaining recovery, encouraging and providing alternatives to AOD use alongside many other benefits. These social aspects of recovery may come from mutual support groups, recovery-focused community groups, non-using friends and family, and other meaningful activities such as engagement in a workplace, education, volunteering, or child-rearing.

## Recovery capital

Cloud and Granfield (2008) noted that a person's capacity to change problematic AOD use was heavily influenced by their environment and internal and external resources they may possess. They define recovery capital (RC) as "...the sum total of one's resources that can be brought to bear on the initiation and maintenance of substance misuse cessation." (p. 1972). They noted that a person's capacity to change problematic AOD use was heavily influenced by their environment and internal and external resources they may possess.

Recovery capital has been conceptualised more recently as having three aspects: personal capital, social capital, and community capital (Best & Laudet, 2010).

**Personal capital** includes both material and economic assets, such as property or money, that may increase recovery options (e.g. the capacity to move away from areas they associate with AOD use), as well as skills, physical and mental health, hopes and aspirations that enable a person to live well.

**Social capital** includes resources to which a person has access as a result of their relationships, including support from and obligations to groups to which they belong, and understanding of cultural and social norms and the ability to act in one's interest within those norms to meet basic needs and to maximise opportunities.

**Community capital** includes a range of community resources that someone can use to assist them in recovery, such as community health centres, accessible AOD services, as well as the collective resources of support and social influence found in visible recovery groups and movements.

It is important to note that people's level of RC is always in flux and will vary across time. People will have many opportunities to accumulate and deplete RC across the lifespan. The domains of RC are dynamic and closely interactive, each influencing a person's overall RC and all need to be considered together. This has implications for workers, as helping clients identify existing recovery capital, which can be used to increase their resources across all domains, and strategising ways to generate more can increase the client's chances of maintaining change over time.

## Social identity and recovery

Recent research has identified that shifts in the way people see themselves, in terms of the social groups they belong to, can help facilitate recovery. As we tend to adopt the attitudes, values and norms of the groups we identify with, membership of groups that are supportive of recovery can help maintain recovery goals by facilitating a shift from a 'using' to 'recovery' social identity (Best, Beckwith et al., 2016).

The larger the proportion of people who don't use AOD clients have in their social networks, the more likely they are to sustain changes in AOD use over time. Even substituting one non-drinking member into one's social network has been shown to increase the likelihood of treatment success (defined as without alcohol 90% of the time) by 27% at 12 months post-treatment (Litt et al., 2009). In addition, greater opposition to a person's drinking from within their social network predicts more days without drinking during and after treatment (Longabaugh et al., 2010). Similar results have also been found for people who are not in treatment who nevertheless stop using heroin or cocaine (Buchanan & Latkin, 2008). Sustained recovery is therefore underpinned by a move from a social network supportive of AOD use, to one supportive of recovery.

Furthermore, the shift from an AOD using identity to a recovery identity early in treatment predicts retention in treatment (Beckwith et al., 2015), and the greater the difference in strength between recovery and AOD-using identities over time, the greater a person's wellbeing six months after treatment (Dingle et al., 2015). An increase in non-using groups in a person's social network is related to an increase in recovery identity strength over time, while a decrease in groups who use heavily is related to a decrease in AOD-using identity strength, with both impacting AOD use outcomes (Beckwith et al., 2019), confirming the link between group influence and the way a person sees themselves in terms of their AOD use. Findings from the Social Networks and Recovery (SONAR) study (Best, Haslam et al., 2016) shows that staying



in treatment for three months or more provides the necessary environment to support this positive identity change, resulting in greater wellbeing and commitment to recovery goals 12 months later.

These findings have implications for workers, as assisting clients to engage with more non-using groups could have a significant impact on whether other recovery goals are met. Workers can help clients identify groups that don't use AOD in their world and encourage participation in more recovery groups or other groups in which people do not engage in AOD use, including meaningful activities such as sport, work, or volunteering. Peer support groups can play an invaluable role in helping this process, yet a sense of belonging to any non-using group that is meaningful to the person can help foster an identity shift that helps the person to sustain a positive recovery trajectory.

## Notes for practice

Recovery research focused on service users has highlighted some issues for workers to be mindful of when working in AOD services or with AOD-using clients.

Firstly, clients can have differing expectations of recovery than their workers, focusing more on coping than a cure (Neale et al., 2015), thus workers need to be mindful of imposing their own expectations of recovery onto their clients. In focus groups with service users, Neale and colleagues (2015) found many reported that workers would seem to forget that a lot of the people who access AOD services had entrenched vulnerabilities that made some of the outcomes expected of them difficult to achieve, and some reported they felt pressure from their workers to achieve 'transformative' change. These focus groups highlighted the need for workers to take into account the client's wishes and capabilities, support their agency and autonomy, and recognition that perceived 'failures' may present a positive opportunity for growth.

Furthermore, 'pathologising' every aspect of a client's presentation can be unhelpful. As service users quite rightly point out, people who have never used illicit drugs break the law, get into debt, and have bad relationships. They can also experience anxiety, uncertainty, loneliness, guilt and shame (Neale et al., 2014). Attributing the difficult aspects of a client's life to their AOD use does not allow the client to frame these experiences as a normal, if not unfortunate, aspect of being human; instead it contributes to the stigmatisation of people who use AODs, who may be excluded as 'other'.

## Recovery and harm reduction

Whilst some concern from user groups has been expressed around a 'new recovery' movement and what this could mean for Australia's well-established policy of harm reduction (Australian Injecting & Illicit Drug Users League, 2012), harm reduction can be consistent with the values of recovery. If recovery is simply working towards improved quality of life, a harm reduction approach is a logical part of a recovery framework, particularly in jurisdictions that do not insist on viewing recovery from an abstinence-only perspective. Furthermore, as Hunt (2012) points out, recovery and harm reduction are related, but distinct concerns. Recovery-oriented care will often concern itself with people who are experiencing significant issues with their AOD use and want to change this, with harm reduction information, strategies, and support being part of the care workers provide for their clients. However, harm reduction approaches can take a much broader view, in that they aim to address the need of people who use alcohol and/or other drugs, whether or not they seek to change their use. For example, people who use AODs experimentally, or casually, or recreationally, can still benefit from a harm reduction approach, but may be less likely to have anything to 'recover' from.

## Ten Guiding Principles of Recovery

The Substance Abuse and Mental Health Services Administration (SAMHSA) in the United States has developed ten guiding principles of recovery (2012). Whilst most US definitions of recovery hold abstinence as a key concept of recovery, unlike the UK and Australia, the Guiding Principles offer consumers and workers a framework from which to negotiate recovery-oriented goals.

- **Hope** – That people can and do overcome the challenges, barriers and difficulties they face underpins the principle of hope. Hope is a catalyst for positive change.
- **Person-driven** – Individuals are provided space to identify and define their own goals and formulate their own pathways to recovery. Individuals are independent and autonomous to the greatest possible extent. They exercise choice regarding the supports and services that will assist them in the pursuit of their recovery goals.

- **Many pathways** – This principle recognises that people have unique needs, strengths, preferences, goals, culture and backgrounds (including trauma histories) that impact their recovery needs. As a result, recovery pathways will be highly individual, and people will access support from a variety of sources, as identified by the individual. This principle also recognises that recovery is a non-linear process of growth and setbacks can occur. The fostering of resilience in individuals and families is an essential part of recovery support.
- **Holistic** – Recovery envelops all aspects of a person, including physical, emotional, mental, social and community. Areas of life that may be addressed include: self-care, family, housing, employment, transport, education, clinical treatment, faith, spirituality, social networks, and community participation.
- **Peer support** – This principle recognises the important role mutual support and mutual aid groups can play in an individual's recovery. The sharing of knowledge and skills, as well as opportunity for social learning, can be invaluable to a person's recovery. Peers who engage and encourage other peers provide a vital sense of belonging, positive group identity, and community.
- **Relational** – The presence and involvement of people supporting of recovery is an important factor in recovery. Supportive people who offer hope and encouragement and provide resources for change enable the individual to move away from unfulfilling life roles and move towards those which offer greater fulfilment, empowerment and community participation.
- **Culture** – The values, traditions and beliefs of an individual's cultural background play an important role in determining an individual's pathway to recovery. Services should ensure cultural competency in all aspects of service delivery.
- **Addresses trauma** – A trauma history is common among people who have a lived experience of AOD use and / or mental health issues. Services should become 'trauma informed', ensuring they offer choice, trustworthiness, empowerment, collaboration and safety for the individual and consider the impacts of cultural, historical and gender. Services need to ensure their practices do not risk re-traumatising vulnerable people (see chapter on **Co-occurring trauma issues**).
- **Strengths/responsibility** – This principle acknowledges that individuals, families and communities have strengths and resources that can serve as a base from which recovery can grow. Furthermore, people have a responsibility to their own self-care and recovery. Families and significant others have responsibilities to support their loved ones, and communities have responsibilities to provide opportunities and resources to address discrimination and to encourage social inclusion and recovery.
- **Respect** – Recovery is based on respect. Acceptance of the difficulties that can be faced by people with AOD use issues in meeting recovery goals needs to be appreciated by support systems and the wider community. This includes protecting their rights and eliminating discrimination. For individuals embarking on a recovery journey, self-acceptance and developing a positive and meaningful sense of identity are particularly important.

## Recovery - Tip Sheet

Workers need to be mindful not to impose their own expectations of recovery onto the client. Any recovery-oriented therapeutic goals need to reflect the client's wishes and capabilities.

Workers need to ensure they do not 'pathologise' every aspect of a client's presentation. Assigning the negative aspects of a client's life to their AOD use does not allow them to frame much of their experiences as normal human responses and can further otherise and stigmatise them.

A person's capacity to change problematic AOD use is heavily influenced by their environment and internal and external resources they may possess.

Helping clients identify deficits in their recovery capital and strategising ways to increase their resources across the domains can increase the client's chances of maintaining change over time.

Workers can help clients identify non-using groups in their world and encourage participation in more non-using groups.

Peer support groups can play an invaluable role in helping this process. Importantly, however it does not need to be a therapeutic group; membership of any non-using group that is meaningful can help foster the identity shift.

Recovery-oriented care will often concern itself with people who are experiencing significant issues with their AOD use, with harm reduction information, strategies and support being part of the care workers provide for their clients.

## References

- Australian Government Department of Health. (2013). *A national framework for recovery-oriented mental health services: Policy and theory*. Canberra, ACT: Author.
- Australian Injecting & Illicit Drug Users League. (2012). *New recovery', harm reduction & drug use policy statement*. Canberra, ACT: Author.
- Anex (2012). *Australian drug policy: Harm reduction and 'new recovery'*. Fitzroy North, VIC: Author.
- Beckwith, M., Bliuc, A. M., & Best, D. (2016). What the recovery movement tells us about prefigurative politics. *Journal of Social and Political Psychology, 4*(1), 238-251. doi: 10.5964/jpspp.v4i1.548
- Beckwith, M., Best, D., Dingle, G., Perryman, C., & Lubman, D. (2015). Predictors of flexibility in social identity among people entering a therapeutic community for substance abuse. *Alcoholism Treatment Quarterly, 33*(1), 93-104. doi: 10.1080/07347324.2015.982465
- Best, D., Beckwith, M., Haslam, C., Haslam, S. A., Jetten, J., Mawson, E., & Lubman, D. I. (2016). Overcoming alcohol and other drug addiction as a process of social identity transition: The Social Identity Model of Recovery (SIMOR). *Addiction Research & Theory, 24*(2), 111-123. doi: 10.3109/16066359.2015.1075980
- Best, D., Haslam, C., Staiger, P., Dingle, G., Savic, M., Bathish, R., ... Lubman, D. (2016). Social Networks and Recovery (SONAR): Characteristics of a longitudinal outcome study in five Therapeutic Communities in Australia. *Therapeutic Communities: The International Journal of Therapeutic Communities, 37*(3), 131-139. doi: 10.1108/TC-04-2016-0012
- Best, D., Bamber, S., Battersby, A., Gilman, M., Groshkova, T., Honor, S., & White, W. (2010). 'Recovery and straw men: An analysis of the objections raised to the transition to a recovery model in UK addiction services'. *Journal of Groups in Addiction and Recovery, 5*, 264-288. <https://doi.org/10.1080/1556035X.2010.523362>
- Best, D., & Laudet, A. B. (2010). *The potential of recovery capital*. London, United Kingdom: Royal Society for the Arts.
- Buchanan, A. S., & Latkin, C. A. (2008). Drug use in the social networks of heroin and cocaine users before and after drug cessation. *Drug and Alcohol Dependence, 96*(3), 286-289. doi: 10.1016/j.drugalcdep.2008.03.008.
- Burns, J., & Marks, D. (2013). Can Recovery Capital Predict Addiction Problem Severity? *Alcoholism Treatment Quarterly, 31*(3), 303-320. doi: 10.1080/07347324.2013.800430.
- Cloud, W. & Granfield, G. (2008). Conceptualizing recovery capital: Expansion of a theoretical construct. *Substance Use & Misuse, 43*(12-13), 1971-1986. doi: 10.1080/10826080802289762
- Dingle, G. A., Stark, C., Cruwys, T., & Best, D. (2015). Breaking good: Breaking ties with social groups may be good for recovery from substance misuse. *British Journal of Social Psychology, 54*(2), 236-254. doi: 10.1111/bjso.12081
- Gaumont P., and Whitter M., Access to Recovery (ATR), (2009). *Approaches to Recovery-Oriented Systems of Care: Three Case Studies*. HHS Publication No. (SMA) 09-4440. Rockville, MD: CSAT.
- Groshkova, T., Best, D., & White, W. (2013). The assessment of recovery capital: Properties and psychometrics of a measure of addiction recovery strengths. *Drug and Alcohol Review, 32*(2), 187-194. doi: 10.1111/j.1465-3362.2012.00489.x.
- Helfgott, S., & Allsop, S. (2009). Models of addiction behaviour. In S. Allsop & S. Helfgott (Eds.), *Helping change: The alcohol and drug counsellors' training program* (Module 7). Perth, WA: Drug and Alcohol Office.

- Home Office. (2012). *Putting full recovery first*. Retrieved from [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/98010/recovery-roadmap.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/98010/recovery-roadmap.pdf)
- Hunt, N. (2012). Recovery and harm reduction: Time for a shared, development-oriented, programmatic approach? In R. Pates & D. Riley (Eds.), *Harm reduction in substance use and high risk behaviour* (pp. 155-170). Chichester, United Kingdom: Wiley-Blackwell.
- Kelly, J. F., & Hoepfner, B. (2015). A biaxial formulation of the recovery construct. *Addiction Research & Theory, 23*(1), 5-9. <https://doi.org/10.3109/16066359.2014.930132>
- Litt M. D., Kadden R. M., Kabela-Cormier E., Petry N. M. (2009). Changing network support for drinking: Network support project 2-year follow-up. *Journal of Consulting and Clinical Psychology, 77*, 229–242. doi: 10.1037/a0015252
- Longabaugh, R., Wirtz, P. W., Zywiak, W. H., & O'Malley, S. S. (2010). Network support as a prognostic indicator of drinking outcomes: The COMBINE study. *Journal of Studies on Alcohol and Drugs, 71*(6), 837-846. <https://doi.org/10.15288/jsad.2010.71.837>
- Mawson, E., Best, D., Beckwith, M., Dingle, G., & Lubman, D. (2015). Social identity, social networks and recovery capital in emerging adulthood: A pilot study. *Substance Abuse Treatment, Prevention, and Policy, 10*(1). doi: 10.1186/s13011-015-0041-2
- Neale, J., Finch, E., Marsden, J., Mitcheson, L., Rose, D., Strang, J., ... Wykes, T. (2014). How should we measure addiction recovery? Analysis of service provider perspectives using online Delphi groups. *Drugs: Education, Prevention, and Policy, 21* (4), 310-323. doi: 10.3109/09687637.2014.918089
- Neale, J., Tompkins, C., Wheeler, C., Finch, E., Marsden, J., Mitcheson, L., ... Strang, J. (2015). "You're all going to hate the word 'recovery' by the end of this": Service users' views of measuring addiction recovery. *Drugs: Education, Prevention and Policy, 22*, 26-34. doi: 10.3109/09687637.2014.947564
- Slade, M. (2009). 100 ways to support recovery: *A guide for mental health professionals*. Retrieved from [https://recoverylibrary.unimelb.edu.au/\\_\\_data/.../100\\_ways\\_to\\_support\\_recovery.pdf](https://recoverylibrary.unimelb.edu.au/__data/.../100_ways_to_support_recovery.pdf)
- Sheedy, C. K., & Whitter, M. (2009). *Guiding principles and elements of recovery-oriented systems of care: What do we know from the research?* HHS Publication No. (SMA) 09-4439. Rockville, MD: CSAT.
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2012). *SAMHSA's working definition of recovery: Ten guiding principles of recovery*. Retrieved from <https://store.samhsa.gov/product/SAMHSA-s-Working-Definition-of-Recovery/PEP12-RECDEF>.
- United Kingdom Drug Policy Commission. (2012). *A fresh approach to drugs: The final report of the UK Drug Policy Commission*. London, United Kingdom: Author.
- Valentine, P. (2011) Peer-based recovery support services within a recovery community organization: The CCAR experience. In J.F. Kelly and W.L. White (eds.), *Addiction Recovery Management: Theory, Research and Practice*. Totowa, NJ: Humana Press.
- White, W. (2007). Addiction recovery: Its definition and conceptual boundaries. *Journal of Substance Abuse Treatment, 33*, 229 – 241. doi: 10.1016/j.jsat.2007.04.015.
- White, W. & Cloud, W. (2008). Recovery capital: A primer for addictions professionals. *Counselor, 9*(5), 22-27.

## 19. Stages of change

Prochaska, Norcross, and DiClemente's (1992) transtheoretical model of behaviour change, commonly referred to as the stages of change model, is a well-known model in the AOD field. The model was originally developed through an examination of the process of self-change in tobacco smokers, but has since become a dominant model of behaviour change in a multitude of health and social fields. Behaviour change around substance use, exercise, weight loss, cancer screening and safer-sex practices can all be informed by the stages of change model.

Historically, deciding to change AOD use was seen as a single event rather than a process, with the primary goal being abstinence. The stages of change model suggests that individuals attempting to change behaviour move through five stages of change: precontemplation, contemplation, preparation, action and maintenance. The model suggests that people can be in different stages of readiness for change (Prochaska et al., 1992).

According to the stages of change model, the internal process involved in behaviour change is dynamic and cyclical (Prochaska, Norcross, & DiClemente, 2013). Clients do not necessarily go through the stages in an orderly, linear fashion; rather, progression through the model is conceptualised as a process of cycling 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 withdrawal symptoms and a subsequent decision to use. In addition, most people make several attempts at changing their behaviour before change is sustained and may therefore cycle through the stages of change multiple times (see Figure 1).

The stages of change model provides a template for AOD counsellors to explain the process of behaviour change to clients and tailor interventions to fit their needs (readiness to change). Many people create sustainable change without AOD treatment (Sobell, Ellingstad, & Sobell, 2000), so interventions are not a necessity to achieve long-term behaviour change. However, the model can help counsellors to work in a client-centred way and tailor their interventions to the client's current stage of change.

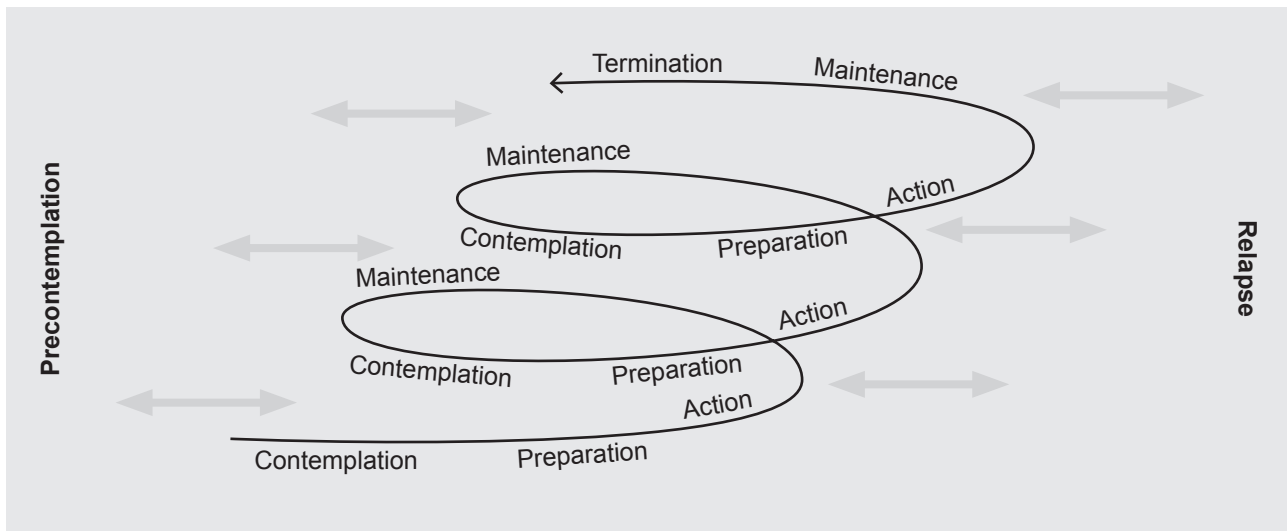


Figure 1: Stages of change (adapted from Prochaska et al., 1992)

The stages of change and tips for working with clients in each stage are as follows.

## Precontemplation

Clients in the precontemplation stage are not considering change. For some clients, the positives of continued AOD use vastly outweigh the negatives. Alternatively, for some clients the negatives of change outweigh the positives. In some cases, individuals may be unaware or under-aware of an issue. Clients likely to be in the precontemplative stage include court-mandated clients and young people brought to treatment by their parents (see chapters on **Coerced clients** and **Working with clients referred by the justice system**).

The precontemplators have historically been characterised as unmotivated, resistant or in denial. These terms are unhelpful and place the client at fault, rather than describing differences between the clinical worker's or family members' expectations and the clients' personal goals (Health Promotion Unit, 2007). In precontemplation, the client usually is motivated, but not in the direction of change.

Precontemplators are sometimes referred to as 'happy users'. In some instances precontemplative individuals are happy or content in their use, but in other cases a precontemplator may not be considering change as they do not believe that change is possible. Using scaling questions to explore perceived importance of change and ability to change will assist in determining this. If a client thinks change is important but unlikely, or not possible, strength-based work can be done to build self-efficacy. It is important that the functionality of AOD use is explored so the client can have realistic expectations about what change may mean for them (e.g. clients may be using alcohol or other drugs to manage mental health symptoms).

Harm reduction work can be particularly beneficial in engaging precontemplative clients, because the focus is not on changing their AOD use but on reducing harm. Whenever possible, provide harm reduction information and negotiate less risky AOD use (see chapter on **Harm reduction**).

Developing good rapport and displaying genuine, open and non-judgemental attitudes during work with precontemplative clients is essential. If a client has a positive experience it increases the likelihood of reengagement if they become concerned about their AOD use.

## Contemplation

The client may feel that AOD use has many benefits for them in the contemplation stage, but rising costs often prompt them to start thinking about change. This internal conflict can be confusing and uncomfortable (Miller & Rollnick, 2013). Most clients entering AOD treatment for the first time are in the contemplation stage.

Counsellors should create an environment in which clients can feel safe to explore all aspects of their AOD use – the functionality of their AOD use as well as the 'not so good' things about using. MI is a particularly useful technique for assisting ambivalent clients to explore and resolve their ambivalence about change (see chapter on **Motivational interviewing**).

Clients may have family members or friends who insist they cease their AOD use. Consequently, they may not feel safe to reflect upon and openly explore perceived negatives of their use due to fear of being further coerced or criticised. This may result in clients feeling misunderstood and needing to defend their AOD use. Counsellors can assist clients to explore both the advantages and disadvantages of their AOD use by creating a safe environment through the use of the MI spirit and the micro-counselling skills – OARS: open questions, affirmations, reflective listening and summarising (see chapter on **Motivational interviewing**). The use of a strengths-based approach in which the counsellor notices and comments on a client's strengths as well as acknowledging their struggles, can help reduce defensiveness and encourage the space for self-reflection to take place (Miller & Rollnick, 2013).

It is important for counsellors not to get ahead of the client's readiness to change (Miller & Rollnick, 2013). For clients who are ambivalent and/or not ready to change their AOD use, harm reduction information is important (see chapter on **Harm reduction**).



## Preparation

During this stage of change, the client is aware that the negative aspects of their AOD use are outweighing the benefits. They have made a decision to change and are planning how to put change into effect. For example, a tobacco smoker may have set a quit date and purchased NRT.

Counsellors can help the client to confirm their decision to change by evoking ‘change talk’<sup>10</sup>, as well as initiating goal-setting, planning, and problem-solving (see chapters on **Problem-solving** and **Goal-setting**). Problem-solving and goal-setting will assist the client to consider some of the actions they will take to change their behaviour and encourage them towards the action stage of change. They may also benefit from considering things that may trigger a lapse (see chapter on **Relapse prevention and management**). Assist clients to build up other areas of their life in preparation for change, including developing new interests and activities to replace AOD-related activities.

It is common for AOD clients to present to counselling with complex needs (co-occurring AOD/mental health, trauma, CIs, higher severity of dependence), and support during the transition from contemplation to action can be of great benefit. Clients with complex issues may find the transition into action distressing, and will need new skills to manage changes in their AOD use.

One criticism of the stages of change model is that it focuses on conscious decision-making and planning processes and “assumes that individuals typically make coherent and stable plans” (West, 2005, p. 1037). Intentional change is not the only way people initiate behaviour change.

Davidson (2001) argued that successful change can occur without having to go through each stage and that stages can be skipped. This may be the case, or it may be that people are transitioning rapidly between stages – for example, from contemplation (or precontemplation) straight into action. Some people create sustainable change without significant time spent in the preparation stage. Examples of this include an unplanned attempt to quit smoking which results in long-term smoking cessation, or a woman discovering she is pregnant and immediately ceasing alcohol use.

Such rapid transition between stages, or the possibility of skipping stages, does not negate the usefulness of the stages of change model, which helps to tailor interventions to the client’s stage (Prochaska et al., 2013). Many individuals benefit from preparing for potential challenges or triggers to use AODs.

## Action

Clients in the action stage are in the process of changing their behaviour. They may be putting a lot of energy into abstinence or reduced AOD use, as well as developing new interests and activities to replace AOD-related activities. Early in this stage people may be experiencing withdrawal symptoms, and after withdrawal clients can get bored unless they have alternative activities that they find engaging. Clients often need to deal with AOD cravings and some experience grief over a lost lifestyle. Clients in the action stage may feel very isolated and anxious and can find it very difficult to relate to the ‘non-using’ world. These experiences should be normalised, as should issues such as anhedonia (the inability to feel pleasure), as neurotransmitter imbalances may also be a contributing factor to a low affect or emotional state (Garfield, Lubman, & Yücel, 2014).

Counsellors can help clients to develop relapse prevention and management skills (see chapter on **Relapse prevention and management**). They can reinforce the positive changes clients have made and help clients to find alternative, rewarding AOD-free experiences. Clients in action can be encouraged to think about longer-term goals and general lifestyle issues such as study, work and leisure activities.

If clients are using medication to manage mental health symptoms, a medication review will be needed when transitioning to action. A change in AOD use may affect the efficacy of mental health (and other) medication.

## 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.

<sup>10</sup> Change talk refers to clients’ statements about their desire, ability, reasons and need for change.



## Relapse

Relapse is not a stage within the stages of change model, but the model does recognise relapse as a common experience, often expected during the process of behaviour change. Clients are likely to lapse from any stage of change to a previous one, and most people make several attempts at changing their behaviour before they create lasting change. Previous unsuccessful attempts to change AOD use may influence the clients' attitude towards future treatment, their self-efficacy and self-worth. Relapse should be normalised when working with clients and be described as a process of learning (see chapter on **Relapse prevention and management**).

### Stages of change – tip sheet

The stages of change model suggests that individuals attempting to change behaviour move through stages, though not necessarily in linear fashion. The individual stages of change are listed below, along with strategies to assist clients.

1. Precontemplation – clients are not interested in changing their AOD use. Provide harm reduction information and negotiate less risky methods of AOD use if possible.
2. Contemplation – clients feel ambivalent about their AOD use and are starting to think about changing their behaviour. MI can help clients explore and resolve their ambivalence about change.
3. Preparation – the client has made a decision to change and is now thinking about putting change into effect. Goal-setting, problem-solving, and identifying triggers for relapse are useful for clients in this stage.
4. Action – clients are changing their behaviour. Assist clients with relapse prevention and management and reinforce positive changes. Counsellors can assist with relapse prevention and management skills.
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 longer-term lifestyle goals.
6. Relapse – clients may relapse from any stage of change to a previous one.

## References

- Davidson, R. (2001). The cycle of change. *Drug and Alcohol Findings*, 5, 19-24. Retrieved from [https://findings.org.uk/docs/Davidson\\_R\\_1.pdf?s=eb&r=&sf=sfnos](https://findings.org.uk/docs/Davidson_R_1.pdf?s=eb&r=&sf=sfnos)
- Garfield, J., Lubman, D., & Yücel, M. (2014). Anhedonia in substance use disorders: A systematic review of its nature, course and clinical correlates. *Australian & New Zealand Journal of Psychiatry*, 48(1), 36-51. doi: 10.1177/0004867413508455
- Health Promotion Unit. (2007). *Stages of behaviour change: Queensland Stay On Your Feet® Community Good Practice Toolkit*. Retrieved from [https://www.health.qld.gov.au/\\_\\_data/assets/pdf\\_file/0026/425960/33331.pdf](https://www.health.qld.gov.au/__data/assets/pdf_file/0026/425960/33331.pdf)
- Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: preparing people for change* (3rd ed.). New York, NY: Guildford Press.
- Prochaska, J., DiClemente, C., & Norcross, J. (1992). In search of how people change: Applications to the addictive behaviors. *American Psychologist*, 47(9), 1102-1114. <http://dx.doi.org/10.1037/0003-066X.47.9.1102>
- Prochaska, J., DiClemente, C., & Norcross, J. (2013). Applying the stages of change. *Psychotherapy in Australia*, 19(2), 10-15. doi: 10.1093/med:psych/9780199845491.003.0034
- Sobell, L., Ellingstad, T., & Sobell, M. (2000). Natural recovery from alcohol and drug problems: Methodological review of the research with suggestions for future directions. *Addictions*, 95(5), 749-64. <https://doi.org/10.1046/j.1360-0443.2000.95574911.x>
- West, R. (2005). Time for a change: Putting the transtheoretical (stages of change) model to rest. *Addiction*, 100(8), 1036–1039. <https://doi.org/10.1111/j.1360-0443.2005.01139.x>

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# 4

## Section Four: Assessment and Treatment Planning

- 20 Treatment planning
- 21 Assessment
- 22 Suicide assessment and management
- 23 Case formulation
- 24 Referral

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## 20. Treatment planning

A treatment plan is a detailed overview of the planned intervention, akin to a road map for therapy. In essence, treatment planning consists of matching a client to a theoretical rationale that both the counsellor and client agree upon, focusing on building a relationship, developing client expectations, and applying interventions that are consistent with the agreed-upon rationale (Wampold, 2015; Wampold & Imel, 2015).

A good treatment plan identifies a comprehensive set of tools and strategies addressing the client's strengths as well as their issues. A treatment plan outlines a sequence of resources and activities, and specifies milestones to guide evaluation (CSAT, 1994).

Counsellors should be familiar with their agency's policy and procedures around treatment planning. However, in general treatment plans should:

- be well developed, articulated, written and highly detailed
- be jointly negotiated between the counsellor and client
- be structured around meeting the client's goals and needs
- identify the client's most pressing needs
- be directly derived from the results of assessment, goal-setting and client choice
- matched to the client's treatment readiness and stage of change
- contain practical, realistic goals and the strategies for achieving these goals
- where appropriate, include parents, partners, families and friends
- be regularly reviewed and updated.

Treatment plans should contain the following:

- an assessment of client needs (support, psychological, parenting, health and other service needs) (see chapters on **Assessment** and **Recovery**)
- a statement of client goals (see chapter on **Goal-setting**)
- a list of strategies for achieving these goals, including counselling strategies, details of referrals and how case management will occur (see chapters on **Referral** and **Case Management**)
- an assessment of constraints and opportunities for meeting client needs and goals
- an outline of methods for evaluating progress and outcome (e.g. formal or informal measures of change in symptoms and AOD use, whether referrals were successful, whether client remains engaged in treatment) (see chapter on **Best practice outcome performance indicators**).

### Feedback-informed treatment

Treatment plans are not static documents; they should be re-evaluated regularly to see if they are meeting the client's needs or when the client's situation changes. This can be done in a session using feedback-informed treatment, which involves gathering real-time input from clients through structured yet flexible measures that identify what is and is not working in therapy, and how to better meet clients' needs (Prescott, Maeschalck, & Miller, 2017). Client-directed, outcome-informed counselling is not a model of counselling per se but a commitment to customising therapy in response to client preferences and treatment response (Beel, 2016).

Counsellors can use the Session Rating Scale (SRS) and the Outcome Rating Scale (ORS) to help ensure that the goals and objectives of the counselling match the client's expectations. These tools also provide an indication of the strength of the therapeutic alliance between the client and counsellor.

The SRS (see Appendix 9) is a very brief therapeutic alliance measure designed specifically for use in every session (Duncan et al., 2003). Research has shown that clinicians are generally poor at gauging their client's experience of the therapeutic alliance (Norcross, 2010) and need to request real-time alliance feedback. The benefits of requesting real-time feedback on the therapy alliance include empowering clients, promoting collaboration, the ability to adjust therapy, and enhancing outcomes.

The SRS measures:

- the relational bond between the counsellor and client
- agreement on the goals of therapy
- agreement on the method or approach towards addressing the issue
- clients overall feeling about the counselling session.

Instructions for using the SRS are included in Appendix 9.

The ORS can be used to evaluate progress against goals and the treatment plan. The ORS is a simple, four-item, session-by-session measure designed to assess areas of life functioning known to change as a result of therapeutic intervention (see Appendix 9) (Duncan & Miller, 2000). The ORS assesses four dimensions of client functioning that are widely considered to be valid indicators of successful outcome:

- personal or symptom distress (individual wellbeing)
- interpersonal wellbeing (how well the client is getting along in intimate relationships)
- social role (satisfaction with work/school and relationships outside of the home)
- overall wellbeing.

Instructions for using the ORS are included in Appendix 9.

## Treatment planning – tip sheet

Treatment plans match clients to a theoretical rationale that both the counsellor and client agree upon, focusing on building a relationship, developing client expectations, and applying interventions that are consistent with the agreed-upon rationale.

Treatment plans should contain the following:

- an assessment of client needs (support, psychological, parenting, health and other service needs)
- a statement of client goals
- a list of strategies for achieving these goals, including counselling strategies, details of referrals and how case management will occur
- an assessment of constraints and opportunities for meeting client needs and goals
- an outline of methods for evaluating progress and outcome.

Treatment plans are not static documents; they should be re-evaluated regularly to see if they are meeting the client's needs or when the client's situation changes.

The SRS and the ORS can help counsellors monitor and adjust therapeutic interventions as a client's situation or treatment preferences change. Using these tools may assist counsellors and clients in discussing future directions, measuring progress and/or monitoring the therapeutic alliance.

## References

- Center for Substance Abuse Treatment (CSAT). (1994). *Practical approaches in the treatment of women who abuse alcohol and other drugs* (DHHS Publication No. (SMA) 94-3006). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Beel, N. (2016). Therapy that fits: Feedback informed, client directed counseling. In E. Day & C. Noble (Eds.), *Psychotherapy and counselling: Reflections on practice* (pp. 88-99). South Melbourne, VIC: Oxford University Press.
- Duncan, B. L., & Miller, S. D. (2000). The client's theory of change: Consulting the client in the integrative process. *Journal of Psychotherapy Integration*, 10(2), 169-188. doi: 1053-0479/00/0600-0169\$18.00/0
- Duncan, B. L., Miller, S. D., Sparks, J., Claud, D., Reynolds, L., Brown, J., & Johnson, L. (2003). The Session Rating Scale: Preliminary psychometric properties of a "working" alliance measure. *Journal of Brief Therapy*, 3(1), 3-12. Retrieved from <https://www.scottmiller.com/wp-content/uploads/documents/SessionRatingScale-JBTv3n1.pdf>
- Norcross, J. C. (2010). The therapeutic relationship. In B. L. Duncan, S. D. Miller, B. E. Wampold, & M. A. Hubble (Eds.), *The heart and soul of change: Delivering what works in therapy* (2nd ed., pp.113-141). Washington, DC: American Psychological Association.
- Prescott, D. S., Maeschalck, C. L., & Miller, S. D. (Eds.). (2017). *Feedback-informed treatment in clinical practice: Reaching for excellence*. Washington, DC: American Psychological Association.
- Wampold, B. E. (2015). How important are the common factors in psychotherapy? An update. *World Psychiatry*, 14(3), 270–277. doi: 10.1002/wps.20238
- Wampold, B. E., & Imel, Z. E. (2015). *The great psychotherapy debate: The evidence for what makes psychotherapy work* (2nd ed.). New York, NY: Routledge.

## 21. Assessment<sup>11</sup>

The initial sessions with a client should be focused on engagement and assessment. In addition, if the counsellor does not expect that the client will return for further sessions, they should consider including harm reduction strategies in the initial session (see chapters **Brief intervention** and **Harm reduction**).

A good assessment paints a thorough and detailed picture of the client's AOD issues and how they fit in the context of their life. In formulating how and why a client has developed AOD-related issues, it is useful to consider Zinberg's (1984) Interaction model. This model suggests that three factors influence a person's experience of AOD use: the drug itself, the person, and the person's environment or social setting (Zinberg, 1984). Understanding the context of a client's AOD use enables the development of a clear case formulation, which provides the foundation for an individually tailored treatment plan and effective AOD counselling (see chapter on **Case formulation**).

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 experiences. In addition to the assessment interview, particular information can be gathered using standardised assessment tools and questionnaires, preferably ones evaluated as reliable and valid. Counsellors should only use standardised assessment tools for which they have appropriate training. Inappropriate use of assessment tools and questionnaires can be detrimental to the client due to mislabelling clients, misinterpreting the test results and providing inaccurate feedback.

### The assessment interview

The initial assessment is not just about the counsellor collecting information about the client; it is also central to:

- developing a therapeutic relationship based on trust, empathy and a non-judgemental attitude
- helping the client to accurately reappraise their AOD use, which in turn may facilitate the desire for change
- helping the client to link their current issues with their AOD use
- acknowledging the client's strengths, which may increase their confidence to change
- facilitating a review of the client's past and present and linking these to current drug use
- encouraging the client to reflect on the choices and consequences of their 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 idea of the client's needs. The next session or two tend to be devoted to understanding the client's current difficulties in the context of their experiences throughout their life; presenting this understanding (or case formulation) to the client; seeking their feedback and modifying your understanding as necessary; and, finally, working with the client to develop a plan to meet their treatment needs (see chapter on **Case formulation**).

The assessment interview should take the form of a semi-structured narrative, and evaluate:

- source of referral and current health care providers
- mental state – appearance, behaviour, speech and language, mood and affect, thought content, perception, cognition, insight and judgement
- presenting issues – those identified by the client as their reasons for seeking help and others that they are experiencing
- AOD use, including:
  - current pattern(s) of use, AOD use history and periods of abstinence
  - the impacts of AOD use, including impacts on health and mental health, physical functioning and fitness, family and social relationships, employment/education, legal impacts and financial costs
  - previous AOD treatment history, experiences and expectations of treatment

<sup>11</sup> For a very thorough explanation of assessment, including many useful examples of how to ask particular questions, see the Alcohol and other drugs assessment form: clinician's guide (2018), produced by the Mental Health Commission of WA, available from <http://www.wanada.org.au/resources-and-publications/tools-for-aod-workers.html>

- readiness to change
- mental health issues and treatment history
- physical health and medical history
- prescribed medications
- legal issues and history
- risk – including suicidal thoughts/attempts, self-harm, homicidal thoughts/intent, domestic violence and other risk of harm from others, safety and welfare of children, risks associated with sexual practices, injecting practices and other high-risk behaviours
- current social situation and obligations – accommodation, work or study commitments, childcare commitments, 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
- strengths – e.g. coping strategies, psychological resilience, supports
- beliefs about self, others and the world.

## Source of referral

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

## Mental state

Counsellors should evaluate the client's 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 areas to be covered include the following (adapted from Marel et al., 2016, pp. 65–66):

- appearance – physical appearance, posture, grooming, signs of AOD use, nutritional status
- behaviour – general behaviour/reaction to situation and clinician; angry/hostile, uncooperative, withdrawn, inappropriate, fearful, hypervigilant
- speech – rate, volume, tone, quality and quantity of speech
- language – form of thought, incoherence/illogical/irrelevant thinking, amount, rate
- mood and affect; mood – how does the client describe their emotional state? Affect – what do you observe about the person's emotional state? Are mood and affect consistent and appropriate?
- thought content – delusions, suicidality, homicidality, depressed/anxious thoughts
- perception – hallucinations, depersonalisation, derealisation
- cognition – level of consciousness, attention, memory, orientation, abstract thoughts, concentration
- insight and judgement – awareness, decision-making.

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

A mental state examination (MSE) form and guidance for describing mental state are included in Appendix 10. A useful guide to the MSE is provided in *Understanding the mental state examination (MSE): a basic training guide*, which was produced by the Perth Co-occurring Disorders Capacity Building Project Consortium (non-residential) and can be downloaded free of charge<sup>12</sup>.

<sup>12</sup> Understanding the mental state examination (MSE): A basic training guide is available from: <https://tnicholson2013.files.wordpress.com/2014/01/msevdbookletoct2011highresolution.pdf>

Note that it is not unusual for AOD clients to experience impairments in cognitive functioning, with the severity of the impairments often dependent on the nature and extent of the drugs used (see chapter on **Cognitive impairment**). These impairments are not always obvious upon presentation and may require a formal assessment through referral to a neuropsychologist. Most clients with alcohol use disorders experience mild to moderate deficits in learning and memory, visual spatial abilities and executive functions (Cooper, 2011). In extreme cases chronic drinkers may develop Wernicke–Korsakoff’s syndrome, which consists of severe memory and learning impairments, inability to plan activities and comprehend abstract information. Illicit drug use can also be associated with CIs; many people who have used large amounts of amphetamines, ecstasy, cannabis, cocaine and opioids show evidence of deficits in memory and executive functioning (Cooper, 2011). For example, long-term methamphetamine use may result in deficits in memory, executive functions and processing speed, as well as motor, verbal and visuospatial skills (Scott et al., 2007). In addition to the direct effects of AOD use, people involved in an AOD-using lifestyle may be exposed to violence and/or accidents resulting from intoxication, which can also result in head injuries and CIs.

As part of assessing mental state, counsellors should make observations about indications of poor cognitive functioning, such as difficulty concentrating and comments from clients about poor memory or difficulties organising their lives. If CI is suspected, a referral to a neuropsychologist is recommended, if possible. Although these issues may be related to the effects of a drug-using lifestyle, such as a lack of sleep, they can reflect CI, in which case treatment strategies may need to be adapted. For more information, see chapter on **Cognitive impairment**.

## 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 issues and can include issues in any area of a person’s life such as psychological, social, health, legal, accommodation and financial issues.

## Alcohol and other drug use

It is important to gain a clear understanding of the client’s current AOD use, as well as the evolution and development of their AOD use over time, including periods of abstinence and what enabled them. The counsellor should explore a variety of issues including range of AODs used, quantity and frequency of use, circumstances of use, current and previous AOD-related issues, risk behaviours in terms of blood-borne virus (BBV) transmission or overdose, and any previous attempts at change.

The 4Ls model (attributed to Roizen, 1983) can be particularly useful for assessing AOD-related issues across areas of a client’s life:

- **Liver** - health
- **Lover** - relationships
- **Legal** - the law
- **Livelihood** - finances, housing, work.

Casey and Keen (2005) adapted the 4Ls model to make it more culturally appropriate for Aboriginal people. This model can be used to explore possible issues associated with AOD use that Aboriginal people are experiencing:

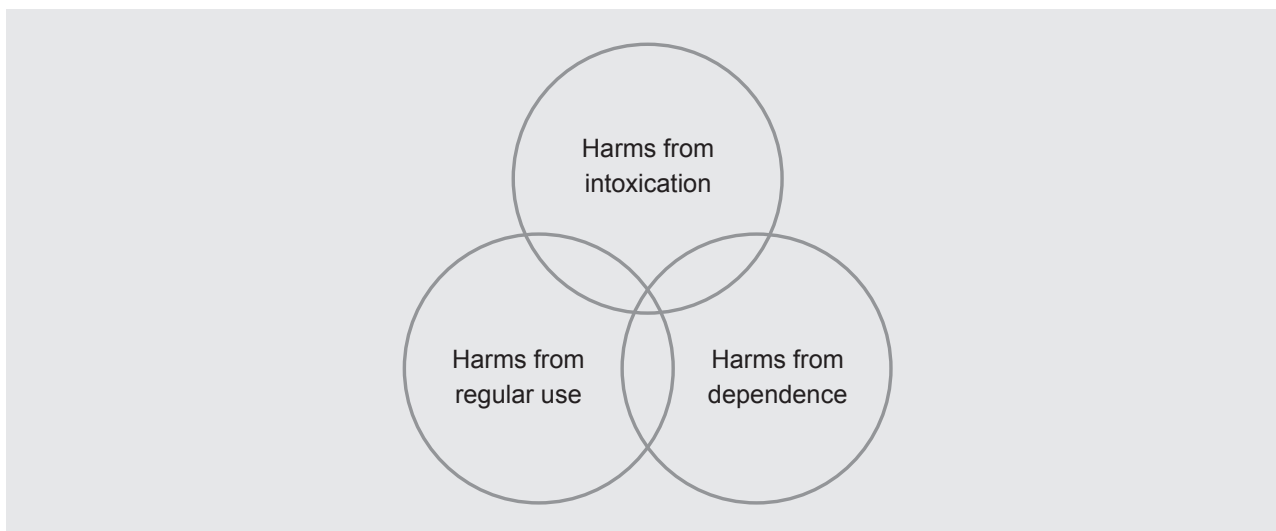
- **Liver** – health. Health in an Aboriginal context includes social and emotional wellbeing and is a holistic way of viewing health.
- **Lover** – family and community
- **Livelihood** – money and work
- **Aboriginal Law** – governance structures of traditional life, social and cultural obligations
- **Legal** – problems related to the mainstream Australian legal system
- **Loss** – grief and loss, both intergenerational and current, Stolen Generations, family in prison. Given the lower life expectancy of Aboriginal people, it is especially important to acknowledging competing family and cultural obligations during Sorry Time/funerals
- **Land** – maintaining connections to country and culture.

(See chapter on **Aboriginal clients, their families and communities**)



It is important to explore previous AOD treatment experiences, including what worked well and what didn't work, and the client's expectations about current treatment. This assists the counsellor 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.

It is also necessary to highlight that harmful AOD use is not exclusive to dependence. Thorley (1980) provides a broader perspective of what constitutes harmful AOD use by identifying that a range of issues are associated with intoxication, regular use and dependence, and there may be overlap between these AOD-related issues. This model is shown in Figure 2.



**Figure 2: Thorley's model of AOD-related harms (adapted from Thorley, 1980)**

The numerous harms associated with intoxication include accidents, injuries, overdose, damage to health, increased suicide risk, damage to property, excessive spending, risk-taking behaviours, arguments, assault, violence, abuse and/or neglect of children.

Issues associated with regular AOD use include health issues specific to the primary drug of concern. For example, regular alcohol use is associated with liver cirrhosis, pancreatitis, cancer, diabetes and brain damage. Other harms associated with regular heavy alcohol use include strained relationships, criminal activity and financial issues.

Dependence occurs when a person becomes physically dependent on the drug to function. In particular, it causes neuroadaptation, meaning changes occur in the brain as a result of AOD use<sup>13</sup>. There are many harms associated with AOD dependence, including the physical and psychological experience of tolerance and withdrawal.

Thorley's model is useful in assessing what issues the client might be experiencing from the pattern of use. A client may experience the issues associated with intoxication and regular use, but may not be dependent. Similarly, a client may experience issues associated with regular use and dependence, but not issues associated with intoxication. Although the model was developed to describe alcohol-related issues, it can also be applied to other drugs.

## Readiness to change

Readiness to change can be assessed by exploring the perceived pros and cons of the client continuing or changing their AOD use. This is best done using MI, which assesses the positive aspects of AOD use but places more emphasis on eliciting and exploring the less good aspects as these provide the motivation for change (see chapter on **Motivational interviewing**). This is more likely to encourage change than a balanced exploration of the pros and cons of using (Miller, 2013). A client's motivation to change is important in determining the appropriate type of treatment. For example, if a client is in the pre-contemplation stage the provision of harm reduction information is an appropriate treatment strategy, whereas goal-setting, problem-solving and relapse prevention may be more appropriate for clients in the action stage (see chapter on **Stages of change**).

<sup>13</sup> Alcohol or other drug use results in progressive changes to the brain's stress and reward circuitry and emotional circuits. In dependence, these changes include alterations in the functioning of the prefrontal cortex, which result in problems with executive functions such as inhibitory control, self-regulation and decision making (Volkow, Koob, & McLellan, 2016).

## Mental health issues and treatment history

Clients should be asked about current and past mental health issues, diagnoses and treatment, and the context of their mental health issues (e.g. stress, AOD use). They should also be asked what worked well and what was ineffective in previous mental health treatment. Identification of a mental health issue does not necessarily mean that the counsellor has to personally treat the issue. However, counsellors do need to consider the impact of these issues, help the client manage them and engage other services when appropriate (Marel et al., 2016) (see chapters on **Co-occurring AOD and anxiety**, **Co-occurring AOD and depressive disorders**, **Co-occurring severe mental health disorder and Co-occurring trauma issues**).

## Physical health and medical history

Clients should be asked briefly about physical health issues and medical history, particularly those relevant to current AOD issues and circumstances.

## Legal issues and history

Counsellors should enquire into the client's current legal issues and legal history, particularly in relation to AOD use or family violence.

## 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 any children in client's care. See **Suicide assessment and management** chapter, as well as the format for suicide risk assessment included in Appendix 13.

For clients engaging in sex with multiple partners or who are involved in sex work, sexual practices should be evaluated for risks associated with BBV and sexually transmitted infection (STI) transmission and personal safety.

## Current situation

This should include gathering current information on accommodation, who the client lives with, children, work or study commitments, support networks, family and social networks, source of income, legal issues and financial issues.

## 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, AOD 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 the importance of their AOD use can help them to develop compassion and understanding for themselves. Exploring these areas can also help the client make links between the impact of AOD use and their current life situation.

The following areas can be explored:

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

See the section below – *Raising sensitive issues in the assessment phase* – for tips on how and when to raise some of these issues.

## How clients view themselves and others

Explore how clients see themselves in order to assess their levels of self-esteem, sociability and trust. Much of this information is gleaned from what clients say directly 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?*

Answers to such questions can form the basis of counselling to combat unhelpful thoughts (see chapters on **Challenging unhelpful thinking** and Mindfulness).

The Young Schema Questionnaire<sup>14</sup> can also be used to guide the assessment of a client’s core beliefs or ‘schemas’ about themselves, others and the world.

## Strengths and weaknesses

Assist the client to identify their 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 counselling to help the client achieve their goals.

## Raising sensitive issues in the assessment phase

In conducting a thorough assessment, counsellors often need to raise sensitive issues including childhood trauma, eating disorders, domestic violence and suicidal ideation. While raising such issues may cause discomfort for clients, knowledge of them is often necessary for a full understanding of the context of AOD use.

To raise these issues sensitively, do the following:

- explain that these issues are common among people presenting with AOD issues
- acknowledge how difficult it can be for people to talk about these issues
- let the client know they can choose not to discuss it, or how much to discuss it
- give a rationale for raising the issue (i.e. it is important to know in order to provide the best intervention for the AOD use)
- be non-judgemental and empathic
- link sensitive issues to presenting concerns and issues
- start with open-ended questions.

It is often inappropriate to raise sensitive issues during the first session and it is important that clients know that they can choose not to discuss them. Counsellors providing only BIs should use clinical judgement in relation to raising sensitive issues. It may be inappropriate 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 and/or sexual abuse (see chapter on **Co-occurring trauma issues**). Although it is important to know whether a client has had these experiences, it is even more important to avoid further traumatising a client. Counsellors should establish a safe environment and a strong therapeutic relationship before asking clients to discuss traumatic issues (Herman, 1992). 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 discussion of memories. Preface any discussions of traumatic events by explaining that you only need a broad overview of the client’s history.

<sup>14</sup> The Young Schema questionnaire (Jeffrey Young) is available from <http://www.schematherapy.com>

Cloitre, Cohen, and Koenen (2006) suggested describing the rationale in detail by saying something like:

*Now I am going to ask you some questions about some difficult experiences that you may have had in childhood. I am not going to ask you to go into detail at this time, but just collect some general information about things you have been through.*

Note that many clients who experienced early and repeated trauma may never be sufficiently stable to talk in depth about their traumatic experiences without becoming overwhelmed and re-traumatised (see chapter on **Co-occurring trauma issues**). Some clients will volunteer information about traumatic experiences in the first session. If a client starts going into a lot of detail, it may be necessary to 'protectively interrupt'; that is, gently stop the client by explaining that talking about their traumatic experiences in great detail is not necessary at this stage. End with a question such as "Is this alright with you?" so that the client has the opportunity to respond and move forward (Cloitre et al., 2006). It is also necessary to keep a check on the client's emotional state, because it is easy for them to become 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 trauma, then ask broad questions. Make it clear that great detail is unnecessary 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. Only give me this information when you feel ready. How would you feel about me asking you a few 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 or sexual abuse as a child? Or adult? Have you experienced other traumas?*

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

## Standardised assessment

AOD agencies all have procedures for initial assessment. This initial assessment procedure usually takes considerable time, and staff can be reluctant to burden the client with additional questionnaires. However, it can be useful for clinicians to screen for additional areas of interest, depending upon client presentation and the clinician's comfort with the screening tools. Standardised assessment involves using standardised assessment tools, such as questionnaires that have been evaluated scientifically as reliable and valid means of gathering information about clients.

Standardised assessment tools aim to achieve the following:

- provide support for hypotheses developed during the course of an assessment
- highlight issues that may not have appeared salient during the assessment
- provide an objective measurement of the client's circumstances
- provide an objective means to measure change and treatment success.

### Introduction and use of standardised assessment tools

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

Be aware of any difficulties that may arise for the client in completing the questionnaires (e.g. poor literacy skills). In such instances, offer to read the questions to the client, possibly over multiple sessions in order to reduce client fatigue.

## Key areas for standardised assessment

Screening instruments are suggested for the following areas:

- AOD issues
- co-occurring mental health issues
- general wellbeing
- client satisfaction with treatment.

Assessment instruments should be selected depending on the client's presenting AOD issues and related issues. For a detailed review of standardised assessment tools that may be relevant to AOD clients, see Deady (2009) *A review of screening, assessment and outcome measures for drug and alcohol settings*, produced for the Network of Alcohol and Other Drug Agencies (NADA). Most of the following tools are freely available online.

**AOD issues.** Measures that assess AOD use issues and are freely available online include the AUDIT (Saunders, Aasland, Amundsen, & Grant, 1993) and the Drug Abuse Screening Test (DAST) (Skinner, 1982). Measures of withdrawal from opioids, alcohol, benzodiazepines, amphetamines and cannabis are included in Appendices 4 to 8. The measurement of withdrawal syndromes when objective signs are present and quantifiable (such as alcohol and opioid withdrawal) can provide cut-off scores and indications for medication administration as is presently done with the CIWA-Ar scale (Metcalfe, Sobers, & Dewey, 1995). However, withdrawal scales for those syndromes, when symptoms are subjective and no objective signs have been identified (such as scales for benzodiazepine, amphetamine and cannabis withdrawal), may be less useful (see chapter on **Withdrawal management**).

**Co-occurring mental health issues.** Screening instruments can alert the clinician to possible psychological difficulties such as depression, anxiety, psychosis, dissociation or PTSD. An instrument with demonstrated reliability and validity, the Depression Anxiety Stress Scale (DASS) (Lovibond & Lovibond, 1995) is included in Appendix 11. The Psychosis Screener (Degenhardt, Hall, Korten, & Jablensky, 2005), which was developed to screen for psychosis in the general population, is shown in Appendix 12. This instrument may be useful to assess the presence of psychotic symptomatology in users of drugs such as amphetamines. If indicated, the PTSD Checklist (PCL) (Weathers et al., 2013) can be used to screen for symptoms of PTSD.

**General wellbeing.** Miller and Duncan (2000) developed a short 4-item scale – the Outcome Rating Scale (ORS) – to assess outcome and progress in terms of wellbeing from session to session. It assesses several areas: personal sense of wellbeing; interpersonal wellbeing in terms of family and other close relationships; social wellbeing in terms of work, school and social networks; and overall sense of wellbeing. The scale is included in Appendix 9.

**Treatment satisfaction.** Treatment services often have their own preferred treatment satisfaction scales. Miller and Duncan (2000) produced a short (4-item) and easy-to-use scale – the Session Rating Scale (SRS) – for measuring treatment satisfaction. The scale assesses perceptions of the strength and utility of the therapeutic relationship as counselling progresses. The measure can assist counsellors to understand how clients are experiencing the therapy relationship, potential disruptions to the therapeutic alliance, and any areas that clients believe are being missed. The scale is included in Appendix 9.

The instruments mentioned above all have sound psychometric properties and hence are reliable and valid measures. They are not, however, diagnostic, and should only be used in conjunction with a thorough assessment. Note also that counsellors should investigate the reliability and validity of any other questionnaires that they plan to administer to clients. It is also important to examine the cultural appropriateness of questionnaires when considering administration to Aboriginal or CALD people, as few tools that have reliability and validity data have been tested on culturally diverse populations.

Assessment of the safety of children should also occur when working with parents with AOD issues (see **Child protection and parenting interventions**). If concern exists as a result of the assessment interview, structured assessment instruments can be used to explore child safety in more detail. An instrument to assist with assessing parenting and child safety in the context of parental AOD use, including violence and exposure to potential risk, is the Risk Assessment Checklist for Parental Drug Use<sup>15</sup>. This instrument is freely available on the internet, but has not been evaluated for reliability and validity.

<sup>15</sup> Available from Drugnet website: <http://www.drugnet.bizland.com/assessment/checklis1.htm>

The 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, Howlett, Sedgewick, & Ghodse, 2000). Situations in which self-reported behaviour could be misleading include those in which clients receive sanctions for accurate reporting (such as when they are involved in the criminal justice system), feel shame and embarrassment, or fear disappointing the counsellor. In situations in which clients fear telling the truth to a counsellor, normalising the issues being asked about (e.g. relapse) can help.

Contrary to the concerns of some practitioners about the impact of administering standardised assessment measures, the literature and anecdotal evidence indicates that when conducted appropriately the process of standardised assessment can build rapport (Marsh & Dale, 2006). However, it is acknowledged that it can be difficult for counsellors to administer numerous assessment instruments in addition to the general assessment process. If time and resources do not allow for the use of standardised instruments, then it is recommended that counsellors and clients use simple rating scales to reflect the severity of key issues such as AOD use, crime and depression. Ratings given at the start and finish of treatment can be compared to gain an idea of change, 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 can enlist the assistance of their supervisor in the interpretation of standardised assessment results if necessary.

While counsellors may be able to distinguish between clients with co-occurring psychological disorders (e.g. anxiety disorders) and more severe psychiatric disorders (e.g. psychotic disorder), only qualified clinicians should undertake diagnosis of these conditions.

### **Outcome measures**

By administering the same standardised assessment tools throughout treatment, on completion of treatment, and preferably at follow-up as well, the counsellor and client will be able to note changes in relation to key areas.

Client engagement in treatment can also be monitored. Standardised measures are not usually used for this, because 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, and reasons for treatment dropout. This sort of information is important for individual clinicians, for agencies as a whole and for research purposes, because it can provide valuable information about what works for which clients, as well as direction in terms of counselling and agency practices that might need improving.

## **Documenting the assessment**

The results of the assessment interview should be documented and integrated with the results of any standardised assessments. The form of the documentation will vary according to its purpose, 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 or 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 and tend to require slightly different presentation of information. Ensure that all 'permission to release information' documents are signed by clients prior to providing reports to third parties (see chapter on **Confidentiality**).



When writing an assessment report for an external party:

- 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
- do not use biased terms or wording
- 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 conclusion – do not base your conclusions solely on the basis of test score
- mark all reports “STRICTLY CONFIDENTIAL”.

(Note that the exception to ensuring a client signs a permission to release information form before providing information to third parties is when notes are subpoenaed, in which case they must be provided whether the client signs the form or not. Most agencies have a process for responding to subpoenaed records).

## Treatment matching

As well as building rapport, the main purpose of assessment is to formulate the client’s issues (see chapter on **Case formulation**) and match the individual client to the appropriate treatment intervention, thereby maximising treatment effectiveness. The following factors should be considered in treatment matching.

### Dependence and issue severity

Clients who present with high levels of AOD dependence and other issues may be more likely to benefit from intensive, highly structured treatment programs, residential treatment, more frequent outpatient sessions and linking with other relevant services (Chen, Barnett, Sempel, & Timko, 2006; Timko & Sempel, 2004). Clients enmeshed in an AOD-using lifestyle and associating primarily with other people who use AOD 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 (Adamson & Sellman, 2001). 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 (Rosenberg & Melville, 2005). A period of abstinence should be encouraged prior to the introduction of controlled drinking. Note that people who are severely dependent on alcohol should be advised to have a medical assessment before stopping their alcohol use, as an unmanaged severe alcohol withdrawal can be life threatening (see chapter on **Withdrawal management**).

### Cognitive factors

As noted earlier, cognitive deficits often result from AOD use and can hold significant implications for the process and outcome of treatment. Clients with some degree of CI may be more likely to benefit from highly structured residential treatment. When working with clients who have CI, interventions should be tailored accordingly. For clients with moderate to severe cognitive deficits, treatment should include a strong life skills component addressing issues around finances, accommodation, domestic duties and involvement in a non-AOD-using community. See chapter on **Cognitive impairment** for more information on tailoring interventions.

### Co-occurring issues

Co-occurring issues in various aspects of a client’s life may indicate the need to match clients to specific components of broad-based treatment. Factors to consider include finances, housing, social support, physical stability, mental health issues and parenting difficulties.

## 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 (Adams & Drake, 2006). Client motivation and choice is also relevant for the use of addiction pharmacotherapies. Methadone maintenance and buprenorphine, which have opioid effects, are effective treatment options for long-term users with severe opioid dependence who are not ready to be completely drug free. Naltrexone treatment is likely to be successful for those clients who are highly motivated to become abstinent and who have a social network supportive of abstinence. See chapter on **Pharmacotherapies for AOD dependence**.

## Other client characteristics

Other client characteristics that should be considered in allocating treatment include age, gender, sexuality, financial, physical and emotional security, cultural issues, degree of coercion for treatment and the nature and severity of mental health issues. See relevant chapters of this guide, such as **Young people, Coerced clients, Gender and sexual diversity, Culturally and linguistically diverse people, Aboriginal clients, their families and communities** when considering treatment options.

### 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 for an individual's tailored treatment program.

Standardised assessment tools used during a formal assessment, throughout treatment, on completion of treatment, and preferably at follow up can be used to note changes in relation to key areas and evaluate the treatment.

#### Assessment interview

The assessment interview should cover:

- source of referral
- presenting issues
- drug use history and related harms
- readiness to change AOD use (use MI)
- 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, others and the world
- strengths and weaknesses
- presentation and mental state.

If CI or severe psychological difficulties are suspected, expert consultation and referral should be sought.

## Standardised assessment

Standardised assessment:

- can 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
- can be completed upon entry into and exit from a treatment program, as well as at follow-up.

Key areas for standardised assessment include:

- level of AOD dependence
- AOD withdrawal symptoms
- co-occurring mental health issues
- client satisfaction with treatment.

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 be provided 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.

## References

- Adams, J. R., & Drake, R. E. (2006). Shared decision-making and evidence-based practice. *Community Mental Health Journal, 42*(1), 87-105. doi: 10.1007/s10597-005-9005-8
- Adamson, S. J., & Sellman, J. D. (2001). Drinking goal selection and treatment outcome in out-patients with mild-moderate alcohol dependence. *Drug and Alcohol Review, 20*(4), 351-359. <https://doi.org/10.1080/09595230120092670>
- Beck, J. S. (1995). *Cognitive therapy: basics and beyond*. New York, NY: The Guilford Press.
- Casey, W., & Keen, J. (2005). *Strong Spirit Strong Mind, Aboriginal Alcohol and other drugs worker resource: a guide to working with our people, families and communities*. Perth: Aboriginal Alcohol and other Drugs Program, WA Drug and Alcohol Office.
- Chen, S., Barnett, P. G., Sempel, J. M., & Timko, C. (2006). Outcomes and costs of matching the intensity of dual-diagnosis treatment to patients' symptom severity. *Journal of Substance Abuse Treatment, 31*(1), 95-105. doi: 10.1016/j.jsat.2006.03.015
- Cloitre, M., Cohen, L. R., & Koenen, K. C. (2006). *Treating survivors of childhood sexual abuse: Psychotherapy for the interrupted life*. New York, NY: The Guilford Press.
- Cooper, D. B. (2011). *Introduction to mental health – substance use*. Abingdon, United Kingdom: Radcliffe Publishing.
- Darke, S. (1998). Self-report among injecting drug users: a review. *Drug and Alcohol Dependence, 51*(3), 253-263. [https://doi.org/10.1016/S0376-8716\(98\)00028-3](https://doi.org/10.1016/S0376-8716(98)00028-3)
- Deady, M. (2009). *A review of screening, assessment and outcome measures for drug and alcohol settings*. Sydney, NSW: Network of Alcohol and Other Drug Agencies.
- Degenhardt, L., Hall, W., Korten, A., & Jablensky, A. (2005). *Use of brief screening instrument for psychosis: Results of a ROC analysis*. Sydney, NSW: National Drug and Alcohol Research Centre.
- Herman, J. L. (1992). *Trauma and recovery: From domestic violence to political terror*. New York, NY: Basic Books.
- Kilpatrick, B., Howlett, M., Sedgewick, P., & Ghodse, A. H. (2000). Drug use, self report and urinalysis. *Drug Alcohol Dependence, 58*(1-2), 111-116. [https://doi.org/10.1016/S0376-8716\(99\)00066-6](https://doi.org/10.1016/S0376-8716(99)00066-6)
- Lovibond, S. H., & Lovibond, P. F. (1995). *Manual for the depression anxiety stress scales*. Sydney, NSW: Psychology Foundation.
- Marel, C., Mills, K.L., Kingston, R., Gournay, K., Deady, M., Kay-Lambkin, F., Baker, A., & Teesson, M. (2016). *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*. Sydney, NSW: National Drug and Alcohol Research Centre. Retrieved from <https://comorbidityguidelines.org.au/>
- Marsh, A., & Dale, A. (2006). *Addiction counselling*. Melbourne, VIC: IP communications.

- Metcalfe, P., Sobers, M., & Dewey, M. (1995). The Windsor Clinic Alcohol Withdrawal Assessment Scale (WCAWAS): Investigation of factors associated with complicated withdrawals. *Alcohol and Alcoholism*, 30(3), 367-372. <https://doi.org/10.1093/oxfordjournals.alcalc.a045741>
- Miller, S. D., & Duncan, B. L. (2000). The outcome and session rating scales: Administration and scoring manuals. Retrieved from <http://www.talkingcure.com>
- Miller, W. (2013). From the desert. Confessions of a recovering trainer/what about decisional balance? *Motivational Interviewing: Training, Research, Implementation, Practice*, 1(2). doi: 10.5195/mitrip.2013.30
- Roizen, R. (1983). Loosening up: General population views of the effects of alcohol. In R. Room & G. Collins (Eds.), *Alcohol and disinhibition: Nature and meaning of the link* (pp. 236-257). Washington, DC: US Government Printing Office.
- Rosenberg, H., & Melville, J. (2005). Controlled drinking and controlled drug use as outcome goals in British treatment services. *Addiction Research and Theory*, 13(1), 85-92. <https://doi.org/10.1080/16066350412331314894>
- Saunders, J. B., Aasland, O. G., Amundsen, A., & Grant, M. (1993). Alcohol consumption and related problems among primary health care patients. *Addiction*, 88(3), 349-362. <https://doi.org/10.1111/j.1360-0443.1993.tb00822.x>
- Scott, J. C., Woods, S. P., Matt, G. E., Heaton, R. K., Atkinson, J. H., & Grant, I. (2007). Neurocognitive effects of methamphetamine: a critical review and meta-analysis. *Neuropsychological Review*, 17(3), 275-297. doi: 10.1007/s11065-007-9031-0
- Skinner, H. (1982). The Drug Abuse Screening Test. *Addictive Behaviours*, 7(4), 363-371. [https://doi.org/10.1016/0306-4603\(82\)90005-3](https://doi.org/10.1016/0306-4603(82)90005-3)
- Thorley, A. (1980). Medical responses to problem drinking. *Medicine*, 35, 1816-1822.
- Timko, C., & Sempel, J. (2004). Short-term outcomes of matching dual diagnosis patients' symptom severity to treatment intensity. *Journal of Substance Abuse Treatment*, 26(3), 209-218. doi: 10.1016/S0740-5472(04)00002-9
- Volkow, N. D., Koob, G. F., & McLellan, A. T. (2016). Neurobiologic advances from the brain disease model of addiction. *New England Journal of Medicine*, 374(4), 363-371. doi: 10.1056/NEJMra1511480
- Weathers, F. W., Litz, B. T., Keane, T. M., Palmieri, P. A., Marx, B. P., & Schnurr, P. P. (2013). PTSD checklist for DSM-5 (PCL-5). Retrieved from <https://www.ptsd.va.gov/professional/assessment/adult-sr/ptsd-checklist.asp#obtain>
- Zinberg, N. E. (1984). *Drug, set, and setting. The basis for controlled intoxicant use*. New Haven, CT: Yale University Press.

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## 22. Suicide assessment and management

All workers should familiarise themselves with their organisation's policies and procedures on suicide risk assessment.

Clients presenting for AOD treatment are at a greater risk of suicidal behaviours than the general population (Schneider, 2009). Do not ignore any concerns about suicidal ideation and remember that ensuring client safety is of prime importance.

Clinicians should assess suicide risk as a matter of course at the initial consultation and it should be monitored over the course of counselling. Suicide risk is dynamic and subject to moment-by-moment changes, and thus suicide risk assessment should be considered a process rather than an event. A suicide risk assessment is only a snapshot of a person's risk at that time, and it is extremely important that all clients are regularly assessed for suicide risk. Risk assessments should be conducted at pivotal points in a client's treatment (e.g. intake, transition points, discharge) as well as any time when there is reason to suspect the client is at increased risk. Consider situational changes in the client's life as well as changes in presentation, behaviour and speech around suicide (Marel et al., 2016).

**It should not be assumed that a client who initially presents as not being suicidal will remain this way.**

Suicide risk can escalate as a client moves through treatment, particularly if they have been using alcohol or other drugs to manage trauma symptoms (Marsh & Dale, 2006).

Gatekeeper Suicide Prevention Training (MHC, 2017) recommends using the phrase 'suicide crisis' rather than 'high risk' for people presenting as at imminent risk of suicide. This is because research indicates that assigning a level of risk is not helpful to the client or service, and that most people assessed as high risk will not go on to take their own life, while about half of people classified as low risk do (Large et al., 2016).

### Assessment

Raising the issue of suicide is the first step in a suicide assessment. Recent guidelines advise doing away with a checklist approach to suicide risk assessment (Marel et al., 2016). A 'listen rather than list' approach is recommended, involving maintaining engagement using reflective listening and open-ended questions in a conversational style (MHC, 2017).

Many counsellors may feel uncomfortable about raising the issue of suicide because they:

- worry that questions about suicide will make a non-suicidal client think about suicide
- believe they lack the expertise or experience to assess suicide risk
- fear that questions about suicidal thoughts will seem inappropriate and embarrass the client
- are not sure how to respond, or are worried they may make it worse if the client has suicidal thoughts
- believe that deflecting or distracting from the client's talk of suicide will defuse the situation
- are concerned that suicide attempts may be manipulative or 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 (Marsh & Dale, 2006). Normalise the client's experience of hopelessness and suicidal thinking within the context of difficulties that they are facing (Bryan & Rudd, 2006).

When raising the issue of suicide, consider the following:

- discuss limits of confidentiality (see chapter on **Confidentiality**)
- talk to the client without any family or friends present
- allow sufficient time
- introduce suicide in an open, yet general way, for example, "sometimes people feel so overwhelmed by things they think about suicide, is this something you've considered?"
- link suicide to presenting concerns and issues
- be non-judgemental and empathic
- use non-threatening language
- use clear, unambiguous language such as "thinking about suicide" or "kill yourself".

## Risk factors, protective factors and warning signs

Risk and protective factors for suicide are those that are present across the lifespan and can indicate suicide risk over time. In contrast, warning signs are indicators that are specific to the current state of the client and identify elevated current risk (Marel et al., 2016). It is important to consider all factors when conducting a suicide risk assessment.

### Risk factors

Assessing risk factors can help identify areas of a client's life that put them at greater risk for suicide. Consider the following:

- mental and physical health
- previous suicide attempts
- feelings of hopelessness/helplessness
- social isolation
- suicide of family member or significant other in client's history
- recent loss/death
- family/relationship issues
- legal/financial issues
- lack of problem-solving skills
- poor impulse control
- past history of trauma
- AOD use.

### Protective factors

Protective factors can mitigate the impact of risk factors and can decrease the likelihood that someone will take their own life. Some factors that can protect against suicidal thoughts and behaviours are:

- positive view of self
- resilience and problem-solving skills
- no history of child abuse
- no legal issues
- community and social integration
- access to support services
- stable employment
- strong spiritual or religious faith
- good physical and mental health.

### Warning signs

Any change in normal practices, behaviours, thoughts or feelings can indicate that the client is in crisis.

Warning signs that can indicate heightened risk for suicide include:

- expressing suicidal thoughts and feelings
- withdrawing from loved ones
- impulsive and/or risk-taking behaviour (e.g. marked increase in AOD use)
- verbal expressions of suicidal desire
- indirect verbal expressions (e.g. 'You won't have to worry about me anymore')
- making final arrangements
- loss of interest in usual activities
- changes in cultural practices
- unusual apathy about dress and appearance
- communicating feelings of worthlessness or hopelessness
- expressed feelings of loneliness, fear of abandonment
- giving away precious belongings, saying goodbye to loved ones
- outbursts of anger or other emotions which are out of the ordinary.

Ask about suicide directly. An indirect question may be misunderstood. Remember: if you don't ask, you won't know, and if you don't know, you can't help (MHC, 2017).



Demonstrate empathy and listen reflectively to the client. If the client perceives that you are non-judgemental and willing to talk about their thoughts of suicide, they may be more willing to talk about their underlying feelings of desperation, worthlessness, loneliness and isolation.

## Assessing current suicidal ideation

Be sure to be as direct as possible when asking about suicidal intent. Consider the following:

- **THOUGHTS:** consider frequency, duration, and intensity of suicidal ideation
- **INTENT:** ask about the client's intent to act on suicidal ideation
- **PLAN:** ask whether the client has a plan, and if so, what are the details (how, when, where?)
- **MEANS:** ask about access to firearms, medications, drugs or other means
- **HISTORY:** consider history of suicide attempts, recency, frequency, seriousness
- **COMING EVENTS:** ask about coming events that may increase suicide risk (e.g. anniversary of the death of a loved one)
- **SOCIAL SUPPORTS:** ask about people in their lives who can help keep them safe
- **PROTECTIVE FACTORS:** ask about thoughts, feelings and beliefs opposing suicide.

(Marsh, O'Toole, Dale, Willis, & Helfgott, 2013; MHC, 2017)

Explore each factor in detail and encourage the client to talk about their ambivalence – why they want to die and why they want to live.

## Questions for assessing current ideation

It is important to note that asking about suicidal intent does **NOT** increase suicide risk. Examples of how the counsellor might ask about suicidal ideation are below.

- *Sometimes when people feel really low/depressed, they think about suicide. Is this something you have been thinking about?*
- *Are you thinking about suicide?*
- *How often do you think about suicide?*
- *What has made you feel like life isn't worth living?*
- *How would you kill yourself?*
- *When do you intend to do this?*
- *Have you tried to kill yourself before?*
- *When you have tried to kill yourself before, what did you expect to happen?*
- *Did you expect to die?*
- *How do you feel about this now?*
- *Do you have anything coming up that is worrying you?*

(Marsh et al., 2013)

## Assessing protective factors in relation to suicidal ideation

Protective factors are those that can decrease the likelihood that a client will try to suicide. If protective factors exist, the resilience of clients who are not currently in suicide crisis can be increased. Examples of questions for exploring protective factors are given below.

- *What are your thoughts about staying alive?*
- *What would make it easier for you to cope with your issues at this time?*
- *What else could you do that might change the situation?*
- *What have you done when you have felt like this before?*
- *How does talking about it make you feel?*
- *What are the things that keep you here?*
- *Who do you usually share issues with?*
- *Who else would you feel comfortable talking to – who else might be able to help?*
- *What have you done when you have felt like this before?*
- *Who do you usually share your issues with?*

(Marsh et al., 2013)

## Attitude to treatment/referral

- What is the client's perception of their issue?
- Is there past suicidal behaviour?
- What is their attitude to treatment/referral?

## Available resources and foreseeable changes

Identifying the resources that are currently available to the client and foreseeable changes that would increase suicide risk can inform immediate decisions. For example, if a foreseeable change in the client's life is likely to occur and to be distressing (such as a custodial sentence), and the client has few resources available for support, a more intensive intervention would be warranted (Pisani, Murrie, & Silverman, 2016).

Some organisations still utilise a risk assessment tool that lists questions to ask the client about their suicidal thoughts. While this is not considered best practice (Large et al., 2016), if the organisation requires its use, bear in mind that it should be incorporated into a conversational, therapeutic style of information gathering. Please see Appendix 13 for an example of a suicide risk screener that can provide guidance for a therapeutic conversation.

## Assessing suicide risk

If you determine that the client is in suicide crisis, consult your supervisor or a mental health professional immediately. Contact your local hospital or a mental health emergency phone line. **Do not leave suicidal people unattended.**

Thoroughly document all steps taken to explore the suicidal thoughts and the action taken. Always provide helpline and emergency phone numbers to anyone who has disclosed suicidal ideation. Counsellors should draw up a safety plan for anyone who discloses suicidal thoughts; no client who does so in a session should leave without a plan.

If a client makes a suicide attempt, review the attempt and the factors that led up to it. Adopt a relapse prevention/problem-solving approach by exploring whether the client can change the factors that prompted the attempt and how the client can respond differently in future. Implement approaches for ongoing management of suicide risk.

## Ongoing management

Given that suicide risk can change from moment to moment, it is important for workers to be aware of ongoing risk management for clients who have disclosed ideation but are not currently in suicide crisis. Strategies that strengthen protective factors and reduce risk factors should be considered when working with these clients (MHC, 2017). Along with specific therapeutic interventions that challenge unhelpful thoughts and behaviours (such as CBT), strategies include eliciting social support and developing safety plans with the client (MHC, 2017).

## Safety plans

The client should develop a safety plan with support from the worker. It is a series of steps that the client can follow if they have thoughts of suicide (MHC, 2017). It will often include:

- warning signs, emotions, behaviours and environments that can lead to suicidal thoughts
- strategies the client identifies as being helpful for coping and emotion regulation
- names and contact details of support people
- names and contact details of counsellors and agencies working with the client
- information about making the environment safer
- helpful information such as 24-hour helpline telephone numbers, websites, emergency department contact details and locations.

The client holds the safety plan; the worker should retain a copy. Further copies should be provided for significant people in the client's life, such as family members, supportive friends and GPs, with the client's permission (MHC, 2017).

**Avoid using no-suicide contracts:** Rudd et al. (2006) noted that there is no reliable evidence to support the use of no-suicide contracts. The use of a pseudo-legal contract between client and counsellor may reduce the effectiveness of the counsellor's clinical assessment of risk due to a false sense of security. Furthermore, the use of contracts raises the issue of consequences for non-compliance and may damage the therapeutic alliance and therefore increase the client's suicide risk (Edwards, 2014).

## Chronic suicidality<sup>16</sup>

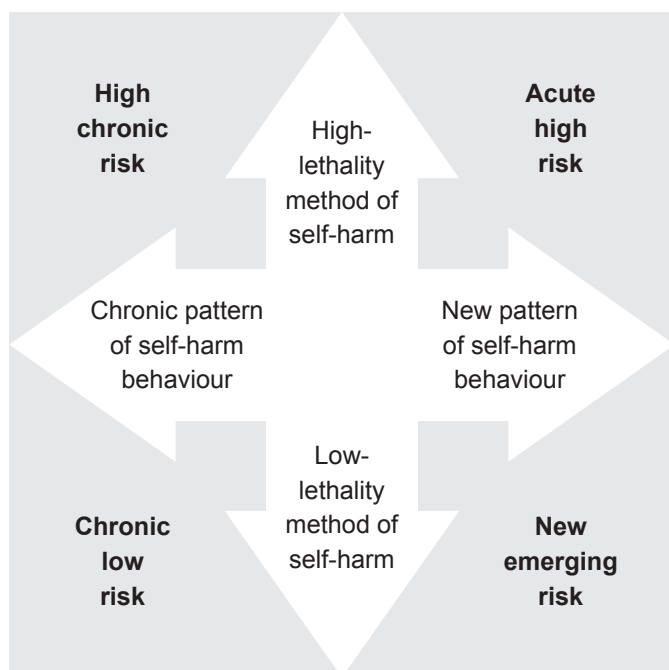
AOD clients who have experienced complex trauma, particularly in childhood, can be chronically suicidal, with the intensity of their suicidality varying over time (see chapter on **Co-occurring trauma issues**). The difficulty for counsellors is to determine when to respond more assertively to disclosures of ideation and plans. Things can change very quickly for traumatised clients, so it is not possible to determine risk with absolute certainty. Regular assessment of suicidality, and building a therapeutic relationship in which the client feels they can talk openly about their suicidality, will help counsellors to make the best estimate of suicide risk (National Health and Medical Research Council [NHMRC], 2012).

The notion of chronic versus acute suicidality is a useful one for clinicians, because chronic suicidality should be managed differently from acute suicidality.

- Attempting to prevent suicide in clients who are chronically suicidal by hospitalisation or close observation tends to be unhelpful and can escalate the behaviour.
- People who are chronically suicidal tend to become less so as the quality of their life improves. Therefore, counselling should focus on issues that will improve their quality of life.
- People who are at immediate acute high risk of suicide in which there is a change from previous risk are likely to need interventions to ensure their immediate safety, such as short-term hospitalisation.

NHMRC (2012)

Figure 3 provides a guide to help estimate the level of risk in chronically at-risk clients. Changes to the level of risk are indicated by changes in the frequency, type or severity of risk behaviour.



**Figure 3: A guide to estimating probable level of risk (NHMRC, 2012, p.57, adapted from Spectrum: [www.spectrumbpd.com.au](http://www.spectrumbpd.com.au))**

The NHMRC (2012, p. 56) described factors that might be used to help determine when the risk of suicide in a client who is chronically suicidal might escalate to being acute:

- changes in usual pattern or type of self-harm (see Figure 3)
- significant change in mental state (e.g. sustained and severe depressed mood, worsening of a major depressive episode, severe and prolonged dissociation, emergence of psychotic states)
- worsening in substance use disorder
- presentation to health services in a highly regressed, uncommunicative state
- recent discharge following admission to a psychiatric facility (within the past few weeks)
- recent discharge from psychiatric treatment due to violation of a treatment contract
- recent adverse life events (e.g. breakdown or loss of an important relationship, legal issues, employment issues or financial issues).

<sup>16</sup> This section on chronic suicidality is adapted from Marsh, Towers & O'Toole. (2012) Chapter 6: Suicide and self-harm.

With respect to the estimated levels of risk shown in Figure 3, the NHMRC (2012) made the following points.

- If a client is at chronic low risk (bottom left-hand quadrant of Figure 3), they are at relatively low risk of suicide. Counselling should focus on issues that will improve their quality of life and risk should be assessed regularly.
- If a client at chronic low risk starts to use increasingly lethal methods of self-harm on a long-term basis, they become at high chronic risk of suicide (top left-hand quadrant of Figure 3). Hospitalisation is probably inappropriate because chronic high risk is likely to continue beyond the length of a hospital admission. Instead, counselling should focus on improving their quality of life and helping them to deal with the issues driving their suicidality.
- If a client who has been at chronic low risk starts to demonstrate new symptoms or behaviours (bottom right-hand quadrant of Figure 3), they should be closely assessed, new risk factors should be addressed, and counselling should continue to focus on improving their quality of life. Hospitalisation is not appropriate unless their behaviours suggest immediate risk of suicide.
- If a client who is at chronic high risk of suicide starts to demonstrate new symptoms, behaviour or mental health issues that suggest increased immediate risk of suicide (top right-hand quadrant of Figure 3), then the person's immediate safety should be secured, perhaps with a brief inpatient admission, and counselling upon discharge should continue to focus on improving their quality of life and monitoring their suicidality.

## Suicide management – tip sheet

Raising the issue of suicide should be done routinely as part of any assessment, as well as ongoing assessment. **It should not be assumed that a client who initially presents at a manageable risk for suicide will remain this way, because risk is dynamic.** Risk assessment should be conducted at pivotal points in a client's treatment (e.g. intake, transition points, discharge) as well as any time when you have reason to suspect the client's ability to cope has changed. When raising the issue of suicide:

- discuss limits of confidentiality
- talk to the client alone – without family or friends present
- allow sufficient time for the conversation
- introduce suicide in an open yet general way
- ask about suicide directly using unambiguous language
- be non-judgemental and empathic
- use non-threatening language
- start with open-ended questions
- use clear, non-ambiguous language
- consult with your supervisor or a mental health professional after conducting a risk assessment.

### Suicide risk assessment

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

- **THOUGHTS:** consider frequency, duration, intensity of suicidal ideation
- **INTENT:** ask about the client's intent to act on suicidal ideation
- **PLAN:** ask whether the client has a plan, and if so, what are the details (how, when, where?)
- **MEANS:** ask about access to firearms, medications, drugs or other means
- **HISTORY:** history of suicide attempts, recency, frequency, seriousness
- **COMING EVENTS:** that may increase suicide risk (e.g. anniversary of the death of a loved one)
- **SOCIAL SUPPORTS:** ask about people in their lives who can help keep them safe
- **PROTECTIVE FACTORS:** ask about thoughts, feelings and beliefs opposing suicide.

Explore each factor in detail and encourage the client to talk about their ambivalence – why they want to die and why they want to live.

On the basis of the suicide assessment, determine if the client is in suicide crisis.

### **Actions in relation to assessed suicide risk are outlined in Appendix 13.**

If the client is not considered to be in suicide crisis, has acknowledged that there are things stopping them from attempting suicide and does not have a well-developed plan, discuss appropriate strategies with the client to help them to manage suicidal thoughts. Develop a safety plan with the client with clear strategies for accessing support and maintaining safety if their suicidal thoughts increase in intensity. Provide the client with appropriate helpline and emergency telephone numbers.

If you determine that the client is in suicide crisis:

- consult your supervisor or mental health professional immediately
- contact your local hospital or a mental health emergency phone line
- do not leave them unattended.

ALWAYS thoroughly document all steps taken to assess suicide risk and the action taken.

If a client makes a suicide attempt, explore the attempt in the next session and adopt a relapse prevention/problem-solving approach. Explore what prompted the attempt, whether the client can do anything to change the factors that prompted the attempt, and how they can respond differently in future.

### **Chronic suicidality**

Chronic suicidality needs a different response from acute suicidality.

- Attempting to prevent suicide in clients who are chronically suicidal by hospitalisation or close observation tends to be unhelpful and can escalate the behaviour.
- People who are chronically suicidal tend to become less so as the quality of their life improves. Counselling should focus on improving quality of life and solving the issues driving the suicidal ideation.
- People who are at immediate risk of suicide in which there is a change from previous risk are likely to need interventions to ensure their immediate safety, such as short-term hospitalisation. Any suicide crisis situation requires an emergency referral.

### **References**

- Bryan, C., & Rudd, D. (2006). Advances in the assessment of suicide risk. *Journal of Clinical Psychology: In Session*, 62, 185–200. doi: 10.1002/jclp.20222
- Edwards, S. J. (2014). Suicide prevention contracting: *The pitfalls, perils, and seven safer alternatives*. Plymouth, United Kingdom: Jason Aronson.
- Large, M., Kaneson, M., Myles, N., Myles, H., Gunaratne, P., & Ryan, C. (2016). Meta-analysis of longitudinal cohort studies of suicide risk assessment among psychiatric patients: Heterogeneity in results and lack of improvement over time. *PLoS ONE*, 11(1), 1–17. <http://dx.doi.org/10.1371/journal.pone.0156322>
- Marel, C., Mills, K. L., Kingston, R., Gournay, K., Deady, M., Kay-Lambkin, F., Baker, A., & Teesson, M. (2016). *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*. Sydney, NSW: Centre of Research Excellence in Mental Health and Substance Use. Retrieved from <https://comorbidityguidelines.org.au/>
- Marsh, A., & Dale, A. (2006). *Addiction counselling*. Melbourne, VIC: IP Communications.
- Marsh, A., O'Toole, S., Dale, A., Willis, L., & Helfgott, S. (2013). *Counselling guidelines: Alcohol and other drug issues* (3rd ed.). Perth, WA: Drug and Alcohol Office.
- Marsh, A., Towers, T., & O'Toole, S. (2012). *Trauma-informed treatment guide for working with women with alcohol and other drug issues* (2nd ed). Perth, WA: Improving Services for Women with Drug and Alcohol and Mental Health Issues and their Children Project.
- Mental Health Commission, Western Australia (MHC). (2016). *Gatekeeper suicide prevention training*. Perth, WA: Author.
- National Health and Medical Research Council (NHMRC). (2012). *Clinical practice guideline for the management of Borderline Personality Disorder*. Melbourne, VIC: Author.
- Pisani, A. R., Murrie, D. C., & Silverman, M. M. (2016). Reformulating suicide risk formulation: From prediction to prevention. *Academic Psychiatry*, 40 (4), 623–629. doi: 10.1007/s40596-015-0434-6.
- Schneider, B. (2009). Substance use disorders and risk for completed suicide. *Archives of Suicide Research*, (13), 303–316. doi: 10.1080/1381110903263191.

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## 23. Case formulation

The main purpose of case formulation is to identify, in conjunction with the client, the best way forward in a treatment plan or intervention. Case formulation can be useful when:

- working directly with a client in treatment planning
- discussing treatment planning in a clinical supervision setting
- providing organisations or services, such as courts, with 'big picture' information on a client's presentation and history.

Developing a case formulation entails integrating the information gathered from a thorough assessment into an explanation, using a theoretical framework, of how the client's presenting issues are caused and maintained. This proposed explanation or hypothesis integrates the clients' relationships, social circumstances and life events into a 'best guess' as to the origins of a person's difficulties (Johnstone, 2017).

Case formulation is a collaborative process; the clinician brings their clinical knowledge and experience from research and practice and integrates this with the clients' expertise in their own life and understanding about how their own experiences have affected them (Johnstone, 2017). This process is different from psychiatric diagnosis, which can label an individual based on deficits and exclude social contexts. Case formulation instead draws on the clients' resources and strengths in surviving what are often very challenging life situations and normalises expressions of distress as an understandable response to overwhelming life circumstances (Johnstone, 2017).

A case formulation should be developed after a thorough assessment is completed and provide the basis for a treatment plan tailored to the individual and their needs. A case formulation is a hypothesis based on data about the client's present situation, so should be flexible and adjusted as more information becomes apparent (British Psychological Society, 2011; Selzer & Ellen 2014).

It is recommended practice that psychiatric diagnosis is not a focus, but the experiences that may have led to the psychiatric diagnosis (low mood, lack of self-worth, unusual beliefs, etc.) are instead formulated (British Psychological Society, 2011; Lee et al., 2007). If the client perceives their psychiatric diagnoses as beneficial terms, this perspective can be included.

### Format of a case formulation

Case formulation differs somewhat according to the theoretical approach and the models individual counsellors may utilise.

Case formulations across different therapeutic modalities must:

- summarise the client's core issues
- suggest how the client's difficulties relate to each other by drawing on psychological theories and principles (e.g. CBT)
- aim to explain the development and maintenance of the client's difficulties
- indicate a plan of intervention
- be open to revision and reformulation.

(Johnstone & Dallos, 2006)

A simple model or template covering this information is the 5Ps model (Weerasekera, 1996). The 5Ps model can be combined with the biopsychosocial model, as shown below in Table 2.

- **Presenting issues.** These include issues the client identifies as bringing them into treatment, as well as any other issues that are identified during the assessment. Presenting issues are usually broader than just AOD issues and can include issues in any area of a person's life such as psychological, social, health, legal, accommodation and financial issues. Presenting cognitive, emotional or behavioural issues should follow a symptom-focused approach, rather than a diagnostic approach (British Psychological Society, 2011; Johnstone, 2017).



- **Predisposing factors.** These are issues in the client's childhood, adolescence and/or adulthood that predispose them towards experiencing AOD issues, mental health conditions and other current difficulties. Predisposing factors can include biological/genetic vulnerabilities (e.g. family history of mental health issues), environmental factors (e.g. early neglect, abuse, trauma, attachment history) and psychological factors (e.g. core beliefs) (Macneil, Hasty, Conus, & Berk, 2012).
- **Precipitating factors.** These are the factors that have brought the client's difficulties to a head and resulted in them seeking treatment. For example, these may include a significant event preceding the onset of AOD use, such as a relationship breakdown or loss of employment. These factors are commonly known as triggers.
- **Perpetuating factors.** These are the factors in the client's life, behaviour, beliefs and psychological state that maintain the presenting issues. Perpetuating factors can be biological (e.g. ongoing substance use, insomnia), psychological (cognitive patterns or unhelpful thinking styles) or social (e.g. financial or relationship issues). A perpetuating factor may also be a precipitating factor (Lee et al., 2007).
- **Protective factors.** These are the client's strengths and resources that may mitigate the impact of the presenting issue (e.g. a supportive partner).

Another case formulation model is the 7Ps model (Lee et al., 2007), which is an extension of the 5Ps, and includes two additional considerations:

- **Pattern and onset.** A description of the pattern of drug use and mental health issues currently and over time. For example, it may include any periods of abstinence or periods without mental health symptoms and/or when the client first showed signs of problematic use and/or dependence.
- **Prognosis.** A clinical judgement of the outlook for the client's symptoms.

When developing a case formulation, it is important to explore the significance and personal meaning of events and experiences to the client (Johnstone, 2017; Selzer & Ellen, 2014). For example, job loss as a precipitating factor may not affect a client psychologically by causing decreased self-efficacy or loss of purpose in life, but may instead cause the client to experience financial loss and social strain around being unable to provide for the family. Personal meaning from the client should be integrated into the psychological theory adopted (e.g. attachment theory, developmental psychology, CBT, etc.) and best practice should be based on a considered choice about what to include and exclude from the case formulation (British Psychological Society, 2011).

## Example of a case formulation

*Karen presented seeking help to stop daily dependent use of cannabis. She described experiencing a low mood, a lack of confidence, lack of self-worth and anxiety. Karen stated she is experiencing relationship difficulties which she sees as being caused by her cannabis use. Her Depression Anxiety Stress Scale results indicated high levels of anxiety, depression and stress.*

*Predisposing factors for Karen's AOD use include poor attachment with her mother, who experienced postnatal depression after Karen's birth and who Karen described as very critical. Karen's father worked long hours and was emotionally unavailable even when he was around due to his alcohol issue. Karen's poor attachment experiences are likely to have interfered with the development of her ability to regulate her emotions and to have resulted in her internalising negative beliefs about her worth. Poor emotional regulation and negative self-beliefs are likely to have predisposed her towards high levels of anxiety, depression and stress. Cannabis use has been Karen's way to gain some control over emotions and block out the distress caused by her negative self-worth.*

*The main precipitating factor for Karen seeking treatment is the threat by her partner to leave unless she stops her cannabis use. She reports that this has increased her anxiety.*

*Perpetuating factors for Karen's cannabis use include her belief that it provides her with the ability to manage her negative emotions and lack of self-worth, in the short term. Karen's cannabis use is also perpetuated by her lack of any other strategies to manage her negative emotions, as well as her fears that she will experience withdrawal symptoms and not be able to cope if she stops.*

*Protective factors include Karen's good social skills, the high value she places on her relationship and that her partner will be supportive as long as she gives up her cannabis use. Karen has engaged with counselling and has insight into what she wishes to improve as well as challenges she may face. She managed to reduce her cannabis use significantly 3 years ago for around 6 months, so has some knowledge of what has and has not worked for her previously.*

Another way of presenting this information is by using a formulation matrix (see Table 2). Some workers use a formulation matrix to help to brainstorm and structure information, identify the most significant information, prompt identification of theories and inform a case formulation (Selzer & Ellen, 2014).

**Table 2: Formulation matrix**

	Biological	Psychological	Social
<b>Presenting issue</b>	Symptoms of depression and anxiety Dependent use of cannabis	Low mood Lack of confidence Lack of self-worth Dependent use of cannabis	Relationship difficulties
<b>Predisposing</b>		Lack of self-worth Poor attachment	Poor attachment with her mother, who experienced postnatal depression Father worked long hours and emotionally unavailable Father had alcohol issue Possible modelling of AOD use by father Critical mother
<b>Precipitating</b>			Threat by her partner to leave unless she stops her cannabis use
<b>Perpetuating</b>	Possible cannabis dependence	Negative beliefs about worth Poor emotional regulation Lack of other strategies to manage emotions Fears regarding withdrawal symptoms and not being able to cope if she stops cannabis use Belief cannabis use assists in managing emotions in the short term and assists with lack of self-worth	
<b>Protective</b>		High value placed on relationship Engagement in counselling Insight into presenting issue and what she wishes to achieve Knowledge of how to reduce cannabis use from previous attempt	Good social skills Partner will be supportive as long as she gives up her cannabis use

## Presenting the case formulation to clients

Assessment results can be presented to clients in the form of a case formulation so as to help them make sense of their difficulties. This can help clients to gain a broad perspective on how their issues developed and are maintained, which can also encourage them to develop compassion and empathy for themselves. The aim of this process is to help the client make sense of their experiences, feel that these experiences are understandable given the circumstances, that they have strengths and are able to overcome their difficulties with support (Johnstone, 2017). The way in which the case formulation is presented is important, as it needs to be readily understood and provide hope for the future. The following points should be considered.

- The case formulation should be linked directly to a treatment plan that offers strategies to address the factors that are perpetuating these difficulties. This provides hope for the client and direction for the future (Marsh & Dale, 2006).
- The case formulation should always be presented to clients in a tentative fashion that encourages them to disagree or alter aspects of it to better fit their own experience and understanding. This provides an opportunity to discuss and negotiate a shared psychological perspective that holds meaning for the client (British Psychological Society, 2011).
- The case formulation should focus on strengths as well as limitations. A focus on strengths contributes to building hope, particularly if these strengths are framed as factors that can help the client to overcome their issues.
- The case formulation should be presented in simple language which takes account of the client's level of education and verbal literacy.
- Counsellors should be trauma informed and have an understanding of the growing body of research that indicates a strong correlation between AOD and trauma (see chapter on **Co-occurring trauma issues**). A trauma-informed formulation can provide great insight into the client's difficulties (British Psychological Society, 2011).
- Always explore the significance and personal meaning of events and experiences for the client (Johnstone, 2017; Selzer & Ellen, 2014).
- It is important that counsellors discuss the case formulation with the client sensitively; some clients may find the feedback saddening, worrying, difficult to process or distressing (Chadwick, Williams, & Mackenzie, 2003; Redhead, Johnstone, & Nightingale, 2015).
- Clients may want to take a copy of the formulation away with them.

## Documenting the formulation

The formulation should be documented in the client's file as a conclusion to the assessment notes and just prior to the documentation of the treatment plan. It can be written as shown in the example earlier in this chapter or as dot points under the 5P or 7P headings.

## Case formulation – tip sheet

A case formulation is an explanation of how a client's presenting issues developed and are maintained. The format will differ according to theoretical approaches and models of counselling.

The main purpose of case formulation is to identify, in conjunction with the client, the best way forward in a treatment plan or intervention.

Case formulation can be useful when working directly with a client in treatment planning, discussing treatment planning in a clinical supervision setting, and/or providing organisations/services with big picture information on a client's presentation and history.

The 5Ps model offers a simple way to construct a case formulation.

- **Presenting issues.** These include issues the client identifies as bringing them into treatment, as well as any other issues that are identified during the assessment. Presenting issues can include issues in any area of a person's life, such as psychological, social, health, legal, accommodation and financial issues. Presenting cognitive, emotional or behavioural issues should follow a symptom-focused approach, rather than a diagnostic approach.
- **Predisposing factors.** These are issues in the client's childhood, adolescence and/or adulthood that predispose them towards experiencing AOD, mental health conditions and other current difficulties.
- **Precipitating factors.** These are the factors that have brought the client's difficulties to a head and resulted in them seeking treatment. These factors are commonly known as triggers.
- **Perpetuating factors.** These are the factors in the client's life, behaviour, beliefs and psychological state that maintain the presenting issues.
- **Protective factors.** These are the client's strengths and resource that may mitigate the impact of the presenting issue (e.g. a supportive partner).

Assessment results can be presented to clients in the form of the case formulation (in a conversational style) so as to help them make sense of their difficulties. Clients should be encouraged to provide feedback on the case formulation and it should be adjusted in response to this feedback.

The case formulation should be linked to a treatment plan that addresses the factors that are perpetuating the client's difficulties.

## References

- British Psychological Society. (2011). *Good practice guidelines on the use of psychological formulation*. Leicester, United Kingdom: Author.
- Chadwick, P., Williams, C., & Mackenzie, J. (2003). Impact of case formulation in cognitive behaviour therapy for psychosis. *Behaviour Research and Therapy*, 41(3), 671-680. [https://doi.org/10.1016/S0005-7967\(02\)00033-5](https://doi.org/10.1016/S0005-7967(02)00033-5)
- Johnstone, L., & Dallos, R. (2006). Introduction to formulation. In L. Johnstone & R. Dallos (Eds.), *Formulation in psychology and psychotherapy: Making sense of people's problems* (pp. 1–16). London, United Kingdom: Routledge.
- Johnstone, L. (2017). Psychological formation as an alternative to psychiatric diagnosis. *Journal of Humanistic Psychology*, 5(1), 30-46. <https://doi.org/10.1177/0022167817722230>
- Lee, N., Jenner L., Kay-Lambkin, F., Hall, K., Dann, F., Roeg, S., ... Ritter, A. (2007). *PsyCheck: Responding to mental health issues within alcohol and drug treatment*. Canberra, ACT: Commonwealth of Australia
- Macneil, A., Hasty, M., Conus, P., & Berk, M. (2012). Is diagnosis enough to guide interventions in mental health? Using case formulation in clinical practice. *BMC Medicine*, 10(111). <http://www.biomedcentral.com/1741-7015/10/111>
- Marsh, A., & Dale, A. (2006). *Addiction counselling*. Melbourne, VIC: IP Communications.
- Redhead, S., Johnstone, L., & Nightingale, J. (2015). Clients' experiences of formulation in cognitive behaviour therapy. *Psychology and Psychotherapy: Theory, Research and Practice*, 88(4), 453-467. doi: 10.1111/papt.12054
- Selzer, R., & Ellen, S. (2014). Formulation for beginners. *Australian Psychiatry*, 22(4), 397-401. <https://doi.org/10.1177/1039856214536240>
- Weerasekera, P. (1996). *Multiperspective case formulation: A step towards treatment integration*. Malabar, FL: Krieger Publishing.

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## 24. Referral

In designing a treatment plan with a client it is often necessary to discuss referral to other services or counsellors. This can be for additional services or because the counsellor finds the client's presenting issues are beyond their level of expertise or training. It is important for counsellors to recognise the skills that they possess, but also to know their limitations. A referral can be to transfer a client either temporarily or permanently, or to share the care of the client (e.g. to initiate trauma counselling alongside AOD counselling). Referral is an ethical practice that can help to ensure that the client receives appropriate treatment. Discuss the possible need for referral early in the counselling process to avoid delays for the client (Nelson-Jones, 2005). In addition, seek supervision and support when considering the need to refer a client to another counsellor or service.

Whenever possible, clients should be retained in AOD treatment whilst accessing other services, rather than excluded from AOD services and referred on. Referral needs to be managed very sensitively because many people are lost to treatment when referred to other services. Some clients may misinterpret the referral as a failure on their behalf or as rejection by the counsellor (Hodges, 2011). Another common concern is having to repeat their presenting issues and history to a new person.

Referral should be done with the client's informed consent. Be clear about the reasons for the referral and explain why the suggested agency or professional is appropriate and potentially helpful for the client.

Clients should be encouraged to air any concerns about referral and counsellors should ensure the process of referral is as smooth as possible to ease the transition for the client. Some clients may require several sessions in preparation for referral (Hodges, 2011). If the client expresses concern about attending appointments with someone new, it may be beneficial to continue to work with the client in collaboration with another counsellor. Some clients, especially young people, may wish counsellors to accompany them to the first session with the new person.

Practical considerations that arise during referral include the release of confidential information. Discuss this issue with the client and only release confidential information with written permission from the client. Confidential information about a client can be shared electronically or sent by post (see chapter on **Confidentiality**).

### 'No wrong door' policy

Historically, health and community services systems were designed to deal with distinct mental health or substance use issues. Substance use and mental health services have been administered and funded separately, giving little incentive for each to assess and treat co-occurring conditions (Proudfoot, Teesson, Brewin, & Gournay, 2003). This often leads to debate about 'which issue came first' or 'what is the primary diagnosis' when determining the service the client needs. The common result is that people with both mental health and substance use issues experience the predicament of being ineligible for treatment at services because of their co-occurring issues (Mental Health Council of Australia, 2005). People with co-occurring mental health and substance use issues often 'fall through the cracks' (Proudfoot et al., 2003).

The 'no wrong door' policy is based upon the principle that all people should receive care that addresses the full spectrum of their mental health and substance use issues regardless of what type of service they present to (i.e. there is no wrong door). This principle clarifies that the responsibility of providing care for a range of health and social needs is the responsibility of the care provider/service where the client presents. It is acknowledged that this requires services to provide care and/or facilitate access to service delivery that falls beyond their specific focus. It removes the onus of negotiating multiple services and providers from the client and thereby aims to reduce the incidence of people 'falling through the cracks' of a complex service delivery system (CSAT, 2005).

One of the primary ways that organisations can improve service delivery to clients presenting with co-occurring mental health and substance use issues is to provide effective education and training programs to enhance the existing skills, knowledge, abilities and general work practice of both substance use and mental health organisations (Australian Institute of Health and Welfare [AIHW], 2005; Croton, 2004).

AOD workers should be aware that in instances where the client needs to leave the AOD treatment setting to have more immediate needs met (e.g. medical conditions), their relationship with the client should not cease. The client may still require AOD treatment after these issues have been addressed and it is important to follow up with the client and referral agency about the provision of this treatment (Marel et al., 2016).

When referring clients with co-occurring conditions, active referral is recommended over passive or facilitated referral (Marel et al., 2016). See Table 3 below.

**Table 3: Referral types**

<b>Passive referral</b>	Passive referral occurs when the client is given the details of the referral agency in order to make their own appointment. This method is almost never suitable for clients with co-occurring mental health and AOD issues.
<b>Facilitated referral</b>	Facilitated referral occurs when the client is helped to access the other service; for example, with the client's permission, the worker makes an appointment with the other service on their behalf.
<b>Active referral</b>	Active referral occurs when the worker telephones the other agency in the presence of the client and an appointment is made. The worker, with the client's consent, provides information about the client with a professional assessment of the client's needs. Such referral is necessary when clients are unmotivated, unlikely, or unable to do so themselves. This method of referral is recommended for clients with co-occurring mental health and AOD issues.

Adapted from Clemens et al. (2006) and Rastegar (2013).

### Referral – tip sheet

In designing a treatment plan with a client, always consider the issue of referral: is there a service or another health professional who could help to ensure that the client receives the most suitable treatment? Referring clients to appropriate services or counsellors is at the heart of client-centred and ethical practice. Discuss the possible need for referral early in the counselling process and seek supervision in this regard. A referral can transfer a client temporarily or permanently, or enable the care of the client to be shared.

The process of referral should aim to ease the transition for the client and should focus on the 'no wrong door' principle. When referring a client, consider the following.

- The client should provide informed consent to the referral, and written permission to exchange information should be obtained prior to a referral being made.
- Referral needs to be managed sensitively as many people are lost to treatment in the referral process.
- If a client requires other services for support (i.e. mental health), support the client using an active referral process. Discuss the issue of referral with the client and address any concerns.
- With written permission from the client, contact the referring agency and, if possible, the appropriate clinician.
- AOD workers should be aware that in instances when the client needs to leave the AOD treatment setting to have more immediate needs met, their relationship with the client should not cease. AOD workers can still work with clients who are accessing other health services. This is a process of negotiation between services with the client's consent; it exemplifies the 'no wrong door' principle.
- Some clients may wish counsellors to accompany them to their first session with the new counsellor or service.



## References

- Australian Institute of Health and Welfare (AIHW). (2005). *National Comorbidity Initiative: A review of data collections relating to people with coexisting substance use and mental health disorders*. Canberra, ACT: Department of Health and Ageing.
- Center for Substance Abuse Treatment (CSAT). (2005). *Substance abuse treatment for persons with co-occurring disorders* (Treatment Improvement Protocol (TIP) Series 42). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Clemens, S., Cvetkovski, S., & Tyssen, E. (2006). *DirectLine telephone counselling and referral service*. Melbourne, VIC: Premier's Drug Prevention Council. Retrieved from <http://www.health.vic.gov.au/vdapc/archive/directline.pdf>
- Croton, G. (2004). *Co-occurring mental health and substance use disorders: An investigation of services system modifications and initiatives designed to provide an integrated treatment response*. Retrieved from [http://www.dualdiagnosis.org.au/Croton\\_Fellowship\\_Co-occurring%20Disorders.pdf](http://www.dualdiagnosis.org.au/Croton_Fellowship_Co-occurring%20Disorders.pdf)
- Hodges, S. (2011). *The counselling practicum and internship manual. A resource for graduate counselling students*. New York, NY: Springer Publishing Company.
- Marel, C., Mills, K.L., Kingston, R., Gournay, K., Deady, M., Kay-Lambkin, F., Baker, A., & Teesson, M. (2016). *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*. Sydney, NSW: National Drug and Alcohol Research Centre. Retrieved from <https://comorbidityguidelines.org.au/>
- Mental Health Council of Australia. (2005). *Not for service: Experiences of injustice and despair in mental health care in Australia*. Canberra, ACT: Author.
- Nelson-Jones, R. (2005). *Practical counselling and helping skills*. London, United Kingdom: Sage Publishing.
- Proudfoot, H., Teesson, M., Brewin, E., & Gournay, K. (2003). Comorbidity and delivery of services. In M. Teesson & H. Proudfoot (Eds.), *Comorbid mental disorders and substance use disorders: epidemiology, prevention and treatment*. Canberra, ACT: Department of Health and Ageing.
- Rastegar, D. (2013). Making effective referrals to specialty care. In R. Saitz (Ed.), *Addressing unhealthy alcohol use in primary care* (pp. 63-71). New York, NY: Springer Publishing Company.

# 5

## Section Five: Counselling Interventions

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## 25. Motivational interviewing

Motivational interviewing (MI) is an evidence-based clinical intervention originally introduced into the AOD field over three decades ago by Bill Miller. It is not a comprehensive treatment in itself, but rather an integrated set of person-centred interviewing skills aimed at resolving ambivalence around change. It is relatively brief (most often tested in 1–4 sessions or in a brief format of 15 minutes or less), generalisable across problem areas such as diet, exercise, management of cardiovascular disease, gambling and HIV risk behaviour (Rollnick, Miller, & Butler, 2008), and complementary to other treatment methods, for example, CBT (Miller & Rollnick, 2013). It appears to increase treatment retention and reduce relapse rates (Burke, Arkowirz, & Menchola, 2003; Hettema, Steele, & Miller, 2005), and foster positive change and deepen engagement (Lundhal, Kunz, Brownell, Tollefson, & Burke, 2010). Outcomes are similar to those for other specific treatments, but MI usually achieves positive results in a shorter time (Lundhal et al., 2010).

O’Shea, Goff, and Armstrong (2017) described MI as:

*... a form of collaborative conversation which strengthens a person’s own internal motivation and commitment to change. It is essentially a brief, person-centred counselling style which addresses the common problem of ambivalence (or uncertainty) about change by paying particular attention to the language of change (or change talk). It is designed to strengthen the individual’s motivation for and movement toward a specific goal by eliciting and exploring the person’s own reasons for change. It is critical that this occurs within an atmosphere of acceptance and compassion. (p. 39)*

### The spirit of motivational interviewing

The spirit of MI is the guiding mindset with which the counsellor approaches change conversations. The spirit consists of four interrelated elements: partnership, acceptance, compassion, and evocation.

Partnership acknowledges that the client and the counsellor work together as equal partners in the therapeutic relationship. It is the client, however, who will ultimately make the decision about change. The counsellor cannot fix, coerce or persuade the client in this process; an attempt to do so would be counterproductive. A person experiencing ambivalence is already aware of and struggling with the arguments both for (change talk) and against (sustain talk) change. If a counsellor voices one side of the struggle, the pros of changes, an ambivalent person will balance the conversations by presenting the other side of the argument, the cons of change. The psychological law underpinning MI is “as I hear myself talk I learn what I believe” (Miller & Rollnick, 2002, p. 21). Therefore, if a client continues to voice the cons of change, these negative aspects will be reinforced.

Partnership or collaboration can be demonstrated in various ways. The counsellor can negotiate the agenda and change goals; be curious about the client’s thoughts/ideas; explicitly acknowledge that the client is the expert on themselves; and focus on strengths, resources and abilities rather than deficits (Miller & Rollnick, 2013).

Acceptance refers to believing the client to be a worthwhile person. It does not mean approving of or accepting their behaviours or actions. Miller and Rollnick (2013) highlight four key aspects to acceptance: absolute worth, accurate empathy, autonomy, and affirmation.

- **Absolute worth:** requires the counsellor to be aware of the client’s unique world view and hold unconditional positive regard for them. The paradox of acceptance is that when people feel accepted as they are, they often feel free to choose.
- **Accurate empathy:** involves seeking to understand the client’s experience, from their perspective, and communicating this understanding to them. It is not sympathy (“you poor thing”) or identification (“I’ve experienced the same thing”). The counsellor strives to understand the client’s world view and circumstances as much as possible without losing their own sense of self in the process. Accurate empathy is demonstrated by using reflective listening, accurately anticipating what the client is saying, asking thoughtful questions, and understanding the client’s emotional experience (Moyers & Miller, 2012).

- **Autonomy:** refers to an individual's right to self-determine and make their own choices however much others might believe they should make different choices. Honouring a person's autonomy in this way helps to diminish defensiveness and opens the way forward for change.
- **Affirmation:** involves genuinely and intentionally acknowledging the client's efforts and strengths. Affirmations support self-efficacy and confidence, which are important for behaviour change.

Compassion involves actively promoting the rights and welfare of clients. The services and interventions offered must benefit the client, not the service provider.

Evocation refers to eliciting a client's own strengths and resources. Clients generally have good reasons for using AODs (the functional aspects of the use). They also have the wisdom to make healthier choices, particularly when they are helped to connect their own values and concerns to the behaviour change they are considering.

## Five core communication skills

According to Miller, Forcehimes, Zweben, and McLellan (2011) the core skills of open questions (O), affirmations (A), reflections (R), and summaries (S), referred to collectively as OARS, are the "four fundamental skills that form a client centred foundation and safety net in counselling" (p. 55). Information-giving, which consists of elicit-provide-elicite (EPE), is the fifth key skill used in an MI intervention.

### Open questions

Open questions invite the client to explore, discuss and reflect. Closed questions are also useful, but a client may feel they are being interrogated if multiple closed questions or even too many open questions are used. Open questions can assist information gathering and identification of change behaviours, and begin to elicit discussions about change; examples are "tell me a bit about your meth use?", and "how does your cannabis use fit into your daily life?"

The rule of thumb when asking questions is:

- listen before asking questions
- avoid asking more than three questions in a row
- offer at least two reflections for each question asked (Miller et al., 2011).

### Affirmations

Affirmations are statements that help strengthen a person's self-efficacy. They must be real and genuine, otherwise they may come across as false or patronising. For example, "being there for your children is important to you," and "you have thought of some good ideas for managing your cannabis use."

### Reflections

Reflections are statements about what the counsellor observes or intuitively regarding the client. They let the client know they are being listened to and that the counsellor is trying to understand. They also help clarify the situation. The use of reflections helps the counsellor gather more information, build rapport and progress the session by encouraging the client to continue talking. For example:

*Client: I don't know how I ended up relapsing again.*

*Counsellor: You're not sure why you had a slip.*

### Summaries

Summaries can be described as a collection of reflections. An MI-consistent summary consists of the client's own change talk, and can be used to:

- focus on important change statements
- link different topics or themes that have emerged during the session
- close one topic or issue and move to a new focus
- close a session.

It is important that summaries:

- gather and reflect the main points of the discussion
- are made throughout the session (rather than making one large one at the end)
- contain focal points of the session, main themes and significant emotions that have been expressed
- reflect both concerns the client has about their situation as well as their change talk
- don't overwhelm the client.

A pause at the end of a summary will allow the client to acknowledge whether the counsellor has understood accurately. It also gives the client an opportunity to clarify or add anything further. An open question can be asked at the end of a summary in order to further the discussion. For example, "is there anything else you'd like to tell me about ...?"

### **Information-giving – Elicit, Provide, Elicit**

There may be times when a counsellor wants or needs to provide the client with important information. This may include providing information about the service and the counsellor's role; discussing consequences and harms associated with current behaviours; and sharing information about treatment options.

The first step is to elicit information from the client, for example, "tell me what you know about the effects of meth use on a person's mental health," and discuss. Then the counsellor can ask permission, for example, "is it ok if I give you some information about meth use and mental health?" Asking permission is fundamental to a collaborative counselling style; unsolicited advice may evoke defensiveness and hinder change.

Once permission has been granted, offer (provide) the client several options or pieces of information without overwhelming them with too much information all at once. Do not offer only one piece of information or advice, because this does not give the client choice.

The final stage in EPE is to elicit the client's response to or understanding of the information that has been shared. For example, ask "what do you think about that?" or "how does that fit for you?" These types of questions will continue to emphasise the client's autonomy, facilitate the collaborative conversation and minimise defensiveness.

## **Four processes of motivational interviewing**

MI uses four key processes to engage a client in a collaborative conversation about change. They are:

- engaging – establishing a helpful, working relationship
- focusing – developing a direction for the change conversation
- evoking – eliciting a client's own motivations for change
- planning – developing a commitment and specific plan of change action.

These processes are not necessarily linear in progression. "Integrated MI involves flexible revisiting of the processes of planning, evoking, focussing and engaging as needed" (Miller & Rollnick, 2013, p. 301).

The process of engaging establishes the therapeutic relationship – the relational foundation of MI. The use of reflective listening will help the client begin to explore their thoughts and feelings about their current circumstances. Reflective listening will also affirm the client's strengths and motivations and is fundamental to all four processes.

The OARS are used throughout the four processes. In the engaging process, they help to ensure the client is heard and understood. Open questions and reflections, rather than closed, fact-finding questions, also facilitate the conversation and develop engagement.

A client's change/sustain talk ratio predicts change, and the counsellor can influence this balance. The more a client voices change talk, the more likely they are to make changes. The decisional balance (evoking and giving equal attention to both the pros and cons of a particular behaviour) is an appropriate tool to use in the early stages of engagement if the counsellor wants to remain neutral and not influence a client's desire to move towards making a health-related behaviour change. It does not mean that a counsellor shouldn't ask about the pros (sustain talk) of the behaviour in an MI intervention. In fact, it is important to ask and reflectively listen to a client's sustain talk in the initial stages of MI, as this will promote engagement and reflect a counsellor's understanding of the client's dilemma. However, it is important that the counsellor does not continue to deliberately evoke sustain talk. Encouraging sustain talk will reinforce the current situation and discourage further change talk and the possibility of subsequent behaviour change.

Focusing is a collaborative process in which the counsellor and the client begin to broadly define one or more behaviour change goals. It is these goals that will provide the direction for the MI intervention.

The purpose of evoking purpose is to resolve ambivalence in the direction of change by eliciting the client's own motivations for change. The counsellor begins to encourage, listen for and reinforce the client's change talk in order to resolve ambivalence. It is important that the counsellor does not fall into the trap of trying to fix or help the client (known as the helper's 'righting reflex') or move them into planning for change too quickly (a 'premature focus trap').

The decision about when to move from evoking into planning is a clinical judgement call. It is indicated by the readiness of the client. Summarising the dilemma and posing a transitional key question such as "what might be the first step towards your goal?" will help the counsellor to decide whether the client is ready to move into planning.

In the planning stage in MI, a commitment is made to begin making changes and a change plan is developed. The focus of the session has now moved from looking at 'why' change is being considered to 'how' change can be carried out. The planning phase is not perceived as a final outcome but rather a beginning of the next step in a client's behaviour change. A counsellor may begin to use CBT at this point, not disregarding the MI clinical style, as it will continue to strengthen the client's commitment to their change plan. Social support and self-monitoring can also help to reinforce change commitments.

## Change talk

Change is more likely to happen when a client experiences a significant discrepancy between important values or goals they hold and how they are currently behaving. In order for a discrepancy to be motivating, however, it cannot be too large (the client becomes discouraged) or too small (the client can ignore or trivialise it).

A client's preparatory change talk which includes statements about desire ("I'd like to stop using"), ability ("I could cut down on my drinking"), reason ("I know I'd feel better if I cut down my use"), and need ("something has to change – I can't go on like this"), are referred to as DARN. These statements indicate that the client is beginning to consider change. Whenever a counsellor recognises change talk they can strengthen it by asking for elaboration, affirming, reflecting or summarising – the micro-counselling skills referred to as EARS. A counsellor can also evoke preparatory change talk by asking open questions, such as:

- How important is it to you that you make a change? (desire)
- How do you think you could start to cut down? (ability)
- What reasons do you have to change your drug use? (reason)
- How urgent is it that start to make some changes? (need)

Other strategies to evoke change talk include the importance ruler, querying extremes, looking forward, looking back, and exploring goals and values.

## Importance ruler

The importance ruler asks an evocative question, such as "on a scale of 1 to 10, 1 being not very important and 10 being very important, how important is it to you to make a change?" The counsellor then helps the client explore their reasons for why they chose that point on the scale. After the reasons have been discussed, the counsellor asks a question designed to elicit change talk, for example, "why are you a five and not a one?"

## Querying extremes

Querying extremes helps a client to describe their own and others' concerns about making no changes to their behaviour; for example, "if you don't make any changes to your AOD use, what is the worst thing that could happen?" It may also be useful to have them consider the best consequences that might arise from making a change, for example, "what would be the best thing that could happen if you cut down your AOD use?"

## Looking forward

Ask the client to consider how they expect the future to be if they continue at their current level of use; for example, "what do you think will happen if you keep using? How do you feel about that?" With young people, the time frame for looking forward should be kept short, weeks or months rather than years.



## Looking back

Ask the client to explore how past expectations differ from their current situation. The counsellor might 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?”

## Exploring values and goals

An exploration of a client’s values (things they care about, believe in, find meaningful and live for) and goals (what they want to achieve) and considering these in light of their current AOD use can enhance motivation for change. Be aware that some clients, particularly those whose basic needs for safety, accommodation and food are unmet, can struggle to identify values and goals. Using a tool such as the Values Card Sort (Miller & Rollnick, 2013) can assist with this process.

Mobilising change talk, referred to as Commitment, Activation and Taking steps (CATs), indicates that the client is starting to resolve their ambivalence. For example, “I will start to go to support meetings” (commitment), “I am ready to start cutting down” (activation), and “I have cut down on my drinking to only two nights each week, instead of five” (taking steps).

## Sustain talk and discord

Sustain talk is any client language that communicates a preference for not making changes – that is, to maintain the status quo. From an MI point of view, sustain talk is not viewed as resistance but rather as a normal part of ambivalence.

Responding to sustain talk and acknowledging the client’s perspective is important. Two main approaches are used: reflective responses (simple or complex) and strategic responses. Strategic responses include:

- emphasising autonomy – e.g. “you’re right. it’s your choice”
- reframing – by offering a different perspective
- agreeing with a twist – involves agreeing with the client’s statement and adding a reframe
- coming alongside – when there is no change talk, join the client in their sustain talk and amplify it in the hope of triggering some change talk.

Discord, which was traditionally seen as resistance and the client’s problem, usually arises out of an interpersonal dynamic which causes disharmony in the therapeutic relationship. A counsellor’s actions can influence discord, either positively or negatively. Discord may occur when a counsellor does things such as:

- takes a confrontational approach
- tries to “fix” the problem
- argues for change
- provides solutions.

Signals from the client that indicate discord include defensiveness, disagreeing, interrupting or disengaging. It is important for the counsellor to step back and reflect on what is happening when discord arises. Discord is associated with poorer client outcomes and hinders change.

In addition to the strategies for responding to sustain talk, further strategies for responding to discord include:

- apologise – if the counsellor was, for example, insensitive or got it wrong
- affirm – genuine affirmations can reduce defensiveness
- shift focus – it can be useful to move attention away from a contentious issue rather than continuing to reinforce it.

## Learning and practising MI

Counsellors are often drawn to an MI approach, as it sits comfortably within their current practice, particularly when they use a similar person-centred approach. As such, they may see MI as being very much practice as usual and therefore underestimate the skills required to practice MI with fidelity. Miller and Rollnick (2013) noted that workshops alone are usually insufficient to integrate MI into a counsellor’s clinical practice. The complex skills required for MI are typically learned with supervision involving feedback, support and observed practice.

## Motivational interviewing – tip sheet

MI aims to evoke and enhance client change talk using a collaborative conversation style. It has been found to be associated with enhanced behaviour change.

The spirit of MI refers to the mindset that underpins this clinical intervention. It consists of four inter-related elements: partnership, acceptance, compassion, and evocation.

Five core micro-counselling skills are used throughout an MI conversation. They are:

- open questions
- affirmations
- reflections
- summaries
- elicit-provide-elicited (for providing information and advice).

MI uses four key processes that are flexibly woven into an MI-based conversation. They are:

- engaging
- focusing
- evoking
- planning.

Preparatory change talk consists of client statements referring to their desire, ability, reasons and needs to consider change. Strategies to evoke change talk include:

- open questions to elicit DARN
- importance ruler
- querying extremes
- looking forward/back
- exploring values and goals.

Sustain talk is a normal part of ambivalence and refers to any client talk that does not support change.

It is not perceived as resistance. It is important that a counsellor responds to sustain talk and acknowledges the client's perspective by:

- using reflective statements
- emphasising autonomy
- reframing
- agreeing with a twist
- coming alongside.

Discord refers to disharmony within the therapeutic relationship. It is important to address in order to support the client's continued engagement in treatment. A counsellor's interventions and responses will influence the outcome of discord. If discord arises, a counsellor can:

- apologise
- affirm
- shift focus.

## References

- Burke, B., Arkowicz, H., & Menchola, M. (2003). The efficacy of motivational interviewing: A meta-analysis of controlled clinical trials. *Journal of Consulting and Clinical Psychology, 71*(5), 843-861. doi: 10.1037/0022-006X.71.5.843
- Hettema, J., Steele, J., & Miller, W. R. (2005). Motivational interviewing. *Annual Review of Clinical Psychology, 1*, 91-111. doi: 10.1146/annurev.clinpsy.1.102803.143833
- Lundhal, B. W., Kunz, C., Brownell, C., Tollefson, D., & Burke, B. L. (2010). A meta-analysis of motivational interviewing: twenty-five years of empirical studies. *Research on Social Work Practice, 20*(2), 137-160. <https://doi.org/10.1177/1049731509347850>
- Miller, W. R., Forchimes, A. A., Zweben, A., & McLellan, A. T. (2011). *Treating addiction: A guide for professionals*. New York, NY: Guilford Press.
- Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York, NY: Guilford Press.
- Miller, W. R., & Rollnick, S. (2013). *Motivational interviewing: helping people change* (3rd ed.). New York, NY: Guilford Press.
- Moyers, T. B., & Miller, W. R. (2012). Is low therapist empathy toxic? *Psychology of Addictive Behaviors: Journal of the Society of Psychologists in Addictive Behaviors, 27*(3), 878-84. doi: 10.1037/a0030274
- O'Shea, J., Goff, P., & Armstrong, R. (2017). *SAOR: Screening and Brief Intervention for Problem Alcohol and Substance Use* (2nd ed.). Dublin, United Kingdom: Health Service Executive.
- Rollnick, S., Miller, W. R., & Butler, C. (2008). *Motivational interviewing in health care*. New York, NY: Guilford Press.

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## 26. Problem-solving

Encountering and successfully negotiating problems is a part of everyday life. When clients are attempting to change their AOD use, encountering problems that may delay or threaten changes is a frequent occurrence. Therefore, ensuring that clients have adequate problem-solving skills is an important aspect of treatment and reduces the risk of relapse. Teaching problem-solving skills is associated with better treatment outcomes.

Many people with psychological, social or AOD issues have poor problem-solving skills. At the same time, most clients have solved problems in their lives and counsellors should encourage clients to recognise and value the skills they already have. A way of doing this is to ask clients what steps they have employed in the past in order to solve problems.

A variety of techniques is beneficial when teaching clients problem-solving skills. Verbal instruction, written information and skill rehearsal can all be useful. People with CI or conditions affecting their executive function, such as fetal alcohol spectrum disorder, schizophrenia, depression and ADHD may find problem-solving a difficult exercise and can require a lot of practice, repetition and simple information (Snyder, Miyake, & Hankin, 2015). For suggestions on techniques to use with cognitively impaired clients, see the chapter on **Cognitive impairment**.

The goals of problem-solving are to assist clients to:

- recognise the existence of a problem
- generate potential solutions to the problem
- choose the most effective option and plan how to implement it
- implement this option and evaluate how effective the approach was.

(Jarvis et al., 2005, p.95).

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 with which they can solve their own problems. Problem-solving steps, based on D'Zurilla and Goldfried (1971), are outlined in the following section.

### Preparing for problem-solving

The client should be encouraged to stand back from the problem and view it 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.

It is also important for clients to be encouraged to deal with one problem at a time. Ensure they have some time and energy to give to problem-solving; writing the problem and possible solutions down can assist the process (Saulsman et al., 2015). For clients who have literacy or learning difficulties such as dyslexia<sup>17</sup> or dysgraphia, writing and reading can be extremely stressful and may require a lot of extra effort. The counsellor can assist them by reading and writing for them, or using other ways to represent the ideas, such as pictures.

### Define the problem

It is important to clearly define a problem before attempting to solve it. The counsellor can encourage the client to be as specific as possible; describing the behaviour, situation, timing, and circumstances that make it a problem. Ask the client to describe the problem in objective terms (i.e. what can be observed) and to avoid using subjective descriptions such as feelings (Saulsman et al., 2015).

### Brainstorm solutions

After defining the problem, the next step is to think of possible solutions and list them. Encourage clients to think of as many solutions as possible – it doesn't matter how silly or unrealistic. Encourage the client to be creative. After the client has generated a few possible solutions, the counsellor can contribute as well. At this time the solutions should not be evaluated. Counsellors can steer the client away from any evaluation by suggesting brainstorming some of the 'sillier' solutions. Brainstorming should be fun – anything goes. When there are no further ideas added to the brainstorm, the counsellor can move to the decision-making stage.

<sup>17</sup> For definitions of dyslexia and dysgraphia, see <https://dsf.net.au/learning-difficulties>

## 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 unrealistic; then ask the client to list the remaining solutions in order of preference. Work with the client to evaluate the probable negative and positive outcomes of each of the top three or four solutions. 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.

## Planning how to implement the solution

Once the preferred solution has been selected, the next step is to develop a plan of how to put the solution into practice. This might entail breaking the solution down into small, achievable steps and encouraging the client to reflect on questions such as how, when, where and who with?

Rehearsing steps in the plan by either thinking the steps through in detail or role-playing aspects of the plan can also be useful. Rehearsal is important as it can identify some of the problems that the client may encounter, as well as increasing their confidence about implementing the strategy. After rehearsing the strategy, evaluate how effective it was. Did it work? Can it be improved? Should another strategy be considered? For further information, see the chapter on **Goal-setting**.

## Putting the plan into action and evaluating the outcome

The client should then put the plan into action. In the next session the client and counsellor should evaluate how it went and if necessary adjust the plan for next time.

Appendix 14 contains a problem-solving practice sheet for clients.

### Problem-solving – tip sheet

Teaching problem-solving skills is an integral part of any AOD treatment program. Give written information (see problem-solving practice sheet in Appendix 14), verbal instructions and skill rehearsal.

Clients with CI may require additional practice.

Clients with literacy issues may require alternative strategies to reading and writing.

Problem-solving steps:

- orientation – step back from the problem
- define the problem – be specific
- brainstorm solutions – anything goes
- decision-making – consider the 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.

## References

- D’Zurilla, T. J., & Goldfried, M. R. (1971). Problem solving and behavior modification. *Journal of Abnormal Psychology, 78*(1), 107-126. doi: 10.1037/h0031360
- Saulsman, L., Nathan, P., Lim, L., Correia, H., Anderson, R., & Campbell, B. (2015). *What? Me worry!?! Mastering your worries*. Perth, WA: Centre for Clinical Interventions.
- Snyder, H. R., Miyake, A., & Hankin, B. L. (2015). Advancing understanding of executive function impairments and psychopathology: Bridging the gap between clinical and cognitive approaches. *Frontiers in Psychology, 6*(328). doi: 10.3389/fpsyg.2015.00328

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## 27. Goal-setting

Goal-setting is a technique derived from CBT. It entails the client and counsellor using information gathered during the assessment to develop a plan for achieving mutually agreed outcomes.

Goal-setting:

- provides directions for treatment planning (see chapter on **Treatment planning**)
- clarifies the client's expectations of counselling
- clearly establishes what can and cannot be achieved in counselling
- provides a basis for selecting and using particular therapeutic techniques and strategies
- enables progress to be measured over time, which allows clients to experience success
- ensures that counselling remains client focused and directed, irrespective of the theoretical orientation of the counsellor.

Although AOD use goals will be central to most AOD treatment programs, clients present with a range of goals relating to various aspects of their lives (e.g. relationships, social functioning, study, work, criminal behaviour, physical and/or mental health). Therefore, as well as acting as a source of motivation for clients, goals assist in determining whether the counsellor and/or service meets the client's needs in working towards their goals and whether referrals for additional services are likely to be required (see chapter on **Referral**). A client's particular AOD use goals are also relevant to the suitability of a particular service, treatment approach, or counsellor. For example, if a client's goal is controlled AOD use or opioid pharmacotherapy use, then an abstinence-based program will not be suitable.

### Issues to consider when setting goals

Counsellors should consider the following issues, adapted from Allsop and Helfgott (2009), when they assist their clients to set goals. Goals should be:

#### Geared towards the client's stage of change

For example, a goal of complete abstinence is inappropriate for clients who are still contemplating whether they want to change their AOD use (see chapter on **Stages of change**).

#### Negotiated

Goals should be client directed, as this ensures that the client is committed to the goals. Client-directed goals are more likely to be meaningful to the client. At the same time, counsellors should guide clients to identify goals that are realistic and achievable. When a client is intent on a goal that the counsellor believes to be unrealistic and the client is not open to negotiation, it is pointless to insist on a more realistic goal. Instead, agree to the client's goal and negotiate a trial period (e.g. 5 weeks) during which the client's progress towards the goal will be monitored and reviewed. If at the end of this time it becomes clear that the original goal is unrealistic, then the counsellor and client agree to review the goal.

#### Specific and achievable

Goals need to be defined in clear, specific and achievable terms. As an example, Allsop and Helfgott (2009, p. 2) suggest that the goal '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 their goals.

## Short-term

It is important that goals are achievable in the short term. While longer-term goals for counselling or treatment need to be set, these can be broken down into their smallest components to produce short-term goals. Ideally, these short-term goals would be developed weekly, thereby giving the client a sense of success and achievement as they meet these goals and thus increasing their motivation to stay dedicated to the long-term goals. The other benefit of creating short-term goals and reviewing them often is that frequency of monitoring the progress towards goals is related to goal attainment (Harkin et al., 2016).

## Described in 'presence' rather than 'absence' terms

Focusing on skill acquisition rather than behaviour reduction has a long history in psychology and related disciplines. Whenever possible, goals should be phrased in terms of someone doing something (presence), rather than not doing something (absence). For example, the goal to 'reduce drug use to only two days per week' is expressed in absence terms. The same goal, expressed in presence terms is, 'I will increase the number of drug-free days to five out of seven and on each of those days I will do at least one of the pleasant activities I have listed'.

## Not limited to AOD use

The concept of recovery, as used in mental health settings, emphasises the importance of addressing clients' needs holistically (see chapter on **Recovery**). In most situations several goals may be considered. These might include:

- an increase in AOD-free days
- improved physical health
- improved mental health
- improved social adjustment and functioning
- reduced harms associated with AOD use.

## SMART goals

SMART is a useful acronym for setting goals. Goals should be:

- **specific** – clear, not vague. Setting specific goals is related to better goal achievement because it removes ambiguity (Kaminer, Ohannessian, McKay, Burke, & Flannery, 2018). If possible, set dates, times and identify resources that will be needed to achieve the goal
- **measurable** – can be measured in quantity or time in order to assist clients to monitor their progress and identify when their goals have been reached
- **achievable** – realistically able to be achieved
- **realistic** – can be attained along with other commitments
- **time-limited** – the goal can be achieved within a specific time frame.

(Farrand & Woodford, n.d; Fenn & Byrne, 2013)

## Questions to help clients think through their goals

Marsh and Dale (2006) recommend assisting clients to set realistic and achievable goals by helping them to think through the following issues:

- why they want to achieve the goal
- what might get in the way of achieving the goal
- ways to overcome threats to achieving the goal
- ways in which other people can help them achieve the goal
- how they will start to achieve the goal
- how they will know when they have achieved the goal.

There is a goal-setting worksheet in Appendix 15.



## Goal-setting – tip sheet

Always set goals when working with clients. They provide direction for counselling, give a standard against 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 client and counsellor
- goals should be defined in clear, specific and achievable terms (e.g. "I will have three alcohol-free days per week")
- goals should be short-term. Set an overall goal for counselling and then break it down into its smallest components. Small goals should be set and reviewed weekly
- goals should ideally be described in presence not absence terms. They should focus on skill acquisition. For example, rather than the client aiming to reduce drug use to two days per week, frame the goal in terms such as 'I will increase the number of drug-free days to five out of seven, and on each of those days I will do at least one of the pleasant activities I have listed'.

Goals should not be limited to reducing AOD use. Other areas to consider include:

- physical health
- mental health
- social adjustment and functioning
- harm associated with AOD use.

A goal-setting worksheet is provided for use with client in Appendix 15.

## References

- Allsop, S., & Helfgott, S. (2009). Goal setting. In S. Helfgott & S. Allsop (Eds.), *Helping change: The drug and alcohol counsellors' training program*. Perth, WA: Drug and Alcohol Office.
- Farrand, P., & Woodford, J. (n.d). Goal setting in low intensity CBT. Retrieved from [https://cedar.exeter.ac.uk/media/universityofexeter/schoolofpsychology/cedar/documents/Goal\\_setting\\_workbook\\_website.pdf](https://cedar.exeter.ac.uk/media/universityofexeter/schoolofpsychology/cedar/documents/Goal_setting_workbook_website.pdf)
- Fenn, K., & Byrne, M. (2013). The key principles of cognitive behavioural therapy. *InnovAiT: Education and Inspiration for General Practice*, 6(9), 579-585. doi: 10.1177/1755738012471029
- Harkin, B., Webb, T. L., Chang, B. P., Prestwich, A., Conner, M., ... Sheeran, P. (2016). Does monitoring goal progress promote goal attainment? A meta-analysis of the experimental evidence. *Psychological Bulletin*, 142(2), 198-229. <http://dx.doi.org/10.1037/bul0000025>
- Kaminer, Y., Ohannessian, C. M., McKay, J. R., Burke, R. H., & Flannery, K. (2018). Goal commitment predicts treatment outcome for adolescents with alcohol use disorder. *Addictive Behaviors*, 76, 122-128. <https://doi.org/10.1016/j.addbeh.2017.07.035>
- Marsh, A., & Dale, A. (2006). *Addiction counselling*. East Hawthorn, VIC: IP communications.

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## 28. Relapse prevention and management

It has been 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 of abstaining from AOD use (Allsop, 1990). A lapse frequently turns into a relapse (a return to pre-treatment levels of AOD use), and research indicates that between 40% and 60% of clients will end up relapsing (National Institute on Drug Abuse, 2009). For example, an American longitudinal study of methamphetamine users found that 61% relapsed within 12 months of finishing treatment, and 14% relapsed in the 2–5 years after treatment (Brecht et al., 2014). Consequently, the probability of relapse needs to be considered with all clients.

It is important to consider some of the factors associated with AOD relapse. The literature suggests the following:

- clients are more likely to relapse when they have support systems that are 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 such as co-occurring mental health conditions or trauma are not dealt with
- clients with CI are more likely to relapse
- young people are extremely likely to relapse
- relapse is often dependent on the quality of the post-change lifestyle
- clients with disease model beliefs are more likely to relapse.

(Miller, Westerberg, Harris, & Tonigan, 1996)

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:

- prevent an initial lapse and maintain abstinence, reduced use or harm reduction
- manage a lapse if it occurs and prevent it continuing to become a relapse.

(Marlatt & Witkiewitz, 2005)

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. Relapse should be normalised and the counsellor and client should develop strategies to reduce the chance of relapse and ensure that if a lapse does occur, that the client feels comfortable to raise this issue with the counsellor. These strategies will increase the likelihood that the client remains in treatment or 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 (see chapter on **Motivational interviewing**). 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 AOD use and the benefits of change. A readily accessible list of these costs and benefits can be a useful reminder and motivator. It is also important that the client experiences some of the 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 AOD or have changed their using behaviour, such as 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 be useful for them to spend a week recording those times when they used alcohol or other drugs, or felt most tempted to use. Alternatively, high-risk situations can be identified from a discussion with the client about situations that caused them difficulties in the past. Clients need to learn how to avoid high-risk situations (people, places), or develop strategies for those that may not be avoidable (feelings, unexpected events).

## Developing coping responses

During the early stages of the change process, clients may find it easier to avoid high-risk situations. However, because 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 practised 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 chapter on **Problem-solving**.

Common themes often underlie high-risk situations. For example, a client may be particularly likely to use alcohol or other drugs when stressed or angry, when something goes wrong and they feel like a failure. In such cases, relaxation training, grounding, mindfulness strategies, or cognitive restructuring may be of benefit. For further detail, refer to the chapters on **Relaxation strategies**, **Grounding**, **Mindfulness** and **Challenging unhelpful thinking**.

Assist the client to identify social supports related to their recovery (Kim et al., 2015; Warren, Stein, & Grella, 2007) such as non-using family and friends who are supportive of their recovery efforts. Furthermore, workers can encourage clients to seek non-using groups such as peer support groups to assist them to shift their AOD-using identity to a non-using social identity (see chapter on **Recovery**).

Self-efficacy or the perceived ability to carry out a particular behaviour is an important factor in behavioural change. Self-efficacy varies from day to day, and some studies have found that participants had lower self-efficacy on the day before a relapse (Hendershot, Witkiewitz, George, & Marlatt, 2011). Conversely higher self-efficacy can be a predictor of reduced AOD use after treatment (Hendershot et al., 2011; Warren et al., 2007).

Self-efficacy can increase with cumulative achievement of AOD abstinence or controlled use. Clients can also develop improved self-efficacy through assertiveness training and AOD refusal skills development (see chapter on **Assertiveness training**). Counsellors can assist clients by focusing on client's strengths and previous successes as a means to increase their self-efficacy.

## Helpful hints

Encourage clients to plan ahead, anticipate high-risk situations and develop a plan to cope with them. A relapse prevention worksheet is attached in Appendix 16.

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 do not take responsibility for their actions. It is useful to examine the chain of events that occurred prior to a lapse and ask the client whether the lapse just happened, or whether the client made choices that precipitated the lapse.

Deconstructing past relapse events by working backwards and exploring what led up to the use/craving can be an effective way for the client to develop insight into what precedes their use. This can often identify early themes that signal that the client is at risk of relapse (e.g. isolation) and strategies for addressing these (e.g. attending a meeting, resuming counselling, contacting family). Research suggests that addressing risk early is more effective than when cravings are acute (Kharb, Shekhawat, Beniwal, Bhatia, & Deshpande, 2018).

## Preparation for a lapse

Harm reduction strategies should be explored as part of preparation for a lapse, as risks associated with AOD use can be increased following a period of abstinence. For example, due to the period of abstinence generally preceding a lapse, the client's tolerance to their drug of choice will have reduced, increasing the risk of overdose. Furthermore, many clients use AOD 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 therefore exploring harm reduction is critically important. For further detail, see chapter on **Harm reduction**.

In addition to considering harm reduction strategies, it is 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 turn into a full-blown relapse. Problem-solving techniques can also 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 lapse
- explore what the client could have done differently
- help the client to renew their commitment to change.

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

## Relapse prevention and management – tip sheet

Goals of relapse prevention are to provide clients with:

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

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

### 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.
- Identify social supports related to recovery.
- Focus on the person's strengths and previous successes.
- Self-efficacy can be a predictor of reduced use post-treatment.

### 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 do differently next time.
- Help the client renew their commitment for change.

A relapse prevention worksheet for clients is included in Appendix 16.

## References

- Allsop, S. (1990). Relapse prevention and management. *Drug and Alcohol Review*, 9(2), 143-153. doi: 10.1080/09595239000185201
- Brecht, M. L., & Herbeck, D. (2014). Time to relapse following treatment for methamphetamine use: A long-term perspective on patterns and predictors. *Drug and Alcohol Dependence*, 139, 18-25. doi: 10.1016/j.drugalcdep.2014.02.702
- Hendershot, C. S., Witkiewitz, K., George, W. H., & Marlatt, G. A. (2011). Relapse prevention for addictive behaviors. *Substance Abuse Treatment, Prevention and Policy*, 6(17). doi: 10.1186/1747-597X-6-17
- Kharb, R., Shekhawat, L. S., Beniwal, R. P., Bhatia, T., & Deshpande, S. N. (2018). Relationship between craving and early relapse in alcohol dependence: A short-term follow-up study. *Indian Journal of Psychological Medicine*, 40(4), 315-321. doi: 10.4103/IJPSYM.IJPSYM\_558\_17
- Kim, H., Tracy, E., Brown, E., Jun, M., Park, M., Min, M., & McCarty, C. (2015). Personal networks of women in residential and outpatient substance abuse treatment. *Addiction Research & Theory*, 23(5), 404-412. doi: 10/3109/16066359/2015.1021339.
- Marlatt, G. A., & Witkiewitz, K. (2005). Relapse prevention for alcohol and drug problems. In G. A. Marlatt & D. M. Donovan (Eds.), *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors* (2nd ed., pp. 1-45). New York, NY: The Guilford Press.
- Miller, W. R., Westerberg, V. S., Harris, R. J., & Tonigan, J. S. (1996). What predicts relapse? Prospective testing of antecedent models. *Addiction*, 91, S155-171. doi: 10.1046/j.1360-0443.91.12s1.7.x
- National Institute on Drug Abuse. (2009). *Principles of drug addiction treatment: A research-based guide* (2nd ed.). Washington, DC: U.S. Department of Health and Human Services.
- Warren, J. I., Stein, J. A., & Grella, C. E. (2007). Role of social support and self-efficacy in treatment outcomes among clients with co-occurring disorders. *Drug and Alcohol Dependence*, 89(2-3) 267-274. doi: 10.1016/j.drugalcdep.2007.01.009

## 29. Harm Reduction

Under the National Drug Strategy (2017–2026), harm reduction is defined as “reducing the adverse health, social and economic consequences of the use of drugs, for the user, their families and the wider community” (Department of Health, 2017, p.1).

Harm reduction can include population-based prevention activities such as raising awareness of strategies to reduce harms, for example, drink-driving campaigns; targeted approaches to at-risk groups, such as NSPs for people who inject drugs; and education about harm reduction strategies with individual clients who use AOD.

Harm reduction recognises that while not using alcohol or other drugs is the most effective way of reducing AOD-related harms, people continue to use them. For this reason, when working with clients it is important to discuss harm reduction strategies.

### Harm reduction strategies

The harm reduction approach for individuals aims to reduce AOD-related harms, both direct and indirect, by implementing a range of diverse, targeted and practical strategies. Harm reduction strategies aim to support clients who choose to use alcohol and drugs, to reduce and prevent physical, social and mental health harms. Harm reduction is useful across all patterns of AOD use – intoxication, regular use and dependence.

Table 4 provides a range of harm reduction strategies related to individual, environment and drug factors. Note that this list of strategies is not exhaustive; counsellors can assist clients using problem-solving (see chapter on **Problem-solving**) to find other harm reduction strategies.

**Table 4: Harm reduction strategies**

Issue	Harm	Strategy
<b>Opioid use</b>	<ul style="list-style-type: none"><li>• Risk of opioid overdose</li></ul>	<ul style="list-style-type: none"><li>• Avoid mixing opioids with other CNS depressant drugs, such as benzodiazepines and alcohol</li><li>• Avoid using drugs alone so you can get help if something goes wrong</li><li>• Use smaller amounts if you have been abstinent, even for a short period of time (e.g. in prison, residential rehabilitation)</li><li>• If unsure of the purity of the drug, take a quarter of the usual amount to gauge purity</li><li>• Have naloxone available if you are using opioids or are likely to witness or respond to an overdose</li></ul>
<b>Injecting drug use</b>	<ul style="list-style-type: none"><li>• Risk of BBVs such as HIV, hepatitis B and C</li><li>• Health risks such as abscesses, endocarditis and vein damage</li></ul>	<ul style="list-style-type: none"><li>• Always use sterile injecting equipment and avoid sharing equipment</li><li>• Use appropriate filters</li><li>• Ensure hands, injecting area and equipment are clean</li><li>• Use a different method of use, e.g. smoking, snorting</li></ul>



Issue	Harm	Strategy
<b>Increased risk of being violent when intoxicated</b>	<ul style="list-style-type: none"> <li>Family and domestic violence</li> <li>Assault</li> <li>Injury</li> <li>Legal impacts</li> </ul>	<ul style="list-style-type: none"> <li>Avoid using when feeling angry</li> <li>Access a sobering-up shelter or other safe place rather than going home to the family when affected by AOD</li> <li>Avoid using AOD when with people with whom you have conflict</li> </ul>
<b>Sex when intoxicated</b>	<ul style="list-style-type: none"> <li>Risk of BBVs such as HIV, hepatitis B and C, risk of STIs, risk of unplanned pregnancy</li> <li>Lack of ability to give consent to sexual activity when intoxicated</li> </ul>	<ul style="list-style-type: none"> <li>Gain information on sexual health testing</li> <li>Discuss condom use to reduce risks of BBVs, STIs and pregnancy</li> <li>Discuss options for contraception</li> <li>Obtain information on treatment options for STIs and BBVs such pre-exposure prophylaxis (PrEP<sup>18</sup>)</li> <li>Discuss consent to sexual activity with your partner or a supportive friend prior to intoxication and plan for the sex you want to have</li> </ul>
<b>Intoxication (general)</b>	<ul style="list-style-type: none"> <li>Fights</li> <li>Falls</li> <li>Injury</li> <li>Road traffic crashes</li> </ul>	<ul style="list-style-type: none"> <li>Use less or lower-strength drugs/alcohol</li> <li>If using alcohol, space your drinks with water</li> <li>Carry less money or restrict your access to money while using</li> <li>Be around people you trust</li> <li>Avoid using alone</li> <li>Discuss planning safer transport options if planning AOD use, e.g. designated driver, taxi/ride share service</li> </ul>
<b>Overheating (particularly with ATS)</b>	<ul style="list-style-type: none"> <li>Dehydration and/or hyperthermia</li> </ul>	<ul style="list-style-type: none"> <li>Move from a hot environment to a cooler one with good airflow and shade to reduce the risk of overheating and dehydration</li> <li>A cool, wet towel or compress on the skin can reduce body temperature</li> <li>Maintain water intake, especially if using ATS and dancing in a hot environment. Sip about 500mls per hour</li> <li>Take breaks from activities such as dancing to reduce the risk of overheating or dehydration</li> </ul>

18 HIV Pre-Exposure Prophylaxis (PrEP) is the regular use of HIV medications by HIV-negative people to prevent HIV acquisition. PrEP has been approved by Australia's Therapeutic Goods Administration (TGA) for use by people who are HIV negative and at risk of acquiring HIV (Australian Federation of AIDS Organisations, n.d.).

Issue	Harm	Strategy
<b>AOD use whilst children are in your care</b>	<ul style="list-style-type: none"> <li>• Children's needs not being met</li> <li>• Children being put at risk</li> </ul>	<ul style="list-style-type: none"> <li>• Avoid AOD use when your child is in your care and allow recovery time before care of your child resumes</li> <li>• If your child is in your care, ensure your child's needs have been met (e.g. dinner) and your child is asleep before using drugs, or do so in the presence of a responsible adult who can respond to your child if sick or in need</li> <li>• If you can't wait until evening, delay AOD use until your child is at school and arrange for a responsible adult to collect your child from school. Do not attempt to drive if you are intoxicated</li> <li>• If your child will be present, ensure they do not witness drug use and related behaviours (e.g. sexual behaviour) that another safe and responsible adult who is not intoxicated is present</li> <li>• Ensure your child knows how to call 000 or a support person on your safety plan if an emergency occurs or your child feels unsafe</li> <li>• Ensure alcohol, drugs or paraphernalia associated with drug use are out of your child's reach</li> </ul>
<b>Personal hygiene</b>	<ul style="list-style-type: none"> <li>• Dental problems</li> <li>• Maintenance of general hygiene</li> </ul>	<ul style="list-style-type: none"> <li>• Brush teeth using toothpaste and plenty of water at least daily. Chewing gum can help to produce saliva which can assist in reducing dental problems</li> <li>• Regular showering and changing into clean clothes can make you feel physically and psychologically better</li> </ul>
<b>Nutrition and sleep</b>	<ul style="list-style-type: none"> <li>• Lack of nutrition</li> <li>• Lack of sleep</li> <li>• Potential health and mental health issues</li> </ul>	<ul style="list-style-type: none"> <li>• Eating fresh, healthy food such as fruit, vegetables and fish, which are high in vitamins and other nutrients, helps maintain physical health</li> <li>• Aim to sleep daily or at least every second day. If this is not possible, rest in a darkened room for a few hours each day</li> </ul>
<b>Increased risk of mental health issues</b>	<ul style="list-style-type: none"> <li>• Drug induced Psychosis</li> <li>• Exposing and underlying mental health vulnerability</li> </ul>	<ul style="list-style-type: none"> <li>• Mental health disturbances are associated with increased frequency of use of ATS and (in some cases) cannabis. Take a break from drug use and avoid using every day</li> <li>• If you do have an underlying mental health condition, AOD use may worsen symptoms. Avoid AOD use or use smaller amounts and/or less frequently</li> <li>• If symptoms such as severe paranoia, hearing voices or strange beliefs occur, seek medical assistance</li> <li>• Some prescribed and over-the-counter drugs such as antipsychotics, antidepressants, benzodiazepines and painkillers can interact badly with some drugs. Seek advice from a doctor, pharmacist or AOD worker on possible interactions</li> </ul>
<b>AOD dependence</b>	<ul style="list-style-type: none"> <li>• Becoming dependent on AOD</li> </ul>	<ul style="list-style-type: none"> <li>• Avoid frequent AOD use</li> <li>• Take a break from AOD use</li> <li>• Stop AOD use</li> <li>• Talk to your doctor, pharmacist or AOD worker if you are concerned about dependency</li> </ul>

(Darke & Hall, 2003; Darke & Farrell, 2014; Donoghue, 2015; European Monitoring Centre for Drugs and Drug Addiction, 2016; Frisher, Baldacchino, Crome, & Bloor, 2012; Jauncey & Nielsen, 2017; Pinkham & Stone, 2015; S-Check Clinic, 2016)

## Harm reduction and AOD treatment

Clients in AOD treatment, including abstinence-based, pharmacotherapy or residential rehabilitation, are at risk of relapse. Supporting the client to identify triggers for relapse, strategies to cope with cravings and withdrawal, as well as knowledge of harm reduction strategies should they use alcohol or other drugs, is an important part of treatment and should be discussed with clients in the context of potential relapse (see chapter on **Relapse prevention and management**). Harm reduction strategies are a key aspect of BIs (see chapter on **Brief intervention**).

### 4Ls model

The 4Ls model is a useful framework for conceptualising the harms associated with AOD use (attributed to Roizen, 1983). Working through the 4Ls with clients can assist them to identify AOD-related harms across four areas of their lives.

- **Liver** – health problems such as liver damage, hepatitis C, HIV, injecting harms, overdose.
- **Lover** – social and relationship problems, e.g. family and domestic violence, relationship breakdowns, loss of friends, withdrawal from socialising, child protection issues.
- **Livelihood** – financial and occupational harm including job loss, debt, inability to maintain stable employment, inability to keep up with education.
- **Law** – legal problems including those from using or selling illegal drugs, road traffic crashes, violent crime, property crime, unpaid fines.

For Aboriginal clients, the 7Ls model (Casey & Keen, 2005) may be appropriate. For more information on the 7Ls model see chapter on **Aboriginal clients, their families and communities** or see <https://www.mhc.wa.gov.au/media/1679/mental-health-commission-aboriginal-parents-and-family-drug-support.pdf>

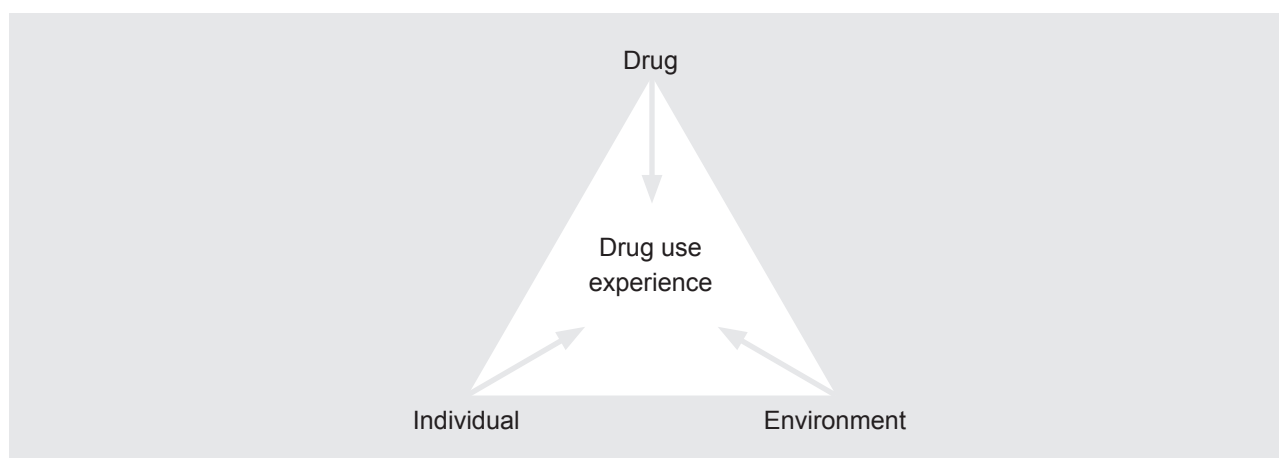
### The Interaction model

The Interaction model (Zinberg, 1984) shown in Figure 4 can be used to assist clients to identify AOD-related harms and strategies. The model proposes that factors that are not related to the effects of alcohol or other drugs are just as important as the effects of the alcohol or other drugs in the AOD using experience. The Interaction model recognises that a person's AOD use is neither all 'bad' or all 'good', and that AOD use in one setting may be issue free, while in another setting issues may occur. Changes in one of the factors can change the drug use experience.

This model suggests that three factors influence whether AOD use is a positive or negative experience:

- **the drug** – psychoactive effects, route of administration, purity, amount, polydrug interactions
- **the individual** – health (physical and mental), personality, tolerance, gender, size, mood, expectations, intention
- **environment or social setting** – price, availability, family situation, culture, legal system.

(Hartogsohn, 2017; Zinberg, 1984)



**Figure 4: Interaction model (Zinberg, 1984)**

Understanding the context of a client's AOD use can open up a conversation about how the client feels they could reduce harms in these areas.

*Example:*

A client may say that they are injecting heroin (Drug), have developed tolerance (Individual) and has been using in prison (Environment). The counsellor can discuss the following harms and harm reduction strategies:

- environment – high BBV prevalence in prison
- drug – alternative modes of administering the drug
- drug – sterile injecting practice
- individual – tolerance; heroin outside prison is easier to obtain and of higher purity, meaning greater overdose risk.

This method enables rapid identification of information about risks and harms, as well as basic and practical harm reduction strategies that clients can employ immediately.

## Barriers to safer AOD use

It is important to consider barriers to clients using alcohol or other drugs in safer ways. Work with the client to explore practical issues such as access to clean injecting equipment and lack of knowledge and find acceptable strategies to reduce the barriers, such as linking the client to an NSP (see chapter on **Problem-solving**).

MI can be used to enhance the clients' motivation to engage in less risky behaviour). Explore the following in a motivational interview:

- the 'good' things about continuing the current practice (e.g. sharing needles, using large amounts of AODs, mixing drugs, unprotected sex)
- the 'less good' things about continuing the current practice, with a thorough exploration of why and how much the client is concerned about their drug-using practices
- ways of enhancing discrepancies between the client's current practices and their values and goals. For example, ask how the client sees their risky practices fitting with their own goals or values, or what the client thinks will happen if they continue to use drugs in the present fashion and how that fits with their wishes for the future
- after summarising what the client has said, encourage them to consider whether they want to change anything ("So, what do you think your first step might be?"), and what compromises can be made to decrease the risk of harms in their AOD using behaviours (see chapter on **Motivational interviewing**).

## Harm Reduction – tip sheet

Harm reduction strategies aim to support AOD-using clients to reduce and prevent physical, social and psychological harms.

Harm reduction can include population-based prevention activities such as raising awareness of strategies to reduce harms, as well as harm reduction with clients in a counselling setting.

For example:

- drink-driving campaigns targeting at-risk groups
- NSPs for people who inject drugs
- education about harm reduction strategies with individual clients who use alcohol or other drugs.

The 4Ls model and the Interaction model are useful for exploring AOD harms and harm reduction strategies with clients.

### 4Ls model

The 4Ls model outlines four areas of life which may be affected by AOD-related harms.

- **Liver** – health problems such as liver damage, hepatitis C, HIV, abscesses, overdose.
- **Lover** – social and relationship problems, e.g. family and domestic violence, relationship breakdowns, loss of friends, withdrawal from socialising, child protection issues.
- **Livelihood** – financial and occupational harm including job loss, debt, inability to maintain stable employment due to AOD use, inability to keep up with education.
- **Law** – legal problems including those from using or selling illegal drugs, road traffic accidents, violent crime, property crime, unpaid fines.

## Interaction model

The Interaction model proposes that factors related to the drug, individual and environment in which AOD use occurs contribute to whether a person has a positive or negative drug use experience. Changes in one of these factors can change the drug use experience:

- **drug** – psychoactive effects, route of administration, purity, amount, polydrug interactions
- **individual** – health (physical and mental), personality, tolerance, gender, size, mood, expectations, intentions
- environment or social setting – price, availability, family situation, culture, legal system.

Harm reduction strategies include:

- ensure good nutrition
- get plenty of rest and sleep
- maintain adequate hydration
- look after personal hygiene
- maintain good dental hygiene
- use AOD less frequently
- decrease the amount of AOD used
- look after other when using AODs
- avoid mixing drugs (polydrug use)
- avoiding overheating by sipping water use sterile equipment
- plan for safer sex
- have naloxone available
- avoid using when your child is in your care
- allow recovery time before care of children resumes.

## References

- Australian Federation of AIDS Organisations. (n.d.). HIV Prevention. Retrieved from: <https://www.afao.org.au/about-hiv/hiv-prevention/prep/>
- Casey, W., & Keen, J. (2005). *Strong spirit strong mind, Aboriginal alcohol and other drugs worker resource: A guide to working with our people, families and communities*. Perth, WA: Aboriginal Alcohol and other Drugs Program, WA Drug and Alcohol Office.
- Darke, S., & Farrell, M. (2014). Would legalizing illicit opioids reduce overdose fatalities? Implications from a natural experiment. *Addiction, 109*(8), 1237-1242. doi: 10.1111/add.12456.
- Darke, S., & Hall, W. (2003). Heroin overdose: Research and evidence-based intervention. *Journal of Urban Health, 80*(2), 189-200. doi: 10.1093/jurban/jtg022
- Department of Health. (2017). *National Drug Strategy 2017–2026*. Canberra, ACT: Author.
- Donoghue, K. J. (2015). Perceived harms and benefits of parental cannabis use, and parents' reports regarding harm-reduction strategies. Retrieved from <https://ro.ecu.edu.au/theses/1592>
- European Monitoring Centre for Drugs and Drug Addiction. (2016). Perspectives on drugs: Preventing overdose deaths in Europe. Retrieved from [http://www.emcdda.europa.eu/system/files/publications/2748/att\\_212359\\_EN\\_EMCD\\_DA\\_POD\\_2013\\_Preventing%20overdose%20deaths.pdf](http://www.emcdda.europa.eu/system/files/publications/2748/att_212359_EN_EMCD_DA_POD_2013_Preventing%20overdose%20deaths.pdf)
- Frisher, M., Baldacchino, A., Crome, I., & Bloor, R. (2012). Preventing opioid overdoses in Europe: A critical assessment of known risk factors and preventative measures. Retrieved from [http://www.drugs.ie/resourcesfiles/ResearchDocs/Europe/Research/2012/Preventing\\_overdose\\_report\\_EMCD\\_DA.pdf](http://www.drugs.ie/resourcesfiles/ResearchDocs/Europe/Research/2012/Preventing_overdose_report_EMCD_DA.pdf)
- Hartogsohn, I. (2017). Constructing drug effects: a history of set and setting. *Drug Science, Policy and Law, 3*(0). doi: 10.1177/2050324516683325
- Jauncey, M. E., & Nielsen, S. (2017). Community use of naloxone for opioid overdose. *Australian Prescriber, 40*, 137-140. doi: 10.18773/austprescr.2017.043
- Pinkham, S., & Stone, K. (2015). A global review of the harm reduction response to amphetamines: An update. Retrieved from [https://www.hri.global/files/2015/10/18/AmphetaminesReport\\_Oct2015\\_web.pdf](https://www.hri.global/files/2015/10/18/AmphetaminesReport_Oct2015_web.pdf)
- Roizen, R. (1983). Loosening up: General population views of the effects of alcohol. In R. Room & G. Collins (Eds.). *Alcohol and disinhibition: Nature and meaning of the link* (pp. 236-257). Washington, DC: US Government Printing Office.
- S-Check Clinic. (2016). Mind and body. Retrieved from <http://www.stimcheck.org.au/#!s-check/c1i8v>
- Zinberg, N. E. (1984). *Drug, set, and setting: The basis for controlled intoxicant use*. New Haven, CT: Yale University Press.

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## 30. Brief intervention

A brief intervention (BI) is a short client contact delivered in the normal course of a workers' day-to-day work, lasting from 1–4 sessions of 5–60 minutes (Heather, 2012, 2014). BIs have been applied to a range of health issues including smoking cessation, changing dietary and exercise habits, weight management, and reducing alcohol consumption or cholesterol levels (Nilsen, Kaner, & Babor, 2008). BIs involve the worker making the most of any opportunity to raise the issue of a client's AOD use and offer a change intervention to those reporting risky or high-risk use. AOD BIs can take place in a range of settings including AOD services, primary health care, GP clinics, allied healthcare, and mental health, community-based, welfare and corrections settings (Heather, 2012, 2014; Webb, Bertoni, & Copeland, 2015).

BI can be part of specialist treatment, such as a routine assessment using a universal tool to screen a client's AOD use, followed by further assessment if dependence is evident. Alternatively, a BI can be opportunistic (an OBI) when delivered to people not seeking treatment but asked about their AOD use as part of a health check at hospital or in the community (DiClemente, Corno, Graydon, Wiprovnick, & Knoblach, 2017; Nilsen et al., 2008).

BIs aim to engage the person in a conversation about the health issue, such as smoking or alcohol use, to determine their level of concern about their current risky or high-risk pattern of use. The intervention can include a combination of brief advice and a brief motivational interview (BMI) (DiClemente et al., 2017; Heather, 2014; Rollnick, Miller, & Butler, 2008). BIs can also be used as part of the Screening, Brief Intervention, and Referral to Treatment (SBIRT) model as described by Madras et al. (2009) and Young et al. (2014).

Because a BI requires minimal worker time and training they can have more client contact in different settings with a greater reach in reducing AOD risk and harms (Heather, 2014). A BI can be cost-effective from a public health perspective, but this depends on the client's level of risk and readiness to change. However, this is only if supported by widely disseminated and routinely implemented policy within a workplace (Heather, 2012; McCambridge & Saitz, 2017; Nilsen et al., 2008).

After nearly three decades, BIs and screening are well established as effective strategies in reducing risky or harmful alcohol consumption, especially in primary health care (Kaner et al., 2018; McCambridge & Rollnick, 2014). BIs for smoking cessation have been well researched and shown to be effective in reducing smoking-related harms (Centre for Population Health, 2015; Stead et al., 2013).

DiClemente et al.'s (2017) review supported the use of BMIs or motivationally enhanced interventions in alcohol and tobacco BIs. Further, Young et al.'s (2014) systematic review confirmed the effectiveness of the SBIRT model and demonstrated BIs as effective in reducing alcohol and tobacco use, while Kaner et al. (2018) concurs with this finding when comparing BIs to minimal or no intervention.

BI for illicit drugs including cannabis, opioids and ATS have been less well studied and evidence for their effectiveness is inconclusive (Bernstein et al., 2009; Young et al., 2014). Webb and colleagues (2015) studied very brief interventions (VBIs) for cannabis, with positive results for interventions 10–20 minutes in duration. Further research is recommended for VBIs less than 10 minutes. Nonetheless, BI consisting of a single session enables a worker to raise the issue of AOD use with clients, including young people, and discuss strategies for reducing use and harms (Bernstein, 2014; McCambridge & Strang, 2004; Stockings et al., 2016).

Rollnick, Mason and Butler (1999) stated that a BI should be delivered in a sensitive and non-judgemental manner as a client may not previously have considered their AOD use an issue. Using a BMI style can help the worker engage the client in a conversation about their risky or high-risk AOD use that may support them to think about change (DiClemente et al., 2017; Heather, 2014).

There are several models for conducting a BI, including:

- FRAMES (Feedback, Responsibility, Advice, Menu, Empathy and Self-efficacy) model (Miller & Sanchez, 1993)
- the 5As model (Ask, Assess, Advise, Assist and Arrange) model and adaptations of it (Centre for Population Health, 2015).



A BI can consist of one or more of the following:

- asking the client about their AOD use
- using a screening tool (e.g. AUDIT or the ASSIST (Alcohol, Smoking, and Substance Involvement Screening Test)) for scoring and offering feedback
- engaging the client in a conversation about their AOD screen, using BMI and/or brief advice
- providing self-help resources, separately or as part of the intervention
- offering a follow-up appointment and referral to other services as needed.

BIs are unsuitable for clients with complex physical or mental health conditions, severe AOD dependence or CI. In these cases further individual assessment is recommended to suit the client's needs and appropriate referral (Babor, 1990, 2001; WHO, 2008).

## Brief intervention – tip sheet

All AOD workers are encouraged to use any opportunity to raise the issue of a client's AOD use and offer a BI to those reporting risky or high-risk AOD use.

A BI can involve 1–4 contacts with sessions lasting 5–60 minutes.

A BI can be undertaken in a diverse range of settings.

A BI can be opportunistic (an OBI) or used as part of the SBIRT and may include a combination of brief advice and a BMI.

BI and screening are well established as effective strategies in reducing risky or harmful alcohol consumption and encouraging smoking cessation, especially in primary health care. The use of BMI or motivationally enhanced interventions increases their effectiveness.

Evidence about the effectiveness of BIs for illicit drugs including cannabis, opioids and ATS is inconclusive.

BI consisting of a single session enables the worker to raise the issue of AOD use and discuss harm reduction strategies with clients.

A BI should be delivered in a sensitive and non-judgemental manner as a client may not previously have considered their AOD use an issue.

Using a BMI style can help the worker engage the client in a conversation about their risky or high-risk AOD use.

BI models include FRAMES (Feedback, Responsibility, Advice, Menu, Empathy and Self-efficacy) and the 5As (Ask, Assess, Advise, Assist, Arrange).

BIs are NOT suitable for clients with complex physical or mental health conditions, severe AOD dependence or CI. In these cases further individual assessment is recommended and/or referral to other services.

## References

- Babor, T. F. (1990). Brief intervention strategies for harmful drinkers: New directions for medical education. *Canadian Medical Association Journal*, 143(10), 1070-1076.
- Babor, T. F., Higgins-Biddle, J. C., Saunders, J. B., & Monteiro, M. G. (2001). *AUDIT: The Alcohol Use Disorders Identification Test. Guidelines for use in primary care*. Geneva, Switzerland: World Health Organization.
- Bernstein, E., Edwards, E., Dofman, D., Heeren, T., Bliss, C., & Bernstein, J. (2009). Screening and brief intervention to reduce marijuana use among youth and young adults in a paediatric emergency department. *Academic Emergency Medicine*, 16, 1174-1185. doi: 10.1111/j.1553-2712.2009.00490.x
- DiClemente, C. C., Corno, C. M., Graydon, M. M., Wiprovnick, A. E., & Knoblach, D. J. (2017). Motivational interviewing, enhancement, and brief interventions over the last decade: A review of reviews of efficacy and effectiveness. *Psychology of Addictive Behaviors*, 31(8), 862-887. doi: 10.1037/adb0000318
- Centre for Population Health. (2015). *Managing Nicotine Dependence: A guide for NSW Health Staff*. North Sydney, NSW: NSW Ministry of Health. Retrieved from <http://www.health.nsw.gov.au/tobacco/Pages/tools-for-health-professionals.aspx>

- Heather, N. (2012, July 17). *Thirty years of evidence: A short history of brief interventions*. Paper presented at Drinkwise North West/ Alcohol Academy Conference, Alcohol Research, Warrington, United Kingdom. Retrieved from [http://www.alcoholacademy.net/uploads/30%20years%20of%20evidence\\_a%20short%20history%20of%20brief%20interventions.pdf](http://www.alcoholacademy.net/uploads/30%20years%20of%20evidence_a%20short%20history%20of%20brief%20interventions.pdf)
- Heather, N. (2014). The two forms of alcohol brief intervention: An uneasy coalition. *Addiction*, *109*(7), 1059-1060. <https://doi.org/10.1111/add.12443>
- Kaner, E. F., Beyer, F. R., Muirhead, C., Campbell, F., Pienaar, E. D., Bertholet, N., ... Burnand, B. (2018). Effectiveness of brief alcohol interventions in primary care populations. *Cochrane Database of Systematic Reviews*, *2018*(2). doi: 10.1002/14651858.CD004148.pub4
- Madras B. K., Compton W. M., Avula, D., Stegbauer, T., Stein, J. B., & Clark, H. W. (2009). Screening, brief interventions, referral to treatment (SBIRT) for illicit drug and alcohol use at multiple healthcare sites: Comparison at intake and 6 months later. *Drug and Alcohol Dependence*, *99*(1-3), 280-295. doi: 10.1016/j.drugalcdep.2008.08.00
- McCambridge, J., & Strang, J. (2004). The efficacy of single-session motivational interviewing in reducing drug consumption and perceptions of drug-related risk and harm among young people: Results from a multi-site cluster randomized trial. *Addiction*, *99*(1), 39-52. <https://doi.org/10.1111/j.1360-0443.2004.00564.x>
- McCambridge, J., & Rollnick, S. (2014). Should BI in primary care address alcohol problems more strongly? *Addiction*, *109*(7), 1054-1058. doi: 10.1111/add.12388
- McCambridge, J., & Saitz, R. (2017). Rethinking brief interventions for alcohol in general practice. *BMJ*, *356*, j116. doi: 10.1136/bmj.j116
- Miller, W. R., & Sanchez, V. (1993). Motivating young adults for treatment and lifestyle change. In S. Howard, P.E. Nathan (Eds.), *Alcohol use and misuse by young adults* (pp. 55-81). Notre Dame, IN: University of Notre Dame Press.
- Nilsen, P., Kaner, E., & Babor, T. F. (2008). Brief intervention, three decades on: An overview of research findings and strategies for more widespread implementation. *Nordic Studies on Alcohol and Drugs*, *25*(6), 453-467. <https://doi.org/10.1177/145507250802500608>
- Rollnick, S., Mason, P., & Butler C. C. (1999). *Health behaviour change: A guide for practitioners*. London, United Kingdom: Churchill Livingstone.
- Rollnick, S., Miller, W. R., & Butler, C. (2008). *Motivational interviewing in health care: Helping patients change behavior*. New York, NY: Guilford Press.
- Stead, L. F., Buitrago, D., Preciado, N., Sanchez, G., Hartmann-Boyce, J., & Lancaster, T. (2013). Physician advice for smoking cessation. *Cochrane Database of Systematic Reviews*, *2013*(5). doi: 10.1002/14651858.CD000165.pub4
- Stockings, E., Hall, W. D., Lynskey, M., Morley, K. I., Reavley, N., Strang, J., ... Degenhardt, L. (2016). Prevention, early intervention, harm reduction, and treatment of substance use in young people. *The Lancet Psychiatry*, *3*(3), 280-296. [https://doi.org/10.1016/S2215-0366\(16\)00002-X](https://doi.org/10.1016/S2215-0366(16)00002-X)
- Webb, L., Bertoni, M., & Copeland, W. (2015). *Very brief interventions cannabis support*. Retrieved from <https://cannabissupport.com.au/workplace-and-clinical-resources/publications/bulletins/very-brief-interventions/>
- World Health Organization (WHO). (2008). *The effectiveness of a brief intervention for illicit drugs linked to the Alcohol, Smoking, and Substance Involvement Screening Test (ASSIST) in primary health care settings: A technical report of phase III findings of the WHO ASSIST randomized control trial*. Geneva, Switzerland: World Health Organization.
- Young, M. M., Stevens, A., Galipeau, J., Pirie, T., Garritty, C., Singh, K., ... Moher, D. (2014). Effectiveness of brief interventions as part of the Screening, Brief Intervention and Referral to Treatment (SBIRT) model for reducing the nonmedical use of psychoactive substances: A systematic review. *Systematic Reviews*, *3*(50). <https://doi.org/10.1186/2046-4053-3-50>

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## 31. Group work

Group work is a common and useful treatment approach in the AOD field. There are many types of groups, including support groups, task-focused and educative groups, as well as therapeutic community groups. The intricacies of group work are beyond the scope of this guide. Instead, this chapter provides an overview of the broad issues underpinning basic group work and information applicable to group work in general.

As the Center for Substance Abuse Treatment ([CSAT] 2005) noted, group work can be highly effective and has many benefits, including:

- providing peer support
- offering inspiration
- enhancing motivation
- reducing feelings of isolation and inadequacy
- providing role models – people who have overcome similar issues
- offering opportunities for clients to practise communication skills
- allowing a single treatment professional to help several clients at the same time.

Yalom and Leszcz (2005) identified ‘therapeutic factors’ leading to therapeutic change in group therapies, some of which are outlined below.

### **Instillation of hope**

The installation and maintenance of hope is crucial in both individual and group counselling. Group therapists can facilitate this therapeutic factor by generating positive expectations of the benefits of group therapy, establishing collective goals, and helping the clients to see a pathway to reach goals, including recognising the changes that other group members have made.

### **Universality**

This therapeutic factor can provide a powerful sense of relief and finds expression in the phrase “we’re all in the same boat” (Yalom & Leszcz, 2005). It is important to help the clients to see that they are not alone in experiencing AOD issues and related difficulties.

### **Imparting information**

Groups often have a focus on the development of insight through information about AOD issues and co-occurring difficulties. Even if the group is primarily a support group, a key therapeutic factor is the information shared among group members, including suggestions and guidance.

### **Altruism**

Group members often benefit from giving as well as receiving help as part of a reciprocal ‘giving–receiving sequence’ (Yalom & Leszcz, 2005). Group therapy gives clients an opportunity to be helpful to another person, which can help them to feel better about themselves. However, many clients require individual counselling in addition to group work, and this should be offered if possible. Group work should not be used to replace individual counselling.

It is important that clients are assessed adequately to ensure they are matched with the group/s best suited to their needs and wants. Some groups may require only that members be participants in a particular program. Others may require a multidisciplinary panel review of the client’s case history. For many groups, pre-group interviews and client preparation are essential (Centre for Substance Abuse Treatment, 2005). Primary placement considerations such as gender, the client’s level of interpersonal functioning (including impulse control, stability, stage of change), and the expectation for the client to succeed need to be considered (CSAT, 2005).

It is important that group members share a common goal. Conflict can arise when group members have discordant goals (e.g. 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 six and nine people is an ideal number, because this allows the larger group to be broken down into subgroups for 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 (e.g. young people in detention will require a smaller group, such as four to six members).

The gender composition of the group should also be considered. There is evidence to suggest that women who attend women-only groups have better outcomes than women who attend mixed groups (Prendergast, Messina, Hall, & Warda, 2011). It is important to consider the nature and focus of the group when determining its gender composition. For example, if sensitive issues such as sexual abuse or domestic violence are likely to be raised, single-gender groups may be more appropriate. Alternatively, mixed-gender groups may be appropriate for educational groups (e.g. relapse, problem-solving, identifying high-risk situations).

The rules of the group 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 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 other 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 occurs, 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 aside 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. Clarify that it may be useful to share personal insight and learning with significant others, but group members should only discuss their own personal experiences and not the experiences of others.

The therapeutic alliance between the counsellor and client is recognised as a significant predictor of treatment outcomes. Similarly, the alliance between group members is an extremely important component of group therapy and there is evidence to suggest that group alliance predicts AOD treatment outcomes (Gillaspay, Wright, Campbell, Stokes, & Adinoff, 2002). Encouraging group alliance and cohesion is a crucial task of group facilitators. This can be facilitated in numerous ways, including encouraging group members to work through problems together and communicate with each other. Instead of always referring to you (the facilitator) when making comments, encourage group members to communicate by talking to each other and asking questions.

### **Example**

*Fred, it sounds like you agree with Freda about how difficult it is not to relapse. Does anyone else feel like that? Why don't you all work together and talk about the strategies that each of you use to avoid relapse...*

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

Groups may experience conflict between its group members (and facilitators). This should be used as an opportunity to practise and model assertive communication skills. Indeed, if conflict is talked about openly and resolved it can be very beneficial to the group process. However, note that if group members become hostile towards each other, it is important for this to be managed, often by encouraging hostile group members to speak privately with the facilitator before problem-solving ways to alleviate their concerns.

## Stages of group development

Groups tend to go through four stages as they develop (Schneider Corey, Corey, & Corey, 2010).

1. Initial stage: group members' expectations, such as trust, roles, norms and goals, are established in this stage. Confidentiality and conflict need to be addressed. The group facilitators' roles are to teach the basic models of group process and interpersonal skills, develop goals and create structure.
2. Transition stage: group members learn how to express themselves and often test the group to determine its safety, resulting in conflict.
3. Working stage: group members commit to the group, may start to feel more comfortable and begin to work on issues at a deeper level. The facilitators' roles are to guide the group to explore issues more thoroughly as well as thoughts and feelings triggered by group interactions.
4. Final/understanding stage: the group members prepare to generalise learning to everyday life. This stage may come with feelings of sadness and separation, as well as concerns for self and others, and group members may need assistance in dealing with this. They will need an opportunity to express and deal with any unfinished business within the group. Feedback is very important at this stage, from facilitators as well as group members.

### Group work – tip sheet

Group work is an effective component of AOD treatment.

Key therapeutic factors in group therapy include:

- instillation of hope
- universality
- imparting information
- altruism.

There are many different types of groups, but the following information relates to generic therapeutic groups. Several factors can influence the success of the group:

- group members working towards a common goal
- group size –six to nine participants is optimal
- gender makeup of the group – single-gender groups may be preferred 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 the 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 any issues discussed during the group remaining confidential.

Group alliance and 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 should be seen as an opportunity to model assertive communication and conflict resolution skills. When conflict occurs, encourage direct, honest and open communication.

Groups tend to develop across four stages: initial, transition, working and the final/understanding stage.

## References

- Center for Substance Abuse Treatment (CSAT). (2005). *Substance abuse treatment: Group therapy* (Treatment Improvement Protocol (TIP) Series, No. 41). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Gillaspay, J. A., Wright, A. R., Campbell, C., Stokes, S., & Adinoff, B. (2002). Group alliance and cohesion as predictors of drug and alcohol abuse treatment outcomes. *Psychotherapy Research*, 12(2), 213-229. <http://dx.doi.org/10.1093/ptr/12.2.213>
- Prendergast, M. L., Messina, N. P., Hall, E. A., & Warda, U. S. (2011). The relative effectiveness of women-only and mixed-gender treatment for substance-abusing women. *Journal of Substance Abuse Treatment*, 40(4), 336-348. <http://dx.doi.org/10.1016/j.jsat.2010.12.001>
- Schneider Corey, M., Corey, G., & Corey, C. (2010). *Groups: process and practice* (8th ed.). Belmont, CA: Brooks/Cole.
- Yalom, I. D., & Leszcz, M. (2005). *The theory and practice of group psychotherapy* (5th ed.). New York, NY: Basic Books.

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## 32. Relaxation strategies

There is a strong association between AOD use and feelings of anxiety and stress. People often begin to use drugs to reduce these feelings. Over time these feelings become triggers for AOD use and are strongly associated with relapse.

The efficacy of relaxation training in reducing anxiety has been established (Manzoni, Pagnini, Castelnuovo, & Molinari, 2008; Pagnini, Manzoni, Castelnuovo, & Molinari, 2010). Further, relaxation training has been found to decrease cravings in people recovering from substance use disorders (Chang & Sommers, 2014) and ex-smokers (Cropley, Ussher, & Charitou, 2007). Relaxation training can therefore play an important role in a client's treatment program. Clients who suffer very 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 (e.g. flashbacks, dissociation), so when introducing relaxation strategies all clients must be given permission to halt the process if they are feeling uncomfortable. Grounding strategies (see chapter on **Grounding**) can be more useful for some traumatised clients and are recommended for traumatised clients in moments of extreme distress.

Some of the most popular relaxation techniques are described below. Their success will vary from one individual to another. The client and counsellor can work together to find acceptable and useful relaxation strategies. Relaxation training can also be delivered effectively in a group format (Manzoni et al., 2008).

### Controlled breathing

A person's breathing reflects the amount of tension carried in the body (Bourne, 2010). We tend to breathe much more shallowly and rapidly when we are tense. For example, rapid, shallow breathing is often associated with panic attacks. Breathing becomes slower and deeper when we are relaxed.

Deep or controlled breathing is the foundation of all relaxation exercises (Segal & Feliciano, 2011). Shallow breathing flexes the ribcage rather than the diaphragm. When teaching clients controlled breathing, it is important they understand and feel the difference between shallow, chest-level breathing and controlled breathing. A good way to do this is to ask clients to practise each type of breathing.

- First, encourage clients to increase the rapidity of their breathing. Ask them to place a 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 controlled breathing. 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. Reassure clients that some people 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 slowly, taking the air deeply into your lungs. If you are breathing from your abdomen you should feel your hand rise. You don't need to take a big breath, just a deep one
  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 10 slow abdominal breaths. Breathe in slowly counting to four, before exhaling to the count of four. Repeat this cycle 10 times
  6. now re-rate your level of anxiety and see if it has changed.
- Clients should be encouraged to practise this routine for 10–20 minutes per day. Controlled breathing can help to reduce overall levels of tension and provide clients with a strategy to use in anxiety-provoking or high-risk situations when they are tempted to lapse.



## Progressive muscle relaxation

Progressive muscle relaxation, originally developed by Jacobson (1938), involves tensing and relaxing different muscle groups in a step-by-step way. This technique can be particularly useful for clients who have trouble using their imagination or tend to dissociate, because 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 10 seconds (counsellors may want to count to 10 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 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 leftover 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 they should cease the exercise if they are having difficulty.

The following instructions are adapted from Gawain (1982, pp. 68-9). 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?
- what can you hear?
- what does the atmosphere smell like?
- what can you see around you?
- how does the air feel against your skin?

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

The positive effects of relaxation training on anxiety increase with the duration of the training and with the addition of homework practice (Manzoni et al., 2008).

Other forms of relaxation include meditation, yoga and exercise. Exercise is a particularly useful form of relaxation because it promotes stress relief, a sense of wellbeing and achievement as well as improved sleep. Moreover, exercise has been found to increase rates of AOD abstinence, ease withdrawal symptoms and reduce anxiety and depression (Wang et al. 2014).

Appendices 17, 18, and 19 contain worksheets for clients on controlled breathing, progressive muscle relaxation and using visual imagery to create a safe place.

## Relaxation – Tip Sheet

There is a strong association between AOD use and feelings of anxiety and stress. Various relaxation strategies can play an important role in a client's treatment program. Clients who suffer very high levels of anxiety and stress may find relaxation training particularly beneficial.

Note that clients who have experienced trauma can have unpredictable and at times negative reactions to relaxation strategies, so when introducing such strategies clients must be given permission to halt the process if feeling uncomfortable.

Grounding strategies (see chapter on **Grounding**) can be more useful for some traumatised clients and are particularly beneficial for traumatised clients in moments of extreme distress.

Some of the most popular relaxation techniques are controlled breathing, progressive muscle relaxation and creating a safe place.

Appendices 17, 18 and 19 contain worksheets for clients on these relaxation techniques.

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

## References

- Bourne, E. J. (1995). *The anxiety and phobia workbook*. Oakland, CA: New Harbinger Publications.
- Bourne, E. J. (2010). *The anxiety and phobia workbook* (5th ed.). Oakland, CA: New Harbinger Publications.
- Chang, B. H., & Sommers, E. (2014). Acupuncture and relaxation response for craving and anxiety reduction among military veterans in recovery from substance use disorder. *American Journal on Addictions*, 23(2), 129-136. doi: 10.1111/j.1521-0391.2013.12079.x
- Cropley, M., Ussher, M., & Charitou, E. (2007). Acute effects of a guided relaxation routine (body scan) on tobacco withdrawal symptoms and cravings in abstinent smokers. *Addiction*, 102(6), 989-993. doi: 10.1111/j.1360-0443.2007.01832.x
- Gawain, S. (1982). *Creative visualisation*. New York, NY: Bantam Books.
- Jacobson, E. (1938). *Progressive relaxation*. Chicago, IL: University of Chicago Press.
- Manzoni, G. M., Pagnini, F., Castelnuovo, G., & Molinari, E. (2008). Relaxation training for anxiety: A ten-years systematic review with meta-analysis. *BMC Psychiatry*, 8(41). <https://doi.org/10.1186/1471-244X-8-41>
- Pagnini, F., Manzoni, M. G., Castelnuovo, G., & Molinari, E. (2010). The efficacy of relaxation training in treating anxiety. *International Journal of Behavioral Consultation and Therapy*, 5(3-4), 264-269. <http://dx.doi.org/10.1037/h0100887>
- Segal, D., & Feliciano, L. (2011). Relaxation training. In J. S. Kreutzer, J. DeLuca, & B. Caplan (Eds.), *Encyclopedia of Clinical Neuropsychology* (pp. 2149-2150). New York, NY: Springer.
- Wang, D., Wang, Y., Wang, Y., Li, R., & Zhou, C. (2014). Impact of physical exercise on substance use disorders: a meta-analysis. *PLoS ONE*, 9(10). <https://doi.org/10.1371/journal.pone.0110728>

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## 33. Grounding

Grounding is a term that is used to refer to several different concepts. In this chapter, grounding is discussed as a therapeutic technique that guides clients to focus outward on the external world rather than inward on negative thoughts and feelings (Najavits, 2017). Grounding could be considered a type of mindfulness, as mindfulness is 'present moment awareness'; the major difference is that in grounding, the emphasis is always on the client's outer rather than their inner world. Grounding has also been referred to as distraction or healthy detachment (Najavits, 2002).

People seeking AOD treatment have high rates of trauma (Breckenridge, Salter, & Shaw, 2012; Deane, Kelly, Crowe, Coulson, & Lyons, 2013; Mills, Teesson, Ross, & Peters, 2006). Research suggests that at least 25% of AOD clients meet criteria for current PTSD (Mills, Lynskey, Teeson, Ross, & Darke, 2003). Moreover, many clients do not meet the diagnostic criteria for PTSD but experience trauma symptoms (see chapter on **Co-occurring trauma issues**).

Trauma reactions such as flashbacks, intrusive memories, panic, fear and dissociation can be prompted very easily in clients who have a trauma history, even by seemingly innocuous things such as a particular smell in the room, practising a breathing exercise, or the colour of the counsellor's jacket. It is believed that grounding is a more effective strategy than relaxation training for people who have PTSD (Najavits, 2002). Grounding strategies can be used to help traumatised clients focus their attention onto the outside world rather than inward on the traumatic memories. Grounding can also stop dissociation.

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.

When introducing grounding to a client:

- describe it as "strategies to use for extreme emotional distress which distract you from that distress and focus you outside yourself"
- ask clients whether they already use strategies that help with extreme emotional distress
- introduce the grounding handout in Appendix 20. Go through the handout with the client, asking them to note any strategies that particularly appeal to them. Counsellors and clients 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 practise a couple of strategies from the list in the counselling session. Assist them with this and ask for feedback
- ask the client to look over the list at home and add strategies that already work for them, try out some of the new strategies and highlight those that work with highlighter pen or ticks.

Clients can practise the strategies and place reminders to use them in various places (such as a note in a diary, stuck on their car's dashboard 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 practising 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, because this will encourage them to use them more often.

Counsellors should 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. Strategies that seem to work well in session are:

- having a picture of a tranquil nature scene on the wall to direct a client's attention to and asking them to describe it in great detail
- asking clients to look out the window and describe something they can see outside (such as a tree) in great detail
- 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.

A grounding handout for clients is included in Appendix 20.

## Grounding – tip sheet

Grounding is also referred to as distraction or healthy detachment (Najavits, 2002). It helps traumatised clients focus their attention onto the outside world rather than inward on the traumatic memories and can help stop dissociation.

Grounding strategies can be categorised as mental, physical, or soothing:

- 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.

A handout on grounding for clients is included at Appendix 20.

## References

- Breckenridge, J. M., Salter, M., & Shaw, E. (2012). Use and abuse: Understanding the intersections of childhood abuse, alcohol and drug use and mental health. *Mental Health and Substance Use*, 5, 314-327. doi: 10.1080/17523281.2012.703224
- Deane, F. P., Kelly, P. J., Crowe, T. P., Coulson, J. C., & Lyons, G. C. (2013). Clinical and reliable change in an Australian residential substance use program using the Addiction Severity Index. *Journal of Addictive Diseases*, 32, 194-205.
- Mills, K., Lynskey, M., Teesson, M., Ross, J., & Darke, S. (2003). *Prevalence and correlates of post traumatic stress disorder (PTSD) among people with heroin dependence: Findings from the Australian Treatment Outcome Study (NSW)*. Sydney, NSW: National Drug and Alcohol Research Centre.
- Mills, K. L., Teesson, M., Ross, J., & Peters, L. (2006). Trauma, PTSD, and substance use disorders: Findings from the Australian National Survey of Mental Health and Well-Being. *The American Journal of Psychiatry*, 163(4), 652-658. doi: 10.1176/appi.ajp.163.4.652
- Najavits, L. (2002). *Seeking safety: A treatment manual for PTSD and substance abuse*. New York, NY: The Guildford Press.
- Najavits, L. (2017). *Recovery from trauma, addiction, or both*. New York, NY: The Guildford Press.

## 34. Mindfulness

Mindfulness therapies have become popular over the past 15 years, but their origins hark back to the teachings of the Buddha over 2500 years ago. Mindfulness is a form of awareness that emerges from “paying attention on purpose, in the present moment, and non-judgementally” to ongoing experience (Williams et al., 2007). All thoughts and feelings, whether pleasant or unpleasant, are accepted as they are. Mindfulness can help clients to be less reactive to thoughts and feelings related to using and emotional distress.

Mindfulness can be practised in both formal and informal ways. Formal practice involves the systematic application of mindfulness through specific exercises such as mindfulness of breath, sitting meditation, body scan meditation or walking meditation. Informal practice involves the application of mindfulness skills to everyday situations, bringing an open, accepting and discerning attention to the activities of day-to-day living such as driving, reading or eating.

Several reviews have examined the efficacy of mindfulness interventions for AOD problems (Li, Howard, Garland, McGovern, & Lazar, 2010; Sancho et al. 2017; Zgierska et al. 2009). The most recent of these reviews (Sancho et al., 2017) found that mindfulness-based therapies were successful at reducing dependence, craving and other addiction-related symptoms by improving mood state and reducing emotional dysregulation.

### Formal mindfulness strategies<sup>19</sup>

The mindfulness techniques described below are simple tools that clients can use to become more engaged in the present and less reactive to thoughts and emotions. Some mindfulness techniques are usually done with eyes closed; however, it is important to offer clients the choice to keep their eyes open, usually by adopting a soft focus on the ground. Traumatized clients in particular can feel unsafe if they shut their eyes with other people nearby, or they can go into trauma memories or dissociate. In addition, because traumatized clients can react unpredictably, only have them try any mindfulness exercise for a very short period of time initially (a minute or so) and make sure they know they can stop the exercise at any time.

#### Mindfulness of the breath

Before introducing mindfulness of the breath, it is necessary to explain the rationale and check that the client is at ease and willing to try the exercise. Many scripts can be used to guide mindfulness of the breath exercises. The following instructions, which can also be found in Appendix 21, illustrate the key themes of mindfulness of the breath and can be modified to suit the client's needs.

1. Either close your eyes or gaze with a soft focus at the ground/your lap, whichever you prefer.
2. For the next few minutes, I'd like you to bring your attention to your breathing. Notice the air as it comes in through your nostrils... down to the bottom of your lungs...and flows back out [pause]. Follow your awareness of the sensations that you feel as the air goes in... and out [pause]. Notice how it is slightly cooler as it goes in and slightly warmer as it goes out [pause]. You may also notice the rise and fall of your chest or the expanding of your abdomen. Focus on the changing pattern of physical sensations that you find most vivid.
3. You might notice that thoughts arise and your mind wanders away from the focus on the physical sensations of breathing. Whatever the thoughts going through your mind, whether they are pleasant or unpleasant, just gently acknowledge their presence and return your attention to your breathing [pause]. Don't get caught up in your thoughts or judge them as good or bad, just allow them to come and go. You might even like to imagine putting the thoughts on a leaf and letting them float down a stream.
4. Time and time again you may notice that your attention has wandered and that you have become caught up in a train of thoughts. This is normal; it is just what our minds do. The important thing is to try not to judge your thoughts or yourself. Just gently notice where your mind has been and bring your focus back to your breath going in... and out... of your nostrils... or the rise... and fall... of your chest [pause]. Simply acknowledge the thoughts that enter your mind, let them be, and refocus on your breath [pause]. Now I'm going to leave you to try this without me talking for a minute...

<sup>19</sup> The following is adapted from Marsh et al. (2012) Chapter 13 'Mindfulness'

After about a minute, ask the client to open their eyes when they are ready. Enquire about their experience during the exercise. Some clients may express concern that they “couldn’t do it” because they were too distracted by thoughts or unpleasant sensations and emotions. If this is the case, point out that their very awareness of being distracted means that they were doing the exercise effectively (Baer, 2006). Explain that the ability to focus on the physical sensations associated with breath will take time. With this in mind, encourage the client to practise mindful breathing for several minutes each day and explore their experience of mindful breathing in future sessions. A client handout is included in Appendix 21.

## Mindfulness of emotions

Mindfulness of emotions involves experiencing emotions, as they are, without judging them or trying to get rid of them or change them. A non-judgemental acceptance of emotions can be very helpful for clients with emotional regulation difficulties. Identifying and labelling emotions is an essential part of therapy for clients with emotional regulation difficulties, and mindfulness of emotions constitutes a form of prolonged exposure that can also reduce the distress that is associated with emotions. Observing and accepting emotions, just as they are, can reduce secondary reactions to emotions, such as guilt, shame, or anger, which are often more distressing than the initial emotion (Baer, 2006). This allows clients to ‘step back from’ and simply observe their emotions with distance so that they can think and use coping strategies (Linehan, 1993).

The mindfulness of emotions skills introduced below are extensions of the core mindfulness skills outlined in mindful breathing. Before instructing clients in how to be mindful of emotions, emphasise that emotions are an inevitable part of life and that it is normal to experience painful feelings (Harris, 2009) and that avoiding or trying to get rid of unpleasant emotions will ensure that they remain powerful. It is important to discuss mindfulness of emotions with the client first and consider whether they will be able to tolerate the distress caused by observing their emotions. If the client is likely to become overwhelmed by the process, which is often the case when clients are feeling trauma-related emotions, then grounding strategies should be covered first.

The following instructions, which can be used to direct clients to observe emotions, have been adapted from various scripts (see Harris, 2009; Linehan, 1993; Spradlin, 2002). The key is to instruct clients to adopt a non-judgemental stance as they observe, describe and participate fully in the experience of an emotion.

1. Observe the emotion that you are feeling. Be attentive to it; don’t try to push it away or cling to it. Just stay in the moment and notice the emotion come and go [pause]. Stand back from the emotion and acknowledge it but don’t judge it. Put words on your emotion. Say to yourself, “I notice that I feel sadness”... or “I notice that I’m agitated”.
2. Stay in the moment and learn as much about the emotion as you can. Notice the emotion comes and goes and changes in intensity. Notice the sensations associated with the emotion [pause]. You might notice physical sensations; some may be uncomfortable. Look for the strongest sensation, perhaps the one that bothers you the most. For example, it may be a lump in your throat, flushed face, nausea, heaviness in the chest, butterflies in the stomach, hot wave, or a knot in your stomach. Notice any actions associated with the emotion, such as withdrawing, crying, or laughing. Perhaps you can also notice urges to perform an action, such as to hit, run or hug. Notice any colour, shape, sound, or temperature associated with the emotion as well as any images, thoughts and smells.
3. Just allow the emotion to be as it is. Don’t make it more or less than it is – don’t judge it. Just acknowledge its presence and gently accept it [pause]. Be aware that you are not your emotion. The part of you that observes the emotion is separate from the emotion. Think of times when you have felt different emotions from this one [pause]. Don’t automatically act on your emotion – decide whether to act or not. Take as long as you need to gently accept your emotion.

As with mindful breathing, it is important to ask clients for feedback and to encourage them to practise mindfulness of emotion when the opportunity arises. As the script suggests, an important aspect of mindfulness of emotions is observing and describing the emotion. Some clients may need help to articulate mindfulness of emotions. Providing examples of emotions and ways to articulate mindfulness of emotions may be beneficial for these clients. You can provide examples of phrases to the client. For example, *when you feel shame, you might say to yourself “I observe that I feel shame... I notice that I feel a hot wave come over my body.”* However, it is important to encourage clients to tune in to their experience of emotions and develop their own words for their emotions. A client handout is included in Appendix 22.



## Mindfulness of thoughts: cognitive defusion

The term 'cognitive defusion' is used in acceptance and commitment therapy (ACT) to describe the use of various strategies to gain distance from thoughts. The idea of cognitive defusion is 'look at' rather than 'look from' thoughts, and to adopt the viewpoint that "a thought is just a thought." That is, to be mindful of thoughts without 'buying into' them and becoming caught up in and upset by them.

Harris (2007) outlines a variety of cognitive defusion techniques, including the following:

- saying to oneself: "I'm having the thought that..."
- saying to oneself: "Thank you mind"
- saying to oneself: "There goes that thought that.... again"
- hearing thoughts in cartoon voices
- naming the story: e.g. "That's the 'I'm a loser' story"
- hearing thoughts sung to "Happy Birthday" or other tunes
- using imagery to pop thoughts onto leaves floating down a stream, or onto clouds and letting them float away.

Another defusion strategy that can work for some clients is to name that spot in the mind that keeps worrying, being self-critical, wanting to use, or whatever else causes distress. Then when the distressing thoughts arise, simply say to oneself, "Oh there goes my worry spot (or self-critical spot, using spot etc.) again." A client handout is included in Appendix 23.

## Informal mindfulness strategies

Informal mindfulness strategies are those that involve being mindful of daily activities such as having a shower, eating or going for a walk. Clients should be encouraged to aim to participate fully in the experience by focusing their attention on what is happening in the present moment. For example, being mindful while taking a shower might involve noticing the sound and feel of the water and the smell of the soap and shampoo. Explain that, just as with mindful breathing, when thoughts arise, the client should gently acknowledge them and then return their attention to the physical sensations of the shower as an anchor to the present moment. Handouts on 'Informal Mindfulness Practice' and 'Simple Ways to Get Present' can be downloaded from <https://www.actmindfully.com.au/>.

## Making up simple mindfulness strategies for clients

Germer (2005) described all mindfulness techniques as involving:

- **stopping** our activity and focusing on some aspect of our experience
- **observing** this aspect of experience, and when other thoughts, feelings and sensations arise and take our attention away from our focus, noticing these without judging
- **returning** our awareness to the original focus when we notice our attention being drawn away.

Using these principles, there are many simple mindfulness strategies that counsellors can devise for their clients – and for themselves! Some examples of such simple strategies are as follows:

- ask clients to notice and name their thoughts and feelings before they start using drugs or drinking
- ask clients to mindfully observe themselves when they use drugs or drink by noticing their thoughts, feelings and sensations as they do so
- ask clients to look out the window of your office and really notice what they can see. Encourage them to gently acknowledge thoughts, feelings and sensations that arise and divert their attention, and return their attention to observing the physical environment outside the window
- encourage clients who live near the beach to go there regularly and be mindful of the sights, sounds and smells of the ocean, again gently acknowledging the thoughts, feelings and sensations that divert their attention, and return their attention to the ocean.

## Mindfulness and cognitive behaviour therapy

Mindfulness is sometimes considered to be a form of CBT, but it is very different to cognitive restructuring as a way of dealing with difficult thoughts and feelings. Instead of challenging unhelpful thoughts as in cognitive restructuring, the idea of mindfulness is to acknowledge but not buy into unhelpful thoughts.

Some clients find that challenging problematic thoughts is useful, whereas others may find a mindfulness approach suits them better. Other clients find different strategies useful for different issues and at different times. For example, a client might challenge thoughts initially, and then use cognitive defusion to avoid buying into them from then on. As an example of how a client might use the two approaches at different times, consider an anxious client who drinks excessively. He might challenge his drinking thoughts to prevent relapse, but use a mindfulness approach to his anxiety-provoking thoughts, as illustrated below.

His drinking thoughts might be “I need to drink now because I’m anxious and can’t calm down any other way.” He might challenge these by evaluating how true they are:

*In fact I have calmed myself down recently by doing something calming. Yesterday I managed by doing some gardening. This took my mind off my anxiety and calmed me down. I could also go for a walk which I did last week. I can do those things again to calm myself so I won’t need to drink.*

His anxiety-provoking thoughts might be “I can’t talk to people because they’ll think I’m boring.” A mindfulness approach could entail noticing the thoughts but not buying into them by using some defusion techniques such as saying to himself: “There go those anxious thoughts again,” “I’m noticing that I’m thinking about how people are judging me again,” “Thank you mind,” or “There goes my anxious spot again.” He would then refocus his attention on the conversation – what the other person is saying and his responses – rather than becoming caught up in his anxiety about being seen as boring.

### Mindfulness – tip sheet

Mindfulness is a form of awareness that emerges from paying attention to the present moment on purpose and non-judgementally. It usually entails focusing on the physical sensations or five senses rather than thoughts, as in breath meditation or informal mindfulness. When thoughts intrude, they should be observed and accepted without reflecting on their implications or trying to change them. Cognitive defusion takes this a step further and involves strategies to help clients create distance from their thoughts. This can help clients become less reactive to thoughts and emotions.

Mindfulness may not be suitable for trauma-related thoughts, feelings and distress that are overwhelming for the client; use grounding strategies instead (see chapter on **Grounding**).

#### Introducing mindfulness exercises

Discuss the concept of mindfulness and explain the rationale. Offer clients the option of engaging in the exercises with their eyes closed or with their eyes open and softly focused on the floor or their lap. This is particularly important for traumatised clients, who can become frightened, go into a trauma reaction, or dissociate when they do exercises in session with their eyes closed.

**Mindfulness of the breath** provides a good foundation for the practice of mindfulness and involves bringing attention to the physical sensations associated with breathing.

**Mindfulness of emotions** can be helpful for clients with emotional regulation difficulties and involves adopting a non-judgemental stance while observing, describing and participating fully in the experience of an emotion. Note: if a client is likely to become overwhelmed by focussing on an emotion, use grounding strategies.

**Mindfulness of thoughts** is referred to as ‘cognitive defusion’ and can help clients to gain distance from thoughts so that they can look at rather than look from thoughts. Simple cognitive defusion techniques include saying to oneself “I’m having the thought that...” and “Thank you mind.”

## Key themes of mindfulness strategies

Using the key principles of mindfulness, counsellors can modify scripts and devise mindfulness strategies to suit the client's needs. All mindfulness techniques involve:

- stopping to focus on some aspect of our experience
- observing this aspect of experience and noticing, without judging, when other thoughts, feelings and sensations arise
- returning our awareness to the original focus when we notice our attention being drawn away.

## Mindfulness and cognitive behaviour therapy

In contrast to the cognitive challenging approach of CBT, the idea of mindfulness is to simply acknowledge thoughts without getting caught up in them or challenging them. It is important to explore with the client the extent to which mindfulness strategies may be helpful for them. Some clients find that challenging problematic thoughts is more useful, whereas others find a mindfulness approach suits them. Others find different strategies useful for different issues and at different times.

Client handouts are included in Appendix 21, 22 and 23.

For further information and resources on mindfulness, refer to Harris's book *ACT made simple* (2009) or <https://www.actmindfully.com.au/>

## References

- Baer, R. A. (Ed.). (2006). *Mindfulness-based treatment approaches. Clinician's guide to evidence base and application*. Burlington, MA: Academic Press.
- Germer, C. (2005). Teaching mindfulness in therapy. In C. Germer, R. Siegel, & P. Fulton (Eds.), *Mindfulness and psychotherapy*. New York, NY: The Guildford Press
- Harris, R. (2007). *The happiness trap*. Auckland, New Zealand: Exisle Publishing Ltd.
- Harris, R. (2009). *ACT made simple*. Oakland, CA: New Harbinger Publications.
- Li, W., Howard, M. O., Garland, E. L., McGovern, P., & Lazar, M. (2017). Mindfulness treatment for substance misuse: A systematic review and meta-analysis. *Journal of Substance Abuse Treatment; 75*, 62-96. doi: 10.1016/j.jsat.2017.01.008.
- Linehan, M. (1993). *Skills training manual for treating borderline personality disorder*. New York, NY: The Guildford Press.
- Marsh, A., Towers, T., & O'Toole, S. (2012). *Trauma-informed treatment guide for working with women with alcohol and other drug issues*. Perth, WA: Women's Health and Family Services.
- Sancho, M., DeGracia, M., Rodriguez, R. C., Mallorqui-Bague, N., Sanches-Gonzalez, J., Trujols, J... Menchon, J. M. (2018). Mindfulness-based interventions for the treatment of substance and behavioural addictions: A systematic review. *Frontiers in Psychiatry, 9*(95), 1-9. doi: 10.3389/fpsy.2018.00095
- Spradlin, S. E. (2002). *Don't let your emotions run your life. How dialectical behavior therapy can put you in control*. Oakland, CA: New Harbinger Publications.
- Williams, M., Teasdale, J., Segal, Z., & Kabat-Zinn, J. (2007). *The mindful way through depression*. New York, NY: The Guildford Press.
- Zgierska, A., Rabago, D., Chawla, N., Kushner, K., Koehler, R. & Marlatt, A. (2009). Mindfulness meditation for substance use disorders: A systematic review. *Substance Abuse; 30*(4), 266-294. doi: 10.1080/08897070903250019

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## 35. Challenging unhelpful thinking

Cognitive restructuring (challenging unhelpful thinking) is based on the idea that our behaviours and feelings are a result of our unconscious or automatic thoughts. In turn, our thoughts are related to our deeply held beliefs about ourselves, others and the world, also termed 'schemas' (core beliefs). While experiencing unhelpful automatic thoughts is very common in the general population, people with anxiety, depression, trauma and other psychological difficulties can experience these unhelpful automatic thoughts more intensely and often (Williams & Garland, 2002). When these unhelpful automatic thoughts occur frequently, almost becoming a default response, they can be considered unhelpful thinking styles.

Cognitive restructuring is a CBT technique based on the premise that changing unhelpful thinking can change clients' emotions and behaviours (Larsson, Hooper, Osborne, Bennett, & McHugh, 2016). It involves clients identifying and then challenging automatic thoughts and the underlying core beliefs that result in negative feelings and unhelpful behaviours. As automatic thoughts are challenged and disputed using cognitive restructuring exercises, their ability to cause negative feelings and unhelpful behaviours is weakened.

The benefit of cognitive restructuring is that as well as reducing the frequency and intensity of unhelpful thinking, clients can learn to distance themselves from their thoughts and view thoughts as "psychological events" (Larsson et al., 2016, p. 453).

### Unhelpful thinking styles

Some common unhelpful thinking styles are listed below (Nathan, Correia, & Lim, 2004). There are some overlaps between different thinking styles.

#### **Mental filter**

Interpreting events based on what has happened in the past.

*I can't trust men, they only let you down.*

#### **'All or none' or 'black and white' thinking**

*If I fail one test it means I am a total failure.*

#### **Overgeneralisation**

Expecting that just because something has failed it always will.

*I tried to give up alcohol once before and relapsed. I will never be able to give up.*

#### **Jumping to conclusions**

Consistently jumping to incorrect negative conclusions, including "mind reading" and "predictive thinking". Mind reading assumes a conclusion based on the idea we know what people are thinking. Predictive thinking occurs when negative conclusions are drawn about what will happen in the future.

*I know that exam is going to be awful and I'll probably fail.*

#### **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.*

#### **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.*

## **Should, must and ought**

Living in the world of the “should”, “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.*

## **Labelling**

Global statements about ourselves or others which are based on behaviour in a specific situation.

*I tried to give up alcohol once before and relapsed. I will never be able to give up.*

## **Emotional reasoning**

When views of a situation, oneself or others are based on the way a person is feeling at the time. This confuses feelings for facts.

*I feel like a failure, so therefore I am a failure.*

## **Magnification and minimisation**

Minimisation is when positive things happen; people discount them and insist that they don't count. At the same time, positive attributes of others are magnified.

*I avoided using drugs because I didn't run into any of my using mates.*

(Beck, 1976; Beck, Rush, Shaw, & Emery, 1979; Marel et al., 2016; Nathan et al., 2004; Williams & Garland, 2002)

A handout for clients listing common unhelpful thinking styles is included in Appendix 24.

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

## **Don't think exercise**

- Explain to the client 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 that you are going to ask the client to do an exercise in which they are to stop thinking for one minute. Ask your client not to think at all for one minute.
- Time one minute.
- Ask your client if they managed to stop thinking (it is more than likely that they spent that minute thinking about not thinking).
- Next, give the client some examples of people feeling differently in response to exactly the same event (see example below).

## **Example**

*Sally had been abstinent for approximately three months. One night she goes out with friends and they decide to get some drugs. Sally has had a bit to drink and decides to use drugs as well. She does use and enjoys herself thoroughly. The next morning, she wakes up and remembers that she used drugs 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 abstinent.*

*Like Sally, John has been abstinent for approximately three months. One night he also goes out with friends who decide to get some drugs. John has been drinking and decides to use drugs too. 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 a junkie again. “Once a junkie, always a junkie,” or so John thinks. As a result, John feels depressed, disappointed and a failure. John returns to using drugs.*

These examples show how our interpretation of events greatly influences how we feel about them. Counsellors should be careful to avoid implying to clients that their interpretations are wrong, as this can be shaming and invalidating. Instead clients should be assisted to examine why they interpret events as they do, and to evaluate how accurate their interpretations are. Events will often be distressing regardless of the client's interpretation, but some interpretations can make them more distressing. For example, a sexual assault will be distressing whatever way a client views it, but when the client blames themselves rather than the person who assaulted them, they can feel more distressed because of self-blame, shame and guilt.

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 (your own and your clients') in order to demonstrate how it works.

## **The ABCDE model**

The ABCDE model of explaining the connections between events, thoughts, emotions, cognitions and behaviours stemmed from Rational–Emotive Behavior Therapy (Ellis, 1962). It provides a framework for step-by-step evaluation of clients' reactions to their environment (Field, Beeson, & Jones, 2015).

### **A: Antecedent event**

This is the event that triggers our automatic thoughts and resulting feelings. It can be situational, interpersonal or internal (e.g. thinking about a past experience, or a body sensation that reminds one of a past experience). Examples of antecedent event are a friend offering drugs, 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 automatic thoughts, or what we say to ourselves. These automatic thoughts might be related to the situation, for example: "I can't turn down free drugs." They can also be related to core beliefs we have about ourselves or other people. For example, "I am stupid, I am a failure, I am worthless, people are not to be trusted and other people are out to hurt me."

Counsellors should help clients explore why they interpret things the way they do, which often entails exploring how messages internalised from negative early childhood experiences still influence the client's beliefs and interpretations in adulthood.

### **C: Consequences**

What we do or how we feel as a result of what we are saying to ourselves. For example, using drugs, getting into a fight, feeling irritable, depressed or 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 and also 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 only used a small amount of drugs because I was out with my mates and had too much to drink."

Another important step, suggested by the examples of John and Sally given earlier, is to move on. This can be referred to as F – Forging ahead.



## F: Forging ahead

Once the issue is resolved, it is important to move on rather than go back over the situation time and time again. Note: cognitive defusion<sup>20</sup> exercises, which are described in the chapter on **Mindfulness**, can assist with moving on.

During counselling sessions, help clients to use the model to think through situations of their own before suggesting that the client practise challenging their thoughts out of session. Appendix 24 contains a client handout sheet listing common unhelpful thinking styles, which clients can use as a basis for identifying their own unhelpful thinking styles.

A worksheet for clients on the ABCDE model is also available in Appendix 25.

It is important that counsellors follow up this work by 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 inquire, the more clients will challenge their own beliefs independently. Counsellors should also continually encourage clients to take step F – Forging ahead.

## Considerations for cognitive restructuring

Cognitive restructuring will not suit every client, for example, clients who have a significant CI such as alcohol-related brain injury. Clients with alexithymia<sup>21</sup> may struggle to identify the feelings associated with their unhelpful thinking styles.

Some clients are unable to identify either external or internal triggering events, or lack the capacity to have insight into their thoughts and emotions. When clients are experiencing immediate threat or distress, they may be unable to stop and think before responding to an activating event. This can be especially true of clients who have experienced trauma or who have difficulties with impulse control. Clients who struggle to intervene in their reactions to events may feel powerless (Field et al., 2015).

The Centre for Clinical Interventions has a range of resources available for clients and counsellors on CBT strategies, available via the Centre's website – <http://www.cci.health.wa.gov.au/>.

<sup>20</sup> Cognitive defusion is the process of stepping back from one's thoughts and viewing them rather than engaging with them.

<sup>21</sup> Alexithymia is difficulty identifying feelings and distinguishing between feelings and the bodily sensations of emotional arousal. It includes difficulty describing feelings to other people; constricted imaginal processes, as evidenced by a lack of fantasies; and a stimulus-bound, externally oriented cognitive style (Lumley, Neely, & Burger, 2007).

## Challenging unhelpful thinking – tip sheet

Cognitive restructuring is based on the idea that our behaviours and feelings are a result of our automatic thoughts, which in turn are related to our core beliefs about ourselves, others and the world.

While experiencing unhelpful automatic thoughts is very common in the general population, people with anxiety, depression, trauma histories and other psychological difficulties can experience these thoughts more intensely and often. Automatic thoughts are often based on unhelpful thinking styles.

Cognitive restructuring involves teaching clients to notice their automatic thoughts, examine the basis for them and replace them with evidence-based thoughts. It is useful to teach clients the ABCDE model of thinking because it provides a framework for understanding the relationship between events, thoughts, emotions, cognitions and behaviours.

### ABCDE model

This model provides a framework for a step-by-step examination of clients' reactions to situations.

- A** Antecedent event – the event that triggers our automatic thoughts and resulting feelings.
- B** Beliefs about the event – the automatic thoughts we have that might be related directly to the event or to our core beliefs about ourselves or other people.
- 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 them.
- E** Alternative explanation – rational alternative thoughts.

Once the issue is resolved, move on rather than continuing to review it and beat oneself up about it. Cognitive defusion (see chapter on **Mindfulness**) can help with this.

Practise using this model during sessions until the client feels confident with it. Then encourage the client to practise challenging thoughts out of session. It is helpful for the counsellor to review the out-of-session practice with the client.

Appendix 24 contains a handout listing unhelpful thinking styles. Appendix 25 includes a client handout for challenging automatic thoughts using the ABCDE model.

## References

- Beck, A. T. (1976). *Cognitive therapy and the emotional disorders*. New York, NY: Meridian.
- Beck, A. T., Rush, A. J., Shaw, B. F., & Emery, G. (1979). *Cognitive therapy of depression*. New York, NY: Guilford.
- Ellis, A. (1962). *Reason and emotion in psychotherapy*. Oxford, United Kingdom: Lyle Stuart.
- Field, T. A., Beeson, E. T., & Jones, L. K. (2015). The new ABCs: A practitioner's guide to neuroscience-informed cognitive-behavior therapy. *Journal of Mental Health Counseling, 37*(3), 206-220. doi: 10.17744/1040-2861-37.3.206
- Larsson, A., Hooper, N., Osborne, L. A., Bennett, P., & McHugh, L. (2016). Using brief cognitive restructuring and cognitive defusion techniques to cope with negative thoughts. *Behavior Modification, 40*(3), 452-482. doi: 10.1177/0145445515621488
- Lumley, M., Neely, L. C., & Burger, A. J. (2007). The assessment of alexithymia in medical settings: Implications for understanding and treating health problems. *Journal of Personality Assessment, 89*(3), 230-246. doi: 10.1080/00223890701629698
- Marel, C., Mills, K. L., Kingston, R., Gournay, K., Deady, M., Kay-Lambkin, F., Baker, A., & Teesson, M. (2016). *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*. Retrieved from <https://comorbidityguidelines.org.au/>
- Nathan, P., Correia, H., & Lim, L. (2004). *Panic stations! Coping with panic attacks*. Perth, WA: Centre for Clinical Interventions.
- Williams, C., & Garland, A. (2002). Identifying and challenging unhelpful thinking. *Advances in Psychiatric Treatment, 8*(5), 377-386. doi: 10.1192/apt.8.5.377

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## 36. Anger management

Many clients who use AODs experience difficulties related to managing anger (Walitzer, Deffenbacher, & Shyhalla, 2015). Novaco (2016) stated:

*Anger is a normal and adaptive human emotion. Anger is an affective (mood or feelings) response to survival threats or otherwise stressful experiences. It is a primary emotion having adaptive functions linked to survival mechanisms that are biological, psychological, and social in nature. (p. 285)*

Anger may become problematic when it occurs frequently, at high intensity, and leads to secondary problems (DiGiuseppe & Tafrate, 2007). These secondary problems can include aggressive behaviour (including family and domestic violence), risk-taking, self-harm, health problems, and high levels of stress and/or psychological distress (Scanlan, Parker, & Montague, 2016). It can cause significant personal distress, such as feeling out of control, guilty and ashamed (Deffenbacher, 2011). Problematic anger, and associated behaviours, can also lead to negative consequences such as strained relationships, difficulties in the workplace and legal issues. In addition, problematic anger is associated with increased AOD problems, problem gambling, self-harm and suicidal ideation. Research also shows that it is associated with depressive and anxiety disorders (Scanlan et al., 2016).

Anger is a highly stigmatised emotion and myths about anger can make it harder for clients to seek help for anger-related problems (Scanlan et al., 2016). Anger is often confused with aggression, but aggression is a behaviour that is intended to cause harm through threats, verbal abuse or violent acts. Anger is an emotion which does not automatically lead to aggression (Reilly & Shopshire, 2013).

Problematic anger is often linked to previous experiences that have left people feeling powerless, lacking in self-worth, or threatened by others (Novaco, 2016). Problematic anger is included in the diagnostic criteria of numerous psychological disorders, including some personality disorders, depressive and anxiety disorders (American Psychiatric Association, 2013). Problematic anger is commonly part of a more complex clinical presentation, and clients presenting with it should undergo a comprehensive clinical assessment.

Not all clients will be motivated to manage their anger and client readiness has a major impact on the effectiveness of an anger management intervention (Howells & Day, 2003). Anger management strategies should not be incorporated into treatment until the client starts to consider the management of their anger a desirable goal. MI can be a very useful technique for clients who demonstrate ambivalence about their anger management.

It is important to normalise the client's experience of anger, which is a common and often appropriate, understandable emotional reaction. This can reduce the client's sense of shame about their anger. It can encourage them to discuss the intensity and frequency with which they experience problematic anger and any inappropriate behaviours that have occurred. It is also important to distinguish between the feeling of anger and how this is expressed (Scanlan et al., 2016). The client's difficulties with problematic anger can be framed in terms of the way it is expressed (e.g. violence, aggression) and what triggers it (e.g. misinterpretations of situations). Learning how to express anger in a healthy way with skills such as assertiveness and problem-solving may be protective against depression and anxiety (Scanlan et al., 2016).

### The role of impulse control

There is growing knowledge in the field of AOD about the effects of AOD use on impulse control and its relationship to problematic anger (Atmaca, 2014). Impulse control issues and conduct disorders manifest in behaviours that violate the rights of others or that bring the individual into significant conflict with societal norms or authority figures (American Psychiatric Association, 2013). More specifically, stimulant use disorder and harmful use of other substances such as alcohol are strongly associated with impulsive behaviours and deficits in executive functioning, behavioural and emotional regulation. These deficits can contribute to aggression or associated social problems (Parrott, Swartout, Eckhardt, & Subramani, 2017; Salo, Ursu, Buonocore, Leamon, & Carter, 2009).

Impulsive behaviour, while perhaps exacerbated by substance use, is also suggested to be derived from genetic susceptibility that predicts vulnerability for compulsive drug taking (Belin, Belin-Rauscent, Everitt, & Dalley, 2015), as well as altered brain processes that create a higher likelihood of relapse after a course of treatment (Everitt, 2014).

## The role of trauma in problematic anger

Rasche et al (2016) suggest that traumatic experiences might be a risk factor for the development of problematic anger. This research also suggests that PTSD, depression, altered impulsivity and emotional dysregulation, and substance use to cope with these issues, seem to have a relationship with problematic anger.

Previous life experiences play a significant role in problematic anger, as does the client's current environment. Clients' histories of trauma may trigger an anger response, resulting in aggressive behaviours with little cognitive awareness or sense of control. When working with clients it is important to be trauma informed to ensure worker and client safety.

## Anger management steps

Anger management can be undertaken in a group or one-on-one setting (for information on anger management groups, refer to Reilly & Shopshire, 2013).

In a one-on-one setting, offer psychoeducation on anger and its functional aspects to normalise it. Cognitive behavioural strategies have been shown to be moderately effective in the management of problematic anger. In anger management, an episode of anger can be seen as consisting of three phases: escalation, explosion and post-explosion. The idea of anger management is to teach clients how to recognise triggers, identify anger cues, and develop strategies to prevent them reaching the explosion phase of the anger cycle (Reilly & Shopshire, 2013).

### Step 1: Recognition

Clients often don't recognise anger cues or signs until their anger has escalated to an explosive or problematic level. Anger cues can be emotional, behavioural, physical or cognitive. Assisting clients to recognise the signs that they are experiencing anger can be very useful. The following is a list of some of the cues commonly associated with anger.

#### *Physical cues:*

- hot or flushed face
- anxiety
- tight or painful stomach
- increased heart rate
- shaking
- eye tension or twitching
- dry mouth or throat, voice quivering
- butterflies in the stomach, nauseous
- shallow, rapid breathing.

#### *Behavioural cues:*

- clenched fists
- grinding teeth, clenched jaw
- pacing
- slamming doors.

#### *Emotional cues:*

- feeling abandoned
- fear
- jealousy
- feeling disrespected.

#### *Cognitive cues:*

- thoughts that occur in response to the anger-provoking event
- self-talk
- images of revenge or aggression.

## Step 2: Identify triggers

It is important to assist clients to recognise the triggers associated with problematic anger. An effective way of doing this is to ask them to investigate and monitor their anger for up to a week. This will involve identifying triggers, noticing cues (see Step 1) and rating how angry they felt with each event on a 1–10 scale (with 1 being not angry at all, and 10 being enraged). A written record is desirable, but a mental record will suffice.

Identifying triggers entails noticing and exploring high-risk situations (see chapter on **Relapse prevention and management**) and identifying anger-provoking situations; these can include people, places, thoughts and emotions. Clients should also be encouraged to examine the effects of AOD use on problematic anger.

Triggers may be related to longstanding issues, including traumatic events, which are a continued point of sensitivity or 'red flags', often from childhood. An example is feeling they are being treated like when they were humiliated as a child. Other triggers may be related to experiences in the present, such as being made to wait for an appointment. Alternatively, triggers may be related to remembering an event in their past, for example, remembering an argument with a partner (Reilly & Shopshire, 2013).

When reviewing the client's monitoring of anger triggers and cues, ask them to describe one situation that caused them to reach highest on the 1–10 anger scale. Explore the cues and triggers with the client, breaking the cues down into each of the four categories (emotional, behavioural, physical or cognitive). This will help the client to more clearly identify their cues and triggers.

## Step 3: Learn strategies and develop an anger control plan

Once clients begin to recognise anger triggers and cues, and associated high-risk situations, several strategies 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. In addition, anger can escalate due to the client's perceived inability to cope (Deffenbacher, 2011), so the following strategies can increase their sense of self-efficacy.

Developing an anger control plan involves the client trying the strategies outlined below to see which of them helps them to control their anger most effectively. Once they have identified the strategies that work for them, they can apply them to the anger cues they experience. Writing these into a formal anger control plan with the client can be helpful in assisting them to solidify a set of helpful strategies in response to anger cues and triggers (Reilly & Shopshire, 2013).

For example, the client's triggering event is being made to wait for an appointment resulting in physical anger cues – shallow breathing and racing heart. The client finds the strategy of controlled breathing helpful in reducing their heart rate and deepening their breathing. The emotional cue in this situation is feeling disrespected, and challenging unhelpful thoughts is the strategy the client finds most helpful in managing this cue. The client's anger control plan is a list of helpful strategies that they can apply in response to different anger cues. Identifying which strategies can prevent them from reaching a 10 on the anger scale (the explosion stage) will assist them to avoid the negative consequences of the post-explosion stage (Reilly & Shopshire, 2013).

### *Controlled breathing*

As anger levels increase, breathing tends to become more rapid and shallow. The controlled breathing technique (see chapter on **Relaxation strategies**) can be an effective means of reducing immediate levels of tension.

### *Backwards counting*

Using mindfulness strategies (see chapter on **Mindfulness**), such as silently counting backwards from 20 to 1 at an even pace, can provide time for some of the anger to dissipate and to think of a rational response to the situation.

### *Grounding*

Other people may find naming items in a room or colours around them can assist in grounding them and thus reducing some of the negative thoughts or feeling they are experiencing (see chapter on **Grounding**).

### *Pleasant imagery*

If anger is not too intense, imagining a peaceful and pleasant scene can be calming. This can be difficult when high levels of anger are being experienced.

### *Time out*

If intense problematic anger is experienced during interpersonal conflict, the time out technique can be imperative. This is particularly important if the anger is associated with aggressive behaviours, such as violence and property damage. Explain to the client that when they notice their anger is getting out of control it is important to leave the situation, perhaps by going for a walk, so that physiological arousal can be reduced. If the client is in a relationship, they can agree with their partner ahead of time that when either party is becoming angry or fearful, they will signal that they require time out but that they will return to discuss the situation once they have calmed. It is important the contract to consistently return to continue the conversation (when calm) is upheld.

### **Step 4: Identify and challenge anger-inducing thoughts**

Explore links between thoughts and problematic anger outbursts. Focus on the interpretation of the situation, rather than the situation itself. Intense anger often follows appraisals of events as intentional, preventable, unjust and blameworthy (Deffenbacher, 2011), so consider these themes in reviewing the client's thoughts. Once the thoughts that result in problematic anger outbursts have been examined, they can be challenged in terms of their accuracy and validity given the situation (see chapter on ***Challenging unhelpful thinking***).

### **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 anger, it is necessary to help them find ways of expressing their anger (e.g. vigorous exercise) 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 (see chapter on ***Problem-solving***).

Clients with problematic anger usually need to discover ways to express their needs and perspectives appropriately. Assertiveness refers to an ability to express one's feelings, wants or opinions comfortably without denying the rights of others and without being hostile or rude (Speed, Goldstein, & Goldfried, 2018). For tips on assertiveness training, see chapter on ***Assertiveness strategies***.

### **Step 6: Relapse prevention and management**

The process of preventing return to the problematic expression of anger and effectively managing situations in which this occurs is similar to the process of relapse prevention and management used to address drug use (see chapter on ***Relapse prevention and management***).

The above steps should be effective in reducing problematic anger and helping clients gain a sense of control. However, counsellors need to remain mindful that while anger management strategies will be sufficient for some clients, others may require help to deal with the underlying issues driving their anger.

## Anger management – tip sheet

- controlled breathing
- backwards counting – counting backwards from 20 to 1
- grounding
- pleasant imagery – imagine a peaceful and pleasant scene if not too intensely angry
- time out technique for situations of interpersonal conflict.

**Step 4:** Identify and challenge problematic anger-producing thoughts; use the cognitive restructuring techniques discussed in the chapter on ***Challenging unhelpful thinking***.

**Step 5:** Find alternative ways to express anger that the client finds useful (e.g. physical exercise). See the chapters on ***Problem-solving*** and ***Assertiveness training***.

**Step 6:** Consider ways of preventing and managing relapse to problematic expression of anger.



## References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- Atmaca, M. (2014). Drug-induced impulse control disorders: A review. *Current Clinical Pharmacology*, 9(1), 70–74. doi: 10.2174/1574884708666131111202954
- Belin, D., Belin-Rauscent, A., Everitt, B., & Dalley, J. (2015). In search of predictive endophenotypes in addiction: Insights from preclinical research. *Genes Brain Behaviour*, 15(1), 74–88. doi: 10.1111/gbb.12265
- Deffenbacher, J. (2011). Cognitive-behavioral conceptualization and treatment of anger. *Cognitive and Behavioral Practice*, 18, 212–221. <https://doi.org/10.1016/j.cbpra.2009.12.004>
- DiGiuseppe, R., & Tafrate, R. C. (2007). *Understanding anger disorders*. New York, NY: Oxford University Press.
- Everitt, B. (2014). Neural and psychological mechanisms underlying compulsive drug seeking habits and drug memories—indications for novel treatments of addiction. *European Journal of Neuroscience*, 40(1), 2163–2182. doi: 10.1111/ejn.12644
- Howells, K., & Day, A. (2003). Readiness for anger management: Clinical and theoretical issues. *Clinical Psychology Review*, 23, 319–337. [https://doi.org/10.1016/S0272-7358\(02\)00228-3](https://doi.org/10.1016/S0272-7358(02)00228-3)
- Novaco, R. W. (2016). Anger. In G. Fink (Ed.), *Stress: Concepts, cognition, emotion, and behavior* (Handbook in Stress Series, Volume 1, pp 285-292). Retrieved from [https://www.researchgate.net/publication/317026245\\_Stress\\_Concepts\\_Cognition\\_Emotion\\_and\\_Behavior\\_Handbook\\_of\\_Stress](https://www.researchgate.net/publication/317026245_Stress_Concepts_Cognition_Emotion_and_Behavior_Handbook_of_Stress)
- Parrott, D. J., Swartout, K. M., Eckhardt, C. I., & Subramani, O. S. (2017). Deconstructing the associations between executive functioning, problematic alcohol use and intimate partner aggression: A dyadic analysis. *Drug and Alcohol Review*, 36(1), 88-96. doi: 10.1111/dar.12454
- Rasche, K., Dudeck, M., Otte, S., Klingner, S., Vasic, N., & Streb, J. (2016). Factors influencing the pathway from trauma to aggression: A current review of behavioral studies. *Neurology, Psychiatry and Brain Research*, 22(2), 75-80. <https://doi.org/10.1016/j.npbr.2016.01.009>
- Reilly, P. M. & Shopshire, M. S. (2013). *Anger management for substance abuse and mental health clients: A cognitive behavioral therapy manual*. HHS Pub. No. (SMA) 13-4213. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Salo, R., Ursu, S., Buonocore, M., Leamon, M., & Carter, C. (2009). Impaired prefrontal cortical function and disrupted adaptive cognitive control in methamphetamine abusers: A functional magnetic resonance imaging study. *Biological Psychiatry*, 65(8), 706–709. doi: 10.1016/j.biopsych.2008.11.026
- Scanlan, F., Parker, A., & Montague, A. (2016). *Evidence summary: Understanding and assessing anger-related difficulties in young people – a guide for clinicians*. Retrieved from <https://headspace.org.au/assets/Uploads/OR17177-EvidenceSummary-Anger-WEB.pdf>
- Speed, C., Goldstein, B., & Goldfried, M. (2018). Assertiveness training: A forgotten evidence-based treatment. *Clinical Psychology: Science and Practice*, 25, 1-20. <https://doi.org/10.1111/cpsp.12216>
- Walitzer, K. S., Deffenbacher, J. L., & Shyhalla, K. (2015). Alcohol-adapted anger management treatment: A randomized controlled trial of an innovative therapy for alcohol dependence. *Journal of Substance Abuse Treatment*, 59, 83–93. doi: 10.1016/j.jsat.2015.08.003

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## 37. Assertiveness training

There is evidence of a relationship between low assertiveness and social phobia (Chambless, Hunter, & Jackson, 1982), general anxiety (Orenstein, Orenstein, & Carr, 1975), and substance abuse relapse (Marlatt & Gordon, 1980). Meanwhile, there is evidence that assertiveness training can increase self-esteem (Temple & Robson, 1991) and reduce harmful drinking (Connors & Walitzer, 2001) and drug use (Horan & Williams, 1982; Williams, Hadden, & Marcavage, 1983). Assertiveness training can be helpful for clients, particularly those who tend to communicate in an overly passive or aggressive manner.

### Steps in assertiveness training

#### 1. Define aggressive, passive and assertive communication

The first step in assertiveness training is explaining to clients the difference between aggressive, passive and assertive communication (McKay, Davis, & Fanning, 2009). An example explanation is below.

People who communicate in a passive manner tend not to express their feelings, thoughts and wants. If you communicate passively you may believe that your needs come second to the needs of others and you may have difficulty making requests and refusals.

People who communicate in an aggressive manner are capable of expressing their rights. However, they often do so at the expense of others' rights and feelings. If you tend to be aggressive you may find yourself 'on the attack' if things do not go your way.

Assertive communication involves directly expressing your feelings, thoughts and wants while being respectful of the rights and feelings of others. If you communicate in an assertive manner, you can stand up for your rights, make requests and refusals and deal with criticism without becoming hostile.

#### 2. Discuss advantages of assertiveness

Clients need to understand the advantages of assertive communication. For clients who have difficulty managing anger, assertive communication skills can help them to express an opinion without becoming angry and suffering the negative consequences of an anger outburst. For clients who tend to be submissive to others, assertiveness can help them to stand up for themselves and their rights. Explore the client's perceptions of the personal benefits of learning to communicate assertively. It may be useful to develop 'assertiveness goals' and clarify specific situations or relationships in which they would like to be more assertive (McKay et al., 2009).

#### 3. Discuss beliefs about assertiveness

Spend some time discussing the client's beliefs about assertiveness (Jarvis, Tebbutt, Mattick, & Shand, 2005). They may subscribe to beliefs such as "it is selfish to put your own needs before others" or "people don't want to hear how I feel." This will provide insight into why the client may have difficulty communicating assertively. These sorts of beliefs are often linked to experiences (often adverse) in childhood or previous relationships and can take time to work through.

It is also important to address common misconceptions about assertiveness. For example, some clients believe that they should be assertive in all situations, but learning assertive communication does not mean that you have to be assertive at all times (McKay et al., 2009). There are times when it would be appropriate to communicate in an aggressive manner – for example, if your life was threatened (McKay et al., 2009).

## 4. Introduce assertive rights

It can be useful to explain the difference between passive, aggressive and assertive communication with reference to the impact of the communication on the client's rights and the rights of others. Aggressive communication violates the rights of others, whereas passive communication violates the client's own rights. Being assertive respects the rights of the client and other people. During assertiveness training it is important that clients start to think more assertively and have an understanding of their rights as human beings and the rights of others.

Jarvis et al. (2005) provided a Bill of Assertive 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 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.

It is useful to adapt this list to your client's situation (Jarvis et al., 2005). Note: the Bill of Assertive Rights list is included as a client handout in Appendix 26.

An important part of such rights is that they come with responsibilities (Michel, 2008). For example, the right to express feelings and opinions should be accompanied by taking responsibility for the consequences of the expression of these feelings. Sometimes people think they are being assertive, but ignoring the consequences of their actions for others may be aggressive rather than assertive.

## 5. Assertive communication skills

Clients may benefit from learning assertive communication skills. These skills can help clients to explain to people how their actions make them feel without attributing blame. Basic assertive communication skills include using 'observer' comments: commenting on the behaviour or situation objectively and stating the facts. It is also useful to explain how to communicate using 'I-statements', which often involve self-disclosure of feelings, instead of 'You-statements', which tend to attribute blame (McKay et al., 2009).

### Examples:

- *You make me so angry!* (You-statement without commenting on the behaviour)
- *I feel angry when you're late to pick me up from work* (I-statement and observer comment)

It is also important to explain that prefacing a sentence with "I feel" does not guarantee that you're expressing a feeling (e.g. I feel that you're so selfish!).

## 6. Practise challenging situations

Clients should have the opportunity to practise assertive responses in challenging situations by role-playing in session (if they feel comfortable doing so). In addition, encourage clients to start practising assertive communication skills in benign situations (e.g. when they are not feeling angry or guilty) and explain that communication is both verbal and non-verbal: consider tone, volume, pace, eye contact and body posture.

### *Dealing with criticism*

Responding assertively to criticism can be particularly difficult. When dealing with criticism, it can be useful for clients to learn how to agree in part by acknowledging the truth and ignoring the rest, particularly if the criticism is exaggerated (McKay et al., 2009). For example:

Critic: *You're always too busy to spend time with me!*

You: *You're right; I am very busy at the moment.*

A friend introduces Bob as his “junkie friend” even though Bob has not used illicit drugs in a year.

Passive response: *Yeah, I’m his junkie mate.*

Aggressive response: *Get lost and get over it!*

Assertive response: *I feel hurt when you call me a junkie. I understand that you’re resentful about my previous behaviour, but I would prefer that you acknowledge that my drug-using behaviour is now in the past.*

### **Dealing with requests**

Some clients may find it difficult to decline a request. ‘Empathic assertion’ can be helpful; it involves stating the refusal clearly while also indicating an understanding of the other person’s circumstances.

Fred is good at fixing computers and his friends are always asking him to come over and fix their computers at home for free. Fred’s brother has asked Fred to fix his computer, but Fred doesn’t have the time to help because he is very busy with work and looking after his kids.

- Passive response: *Yeah I guess I can fix your computer.*
- Aggressive response: *I’ve had a gutful of being used by you to fix your computer for free!*
- Assertive response: *I know that it’s an inconvenience that your computer isn’t working properly, but I’ve got no spare time to fix your computer. I can recommend a good service.*

A comprehensive assertiveness training workbook, *Assert yourself* (Michel, 2008), is available at this website <https://www.cci.health.wa.gov.au/Resources/Looking-After-Yourself/Assertiveness>

## Assertiveness training – tip sheet

### **Step 1. Explain the difference between aggressive, passive and assertive communication.**

- People who communicate in a passive manner tend not to express their feelings, thoughts and wants. You may believe that your needs come second to the needs of others and have difficulty making requests and refusals.
- People who communicate in an aggressive manner are capable of expressing what they want. However; they often do so at the expense of others’ rights and feelings. You may find that you are on the attack if things do not go your way.
- Assertive communication involves directly expressing your feelings, thoughts and wants, while being respectful of the rights and feelings of others. If you communicate in an assertive manner, you can stand up for your rights, make requests and refusals and deal with criticism effectively.

### **Step 2. Discuss the advantages of assertiveness and develop assertiveness goals.**

### **Step 3. Explore beliefs and common misconceptions about assertiveness.**

### **Step 4. Encourage clients to think more assertively.**

Use the Bill of Assertive Rights included in Appendix 26. Explain that aggressive communication violates the rights of others; passive communication violates the client’s own rights; and being assertive respects the client’s rights and the rights of others.

### **Step 5. Assertive communication skills.**

Use observer comments: commenting objectively on the behaviour or situation.

Explain the difference between You-statements and I-statements. Practise expressing feelings without attributing blame.

You-statement example: *You make me so angry!*

I-statement and observer comment example: *I feel angry when you’re late to pick me up from work.*

### **Step 6. Practise assertive communication.**

Use role-plays of challenging situations, such as responding to criticism or requests.

## References

- Chambless, D. L., Hunter, K., & Jackson, A. (1982). Social anxiety and assertiveness: A comparison of the correlations in phobic and college student samples. *Behaviour Research and Therapy*, 20(4), 403-404. [https://doi.org/10.1016/0005-7967\(82\)90101-2](https://doi.org/10.1016/0005-7967(82)90101-2)
- Connors, G. J., & Walitzer, K. S. (2001). Reducing alcohol consumption among heavily drinking women: Evaluating the contributions of life-skills training and booster sessions. *Journal of Consulting & Clinical Psychology*, 69(3), 447-456. <http://dx.doi.org/10.1037/0022-006X.69.3.447>
- Horan, J. J., & Williams, J. M. (1982). Longitudinal study of assertion training as a drug abuse prevention strategy. *American Educational Research Association*, 19(3), 341-351. <https://doi.org/10.3102/00028312019003341>
- Jarvis, T. J., Tebbutt, J., Mattick, R. D., & Shand, F. (2005). *Treatment approaches for alcohol and drug dependence: An introductory guide* (2nd ed.). West Sussex, United Kingdom: John Wiley & Sons.
- Marlatt, G. A., & Gordon, R. R. (1980). Determinants of relapse: Implications for the maintenance of behaviour change. In P. Davidson & S. Davidson (Eds.), *Behavioural medicine: Changing health lifestyles* (pp. 410-452). New York, NY: Brunner/Mazel.
- McKay, M., Davis, M., & Fanning, P. (2009). *Messages: The communication skills book* (3rd ed.). Oakland, CA: New Harbinger Publications.
- Michel, F. (2008). *Assert yourself*. Perth, WA: Centre for Clinical Interventions. Retrieved from <https://www.cci.health.wa.gov.au/Resources/Looking-After-Yourself/Assertiveness>
- Orenstein, H., Orenstein, E., & Carr, J. E. (1975). Assertiveness and anxiety: A correlational study. *Journal of Behavior Therapy and Experimental Psychiatry*, 6(3), 203-207. [https://doi.org/10.1016/0005-7916\(75\)90100-7](https://doi.org/10.1016/0005-7916(75)90100-7)
- Temple, S., & Robson, P. (1991). The effect of assertiveness training on self-esteem. *British Journal of Occupational Therapy*, 54(9), 329-332. <https://doi.org/10.1177/030802269105400904>
- Williams, J. M., Hadden, K., & Marcavage, E. (1983). Experimental study of assertion training as a drug prevention strategy for use with college students. *Journal of College Student Personnel*, 24, 201-206.

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# 6

## Section Six: Working with specific issues

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## 38. Grief and loss

Issues of grief and loss are almost unavoidable when working in the AOD field. There are many sources of grief and loss including the death of a friend, partner or family member due to the impacts of AOD use. 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. Feelings of grief and loss may also arise from the cessation of drug use itself; grief over a lifestyle that is lost, friends who are lost and the effect 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.

Some clients may have started using AODs as a way of coping with grief or loss issues; other clients may continue to use AODs to cope with unresolved grief issues, even if these issues did not lead to the AOD problems in the first place. Some clients will, therefore need help to resolve grief and loss issues if they are to reduce their AOD use.

### Bereavement

Counsellors must be familiar with the varied experiences of normal or uncomplicated grief in order to avoid pathologising normal bereavement, normalise a client's experience, and facilitate adaptive mourning. An understanding of normal grief processes can help counsellors recognise when a client's grief response is outside their social, cultural or religious norms. These clients may benefit from a referral for specialist support.

### Complicated grief

The Diagnostic and Statistical Manual of Mental Disorders 5 (DSM-5) (American Psychiatric Association, 2013) and the International Classification of Diseases 11 (ICD 11) (WHO, 2018) have identified certain grief responses that are particularly debilitating and long-lasting, compared with what is considered normal. Known in the DSM 5 as Persistent Complex Bereavement Related Disorder and as Prolonged Grief Disorder in the ICD 11, it is characterised by intense feelings of loss and yearning for the deceased loved one that is outside of social, cultural or religious norms (for at least 6 months in the ICD 11 and 12 months in the DSM 5).

Certain types of death have been identified as being more likely to leave the bereaved with this type of grief. For example, the loss of a child, life partner, violent death, and suicide have been associated with complicated grief (Shear, 2015). Losing a loved one to an AOD-related death also carries significant risk for complicated grief (Templeton et al., 2016). Furthermore, an AOD-related death can be particularly stigmatising for the bereaved. AOD-related deaths are often portrayed in the media as a result of self-destructive choices, and families will often conceal the actual cause of death in order to protect the reputation of the deceased (Valentine, Bauld, & Walter, 2016). Loved ones can carry overwhelming feelings of self-blame and shame (Templeton et al., 2016). These responses can lead the bereaved to feeling that their grief is devalued, and make it difficult for them to seek social support for their grief (Valentine et al., 2016).

It is important for AOD counsellors to be aware of the possibility of complicated grief when working with AOD users and their families. There is evidence that people suffering complicated grief responses benefit from a therapeutic intervention (Shear, 2015). If it is apparent that the client is experiencing prolonged, traumatic or complicated grief, liaise closely with a supervisor and consider referral to specialist clinicians who have experience with complicated grief reactions.

### Non-death loss

Grief is generally understood to occur when one experiences the death of a loved one. However, grief responses also arise from losses that are unrelated to death (Harvey & Miller, 1998). Such losses can be categorised as:

- tangible – such as the loss of relationships in divorce or other relationship break-ups or loss due to incarceration, as well as loss of ability, freedom, and access to certain places
- intangible – for example, loss of hope, dignity, identity, self-worth, values, trust
- anticipatory – feelings of anticipatory grief can occur when one is anticipating or fearing the death of a loved one.

Grief responses are similar across death-related and non-death-related losses (Papa, Lancaster, & Kahler, 2014). However, clients may not identify their experience as a grief response when it doesn't involve a death. Thus, counsellors need to be able to respond to grief and loss and to identify and explore it with a client. This can help clients understand their experiences and implement coping strategies that they might not have otherwise considered.

Grief involves a broad range of reactions that can be grouped into four categories: emotional, physical, cognitive and behavioural. The following description of reactions in each of these categories is taken from Worden (2018).

## **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 of losing someone, people may find themselves moving between confusing emotions including sadness, a sense of loss of control, anger, confusion, frustration, panic, guilt, hostility, fear, a desire to blame and yearning for a reappearance of the deceased. It is normal for people to continue to vacillate between and re-experience these emotions over months or years. 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.

## **Physical**

Bereaved people commonly experience physical reactions, including sleep disturbance, appetite disturbance, lethargy, tiredness, reduced libido, gastrointestinal 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. The bereaved may develop symptoms similar to those from which the deceased died, can also occur. Counsellors need to reassure clients of the normality of these reactions and explore AOD-free strategies to help with sleep, relaxation and personal care.

## **Cognitive**

The way that we think changes immensely during the grieving process. Typical cognitions experienced in the first few weeks by bereaved people include disbelief ("it didn't happen"), confusion, preoccupation or obsessive thinking about the deceased, a sense of presence of the deceased and hallucinations. 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 normalise the client's experience of cognitive changes and empathise with the fact that certain thoughts can trigger intense, but normal, feelings. It may be useful for the counsellor to act as a sounding board for the client to work through complex existential issues, as well as their changing religious, moral and ethical views.

## **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. 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 appear to avoid them. It is likely that these people feel uncomfortable and ill-equipped to face the subject of death. 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.

## Goals of grief counselling

The efficacy of grief counselling interventions is an area of controversy as there is some evidence that grief therapy can cause harm to clients who are experiencing normal grief (Lilienfeld, 2007). Worden (2018), however, differentiated grief counselling from grief therapy and argued that supporting the resolution of normal grief responses can be a beneficial part of counselling. It is recommended that counsellors adopt a client-focused approach and explore grief issues if the client expresses concern in this regard.

Worden (2018) conceptualised the normal process of mourning as consisting of four tasks to be achieved in order to adapt to the loss:

- accept the reality of the loss
- process the pain of grief
- adjust to a world without the deceased
- find an enduring connection with the deceased in the midst of embarking on a new life.

The goals of grief counselling should be to facilitate the completion of these four tasks. However, the tasks of grief are to be engaged flexibly; it is not a requirement that each task be completed before moving on to the next task, as often several tasks will be worked on at the same time and previous tasks will need to be revisited. Note that sometimes the grief will not be about the death of a person but about some other loss. The following goals, drawn from Worden (2018), describe the sorts of interventions that facilitate each of the four tasks of mourning.

### Helping clients to accept the reality of the loss

The process of coming to terms with the reality that someone has died takes time and can be facilitated by rituals such as attending the funeral and burial. Counsellors can encourage clients to talk about the loss in detail (When? How? How did they hear? What happened at the funeral?). Clients who are unable to attend the funeral or burial may need to consider other ways of validating the reality of the death, such as visiting the gravesite.

### Helping clients to process the pain of the grief

This involves assisting clients to work through the range of feelings that might arise, 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 (i.e. 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 adjust to a world without the deceased

This task involves adjustments that are external (behaviours), internal (sense of self, cognitions) and spiritual (beliefs, values) in nature. Mourning involves coming to terms with the impact of the loss, such as the prospect of living alone, raising children alone, or no longer having the support of a close friend. Counsellors may find that problem-solving is a useful technique to assist clients to overcome obstacles they may experience when attempting to adjust to a life without their deceased. Given that grief can cloud one's judgement, clients should be discouraged from making any major life decisions or changes at this point.

### Helping clients to find an enduring connection with the deceased in the midst of embarking on a new 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 find ways of developing an enduring connection with the deceased whilst embarking on a new life. Help the client 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.

## Useful techniques

The following techniques, adapted from Worden (2018), can help the client to achieve the tasks of mourning.

### Clear language

Counsellors should use clear language when referring to the deceased in order to evoke feelings and help the client to accept the reality of the death. For example, instead of phrases such as ‘when you lost your friend...’, use ‘when your friend died....’

Speak with the client about the deceased in past tense when possible, for example: “it sounds as though your friend was....”

### Symbols

It can be helpful to encourage the client to bring symbols of the deceased, such as photos or mementos, into the counselling session. This can help to provide a clear focus of the grief counselling and facilitate the client’s mourning.

### Creative expression

Encourage the client to use writing or drawing to express thoughts and feelings about the deceased. This can help to facilitate a sense of resolution. A journal can be helpful at first, and eventually writing a farewell letter to the deceased can help the client to mourn. This can be a very cathartic experience for the bereaved client.

### Cognitive restructuring

Help the client to develop insight into damaging thoughts which reduce their capacity to cope with the loss and adjust to a life without the deceased. In particular, some clients may perceive themselves as incapable of managing without the deceased; they may be preoccupied with thoughts that magnify their sense of anxiety and helplessness. It is important to help the client to question the validity of these thoughts (see chapter on **Challenging unhelpful thinking**). It is also important to help the client to recognise unhelpful thought processes that might lead to undue feelings of guilt or responsibility for the death.

### Memory book

Encourage the client to develop a memory book or an alternative way of reminiscing about the deceased. This process can help the client to recognise that the loved one lives on in their memories and that they can find an enduring connection to the deceased.

## General points when working with grief

While the following points are specific to bereaved people, they are appropriate to bear in mind when working with other grief and loss issues.

- Grief is universal, with common underlying themes.
- Grief is normal, natural and painful and cannot be avoided.
- Be gentle, sensitive and unrushed when working with people bereaved by an AOD-related death.
- No two people will experience grief in the same way, though there may be common elements. Thus it is important 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 among 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.
- Previous losses will affect the current situation. An individual’s reaction may seem inappropriate to the current loss because it is influenced by previously unresolved loss issues that may need to be talked about as well.
- Give the client your undivided attention. Listen actively, and communicate empathy and unconditional positive regard.

- Try to avoid giving someone only a time limited commitment. Working through issues of grief is often a long-term process.
- If you need to give information to someone who is bereaved, always give both verbal and written instructions. When someone is grieving it is often difficult for them to concentrate.
- Be mindful that using the name of the deceased and using the word 'death' is not always culturally appropriate. It is important to ask the client their preferred term for death and how they would like you to refer to the deceased person.
- 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, walking, going to the gym)
  - emotional expression (screaming, crying, yelling).
- Encourage clients to do things to relax and look after themselves.
- The first year, including the first Christmas, birthday and indeed any anniversary can be particularly painful for people.
- Consider the wellbeing of the whole family – partner, siblings and other generations.
- A consistent research finding is that recent bereavement is a risk factor for suicide (Foster, 2011). If suicidal ideation is present, monitor the client's level of suicide risk. Suicidal risk may be elevated two to three days after the funeral and also eight to 12 weeks after death, when most social supports tend to withdraw. See chapter on ***Suicide assessment and management***.
- Be aware of signs that a client's grief is becoming complicated. Work closely with your supervisor and consider referral for specialist support. Drug use tends to be actively condoned during the grieving process. People are often prescribed sleeping pills or antidepressants, or encouraged to drink alcohol. Monitor the client's AOD use without judgement, and actively discuss strategies to reduce the risk for harm if use has escalated.
- There is a lack of conclusive evidence that bereaved parents are more likely to divorce (Schwab, 1998), but the death of a child can place a strain on marital or de facto relationships. It may be useful to encourage grieving parents to seek support or professional help together by attending support groups, such as a parent bereavement support group or couples' counselling.
- Be aware of transference or countertransference issues. 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.
- Counsellors cannot take away someone else's pain. The best they 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 (e.g. loss of a significant other, drug use, dreams or plans). This information can be used as a framework and adapted to suit the client and the source of his or her grief (Marsh, O'Toole, Dale, Willis, & Helfgott, 2013).

When working closely with grieving individuals, counsellors should have the support and guidance of a clinical supervisor experienced in the area.

## Client death

It is normal for counsellors to be saddened and experience a sense of loss and grief following the death of a client. Counsellors are advised to be cognisant of their own needs at this time and seek external support if they need it. If counsellors wish to attend the funeral, discussion with their supervisor about the potential for unintended consequences is encouraged. For example, counsellors should not attend the funeral if they believe it will upset family members.

Counsellors are encouraged to consider formal, professional support, such as from an employee assistance program or therapy, if they are having difficulty adjusting to the loss of a client and experience prolonged and complicated grief reactions that interfere with their social or occupational functioning.

## Grief and loss – tip sheet

Grief can arise from various 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. Normalise clients' varied emotional, physical, cognitive and behavioural reactions to grief.

Adopt a client-centred approach and focus on grief issues if the client expresses concern in this regard. Avoid time-limited counselling if possible, because working through issues of grief is often a long-term process.

The first year, including the first Christmas, birthday or any anniversary, is particularly painful. However, there are no timelines for grief.

Previous losses will affect the current situation.

The story relating to the loss may need to be told several times.

Be open and client centred. Allow the client the freedom to talk about the loss, or about other issues, as they wish.

If information is provided to the bereaved, always give both verbal and written instruction.

People often need practical help as well as emotional support.

Encourage clients to find an avenue to help them express their grief, such as talking, writing, artistic expression, physical expression, emotional expression, relaxation, taking care of themselves.

Recent bereavement is a risk factor for suicide. Monitor levels of depression and suicidal ideation if indicated.

Drug use is actively condoned for grief. For people already struggling with AOD use, adopt a harm reduction approach.

Encourage parents grieving over the loss of a child to seek support or professional help together.

Encourage clients to seek social support from support groups or family and friends.

Be aware of transference and countertransference issues and work closely with your supervisor.

Counsellors cannot take away someone else's pain, but they can give the client support and guidance to grieve.

## References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.
- Foster, T. (2011). Adverse life events proximal to adult suicide: A synthesis of findings from psychological autopsy studies. *Archives of Suicide Research*, 15(1), 1-15. doi: 10.1080/13811118.2011.540213
- Harvey, J. H., & Miller, E. D. (1998). Toward a psychology of loss. *Psychological Science*, 9(6), 429-434. doi: 10.1111/1467-9280.00081.
- Lilienfeld, S. O. (2007). Psychological treatments that cause harm. *Perspectives on Psychological Science*, 2(1), 53-70. doi: 10.1111/j.1745-6916.2007.00029.x
- Marsh, A., O'Toole, S., Dale, A., Willis, L., & Helfgott, S. (2013). *Counselling guidelines: Alcohol and other drug issues* (3rd ed.). Perth, WA: Drug and Alcohol Office.
- Papa, A., Lancaster, N. G., & Kahler, J. (2014). Commonalities in grief responding across bereavement and non-bereavement losses. *Journal of Affective Disorders*, 161, 136-143. doi: 10.1016/j.jad.2014.03.018
- Schwab, R. (1998). A child's death and divorce: Dispelling the myth. *Death Studies*, 22(5), 445-468. doi: 10.1080/074811898201452
- Shear, M. K. (2015). Complicated grief. *The New England Journal of Medicine*, 372(2), 153-160. doi: 10.1056/NEJMcp1315618
- Templeton, L., Allison, F., McKell, J., Valentine, C., Walter, J., Velleman, R., ... Hollywood, J. (2016). Bereavement through substance use: Findings from an interview study with adults from England and Scotland. *Addiction Research and Theory*, 24(5), 341-354. doi: 10.3109/16066359.2016.1153632
- Valentine, C., Bauld, L., & Walter, T. (2016). Bereavement following substance misuse: A disenfranchised grief. *Omega: The Journal of Death and Dying*, 72(4), 283-301. doi: 10.1177/0030222815625174
- Worden, J. W. (2018). *Grief counselling and grief therapy. A handbook for the mental health practitioner* (5th ed.). New York, NY: Springer Publishing Company.
- World Health Organization (WHO). (2018). *International Classification of Diseases-11*. Geneva, Switzerland: Author.



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## 39. Counselling using technology

Electronic communication has rapidly grown in popularity. As technology has advanced and people have become more accustomed to communicating in this way, counselling and support is increasingly being offered across digital formats. Counselling using technology, often referred to as e-therapy, e-counselling, or e-health, encompasses the various types of interventions that can take place via a digital format. These include, but are not limited to, telephone counselling, emails, text messages, internet live chats and smartphone self-help applications.

Online or telephone counselling can be attractive as these modes of treatment can be time efficient and are often available outside of business hours. Furthermore, people with health and mobility issues, or people with certain disorders (e.g. social anxiety or agoraphobia) can find it difficult to attend face-to-face services. Additionally, AOD users can experience stigma and telephone and online interventions can make it easier for people who feel marginalised by stigma to access support (Thomas, McLeod, Jones & Abbott, 2015). In Western Australia, people who live in rural and remote communities can find accessing counselling and support services particularly difficult. Often, their local community will have limited support services, and even if face-to-face counselling is available, some may choose not to access these services due to confidentiality concerns. Online and telephone services generally offer the option of anonymity and Clement et al. (2014) found that feedback for people who use online interventions indicate that anonymity is seen as a significant advantage. Thus, there is the potential to reach far more people and encourage more active participation of AOD users who feel marginalised and stigmatised.

There is a growing body of evidence suggesting that if used appropriately, e-counselling can be as effective as face-to-face counselling (Dunn, 2014). It can be offered in a flexible manner that can be customised to fit each client's needs and preferences. Furthermore, evidence suggests that a therapeutic alliance can be established through this medium (Brenes, Ingram & Danhauer, 2011).

Whilst there are services that are set up as exclusive e-counselling services, others may add e-counselling as an adjunct to the face-to-face services offered. This can be done via telephone, the internet, or using smartphone-based applications to supplement counselling. For example, workers may show a client a self-help app during session that supports the therapeutic work they are doing. The worker may then encourage the client to use it out of session, as an add-on to the in-session therapeutic work.

### Telephone counselling

Telephone counselling was the first of the e-counselling modalities to become commonplace. As such, there is a body of research indicating its efficacy and there is a general assumption that there will be an increased availability of non-traditional therapeutic interventions such as telephone counselling in the future (Roche et al., 2012).

In Australia, telephone helplines for AOD operate in each state and usually provide 24 hour access to counselling, information, advice and referral to people within the jurisdiction. Roche et al. (2012) has identified three levels of telephone support:

- **Level 1:** providing AOD specific advice and information to the wider community, individuals seeking support and guidance for themselves and/or others. Can provide referral to specialist services, and can provide advice and information to health and other professionals.
- **Level 2:** providing screening and assessment. Appropriate referral to specialist services. Can provide brief interventions and counselling in preparation for engagement in a specialist program.
- **Level 3:** provides ongoing specialist counselling (including relapse prevention), ongoing case management that includes call backs and liaison with other service providers. Can also provide written and verbal information and advice to other professional case workers.

## General skills for telephone counselling

Rosenfield (2013) advises the following skills for developing a therapeutic relationship with telephone counselling clients:

- **Active listening:** When listening actively, the worker hears and seeks to understand the words being spoken by the client. Meaning may not be directly expressed, and the worker will need to observe voice tone, pitch and speed. Given that there are no visual cues to indicate that the worker is listening, it is advised that the worker uses small encouragers such as “mmm”, or “aha” to convey listening.
- **Appropriate use of questions:** As in face-to-face counselling, closed questions can be used to help gather information, and open questions can be used to help clients expand on facts and explore themes. The use of closed questions should be kept as minimal as possible. Too many, without open questions to allow the client to expand on their story, can negatively impact the therapeutic relationship.
- **Empathy:** Communicating empathy is a crucial skill for telephone counselling. Paraphrasing and reflecting the client’s words back to them in a non-judgemental manner communicates that the worker has empathy for, and wants to understand, their situation. Rosenfield (2013) recommends keeping the length of a paraphrase short – the client is more likely to identify with a shorter paraphrase, and longer ones can lose their meaning. It is important to pause after a paraphrase to allow the client the opportunity to respond. If the worker follows up with a question too quickly, it can indicate to the client that the worker is not listening.

## Single session calls

Rosenfield (2013) recommends a six stage framework for one-off calls:

### Stage 1: Establishing the relationship

The relationship needs to be established quickly for the call to proceed effectively. The caller will decide very quickly if they are comfortable with the worker’s manner and speech. Open questions and active listening are the skills used in this stage.

### Stage 2: Exploration

The nature and purpose of the call is established in this stage. The client is given the space to tell their story, while the worker communicates empathy and understanding using open questions, acknowledging emotions and reflecting and paraphrasing.

### Stage 3: Clarification

This stage allows the worker to ensure they have understood the client. The key skills used are reflections, paraphrasing, open and closed questions and silences. This stage communicates to the client that the worker wants to understand their story and their issues. It also provides them the opportunity to correct the worker if they feel they need to.

### Stage 4: Information

The worker can provide specific information or resources, such as books or websites if required by a client. The worker can also provide information and, where appropriate, referral to other services at this time. The key skills used in this stage are active listening and checking that the client has received any information provided correctly.

### Stage 5: End

Calls usually end naturally after stage 4, but sometimes it is necessary for the worker to initiate the end. Workers may need to take charge when the call is going round in circles, the client’s concerns have been addressed, everything within the service’s boundaries has been explored or the caller is abusive or threatening. Rosenfield (2013) recommends ending calls by:

- summarising the content of the call, including options for future action that has been discussed
- use a closed question to check if the client wants anything else
- if the service allows people to telephone in ad hoc, remind the client they can call back and speak to someone if they need to
- if the service provides sessions by appointment only, arrange a time for a subsequent session
- say goodbye and hang up.

## **Stage 6: After the call**

Database requirements should be attended to and any resources that need to be mailed or emailed to the client after a call should be sent. Workers should take the time to reflect upon the call before taking another. Consideration should be given to what worked well and not so well, what could have been done differently, how they felt about the call and what (if anything) may need further exploration in supervision (see chapter on **Supervision**).

## **Ongoing counselling via telephone**

A range of therapeutic approaches have been found to be suitable for telephone counselling (see Rosenfield, 2013, chapter 2 for a review). Rosenfield recommends a staged opening call, regardless of the worker's therapeutic orientation. The stages help the counsellor identify the skills specific to effective management of the first session. Once the stages are in place, the counsellor can adapt the process in ways that suit their own therapeutic orientation. The six stages are:

### **Stage 1: Developing the relationship**

Rosenfield (2013) advises that, if the client is the one making the call, that the worker allow the phone to ring three times before picking up. This allows them time to register that the phone is not engaged and to prepare themselves for the session. The worker's answer should be clear, welcoming and professionally appropriate.

It is important that the worker maintains the position of 'naive enquirer', even if they have received information about the client via referral or assessment. Any prompting from the worker could lead the client to discussing issues that are not priority. Simply inviting the client to talk about their concerns allows the client to begin where they wish.

### **Stage 2: Exploration of the client's situation**

The client should do most of the talking in this stage. Rosenfield (2013) advises that the worker does not use words such as 'right' or 'yes' as encouragers, as the situation might not be, and this could be misinterpreted in the absence of visual cues.

### **Stage 3: Clarification of what you have heard**

In this stage, the worker asks questions to ensure they understand the client's situation, and begin to get an understanding of the emotional impact it is having on the client. Stages 2 and 3 take the bulk of the time of the session and the more the client talks in Stage 2, the more the worker will need to do to clarify, communicate understanding and support the client through their story.

### **Stage 4: Strategies**

In this stage, the worker can discuss with the client the strategies that they have already tried and explore what has worked, and not worked, for them in the past. The worker may also suggest some strategies that the client could implement. It is important to communicate with the client, that whether they do or not is their choice. Rosenfield (2013) advises against the worker giving advice, as this can be interpreted as directive and authoritarian. By offering a range of suggestions of strategies, the client is empowered to make their own choices about what would work best for them.

### **Stage 5: Bringing the session to a close**

Rosenfield (2013) suggests that the worker begins to summarise the session at around 6 minutes before the end of the session, and letting the client know that the session is about to end. It is important not to ask any open questions at this time, as sessions should end at the agreed time. Allow sufficient time to schedule the next appointment and say goodbye.

### **Stage 6: After the session**

After each session, the worker should ensure sufficient time to write case notes and reflect on the session. It is particularly important to consider any assumptions about the client the worker may have made during the call. The absence of non-verbal cues in a voice-only contact can make it difficult to ascertain the emotional content of the conversation and workers can misconstrue meaning this way. Reflective practice and adequate supervision are essential to counter this possibility.

## Online counselling

Online counselling and support has increased in popularity in the last 15 years (Robinson, 2009). Online support can be provided in a variety of ways:

- self-help or worker guided
- real-time (synchronous) or delayed communication (asynchronous)
- audio, video or text
- individual or group
- type of therapeutic approach.

(Robinson, 2009)

Whether online counselling with human interaction is via audio, video or text, there are important considerations that workers need to be aware of. The following has been adapted from the Australian Counselling Association's Guidelines for Online Counselling and Psychotherapy (n.d.).

### Considerations

Workers need to be aware of:

- the differences in verbal to written communication skills and the need to be proficient in written communication at a level appropriate for different levels of understanding
- the challenges of building and maintaining adequate therapeutic relationships online
- the potential for misunderstandings to occur and the importance of greater clarification than in face-to-face to mitigate the possibility
- the importance of using assessment skills online to help establish the suitability of online counselling for the individual and their particular issue
- knowledge of legal and ethical considerations
- need for adequate knowledge of technical issues relating to security, privacy etc. Specialist or additional supervision, over and above that required for face-to-face may be required
- providing an easily accessible way for clients to verify a practitioner's identity and the accuracy and adequacy of their stated credentials.

### Cultural issues

Competency across cultural contexts cannot be assumed. It is conceivable that workers can provide services online to anywhere in the world. Workers need to consider any cultural assumptions they carry and how these may impact on clients from culturally and linguistically diverse backgrounds. This also applies to cross-cultural interactions within national boundaries.

### Gender, race and disability

Online counselling may reduce the impact of inequalities, because the client's race, gender or disability will not immediately be apparent. However, workers need to be aware of how the lack of familiar cues may impact their ability to be sensitive to these important issues.

### Age

Online counselling need to be appropriate when offered to minors. Workers should ensure they are aware of the definition of 'minor', and what regulations exist for working with minors in their state.

### Informed consent

It can be difficult for workers to verify if a client is old enough to give informed consent, or whether their ability to do so is otherwise limited (e.g. due to learning difficulties). Reasonable steps should be taken to establish if third party consent is required, and if so, obtained.

## **System stability and compatibility**

There are important system considerations when providing online counselling:

- ensure a secondary means of contact (e.g. a telephone number)
- ensure the system is set to run with optimal stability to reduce the risk of the technology failing
- ensure the system is compatible with that of the intended client
- do not inadvertently send viruses or other harmful material, and ensure that anti-virus software is installed and up to date
- ensure the equipment can be easily repaired or replaced if necessary.

## **Confidentiality, data protection and storage**

Workers should be aware of the risks of information sent over the internet being intercepted by a third party and take appropriate measures to ensure that the interactions with clients via this medium are protected. The use of firewalls is strongly recommended. Furthermore, workers should ensure they regularly change their passwords and discuss with clients the steps they can take to maintain their privacy. For example, the use of an internet cafe for counselling may not be appropriate due to its public nature. Be mindful that client anonymity may not be an adequate protection of a client's privacy.

Services need to be aware that storing client information in a digital format raises security concerns. For example, many small devices, such as USB storage devices have a limited lifespan and are more easily lost or stolen than traditional paper-based filing systems (Gamble & Morris, 2014). Storing client information on a computer that does not have internet access is considered the ideal. However, if this is not possible, strong encryption and password protection is essential (Gamble & Morris, 2014).

Many systems enable access to 'cloud' based technology, which enables users to 'back up' and store information via the internet. Services need to be aware that cloud services do not store information online; rather it is stored on a physical computer often located internationally (Gamble & Morris, 2014). The information stored will be subject to the privacy laws of the nation it is stored in, which may not comply with Australian standards (Gamble & Morris, 2014). It is, therefore, considered inappropriate for Australian service providers to use public cloud-based storage for confidential client information. Furthermore, workers are advised to switch off cloud services to all mobile devices that store confidential client information (Gamble & Morris, 2014).

## **Crisis Situations**

Some crises that workers may face when conducting e-counselling are suicidal intent, homicidal intent, and worsening symptoms. Although these crises are not unique to e-counselling, they will need to be handled differently than face-to-face counselling. For example, a client in crisis may hang up or shut down an internet chat during a session, preventing the worker from being able to assess the risk thoroughly. Thus, a safety plan should be developed where possible to reduce risk of crises, prevent crises, and to respond appropriately. The safety plan should advise the client of the service's duty of care and what will happen in an emergency and include careful screening for risk of harm to self or others, monitoring for worsening of symptoms, and having a safety protocol in place if a crisis occurs (Luxton, Sirotnin, & Mishkind, 2010). Agencies need to have clear policies and procedures around suicide risk management, and when to notify emergency services to check on a client.

## Counselling using technology - tip sheet

Counselling using technology encompasses the various types of interventions that can take place via a digital format. These include, but are not limited to, telephone counselling, emails, text messages, internet live chats and smartphone self-help applications.

Online or telephone counselling can be attractive to some people because they are time efficient and often available outside of business hours.

Online or telephone counselling can be useful for people with health and mobility issues, and people with certain disorders (such as social anxiety or agoraphobia) who can find it difficult to attend face-to-face services.

Online and telephone services generally offer the option of anonymity and feedback indicates that this is seen as a significant advantage.

Evidence suggests that a therapeutic alliance can be established through this medium.

General skills for telephone counselling include active listening, appropriate use of questions and expressing empathy.

Rosenfield (2013) recommends a six stage framework for one-off calls and the first call of ongoing counselling.

When working online, workers need to be aware of:

- The differences in verbal to written communication skills and the need to be proficient in written communication at a level appropriate for different levels of understanding.
- The challenges of building and maintaining adequate therapeutic relationships online.
- The potential for misunderstandings to occur and the importance of greater clarification than in face-to-face to mitigate the possibility.
- The importance of using assessment skills online to help establish the suitability of online counselling for the individual and their particular issue.
- Knowledge of legal and ethical considerations.
- Need for adequate knowledge of technical issues relating to security, privacy etc. Specialist or additional supervision, over and above that required for face-to-face may be required.
- Providing an easily accessible way for clients to verify a practitioner's identity and the accuracy and adequacy of their stated credentials.

Issues unique to online counselling are system-related stability and compatibility, confidentiality and data protection.

It is inappropriate for Australian service providers to use public cloud-based storage for confidential client information.

Effective protocols for managing crisis situations need to be in place.



## References

- Australian Counselling Association. (n.d.). *Guidelines for online counselling and psychotherapy*. Newmarkert, QLD: Author.
- Brenes, G. A., Ingram, C. W., & Danhauer, S. C. (2011). Benefits and challenges of conducting psychotherapy by telephone. *Professional Psychology: Research and Practice, 42*(6), 543–549. doi: 10.1037/a0026135.
- Clement, S., Schauman, O., Graham, T., Maggioni, F., EvansLacko, S., Bezborodovs, N., . . . Thornicroft, G. (2014). What is the impact of mental health-related stigma on help seeking? A systematic review of quantitative and qualitative studies. *Psychological Medicine, 45*(1), 11-27. doi: 10.1017/S0033291714000129.
- Dunn, K. (2014). The therapeutic alliance online. In P. Weitz (Ed.), *Psychotherapy 2.0: Where psychotherapy and technology meet*. (pp. 75-88). London, United Kingdom: Karnac Books Ltd.
- Gamble, N., & Morris, Z. (2014). Ethical and competent practice in the online age. *InPsych, 36*(3), 18-19. Retrieved from <https://www.psychology.org.au/inpsych/2014/june/gramble>
- Luxton, D. D., Sirotin, A. P., & Mishkind, M. C. (2010). Safety of telemental healthcare delivered to clinically unsupervised settings: A systematic review. *Telemedicine and e-Health, 16*, 705–711. doi: 10.1089/tmj.2009.0179
- Robinson, A. (2009). *Online counselling, therapy and dispute resolution: A review of research and its application to family relationship services*. Melbourne, Vic: Australian Institute of Family Studies.
- Roche, A. M., Evans, K., Steenson, T., Pidd, K., Lee, N., & Cusack, L. (2012) *Australia's Alcohol and Other Drug Telephone Information, Referral, and Counselling Services: A Guide to Quality Service Provision*. Adelaide, SA: National Centre for Education and Training on Addiction (NCETA), Flinders University.
- Rosenfield, M. (2013). *Telephone counselling: A handbook for professionals*. Basingstoke, Hampshire, United Kingdom: Palgrave Macmillan.
- Thomas, N., McLeod, B., Jones, N. & Abbott, J. A. (2015). Developing internet interventions to target the individual impact of stigma in health conditions. *Internet Interventions, 2*, 351–358. doi: 10.1016/j.invent.2015.01.003

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## 40. Coerced clients

All treatment for AOD-related issues can be considered to have some elements of coercion (United Nations Office of Drugs and Crime, 2009). Coerced treatment or counselling refers to that which clients perceive as an imposition on their personal autonomy (Urbanoski, 2010). In this chapter, coerced treatment includes formal non-legal pressures, such as those enforced by employers, child protection services, and other non-legal authorities. It also includes pressure from social networks through informal mechanisms (Urbanoski, 2010). For example, a client's intimate partner tells them they must "do something about their drinking" or that their relationship is over, or a parent threatens to punish their adolescent child if they do not attend counselling. This chapter does not apply to legally mandated treatment (see chapter on *Working with clients referred by the justice system*).

As suggested by motivational theories, individuals seek treatment for AOD-related problems for internal and external motivations (Wild, Cunningham, & Ryan, 2006). Internal motivation includes goals related to personal choice, along with identification with treatment goals (identified motivation) and help-seeking due to shame or guilt (introjected motivation) (Bath, Hawke, Skilling, Chaim, & Henderson, 2019; Cornelius, Earnshaw, Menino, Bogart, & Levy, 2017). People undertaking AOD treatment often experience multiple internal and external motivating factors (Urbanoski, 2010).

Some studies have suggested that self-referrals are more likely to be associated with identified motivation, and referrals that are associated with legal and social pressure are more likely to be associated with external motivation (Ryan, Plant, & O'Malley, 1995; Wild et al., 2006). It is important to note that externally motivating factors can influence internal motivation through the process of internalising information from external factors into one's personal beliefs, and that clients can have a mixture of internal and external motivations for engaging in treatment (Goodman, Peterson-Badali, & Henderson, 2011). Research indicates that AOD treatment which is internally motivated has better outcomes (Cornelius et al., 2017).

### Perceived coercion

It is not clear if there is a difference between the nature and strength of motivation that stems from a legal mandate into treatment and motivation from less quantifiable social pressures, and there is no evidence of a direct correspondence between objective pressure and client perceptions of coercion (Cornelius et al., 2017). For example, in a study of clients on opioid substitution treatment, some clients felt that their vulnerability during life-changing events (e.g. pregnancy, hospitalisation, diagnosis with an illness) was leveraged to coerce them into treatment (Damon et al., 2017). Clients in this situation may feel that they did not really give informed consent to engage in treatment.

Nevertheless, clients who are coerced are sometimes willing to engage in AOD treatment (Wolfe, Kay-Lambkin, Bowman, & Childs, 2013). Prendergast, Greenwell, Farabee, and Hser (2009) found that although the clients they studied were legally coerced to attend treatment, the clients felt they had exercised some degree of choice. These authors also found that higher levels of perceived coercion were associated with lower motivation and that a higher sense of autonomy was related to higher levels of motivation (Prendergast et al., 2009). This indicates that counsellors should respond to client perceptions of coercion, and attempt to gauge the client's perception of coercion during the initial assessment process. Literature on perceived coercion is scarce and offers mixed results (Bath et al., 2019).

Some client groups may be more likely to perceive coercion. For example, young people may be more likely to perceive coercion than their older counterparts (Bath et al., 2019; Wolfe et al., 2013). Bath and colleagues (2019) found that young people who had high levels of perceived coercion were more likely to have co-occurring AOD and mental health disorders, and that although these clients felt highly coerced, treatment was effective (Bath et al., 2019). Clients who are experiencing more severe AOD issues are more likely to perceive that they have been coerced into treatment (Opsal, Kristensen, Vederhus, & Clausen, 2016).

Other research suggests that those who have experienced childhood trauma are more likely to be coerced into AOD treatment through family, financial reasons and health issues, although the researchers did not explore the client's perceptions about coercion (Cimino, Mendoza, Nochajski, & Farrell, 2017).

Although perceptions about coercion can be an issue in AOD counselling, perceived coercion doesn't impact on the therapeutic alliance or treatment outcomes by itself (Wolfe et al., 2013). The most consistent predictor of treatment outcomes is the client's therapeutic alliance with the counsellor (United Nations Office of Drugs and Crime, 2009; Wolfe et al., 2013), suggesting that building a strong therapeutic alliance is important irrespective of the client's perceptions of coercion.

## Strategies for working with coerced clients

While there are some suggestions from the research literature about what is important in working with clients who are coerced, a lot more research in this area is required. Strategies that have been identified in the research literature are as follows:

- be very clear about the limits to confidentiality and under what circumstances information may be shared (see chapters on **Confidentiality** and **Case notes**)
- focus on building the therapeutic alliance through empathic engagement, collaboration and flexibility
- explore clients' perceptions of coercion
- clients should be actively involved in decision-making
- maximise client autonomy and self-determination
- be transparent, provide information about risks and benefits, rationales and processes so the client can make an informed decision about treatment
- ensure information provided by or requested from other service providers is discussed with clients
- avoid assumptions about the likely treatment outcomes for clients based on whether they appear to be coerced or not. If these assumptions arise, discuss them during supervision
- engage in a thorough assessment and treat the individual and the specific issues they bring to therapy
- be aware that young adults may be more likely to perceive that they have been coerced into AOD treatment
- be aware that the more vulnerable the client is, the more they can feel coerced. A trauma informed approach is important
- MI is suitable for working with coerced clients, as it is client-centred and collaborative (see chapter on **Motivational interviewing**)
- using outcome measures such as the ORS and the SRS can empower clients (see chapter on **Treatment planning**).

## Coerced clients – tip sheet

It is common for clients in AOD treatment to experience coercion through both formal and informal means. While many clients can feel coerced, people often enter into AOD treatment due to a range of internal and external motivating factors.

Perceived coercion is more likely to impact on the client's attitude to treatment than actual coercion.

Some client groups are more likely to feel coerced into treatment, such as young people and people with more serious AOD issues. The more vulnerable the client, the more likely they are to feel coerced.

It is important that the counsellor does not make assumptions about the likely treatment outcome based on whether a client has been coerced. Coercion on its own does not impact on the therapeutic alliance or treatment outcomes. Counsellors should conduct a thorough assessment and respond to the specific issues the client brings to counselling.

While counsellors should explore the client's perceptions of coercion, overall treatment outcomes are better when the therapeutic alliance is strong. Focus on building the therapeutic alliance through empathic engagement, flexibility and collaboration.

Strategies for working with coerced clients should also focus on building autonomy and maximising self-determination, along with engaging the client in decision-making.

Counsellors should be transparent about processes (e.g. confidentiality, case notes, exchange of information), rationales for the counsellor's decision-making, and the risks and benefits of treatment options.

Use client-centred and collaborative skills such as MI and maximise opportunities for the client to provide feedback on the counselling.

## References

- Bath, K., Hawke, L. D., Skilling, T., Chaim, G., & Henderson, J. (2019). The service-seeking profiles of youth reporting a legal mandate or perceived coercion for substance use treatment. *Addictive Behaviours, 90*, 27-34. <http://doi.org/10.1016/j.addbeh.2018.10.006>
- Cimino, A. N., Mendoza, N. S., Nochajski, T. H., & Farrell, M. G. (2017). Examining the relationship between psychological functioning, childhood trauma, and types of perceived coercion among drug court enrollees: Results from a pilot study. *Cogent Psychology, 4*(1). doi: 10.1080/23311908.2017.1320859
- Cornelius, T., Earnshaw, V. A., Menino, D., Bogart, L. M., & Levy, S. (2017). Treatment motivation among caregivers and adolescents with substance use disorders. *Journal of Substance Abuse Treatment, 75*, 10-16. doi: 10.1016/j.jsat.2017.01.003
- Damon, W., Small, W., Anderson, S., Maher, L., Wood, E., Kerr, T., & McNeil, R. (2017). 'Crisis' and 'everyday' initiators: A qualitative study of coercion and agency in the context of methadone maintenance treatment initiation. *Drug and Alcohol Review, 36*(2), 253-260. doi: 10.1111/dar.12411
- Goodman, I., Peterson-Badali, M., & Henderson, J. (2011). Understanding motivation for substance use treatment: The role of social pressure during the transition to adulthood. *Addictive Behaviors, 36*(16), 660-668. <https://doi.org/10.1016/j.addbeh.2011.01.011>
- Opsal, A., Kristensen, Ø., Vederhus, J. K., & Clausen, T. (2016). Perceived coercion to enter treatment among involuntarily and voluntarily admitted patients with substance use disorders. *BMC Health Services Research, 16*(1). doi: 10.1186/s12913-016-1906-4
- Prendergast, M., Greenwell, L., Farabee, D., & Hser, Y. (2009). Influence of perceived coercion and motivation on treatment completion and re-arrest among substance-abusing offenders. *The Journal of Behavioral Health Services & Research, 36*(2), 159-176. doi: 10.1007/s11414-008-9117-3
- Ryan, R. M., Plant, R. W., & O'Malley, S. (1995). Initial motivations for alcohol treatment: Relations with patient characteristics, treatment involvement, and dropout. *Addictive Behaviors, 20*(3), 279-297. [https://doi.org/10.1016/0306-4603\(94\)00072-7](https://doi.org/10.1016/0306-4603(94)00072-7)
- United Nations Office of Drugs and Crime. (2009). From coercion to cohesion: Treating drug dependence through health care, not punishment. Retrieved from [https://www.unodc.org/docs/treatment/Coercion\\_Ebook.pdf](https://www.unodc.org/docs/treatment/Coercion_Ebook.pdf)
- Urbanoski, K. A. (2010). Coerced addiction treatment: Client perspectives and the implications of their neglect. *Harm Reduction Journal, 7*. doi: 10.1186/1477-7517-7-13
- Wild, T. C., Cunningham, J. A., & Ryan, R. M. (2006). Social pressure, coercion, and client engagement at treatment entry: A self-determination theory perspective. *Addictive Behaviors, 31*(10), 1858-1872. <https://doi.org/10.1016/j.addbeh.2006.01.002>
- Wolfe, S., Kay-Lambkin, F., Bowman, J., & Childs, S. (2013). To enforce or engage: The relationship between coercion, treatment motivation and therapeutic alliance within community-based drug and alcohol clients. *Addictive Behaviors, 38*(5), 2187-2195. <https://doi.org/10.1016/j.addbeh.2013.01.017>

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## 41. Cognitive impairment

According to Manning, Verdejo-Garcia, and Lubman (2017), the last 20 years of neuropsychological research has consistently demonstrated that dependent AOD users frequently present with cognitive impairment (CI). Factors that contribute to AOD clients experiencing CI include the temporary effects of acute intoxication, long-term effects of chronic alcohol use (e.g. Wernicke–Korsakoff syndrome), traumatic brain injury, overdose, mental and physical health issues, and neurological disease (Ridley et al., 2018). Some studies suggest there is a causal link between AOD use and CI (Bolla, Brown, Eldreth, Tate, & Cadet, 2002; Bolla, Rothman, & Cadet, 1999), whereas others suggest that the CI predates the AOD use (Ersche et al., 2012; Wagner et al., 2013) and may therefore be considered a contributor to addiction. It would appear, however, that the relationship between AOD use and CI is bidirectional, with some clients' cognitive profiles putting them at risk for AOD use or addiction and AOD use further reducing cognitive function (De Wit, 2009).

For AOD clients, impairment in executive functioning and goal-directed behaviour are typically the two most common cognitive difficulties. These two areas also significantly hinder AOD clients' progress in their recovery journey. Executive functioning includes one's ability to regulate, control and manage the flow of information; deficits cause difficulties in planning, short-term memory, attention, problem-solving, verbal reasoning, impulses control, cognitive flexibility, the ability to quickly and efficiently adapt to new situations or move from one task to another, and initiating and monitoring actions (SAMHSA, 2016). Being goal-directed with regard to behaviours requires planning appropriate actions and ensuring focus is maintained on a task or tasks. Ridley et al.'s (2018) review of the literature on CI suggested that one third to two thirds of clients with AOD use disorders who present for treatment also have a degree of CI. They argued, therefore, that CI could be considered as "... the expectation and not the exception among addiction patients" (p. 40).

CI has been referred to as a hidden disability, because unlike a physical injury, a client with CI typically shows no outward signs of injury (Allan, 2014; Network of Alcohol and Drug Agencies [NADA], 2013). Furthermore, the behaviour of AOD clients with unrecognised CI may be readily mistaken and interpreted as a lack of motivation or effort, rather than the impact of impaired executive functioning on ability to undertake important daily tasks which require the ability to analyse, plan, organise and schedule activities. Deficits in executive functioning can also directly affect how clients respond to AOD treatment interventions (Marceau, Lunn, Berry, Kelly, & Solowij, 2016). Therefore, the issue for AOD treatment services becomes, how does CI impact on the service's ability to engage and retain the clients so that they have a better chance of completing treatment programs and reducing their risk of relapse (Ridley et al., 2018)?

AOD services primarily use psychosocial treatment interventions. These interventions focus heavily on cognitive skills, and the ability to readily make behaviour changes. These treatment interventions require intact executive functioning abilities in order to be effective. For example, clients need to be able to attend to discussions, learn, retain and implement new strategies, monitor their thoughts and behaviour, and control their impulses, in order to achieve their goal of AOD reduction or cessation (Carroll et al., 2011). Clients with CI may not be able to fully engage in or benefit from this treatment approach, and could disengage early, risking relapse. Even mild CI has been demonstrated to worsen treatment outcome (Aharonovich et al., 2005; Aharonovich, Brooks, Nunes, & Hasin, 2008).

Despite widespread recognition in the literature that CI can harm treatment outcomes, treatment services do not regularly screen for CI as a part of their standard assessment procedures (Ridley et al., 2018) and therefore do not necessarily address it by either adapting counselling strategies (see Managing cognitive impairment section below) or through the use of interventions referred to collectively as cognitive rehabilitation therapies (CRT) (Rezapour, DeVito, Sofuoglu, & Ekhtiari, 2016). This may be due to the fact that CI is unlikely to be apparent in a routine AOD assessment due to a client's intact verbal skills and their own lack of awareness (Mantell, 2010; Manning et al., 2018). It is often presumed that once sustained abstinence is achieved, cognitive deficits will resolve (Rezapour et al., 2016). However, Rezapour et al. (2016) stated that "... in many cases, neurocognitive function may further deteriorate in early abstinence" (p. 345).

As a first step towards managing CI in AOD services, it is imperative that CI screening measures become routine clinical practice in order to identify and determine an appropriate treatment response (Ridley et al., 2018).

## Screening for cognitive impairment

Neuropsychological assessments are considered the gold standard in terms of assessing CI, but the time and cost involved is prohibitive for most AOD services and clients. A brief screening tool, on the other hand, that is inexpensive, easy to administer, and able to indicate whether clients have a degree of CI, is a good alternative (Marceau et al., 2016). However, screening tools are not valid when a client is intoxicated or in withdrawal. Generally, two to three weeks abstinence before screening for CI is optimal and screening should be conducted at a time of day when the client is most alert and rested (NADA, 2013).

Ridley et al. (2018) compared the accuracy of three brief screening measures – the Mini-Mental State Examination, Addenbrooke's Cognitive Examination-Revised (ACE-R) and the Montreal Cognitive Assessment (MoCA) – in detecting CI in outpatient AOD treatment clients. They found that the ACE-R and the MoCA detected CI, but the MoCA is briefer, and therefore they concluded it was better suited for use in an outpatient AOD treatment setting where time is short.

The MoCA is freely available online and was developed specifically to detect mild CI. It assesses a range of cognitive abilities including executive functioning, memory, attention and concentration, visuospatial abilities, language and orientation. It takes 5–10 minutes to administer and provides a quick indication of whether a client has impairments in their thinking abilities. It is important to note that even if a MoCA score does not indicate the presence of CI, the client may still experience cognitive difficulties; it is just that the CI may be too subtle for the screening measure to detect.

## Managing cognitive impairment

It is important to explore possible AOD-related cognitive difficulties with clients early in the assessment and engagement phase of treatment, regardless of whether they have been screened for CI. Counsellors should explore and discuss how CI might interfere with the client's efforts to reach their treatment goals and how different strategies could be used to maximise the effectiveness of AOD treatment. For example, research has shown that AOD-using clients have impairments in 'prospective memory', that is, remembering to do things at the intended time. Deficits in prospective memory cause difficulties for clients in keeping appointments and scheduling daily life in general (Weinborn, Woods, Kellogg, & Moyle, 2011). In order to help clients to 'remember to remember', counsellors can ask clients if they struggle to remember appointments and offer helpful strategies to remember them (e.g. alarms, text reminders, a calendar on the fridge, setting the time and day of the week for future counselling sessions).

A neuropsychological assessment with specific treatment recommendations for each area of CI would be ideal, and the gold standard for practice. As neurological assessments are typically unavailable in counselling agencies, it is often difficult for counsellors to be clear about the exact nature of CIs and the approach that would be most helpful for a client.

Nonetheless, clients with AOD-related CI find a range of strategies helpful, and these can be discussed with clients when difficulties are identified. In general, a first line approach to managing possible CI in counselling is to integrate cognitive rehabilitation strategies such as repetition, writing, and using cues to recall important information (Crean, Crane, & Mason, 2011).

Strategies which are helpful in targeting particular cognitive difficulties are highlighted below. You may wish to explore each area of functioning with your clients, such as attention, memory and problem-solving, to see how they are managing in these areas. If an area of difficulty is identified, specific strategies which improve functioning can be explored and adapted to a client's situation.

The current *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings* (Marel et al., 2016) outline some simple techniques that AOD workers can adapt and use with clients to manage suspected CI, whether due to recent AOD use, long-term impairment from AOD use, or other factors.



### Techniques to address attention problems

- Have a clear structure for each session.
- Consider shorter but more frequent sessions.
- Avoid overloading by limiting the content of each session.
- Keep sessions focused on relevant topics.
- Reduce session pace and provide breaks.
- Conduct sessions in a quiet, non-distracting environment.
- Provide written handouts of important information.

### Techniques to address learning and memory problems

- Present information to be remembered both verbally and visually (e.g. draw diagrams).
- Repeat and summarise key information.
- Ask the client to recall information from previous sessions, and suggest techniques to improve recall (e.g. writing things down, using memory aids).
- Review key points from previous sessions at the start of each session to compensate for poor memory.
- Remind client of appointment times and keep appointments regular.

### Techniques to address difficulties with mental flexibility, problem-solving, planning, and organising

- Encourage routines and daily planning.
- Explain step-by-step problem-solving and how to break goals into smaller, more manageable tasks.
- Discuss and practise responding to high-risk situations.
- For impulsive clients, encourage self-monitoring and use of cue cards with strategies to use.

It is also helpful to encourage clients to engage in healthy behaviours such as physical, social and leisure activities that could enhance cognitive function and possibly protect against any further cognitive decline (James, Wilson, Barnes, & Bennett, 2011). Stress may be a contributing factor in relapse and reduce the brain's ability to repair, therefore including strategies such as mindfulness in treatment may be beneficial (Smith, 2013) (see chapter on **Mindfulness**).

### Recovery of cognitive deficits

Manning et al. (2017) stated that "... with the growing evidence of neuroplasticity, recent research has found that cognitive deficits can recover with abstinence, and may be ameliorated with targeted neurocognitive interventions" (p. 43). It is important to talk to clients about neuroplasticity and the brain's ability to repair and recover, particularly with abstinence and targeted neurocognitive interventions (Manning et al., 2017).

Cognitive rehabilitation therapies such as goal management training (GMT) (Manning et al., 2017), cognitive stimulation therapy, strategy training, mediation, mindfulness and metacognitive training, and physical exercise, used independently or in combination, could improve cognitive deficits (Rezapour et al., 2016). Essentially, CRTs involve structured cognitive exercises and skills training (Fals-Stewart & Lam, 2010) that target memory and learning, motor functions, social and emotional processing, attention and short-term memory, impulsivity, inhibition and self-control, as well as other executive functions (e.g. flexibility, planning, reasoning and decision-making). Verdejo-Garcia, Alcarzar-Corcoles and Albein-Urios (2018) found that GMT and contingency management, when combined with CBT, could modify decision-making in people who use AOD, although noted that randomised controlled trials are still needed to establish the effectiveness of these interventions.

The studies that Rezapour et al. (2016) summarised also supported the effectiveness of CRT for improving particular cognitive deficits, but they cautioned that:

*...it is unknown that [sic] the degree to which these improvements in cognitive function can translate to meaningful longer-term clinical outcomes such as drug use, improved social, or occupational functioning. Future controlled studies using long-term follow-up should address this challenge. (p. 359)*

## Cognitive impairment – tip sheet

CI can be considered the norm, not the exception, in AOD-using clients.

All AOD services should routinely screen AOD-using clients.

As much as possible, AOD interventions should be adapted to match the client's current cognitive abilities.

A first line approach is to integrate strategies such as repetition, writing things down, and cues to recall important information into counselling.

The general counselling approach can be adapted by providing structure, reducing the pace, and avoiding overloading clients with information.

Encourage healthy behaviours such as social and leisure activities.

Encourage or incorporate stress reduction strategies such as mindfulness.

Support motivation and realistic hope by informing clients that CI from AOD use can improve, particularly with ongoing abstinence and targeted interventions.

With AOD reduction and cessation, clients should improve their cognitive functioning over time.

## References

- Aharonovich, E., Brooks, A. C., Nunes, E. V., & Hasin, D. S. (2008). Cognitive deficits in marijuana users: Effects on motivational enhancement therapy plus cognitive behavioural therapy treatment outcome. *Drug and Alcohol Dependence*, *95*(3), 279-283. doi: 10.1016/j.drugalcdep.2008.01.009
- Aharonovich, E., Hasin, D. S., Brooks, A. C., Liu, X., Bisaga, A., & Nunes, E. V. (2005). Cognitive deficits predict low treatment retention in cocaine dependent patients. *Drug and Alcohol Dependence*, *81*(3), 313-322. doi: 10.1016/j.drugalcdep.2005.08.003
- Allan, J. (2014). A hidden disability: cognitive impairment and AOD treatment. *Of Substance: The National Magazine on Alcohol, Tobacco and Other Drugs*, 18-19. Retrieved from [https://www.researchgate.net/publication/268523297\\_A\\_Hidden\\_Disability\\_Cognitive\\_impairment\\_and\\_AOD\\_treatment](https://www.researchgate.net/publication/268523297_A_Hidden_Disability_Cognitive_impairment_and_AOD_treatment)
- Bolla, K. I., Brown, K., Eldreth, D., Tate, K., & Cadet, J. L. (2002). Dose-related neurocognitive effects of marijuana use. *Neurology*, *59*(9), 1337-1343. <https://doi.org/10.1212/01.WNL.0000031422.66442.49>
- Bolla, K. I., Rothman, R., & Cadet, J. L. (1999). Dose-related neurobehavioral effects of chronic cocaine use. *Journal of Neuropsychiatry and Clinical Neuroscience*, *11*(3), 361-369. doi: 10.1176/jnp.11.3.361
- Carroll, K. M., Kiluk, B. D., Nich, C., Babuscio, T. A., Brewer, J. A., Potenza, M. N., & Lejuez, C. W. (2011). Cognitive function and treatment response in a randomized clinical trial of computer-based training in cognitive-behavioral therapy. *Substance Use Misuse*, *46*(1), 23-34. doi: 10.3109/10826084.2011.521069
- Crean, R. D., Crane, N. A., & Mason, B. J. (2011). An evidence based review of acute and long-term effects of cannabis use on executive cognitive functions. *Journal of Addiction Medicine*, *5*(1), 1-8. doi: 10.1097/ADM.0b013e31820c23fa
- De Wit, H. (2009). Impulsivity as a determinant and consequence of drug use: a review of underlying processes. *Addiction Biology*, *14*(1), 22-31. doi: 10.1177/0269881107081545
- Ersche, K. D., Turon, A. J., Chamberlain, S. R., Muller, U., Bullmore, E. T., & Robbins, T. W. (2012). Cognitive dysfunction and anxious-impulsive personality traits are endophenotypes for drug dependence. *American Journal of Psychiatry*, *169*(9), 926-936. doi: 10.1176/appi.ajp.2012.11091421
- Fals-Stewart, W., & Lam, W. K. (2010). Computer assisted cognitive rehabilitation for treatment of patients with substance use disorders: A randomized control trial. *Experimental and Clinical Psychopharmacology*, *18*(1), 87-98. doi: 10.1037/a0018058
- James, B. D., Wilson, R. S., Barnes, L. L., & Bennett, D. A. (2011). Late-life social activity and cognitive decline in old age. *Journal of the International Neuropsychology Society*, *17*(6), 998-1005. doi: 10.1017/S1355617711000531
- Manning, V., Arunogiri, S., Frei, M., Ridley, K., Mroz, K., Campbell, S., & Lubman, D. (2018). *Alcohol and drug withdrawal guidelines* (3rd ed). Richmond, VIC: Turning Point.
- Manning, V., Verdejo-Garcia, A., & Lubman, D. (2017). Neurocognitive impairment in addiction and opportunities for intervention. *Current Opinion in Behavioral Sciences*, *13*, 40-45. doi: 10.1016/j.cobeha.2016.10.003
- Mantell, A. (2010). Traumatic brain injury and potential safeguarding concerns. *The Journal of Adult Protection*, *12*(4), pp.31-42. <https://doi.org/10.5042/jap.2010.0642>
- Marceau, E. M., Lunn, J., Berry, J., Kelly, P. J., & Solowij, N. (2016). The Montreal Cognitive Assessment (MoCA) is sensitive to head injury and cognitive impairment in a residential alcohol and other drug therapeutic community. *Journal of Substance Abuse Treatment*, *66*, 30-36. doi: 10.1016/j.jsat.2016.03.002

- Marel, C., Mills, K.L., Kingston, R., Gournay, K., Deady, M., Kay-Lambkin, F., Baker, A., & Teesson, M. (2016). *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*. Sydney, NSW: National Drug and Alcohol Research Centre. Retrieved from <https://comorbidityguidelines.org.au/>
- Network of Alcohol and Drug Agencies (NADA). (2013). *Complex needs capable: A practice resource for drug and alcohol services*. Sydney: NSW, Author.
- Rezapour, T., DeVito, E. E., Sofuoglu, M., & Ekhtiari, H., (2016). Chapter 16 – Perspectives on neurocognitive rehabilitation as an adjunct treatment for addictive disorders: From cognitive improvement to relapse prevention. *Progress in Brain Research*, 224, 345-369. <https://doi.org/10.1016/bs.pbr.2015.07.022>
- Ridley, N., Batchelor, J., Draper, B., Demirkol, A., Lintzeris, N., & Withall, A. (2018). Cognitive screening in substance users: Diagnostic accuracies of the Mini-Mental State Examination, Addenbrooke's Cognitive Examination-Revised, and Montreal Cognitive Assessment. *Journal of Clinical and Experimental Neuropsychology*, 40(2), 107-122. doi: 10.1080/13803395.2017.1316970
- Smith, G. S. (2013). Aging and neuroplasticity. *Dialogues in Clinical Neuroscience*, 15(1), 3-5. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3622467/pdf/DialoguesClinNeurosci-15-3.pdf>
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2016). *Chronic substance use and cognitive effects on the brain: An introduction*. Retrieved from <https://store.samhsa.gov/system/files/sma16-4973.pdf>
- Verdejo-Garcia, A., Alcarzar-Corcoles, M. A., & Albein-Urios, N. (2018). Neuropsychological interventions for decision-making in addiction: a systematic review. *Neuropsychology Review*. <https://doi.org/10.1007/s11065-018-9384-6>
- Wagner, M., Schulze-Rauschenback, S., Petrovsky, N., Brinkmeyer, J., von der Goltz, C., Grunder, G., ... Winterer, G., (2013). Neurocognitive impairments in non-deprived smokers – results from a population-based multi-center study on smoking-related behavior. *Addiction Biology*, 18(4), 752-761. <http://dx.doi.org/10.1111/j.1369-1600.2011.00429>
- Weinborn, M., Woods, S. P., O'Toole, S., Kellogg, E. J., & Moyle, J. (2011). Prospective memory in substance abusers at treatment entry: associations with education, neuropsychological functions, and everyday memory lapses. *Archives of Clinical Neuropsychology*, 26(8), 746–755. doi: 10.1093/arclin/acr071

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## 42. Working with clients referred by the justice system

Much has been written about the relationship between offending and AOD use, and it has long been accepted that people involved in the justice system have a much higher rate of AOD use than the general population (Makkai & Payne, 2003). Australian research shows most offenders report high rates of tobacco smoking (AIHW, 2015); alcohol consumption (Davison, et al., 2015); illicit drug use (Patterson, Sullivan, Ticehurst, & Bricknell, 2018) and injecting drug use (Butler & Simpson, 2017). Polydrug use is common within this population, as are drug-related harms, including unsafe injecting practices and BBV infection (Butler & Simpson, 2017). Consequently, it is becoming increasingly common for AOD treatment services to collaborate with the community justice and prison system.

Clients encountered in justice referral pathways can be involved in pre-arrest police diversion programs, pre-sentence court diversion programs, post-sentence court-ordered treatment orders, incarcerated in custodial settings or have post-release parole requirements.

### Working with offenders in the community

Offenders in the community may be voluntary or legally mandated clients, including those who have been issued a police diversion intervention (pre-charge<sup>22</sup>), people appearing in court (pre-sentence voluntary programs or post-sentence orders) and those on parole with a treatment condition. Clients referred by the justice system in the community may be individuals abstaining from AOD use, looking to reduce their use, or actively using. It is important that counsellors work in a client-centred way and determine their client's priorities. For example, securing housing, employment or maintaining relationships may have higher priority than abstaining or reducing AOD use (see chapter on **Goal-setting**).

### Voluntary and legally mandated AOD counselling

Western Australia Police can issue police diversion intervention for simple illicit drug offences to eligible individuals. These notices compel recipients into treatment interventions within prescribed time periods. Similarly, parole conditions on exit from prison may include a requirement to attend AOD counselling in the community. It is important that both the counsellor and the client understand the requirements for mandated clients in these circumstances, and that the consequences of non-compliance are equally understood. In many instances, especially one-off therapeutic interventions (e.g. the 'Cannabis Intervention Session' in Western Australia), the session is not prescriptive, but counsellors are advised to follow guidelines.

In the Magistrates Court of Western Australia, voluntary diversion programs operate at the pre-sentence level to enable people to engage in counselling and address their AOD and related issues before their court matters are finalised. The WA Diversion Program, MHC maintains police and court diversion program manuals that detail specific processes and administrative procedures that treatment providers must undertake and inform the program treatment objectives. If a person hasn't volunteered for a pre-sentence program, and sometimes even if they have, at sentencing they may be given an order that includes an AOD treatment component and case management in the community by a community corrections officer. Court-ordered treatment is legally mandated treatment.

Whether working with voluntary or mandated clients, the limits of confidentiality should be clearly explained, and similarly to when working with offenders within the prison environment, counsellors of community-based offenders should be mindful of increased mental health problems, overdose and suicide risk (AIHW, 2015; Andrews & Kinner, 2012; Willis, Baker, Cussen, & Patterson, 2016). Counsellors should also be trauma informed (see chapter on **Co-occurring trauma issues**).

22 Pre-charge refers to charges that will not progress to court if the person satisfies the treatment requirement (i.e. those charges that resulted in the issue of the diversion notice will be dropped if the requirement treatment is successfully completed). The person may have concurrent charges that will still progress to court. For more information about diversion in Western Australia see <https://www.mhc.wa.gov.au/getting-help/diversion-support-programs/>

As with people incarcerated in prison, it may take time for mandated clients to establish trust in a therapeutic relationship and to disclose personal issues of value to them, especially if they have a long history of being ‘managed’ by the criminal justice system. It may be particularly difficult to engage mandated clients who lack motivation to attend or engage in counselling or treatment. In these cases it can be helpful for the client to witness the counsellors’ commitment by being patient, meeting them each week, and focusing on building the therapeutic alliance via role clarification and collaborative goal-setting (Bourgon & Guitierrez, 2013). See chapters on **Coerced clients** and **Goal-setting** for further information.

MI and the collaborative spirit of MI conflicts with the lack of control and autonomy involved in being mandated to attend counselling. However, the counsellor can work in an MI-consistent way and increase engagement by encouraging their client to have a voice in the therapeutic process (see chapter on **Motivational interviewing**). MI can assist mandated clients to explore any negatives of their AOD use, including the relationship with offending behaviour. Harm reduction is also beneficial for engagement as it addresses the client’s current situation with regard to AOD use and/or other high-risk behaviours (see chapter on **Harm reduction**).

Reasons for relapse into AOD use can mirror reasons for relapse into offending behaviour (NADA, 2013; Payne, 2007) and similar counselling tools can be used to address both areas for those wanting to make or sustain change. Relapse prevention can assist in the identification of high-risk situations, manage urges and cravings and learn refusal skills (Wanberg & Milkman, 2006; see chapter on **Relapse prevention and management** for further information). CBT can promote the adoption of positive social and coping skills, identification of cognitive distortions and thinking errors (e.g. “I can’t get a decent job now that I have a record so I have to sell drugs to survive”), self-monitoring when these errors occur and exploration of alternatives (see chapter on **Challenging unhelpful thinking**). Some mandated and voluntary clients referred by the justice system may have adopted a criminal identity, and criminal thinking should be explained as an outcome of maladaptive coping strategies rather than as a permanent fixture of their personality (Wanberg & Milkman, 2006).

It is common for clients with a justice history, particularly one involving violent offending, to experience impulse control issues and difficulties managing negative emotions (Robertson, Daffern, & Bucks, 2014). When problems with emotional regulation surface, it can be useful to help clients recognise their affective states and to understand the difference between feelings and actions (see chapter on **Anger management**).

## **Release from prison**

Transition from prison to the community can be challenging, especially for people with a history of mental health issues or lengthy imprisonment, returning to a community with few opportunities, or to an AOD-using peer group or community. People who have been incarcerated face leaving a controlled environment with a strict routine, stable accommodation and regular meals. On release, many need to secure suitable accommodation, seek employment, reunite with family/peers, manage finances on a low income and attend multiple appointments (e.g. Centrelink, housing, community corrections, medical etc.).

Furthermore, benefits gained from contact with prison health services can be lost once prisoners return to the community (Kinner, Streitberg, Butler, & Levy, 2012). Stress is often a contributing factor for relapse (see chapter on **Relapse prevention and management**) and this transition to the community can be a stressful time. Post-release support and transitional support services in Western Australia can help offenders overcome barriers to reengaging with the community, but the increasing prison population has led to services becoming over-stretched and difficult to access (Office of the Inspector of Custodial Services, 2016).

Protective factors for clients after their release from prison include engagement in an AOD treatment program, use of community resources including self-help groups, and availability of social supports (Binswanger et al., 2012). Several Western Australian AOD agencies provide AOD through-care services which include individual counselling support while incarcerated and after release. It is important for counsellors to be well informed of the support services and programs available to individuals released from prison so as to give their clients care that is responsive to their circumstances.



## Working with incarcerated clients in a prison environment

Incarcerated clients experience significant health and social disadvantage compared to the general population. Along with high rates of AOD use, prisoners have significantly higher rates of mental health disorders (Davison et al., 2015) and CIs including general learning disabilities, acquired brain injury and foetal alcohol spectrum disorder than the general population (Bower et al., 2018; McCausland, Baldry, & Johnson, 2013; Popova, Lange, Bekmuradov, Mihic, & Rehm, 2011; Schofield, Rushworth, Mugford, Simpson, & Butler, 2016). People in Australian prisons generally have poor education and limited employment histories, a family history of incarceration and have experienced childhood neglect, trauma and/or domestic violence (AIHW, 2015).

Many female offenders in prison have especially high rates of exposure to traumatic events, with up to 90% being victims of interpersonal violence, ranging from childhood abuse to sexual assault and domestic violence (Stathopoulos, Quadara, Fileborn, & Clark, 2012). Male prisoners, who account for 92% of the Australian prison population (Australian Bureau of Statistics [ABS], 2017), also have high rates of prior exposure to trauma, including witnessing violence, the death or absence of family members, prolonged bullying as a child, and sexual abuse (Sindicich et al. 2013). Prison itself can be a traumatising experience (DeVeaux, 2013). It can separate parents from children, people from familiar social support networks, remove previous coping strategies, take away autonomy, break connection to culture and land for Aboriginal peoples, and expose individuals to abuse or trauma within the correctional setting (DeVeaux, 2013; Honorato, Caltabiano, & Clough, 2016; Sindicich et al., 2013).

In 2018 Aboriginal peoples were significantly overrepresented in prisons, accounting for 28% of the Australian adult prison population in the September 2018 quarter, whilst accounting for approximately 2% of the total Australian population aged 18 years and over (ABS, 2018). Aboriginal young people accounted for over 73% of young people incarcerated in Western Australia in the March 2017 quarter (Department of Corrective Services, 2017). For this reason, counsellors working within the prison environment need to be culturally aware and work in a culturally secure way (see chapter on **Aboriginal clients, their families and communities**).

Clients in prison are more likely to have complex needs. However, incarceration may enable offenders to access high-quality physical and mental health care that was not available in the community (AIHW, 2015). While some report their mental health deteriorates in the prison environment, other offenders report their mental health status improves (AIHW, 2015), possibly due to respite from chaotic lives and the introduction of daily structure, routine healthcare, consistent meals and reduced AOD use.

### Counselling within the prison environment

Counsellors should have a clear understanding of the policies and procedures relevant to working in prisons, as well as knowledge of the general operations of the prison. Relevant issues include security, levels of authority, to whom they should report, and appropriate information disclosure. Incarcerated clients can be challenging to work with, especially as the counsellor may be required to work in a system that is not geared to therapeutic change.

As with voluntary and legally mandated AOD counselling, CBT within prison can help offenders learn positive social and coping skills, identify cognitive distortions and thinking errors. Several rehabilitation programs offered within Western Australian prisons address AOD use and offending behaviour, many of which are comprehensive (100+ hours) and CBT based. The Pathways Program is delivered to Western Australian prisons by multiple service providers, and has a large focus on mental self-control skills, attending to both personal circumstances and intrapersonal processes (thoughts, emotions, beliefs and attitudes) that lead to criminal conduct and substance use. Moral Reconciliation Therapy (Timko et al., 2014) is a program more recently delivered in Western Australian prisons which has a focus on promoting positive self-identity and helping consumers make better decisions for themselves and for the people around them.

While prisons adopt strategies to reduce the supply of drugs, alcohol and prescription medicines, AOD use in prison is common. Supply reduction strategies such as routine inspections, drug detection dogs and urinalysis do not completely prevent access to AOD in prison (Office of the Auditor General of Western Australia, 2017). Australian prisoners have reported the use of cannabis, methamphetamine, cocaine, ecstasy, and heroin, as well as a large range of other psychoactive substances (Justice Health and Forensic Mental Health Network, 2017).

Confidentiality is important when working with this client group. Due to an environmental culture of mistrust, incarcerated clients may 'test the waters' with counsellors and release information slowly to gauge a counsellor's reaction (Dornan & Aird, 2015). The focus in counselling should be on establishing a safe and supportive



therapeutic alliance and building trust. It is essential that the limits of confidentiality are clearly explained to clients prior to treatment (see chapter on **Confidentiality**).

Counsellors working with prisoners should be very clear about the limits to confidentiality in this setting, which may differ from those in the community. The penalties attached to AOD use while incarcerated, such as extended sentence time, mean current drug use may need to be discussed in a hypothetical sense, otherwise counsellors may find that clients are reluctant to discuss their drug use activities.

Individuals use AODs within correctional settings for multiple reasons, many of which reflect the reasons non-offenders choose to use them. Reasons may also include stress alleviation, relief from boredom and/or emotions associated with incarceration, peer alliances and group norms, enhanced status and symbolic capital through drug dealing, to defy authority and the institutional rules and expectations, and alleviation of anxiety, depression, and other mental problems (Kolind & Duke, 2016; Tompkins, 2016; Woodall, 2011).

Harm reduction is critically important when working with incarcerated clients. Due to the presence of drug testing and the unpredictable availability of substances within the prison environment, offenders may switch from a preferred drug to another substance, which can be risky. For example, switching from cannabis use in the community to heroin use in prison could mean high overdose risk due to low tolerance for the unfamiliar drug. Prison can also be a high-risk environment for initiation into drug use or recommencing drug use. Clients and counsellors should aim to work together to develop harm reduction strategies that the client is willing and able to implement.

Prisoners with a history of opioid use are at increased risk of fatal overdose due to high rates of poly-drug use and reduced drug tolerance; particularly in the first month following release (Andrews & Kinner, 2012; Binswanger et al., 2012) and counsellors should discuss this risk with the client and assist with access to naloxone where possible.

Australian data indicates a high prevalence of unprotected sex and sharing of injecting-related equipment, and consequently the transmission of BBVs, among offenders in both metropolitan and regional prisons (Butler & Simpson, 2017). Given the lack of access to sterile injecting equipment within most Australian prisons, syringes used are often a mixture of manufactured and prison-made implements which can be in circulation and used amongst multiple offenders for long periods of time (Treloar, McCredie, & Lloyd, 2016). Offenders who were injecting drug users in the community should be advised of the risks and of safer ways to use drugs in prison. For example, if an offender must reuse equipment, encourage them to reuse their own injecting equipment without sharing with others. STIs are also a concern (Butler & Simpson, 2017) and counsellors should offer harm reduction advice about safer sex practices. Condoms and dental dams are available free for prisoners in Western Australia (Department of Justice, 2018).

Given the high rates of trauma within this population, it is crucial that counsellors utilise trauma-informed approaches (see chapter on **Co-occurring trauma issues**). Prison can be a challenging setting for trauma-informed care. The correctional environment may have unavoidable triggers such as discipline from authority figures, pat-downs, strip searches, surveillance by male staff, enclosed spaces and potentially violent or abusive inmates. Australian research shows offenders with a history of sexual coercion outside prison are at greater risk of sexual coercion inside prison (Simpson et al., 2016).

Offenders may not have had counselling previously and may have never disclosed their personal trauma histories to a third party (Dornan & Aird, 2015). While counselling may be focused on AOD-related issues, clients may disclose a trauma history to a trusted counsellor. If trauma-related issues are raised within a counselling session, care should be taken to ensure the client is emotionally safe following the session. It is important that offenders do not feel exposed or vulnerable after counselling as they may become a target or at risk for further abuse within the prison system (Dornan & Aird, 2015). This can be challenging therapeutically, as some offenders report they find it difficult to fully process emotions outcomes from counselling because they have to maintain a specific identity with other offenders (Dornan & Aird, 2015). For some individuals who have experienced past trauma, open discussion of past traumatic experiences is inappropriate; instead counsellors should assist to contain and manage symptoms and enhance safety, with no direct focus on the trauma.

The prison population represents a particularly vulnerable and high-risk group for suicide and remain at elevated risk of suicide after release (Willis, Baker, Cussen, & Patterson 2016). Counsellors should be aware of the debriefing and liaison process when offenders express suicidal ideation or are self-harming. Counsellors have a duty of care to ensure client safety and inform the appropriate prison staff when a client appears to be in suicide crisis (see chapter on **Suicide assessment and management**).

Counsellors should also be mindful of any emotions that arise when working with particular offenders and/or specific offences that conflict with their value system in a way that may damage the therapeutic alliance or treatment. It is important to discuss these instances in clinical supervision to avoid countertransference<sup>23</sup>. Additionally, counsellors should be mindful of their potential to be exposed to vicarious trauma when working within a prison environment (Boudoukha, Altintas, Rusinek, Fantini-Hauwel, & Hautekeete, 2013). For further information, see the chapter on **Secondary traumatic stress, compassion fatigue, and vicarious trauma**.

It is important for counsellors working in the prison environment to maintain strong professional therapeutic boundaries when working with offenders in prison and to be conscious of any grooming behaviours (Kremer, Symmons, & Furlonger, 2018). Concerns about professional boundaries should be raised in supervision.

A treatment plan for an individual close to release should include a focus on the gradual transition back into the community, enhancing protective factors (e.g. engagement in an AOD treatment program, self-help groups, social supports) and helping the client to manage environmental stressors and triggers (see chapter on **Relapse prevention and management**). For example, if the community the individual is returning to after prison is a drug-using community, it can be particularly challenging and a significant trigger for relapse, so this should be explored. Clients with a history of opioid use should be educated about overdose prevention and informed about the availability of naloxone (Petterson & Madah-Amiri, 2017).

### Working with clients referred by the justice system – tip sheet

Clients may be involved in pre-arrest police diversion programs, pre-sentence court diversion programs, post-sentence court-ordered treatment orders, incarcerated in custodial settings or have post-release parole requirements.

Counsellors with clients referred by the justice system need to be clear about the type of information they need to disclose to whom, and these limits of confidentiality should be clearly explained to clients.

The high rates of trauma in the offender population mean counsellors working with offenders should be trauma informed.

Aboriginal peoples are overrepresented in both the adult and juvenile justice systems and counsellors should work in a culturally secure way.

CBT, MI and relapse prevention are all useful therapies when working with clients referred by the justice system.

Clients and counsellors should aim to work together on harm reduction strategies.

Some people who are referred by the justice system may have problems with emotional self-regulation. It can be useful to help these clients recognise their affective states and understand the difference between feelings and actions.

People who are incarcerated and have a history of opioid use are at increased risk of fatal overdose due to reduced tolerance, especially immediately after release. Counsellors should discuss this risk with the client and assist with access to naloxone where possible.

Counsellors need to be aware of the debriefing, liaison and reporting process when suicidal ideation or self-harming is mentioned or identified.

A treatment plan for an individual close to release from prison should include a focus on a gradual transition back into the community, enhancing protective factors, and helping the client to manage environmental stressors and triggers.

Counsellors should be mindful of any emotions that arise when working with particular offenders and/or specific offences that conflict with their value system, and seek clinical supervision.

Counsellors should be mindful of their potential to be exposed to vicarious trauma when working within a prison environment.

Counsellors working in the prison environment need to maintain strong professional therapeutic boundaries when working with offenders and be conscious of grooming behaviours.

<sup>23</sup> The clinician's emotions or feelings toward a client, stemming from their own personal experiences and histories. Countertransference can be problematic when left unchecked.

## References

- Andrews, J., & Kinner, S. (2012). Understanding drug-related mortality in released prisoners: A review of coronial records. *BMC Public Health*, 12(270). 10.1186/1471-2458-12-270
- Australian Bureau of Statistics (ABS). (2017). *Prisoners in Australia 2017* (No. 4517.0). Retrieved from <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4517.0>
- Australian Bureau of Statistics (ABS). (2018). *Corrective Services Australia, September 2018: Persons in Corrective Services* (No. 4512). Retrieved from <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4512.0>
- Australian Institute of Health and Welfare (AIHW). (2015). *The health of Australia's prisoners 2015* (Cat. no. PHE 207). Canberra, ACT: Author.
- Binswanger, I., Nowels, C., Corsi, K., Glanz, J., Long, J., Booth., & Steiner, J. (2012). Return to drug use and overdose after release from prison: A qualitative study of risk and protective factors. *Addiction Science & Clinical Practice*, 7(3), 1-9. 10.1186/1940-0640-7-3
- Boudoukha, A., Altintas, E., Rusinek, S., Fantini-Hauwel, C., & Hautekeete, M. (2013). Inmates-to-staff assaults, PTSD and burnout: Profiles of risk and vulnerability. *Journal of Interpersonal Violence*, 28(11), 2322-2350. doi: 10.1177/0886260512475314
- Bourgon, G., & Guterrez, L. (2013). The importance of building good relationships in community corrections: Evidence, theory and practice of the therapeutic alliance. In P. Raynor & P. Ugwu-dike. *What Works in Offender Compliance* (pp. 256-275). Basingstoke, United Kingdom: Palgrave Macmillan. doi: 10.1057/9781137019523\_15
- Butler, T. & Simpson, M. (2017). *National Prison Entrants' Bloodborne Virus Survey Report - 2004, 2007, 2010, 2013, and 2016*. Sydney, NSW: Kirby Institute.
- Bower, C., Watkins, R. E., Mutch, R. C., Marriott, R., Freeman, J., Kippin, N. R., ... Giglia, R. (2018). Fetal alcohol spectrum disorder and youth justice: A prevalence study among young people sentenced to detention in Western Australia. *BMJ Open*, 8, e019605. doi: 10.1136/bmjopen-2017-019605
- Davison, S., Fleming, J., Butler, T., Morgan, V., Petch, E., Morgan, F., ... & Janca, A. (2015). *Mental health and substance use problems in Western Australian prisons - Report from the Health and Emotional Wellbeing Survey of Western Australian Reception Prisoners, 2013*. Perth: WA, Department of Health, Western Australia.
- Department of Corrective Services. (2017). Young people in detention quarterly statistics – March quarter 2017. Retrieved from [https://www.correctiveservices.wa.gov.au/\\_files/about-us/statistics-publications/statistics/2017/quarterly/2017-quarter1-youth-custody.pdf](https://www.correctiveservices.wa.gov.au/_files/about-us/statistics-publications/statistics/2017/quarterly/2017-quarter1-youth-custody.pdf)
- Department of Justice. (2018). Health care. Retrieved from <https://www.correctiveservices.wa.gov.au/rehabilitation-services/health-care/default.aspx>
- DeVeaux, M. (2013). The trauma of the incarceration experience. *Harvard Civil Rights-Civil Liberties Law Review*. 48(1), 57-77. Retrieved from [http://harvardcrcl.org/wp-content/uploads/2013/04/DeVeaux\\_257-277.pdf](http://harvardcrcl.org/wp-content/uploads/2013/04/DeVeaux_257-277.pdf)
- Dornan, T., & Aird, E. (2015). *An evaluation of the counselling in prison trial*. Parramatta, NSW: NSW Department of Justice.
- Honorato, G., Caltabiano, N., & Clough, A. (2016). From trauma to incarceration: Exploring the trajectory in a qualitative study in male prison inmates from north Queensland, Australia. *Health Justice*, 4(3). doi: 10.1186/s40352-016-0034-x
- Justice Health and Forensic Mental Health Network. (2017). *Network patient health survey 2015*. Malabar, NSW: Author. Retrieved from [http://www.justicehealth.nsw.gov.au/publications/2015\\_NHPS\\_FINALREPORT.pdf](http://www.justicehealth.nsw.gov.au/publications/2015_NHPS_FINALREPORT.pdf)
- Kinner, S. A., Streitberg, L., Butler, T., & Levy, M. (2012). Prisoner and ex-prisoner health – improving access to primary care. *Australian Family Physician*, 41(7), 535-537. Retrieved from <https://www.racgp.org.au/download/documents/AFP/2012/July/201207kinner.pdf>
- Kolind, T., & Duke, K., (2016). Drugs in prisons: Exploring use, control, treatment and policy. *Drugs: Education, Prevention and Policy*, 23(2), 89-92. <https://doi.org/10.3109/09687637.2016.1153604>
- Kremer, P., Symmons, M., & Furlonger, B. (2018). Exploring the why of psychologist misconduct and malpractice: A thematic analysis of court decision documents. *Australian Psychologist*, 53(5). doi: 10.1111/ap.12343.
- Makkai, T., & Payne, J. (2003). *Key findings from the Drug Use Careers of Offenders (DUCO) study* (No. 267). Canberra, ACT: Australian Institute of Criminology.
- McCausland, R., Baldry, E., Johnson, S., & Cohen, A. (2013). *People with mental health disorders and cognitive impairment in the criminal justice system: Cost-benefit analysis of early support and diversion*. Sydney, NSW: Australian Human Rights Commission.
- Network of Alcohol and Drug Agencies (NADA). (2013). *Complex needs capable: a practice resource for Drug and Alcohol Services*. Sydney, NSW: Author.
- Office of the Auditor General Western Australia. (2017). *Minimising drugs and alcohol in prisons* (Report 22). Retrieved from [https://audit.wa.gov.au/wp-content/uploads/2017/11/report\\_2017\\_22-AlcoholDrug.pdf](https://audit.wa.gov.au/wp-content/uploads/2017/11/report_2017_22-AlcoholDrug.pdf)
- Office of the Inspector of Custodial Services. (2016). *Transitional services in Western Australian prisons*. Retrieved from [http://www.parliament.wa.gov.au/publications/tabledpapers.nsf/displaypaper/3914341a36a5826afacf967248258011002aed69/\\$file/4341.pdf](http://www.parliament.wa.gov.au/publications/tabledpapers.nsf/displaypaper/3914341a36a5826afacf967248258011002aed69/$file/4341.pdf)
- Patterson, E., Sullivan, T., Ticehurst, A., & Bricknell, S. (2018). *Drug use monitoring in Australia: 2015 and 2016 report on drug use among police detainees* (Statistical Reports No. 4). Retrieved from <https://aic.gov.au/publications/sr/sr4>
- Payne, P. (2007). *Recidivism in Australia: Findings and future research* (Research and public policy series no. 80). Canberra, ACT: Australian Institute of Criminology.
- Petterson, A. G., & Madah-Amiri, D. (2017). Overdose prevention training with naloxone distribution in a prison in Oslo, Norway: A preliminary study. *Harm Reduction Journal*, 14(74). <https://doi.org/10.1186/s12954-017-0200-z>
- Popova, S., Lange, S., Bekmuradov, D., Mihic, A., & Rehm, J. (2011). Fetal alcohol spectrum disorder prevalence estimates in correctional systems: A systematic literature review. *Canadian Journal of Public Health*, 102(5), 336–340. <http://dx.doi.org/10.17269/cjph.102.2718>

- Robertson, T., Daffern, M., & Bucks, R. (2014). Maladaptive emotion regulation and aggression in adult offenders. *Psychology, Crime & Law*, 20(10), 933-954. <https://doi.org/10.1080/1068316X.2014.893333>
- Schofield, P., Rushworth, N., Mugford, S., Simpson, M., & Butler, T. (2016). *Brain injury and the criminal justice system: Workshop report*. Kensington, NSW: NHMRC Centre of Research Excellence in Offender Health.
- Simpson, P., Reekie, J., Butler, T., Richters, J., Yap, L., Grant, L., ... Donovan, B. (2016). Factors associated with sexual coercion in a representative sample of men in Australian prisons. *Archives of Sexual Behavior*, 45(5), 1195–1205. doi: 10.1007/s10508-015-0653-7
- Sindicich, N., Mills, K., Barrett, E., Indig, D., Sunjic, S., Sannibale, C., ... Najavits, L. (2014). Offenders as victims: Post-traumatic stress disorder and substance use disorder among male prisoners. *The Journal of Forensic Psychiatry & Psychology*, 25(1), 44-60. <https://doi.org/10.1080/14789949.2013.877516>
- Stathopoulos, M., Quadara, A., Fileborn, B., & Clark, H. (2012). *Addressing women's victimisation histories in custodial settings*. Melbourne, VIC: Australian Centre for the Study of Sexual Assault, Australian Institute of Family Studies.
- Timko, C., Midboe, A. M., Maisel, N. C., Blodgett, J. C., Asch, S. M., Rosenthal, J., & Blonigen, D. M. (2014). Treatments for recidivism risk among justice-involved veterans. *Journal of Offender Rehabilitation*, 53(8), 620-640. doi: 10.1080/10509674.2014.956964
- Tompkins, C. (2016). 'There's that many people selling it': Exploring the nature, organisation and maintenance of prison drug markets in England. *Drugs: Education, Prevention and Policy*, 23(2), 144-153. <https://doi.org/10.3109/09687637.2015.1085490>
- Treloar, C., McCredie, L., & Lloyd, A. R. (2016). The prison economy of needles and syringes: What opportunities exist for blood borne virus risk reduction when prices are so high?. *PloS one*, 11(9), e0162399. doi: 10.1371/journal.pone.0162399
- Wanberg, K., & Milkman, H. (2006). *Criminal conduct and substance abuse treatment: Strategies for self-improvement and change, pathways to responsible living – The participant's workbook*. Thousand Oaks, CA: Sage Publications.
- Willis, M., Baker, A., Cussen, T., & Patterson, E. (2016). *Self-inflicted deaths in Australian prisons* (Trends & Issues in Crime and Criminal Justice No. 513). Canberra, ACT: Australian Institute of Criminology.
- Woodall, J. (2011). Social and environmental factors influencing in prison drug use. *Health Education*, 112(1), 31-46. <https://doi.org/10.1108/09654281211190245>

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## 43. 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 in relation to each adolescent's development, and tailor their approach accordingly.

### Developmental issues and tasks

Developmental issues and developmental tasks that characterise adolescents and young people can include (Winters, 1999):

- 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 self 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
- instant gratification
- feeling immortal
- being unpredictable in their moods and behaviour
- wanting to rebel against the older generation in society
- being excitable and restless
- finding it difficult to talk about feelings
- intense displays of emotion.

Because the term 'young people' spans several developmental stages, these issues will not apply to every young person. However, counsellors should be aware of the developmental issues that are relevant for their young clients and adapt their counselling approach to accommodate or assist the young person accordingly.

### Risk and protective factors

Adolescent drug use occurs in the context of risk and protective factors that need to be targeted in a multidimensional way in treatment. Risk factors for AOD use can be grouped into individual, family, peer, school, neighbourhood/community and societal influences (National Institute on Drug Abuse, 2014). Risk factors at the individual level include early behavioural problems, difficulties at school, associations with drug-using peers, and early onset of AOD use. Risk factors within the family include a family history of AOD use problems, family conflict, childhood maltreatment, poor early attachment and poor parent–child relationships. Risk factors within the young person's community include normalisation and acceptance of AOD use, availability of substances and the stressors associated with lower socio-economic status (Felitti et al., 1998).

These risk factors can influence and reinforce each other in complex ways. For example, parental psychological difficulties may be linked to an insecure attachment between the child and parent and associated 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, as well as to cope with emotional distress. Alternatively, a teenager who is prone to extreme emotional reactions may influence family relationships and parenting. For example, if the adolescent reacts with intense anger when parents attempt



to set boundaries, 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 AOD-using peers.

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 reverse the effects of negative peer influences once problems have begun to develop (Stone, Becker, Huber, & Alice, 2012).

## **Treatment approach**

Several principles should guide treatment with adolescents.

### ***Take a multidimensional approach***

Many young people entering AOD treatment may experience family, psychological, accommodation, legal, education and training, social and recreational issues. It is important to address these issues in cooperation with young people and where appropriate link them to additional services, and to work with other services involved with the young person (see chapter on **Case management**).

### ***Include family members where possible and appropriate***

Family is central to positive adolescent development and positive family relationships are protective against problematic adolescent behaviour, including AOD use. Involving families in AOD treatment, particularly with young people, is widely researched and recommended (see chapter on **Working with significant others**). Parents or caregivers, if appropriately resourced, can have a positive impact on the young person's behaviour, including their substance use (Hornberger & Smith, 2011). It is recommended that AOD treatment agencies have trained family therapists on staff and offer family therapy training to as many staff members as possible, as this therapeutic approach is likely to be necessary for more complex family situations. However, although counsellors need training to conduct family therapy, training is not needed for counsellors to work with young people and their parents to enhance family functioning.

### ***Avoid scare tactics***

Many young people engage in risk-taking behaviours, and trying to scare them out of doing so, particularly when they have engaged in the behaviour and suffered no negative consequences, is unlikely to change (Jenkins, Slemon, & Haines-Saah, 2017). If AOD information is provided with the aim of frightening the young person and does not fit with the young person's experience of that drug use, they may be less likely to believe other information provided.

### ***Provide structure and clear, fair limits***

Counsellors need to be stable, consistent, reliable support people. As part of this approach, they need to provide structure around the behaviour of their young clients by communicating clearly about limits and why they are important, while accepting that many young people will test these limits (Crane, Francis, & Buckley, 2013).

### ***Provide options and freedom of choice***

Young people need to be able to express their own opinions and sense of self, and to be offered help to work out their own solutions. Where possible, involve young people in making decisions about rules and limits, as they will be more likely to cooperate (Towers & Carmichael, 2009).

### ***Encourage discussion by listening and displaying respect***

This applies particularly to discussions about topics such as drug use and sexuality, as it enables the young person to talk honestly about what is happening and their feelings about it (Towers & Carmichael, 2009).



### ***Include harm reduction strategies***

It is unrealistic, at least initially, to expect many young people to completely cease using all substances and engaging in other risk-taking behaviours (such as driving at high speeds or promiscuity). 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 (see chapter on ***Harm reduction***).

### ***Provide practical coping strategies***

MI, problem-solving, relapse prevention, social skills training, emotion regulation and cognitive restructuring can all be helpful. These strategies entail the young person considering their own feelings and opinions and providing them with practical strategies to solve their own problems.

### ***Be 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 (such as talking while playing pool or going to a coffee shop) are often important components of effective treatment with adolescents.

### ***Consider communication style***

It is important for a counsellor to relate to young clients and become familiar with youth culture, but it is equally important to present appropriately and genuinely. Counsellors should clarify what a young person is referring to and use language and terminology with which they are comfortable (Towers & Carmichael, 2009). Counsellors should also be aware of the language they use and avoid using words that their clients may not understand.

### ***Respond to co-occurring mental health conditions***

Mental health conditions are common among young people presenting for AOD treatment. These can include mood disorders, conduct disorder, anxiety disorders, attention deficit hyperactivity disorder (ADHD), psychotic symptoms and eating disorders. Late adolescence is the most common time for a psychotic disorder (e.g. schizophrenia, bipolar disorder) to emerge, and it can be difficult to distinguish between symptoms of a psychiatric disorder and symptoms of a drug-induced psychosis. Young people with co-occurring mental health conditions have poorer outcomes from traditional AOD treatment approaches than those without mental health conditions and are also more likely to experience relapse following treatment for their AOD use (Hulvershorn, Quinn, & Scott, 2015). This highlights the need to be thorough in assessing for mental health problems, thus enabling an effective therapeutic response, which may entail referral for psychiatric assessment and intervention, as well as more intensive treatment. Building effective working relationships with youth mental health services is key to providing an effective service to many young people with complex co-occurring AOD and mental health conditions.

## **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. Young people under the age of 18 years are legally considered to be children. Given this, individuals under the age of 18 years should be assessed on a case-by-case basis. Generally, a person under the age of 18 years can consent to medical treatment and make other healthcare decisions, including around confidentiality, if they are assessed to be a mature minor.

*The assessment of a child as a “mature minor” is not made on the basis of the child’s chronological age alone and does not need to involve an accompanying parent or guardian. It is based on the child’s experience, emotional maturity and intellectual capacity. (Department of Health, Western Australia, 2013, p. 13)*

Ultimately, assessment as a mature minor rests on the child’s ability to understand the risks and the benefits of what is being offered in order to give informed consent. The limits of confidentiality should be discussed with the young person before assessment, and may need to be reiterated throughout treatment. However, in most circumstances it is helpful to have parents involved in treating young people. This should be discussed with the young person at the outset of treatment, their consent for parental involvement sought and agreement reached regarding what information is to be shared.

When working with a young person who is unable to give voluntary informed consent, a clinician 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 interests takes precedence over the young person's wishes. However, counsellors should explain these limits of confidentiality to the young person and endeavour to gain their consent.

Counsellors may be required to work with a young person who is a mandated or coerced client due to a court diversion program or school drug policy. It is important to explain to the young person what information will be provided to the referral source. In addition, some young people's parents may coerce them into therapy. Working with coerced young people requires a different therapeutic approach (see chapter on **Coerced clients**).

## Child Protection Issues

Child protection can be a difficult issue for clinicians who work with young people. For purposes of child protection, young people are considered children when they are under the age of 18 years. AOD counsellors and other professionals have a duty of care and ethical responsibility to report a child who is at immediate risk of harm, including abuse or neglect. This is irrespective of whether they are a mandatory reporter (see chapter on **Child protection and parenting interventions**). It is also important to be familiar with your agency's policy around child protection and reporting, and your professional code of ethics.

There will be times, when working with young people, where it strengthens the therapeutic relationship to either report or support the young person in reporting current or previous abuse to the police or child protection services. It can be the first time anyone has taken their concerns and safety seriously and their first experience of being protected by an adult.

There will also be times when the clinician is clear that the abuse should be reported but the client does not want it reported. For example, clinicians can find themselves working with young people under the age of 18 years who are continuing to be physically or sexually abused but do not want intervention for various reasons.

In these situations, when the clinician suggests reporting the abuse, the worst outcome is that the client feels betrayed and withdraws from counselling. However, even when the client does not want the abuse reported, it is often possible to work with the client to reach agreement that this needs to occur and enlist their active involvement in reporting it, and thus maintain the therapeutic relationship.

There will also be situations where in the absence of mandatory reporting, and in the interests of maintaining a therapeutic relationship, clinicians are uncertain whether to report the abuse. These issues should be discussed in clinical supervision to assist with the decision-making process. It may also be useful to contact the child protection agency to discuss the case (without providing the client's details) to gain information about how they are likely to act should a report be made.

Clinicians should always seek advice and support from supervisors and colleagues regarding risk assessments and whether to report abuse to the authorities (see chapter on **Child protection and parenting interventions**).

## Young people – tip sheet

Interventions with young people who use drugs 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 young person.

Involving families in AOD treatment with young people is highly recommended. Families need to be involved in the solution where possible and therapeutically appropriate, as treatment that does not include the family is less likely to be successful in the long term. Counsellors do not need to be trained in family therapy to offer family-inclusive counselling, but agencies should have counsellors with family therapy training for more complex family situations.

Effective treatment with young people should:

- be multidimensional and include referral and liaison with other workers and agencies as necessary
- include the family where possible and appropriate
- avoid scare tactics
- be flexible in approach, using outreach services
- provide practical and clear, fair limits
- provide options and freedom of choice
- encourage discussion by displaying respect
- include harm reduction strategies
- provide practical and concrete strategies
- include use of mediums such as art and music
- consider communication style – be appropriate to the young person without being uncomfortable and out of character for the counsellor
- include assessment of co-occurring mental health conditions.

The limits of confidentiality in terms of conveying information to parents are influenced by assessment of the maturity of the young person to provide informed consent and by the young person's issues. For example, if disclosure of information poses a risk to the young person, confidentiality limits may not apply. 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.

## References

- Crane, P., Francis, C., & Buckley, J. (2013). *Youth Alcohol and Drug Practice Guide 3: Practice strategies and interventions*. Brisbane, QLD: Dovetail.
- Department of Health, Western Australia. (2013). *Working with youth – a legal resource for community-based health workers*. Perth, WA: Author. Retrieved from [http://www.health.wa.gov.au/docreg/Education/Population/Child\\_Health/Child\\_Health\\_Services/HP010283\\_working\\_with\\_youth\\_FNL\\_legal\\_resource.pdf](http://www.health.wa.gov.au/docreg/Education/Population/Child_Health/Child_Health_Services/HP010283_working_with_youth_FNL_legal_resource.pdf)
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., ... Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: The Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine*, 14(4), 245–258. [https://doi.org/10.1016/S0749-3797\(98\)00017-8](https://doi.org/10.1016/S0749-3797(98)00017-8)
- Hornberger, S., & Smith, S. L. (2011). Family involvement in adolescent substance abuse treatment and recovery: What do we know? What lies ahead? *Children and Youth Services Review*, 33(1), S70-S76. <https://doi.org/10.1016/j.childyouth.2011.06.016>
- Hulvershorn, L. A., Quinn, P. D., & Scott, E. L. (2015). Treatment of adolescent substance use disorders and co-occurring internalizing disorders: A critical review and proposed model. *Current Drug Abuse Reviews*, 8(1), 41-49. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4819236/>
- Jenkins, E. J., Semon, A., & Haines-Saah, R. J. (2017). Developing harm reduction in the context of youth substance use: Insights from a multi-site qualitative analysis of young people's harm minimization strategies. *Harm Reduction Journal*, 14(53). doi: 10.1186/s12954-017-0180-z
- National Institute on Drug Abuse. (2014). *Principles of adolescent substance use disorder treatment: A research-based guide*. Retrieved from <https://www.drugabuse.gov/publications/principles-adolescent-substance-use-disorder-treatment-research-based-guide>
- Stone, A. L., Becker, L. G., Huber, A. M., & Catalano, A. F. (2012). Review of risk and protective factors of substance use and problem use in emerging adulthood. *Journal of Addictive Behaviors*, 37(7), 747-775. doi: 10.1016/j.addbeh.2012.02.014.
- Towers, T., & Carmichael, C. (2009). Responding to youth drug issues. In S. Helfgott & S. Allsop (Eds.), *Helping change: The drug and alcohol counsellors' training program*. Perth WA: Drug and Alcohol Office, Government of Western Australia.
- Winters, K. (1999). *Screening and assessing adolescents for substance use disorders* (Treatment Improvement Protocol Series, No. 31). Rockville, MD: Substance Abuse and Mental Health Services Administration.

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## 44. Child protection and parenting interventions

### Child protection

Although AOD use does not necessarily result in poor parenting, it is often a contributing factor, with children of parents with AOD problems at greater risk of developing emotional, behavioural or social problems (Dawe et al., 2007; Solis, Shadur, Burns, & Hussong, 2012). Although AOD use is commonly implicated in child abuse and neglect, it is rarely the only factor. Usually at-risk families have multiple risk factors including family and domestic violence, mental health conditions, 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 the client's care
- work in a multi-systemic manner with the parents to address other areas of difficulty that impact on their parenting capacities.

It is important for counsellors to be familiar with their agency's policies and procedures about child abuse, and seek advice from their supervisor or line manager if they are unsure what to do.

Where a child is at immediate risk of harm, counsellors have an ethical responsibility and duty of care to contact Child Protection and Family Support (CPFS), irrespective of whether mandatory reporting applies to them. When a child is at risk of harm, confidentiality of client information relating to this risk does not apply.

### Definitions of abuse and neglect

It is useful for counsellors to know what constitutes abuse and neglect. The following definitions are adapted from the Western Australia Department of Health's (2015) *Guidelines for protecting children 2015*.

- Physical abuse occurs when a child has experienced severe and/or enduring mistreatment through behaviours such as, but not limited to, beating, shaking, attempted suffocation, excessive discipline or physical punishment, and inappropriate administration of alcohol or other drugs.
- Sexual abuse occurs when a child has been exposed and/or subjected to sexual behaviours that are exploitative and inappropriate to their age and development. Examples include sexual penetration, inappropriate touching, and exposure to sexual acts and pornography.
- Emotional or psychological abuse refers to enduring and inappropriate mistreatment of a child through parenting which is often characterised by behaviours such as threatening, isolating, belittling, teasing, humiliating and bullying. This form of abuse causes the child to become fearful, withdrawn and distressed, and damages the child's emotional and psychological development.
- Neglect occurs when the caregiver persistently fails to provide the child with basic needs such as adequate food or shelter, medical treatment, care and nurturance. Severe neglect results in significant risk of harm to the child's health and safety.

### Assessment of child safety

Issues of child safety should be raised gently in the context of a supportive therapeutic relationship.

It is important not to make assumptions about whether a client poses a risk to their child's safety. At a client's initial assessment, counsellors should establish whether the client has children in their care, or has access visits to their children. Their children's safety should be assessed and the client's motivation to improve their relationships with their children explored, even if they do not have consistent contact with them.

If concerns are raised as a result of the assessment interview, further information should be elicited, including exploration of the child's functioning, parents' functioning and protective factors in the child's environment.

When attempting to conduct an accurate risk assessment and design an appropriate plan, counsellors may encounter difficulties due to restrictions, such as an inability to see the children in the home environment. These difficulties may be compounded by the fact that many AOD-using parents may be unable or unwilling to accurately describe the impact of their use and the consequences it has on children in their care. Therefore, counsellors can encourage the client to involve the children at some point in the counselling process, by asking to see them. For example: “I’d love to meet your kids – you talk so much about them, it would be great to put faces to names. How would you feel about bringing them in next session, even for a little while?” Seeing whether the children are well cared for and how they interact can provide useful information.

Counsellors can also consider involving non-using significant others to establish the children’s situation. It may be necessary, particularly when young children are involved, to refer the family to a service that has the capacity for home visits and intensive support<sup>24</sup>. Referrals to more intensive services may also enable the complex issues often faced by families with AOD-using difficulties to be dealt with more effectively.

Structured assessment instruments can be used to assess child safety among parents with AOD use issues. The following instruments can be used as part of a thorough assessment of child safety issues.

The *Signs of Safety Assessment Tool* (Turnell & Edwards, 1997, 1999) is a one-page assessment and planning guide for child safety issues<sup>25</sup> and part of the Signs of Safety approach currently used by CPFS and related agencies. The approach is constructive and collaborative and aims to engage professionals and family members in a partnership to address situations of child abuse (Department for Child Protection, 2011). The framework contains four domains for inquiry:

- What are we worried about? (e.g. past harm, future danger, complicating factors)
- What’s working well? (existing strengths and safety)
- What needs to happen? (future safety)
- Where are we on a scale of 0 to 10? (10 means there is enough safety for child protection authorities to close the case, and 0 means it is certain that the child will be abused).

This simple assessment helps to map the harm, danger, complicating factors and strengths of the situation, measure current child safety and determine what is required for the safety of the child in the future. It also provides a quick assessment to decide if reporting is necessary. It can be revisited at each session with clients about whom the counsellor has parenting concerns. It is used and understood by many stakeholders meaning it is a ‘common’ language for services including CPFS.

The *Risk Assessment Checklist for Parental Drug Use*<sup>26</sup> can be used in assessing parenting and child safety in the context of parental drug use. This Australian instrument is designed to assist clinicians and clients to identify the impact of AOD use on parenting and to track improvement. It covers psychosocial domains that are relevant to assessing potential risks, such as the parent’s AOD use patterns, home environment, provision of basic needs, and health issues. The Risk Assessment Checklist for Parental Drug Use is freely available online and does not require training. It has not been evaluated for reliability and validity.

This assessment can provide a detailed picture of the issues, risks and protective factors that exist for the client’s children. It can be used in conjunction with ‘Working with a Parent or Care-giver with an Alcohol or Other Drug Use Problem’ (also available at the DrugNet website – [http://www.drugnet.bizland.com/parent\\_child/parent.htm](http://www.drugnet.bizland.com/parent_child/parent.htm)).

## Parental risk factors for abuse and neglect

The Department of Health (2015) guidelines indicate that children are at increased risk of abuse and neglect if the primary caregiver has:

- a history of abuse or neglect in childhood
- a diagnosed mental health disorder
- AOD problems
- a history of criminal activities, or
- there has been family or domestic violence within the past 12 months.

<sup>24</sup> In WA see the Western Australian Network of Alcohol and other Drug Agencies (WANADA) website –<http://www.wanada.org.au> – for a directory of relevant services, such as ‘Attach’ (<http://www.unitingcarewest.org.au>) and ‘Saranna – Women’s Residential Program’ ([www.cyrenianhouse.com](http://www.cyrenianhouse.com)).

<sup>25</sup> Signs of Safety resources, including a DVD with case examples, are available at <https://www.signsofsafety.net>

<sup>26</sup> Available from DrugNet website: <http://www.drugnet.bizland.com/assessment/checklis1.htm>

Additional parental risk factors to take into consideration (Department of Health, 2015) include:

- history of abuse towards another child
- prior involvement with child protection services
- postnatal depression
- significant cognitive or intellectual impairment
- disadvantaged background
- under 21 years of age
- poverty and/or a transient lifestyle
- minimal family or community support
- poor parent/child attachment
- engages in punitive parenting and/or has unrealistic expectations of the child.

## Management of child risk/safety

Counsellors should be familiar with their agency's child protection policies and procedures.

The following provides general information on management of risk and has been adapted from the Metro Community Drug Services and Drug and Alcohol Youth Services Integrated Services – Child Protection Policy (MHC, 2018).

### Immediate risk is indicated by:

- evidence of physical abuse
- disclosure or evidence of sexual abuse
- child prostitution has been disclosed or evidenced
- threats or behaviours that indicate probable intent to harm the child
- the child being left unsupervised or with irresponsible/unsafe adults
- the parent's ability to ensure the safety of a child being grossly impaired by their current level of intoxication, or acute mental health condition
- the parent/s behaviour being chaotic, with escalating levels of unsafe AOD use
- homelessness.

Note that increased risk is also indicated if the child is younger than 5 years of age (Department of Health, 2015).

### Managing immediate risk:

- if the child is present at the time of assessment, delay the child from leaving the premises until consultation with a supervisor, manager, or senior worker has occurred and/or a referral to CPFS has been made to ensure the child's safety
- consider any cultural or disability issues
- consult with a CPFS duty officer prior to referring. Call 1800 273 889 to report concern for a child in the Perth metropolitan area
- record all relevant information and referral details in the client's file and on the Child Protection Referral Form
- email the referral form to the CPFS on CPDUTY@cpfs.wa.gov.au as soon as possible.

### Possible risk is indicated by:

- the client's child not being engaged with any other services or other responsible adults who can monitor their safety (e.g. are not at childcare, school or being cared for by other family members if the parent is unable to care for them)
- the child has a medical condition and/or disability and appropriate care is not being provided
- there is evidence of inadequate housing, food, clothing or hygiene
- the parent's mood/behaviour is unstable, possibly due to AOD use, mental health condition or other issues
- current family or domestic violence
- defensiveness when talking about relationships with family members
- the child residing with unknown older adults.

Note that increased risk is also indicated if the child is younger than 5 years of age.



## Managing possible risk:

- document concerns, using CPFS Department Referral form as a guide
- consult with your supervisor, manager or senior worker
- raise concerns with the parent/s and advise them of counsellor's duty of care
- consider contacting the central CPFS office to determine if the Department is currently engaged with the child or has had contact (a report does not need to be made)
- encourage the 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 consider making a report to CPFS following immediate risk management strategies.

Counsellors should always seek advice and support from supervisors regarding risk assessments and treatment plans. Counsellors can also consult anonymously with CPFS and the Child Protection Unit at the Perth Children's Hospital regarding child protection and safety issues. It is recommended that counsellors undertake training on child protection, which is available through CPFS.

## Reporting of abuse and neglect

In Western Australia, it is mandatory for some professionals (doctors, nurses, midwives, teachers and police officers) to report any sexual abuse (but not other forms of abuse) of a child that occurred after 1st January 2009 to CPFS. Although it is not mandatory in Western Australia for other professionals to report child sexual abuse, agencies have their own policies around these issues. Clinicians should ensure that they are familiar with their legal and agency responsibilities.

When reporting is not mandatory, the clinician has an ethical responsibility to intervene and report child abuse or neglect to the authorities. Client confidentiality does not apply to information about the client which relates to a child who is at immediate risk.

When there is no immediate risk, a counsellor can work with their clients to help them with their parenting in various ways, as outlined below.

## Parenting interventions<sup>27</sup>

Interventions with a specific focus on parenting should be framed in positive terms – as a way to improve parenting and build on strengths – rather than a form of punishment. Always make it clear that you want to help parents keep their children, not the reverse, while clarifying your duty of care. In establishing a supportive therapeutic alliance it can be useful to raise the following points, which are adapted from Marsh et al. (2012):

- parenting is not always easy
- there is no one “right way” of raising a child
- all parents make mistakes
- a parent only needs to be a “good enough” parent
- if parents were perfect, they would not be preparing their child well for the imperfect world
- most parents can benefit from parenting help at times
- people who had poor parenting role models often lack knowledge about children and parenting that would really benefit their children.

Counsellors need to be aware of the stigma associated with being a parent with an AOD problem and the pervasive fear of having children taken away. These feelings often prevent parents with AOD problems from accessing treatment services, which is likely to increase the risk to the children. Those parents who do enter treatment can be extremely defensive about issues surrounding childcare, making it difficult to accurately assess the level of risk to the child. This highlights the need to 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.

<sup>27</sup> For more detail regarding parenting interventions, particularly with clients with AOD and trauma issues, see Marsh, Towers, & O'Toole (2012), Chapter 21 – 'Parenting – Parenting Assistance'.

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.

Intervention with AOD-using parents involves balancing child protection with interventions to improve parents' lives. It involves multisystemic interventions to enhance protection and care for children and improve the parent's quality of life by helping them with a range of co-occurring issues, as necessary. Relevant co-occurring issues can include poor parenting skills, drug-related problems, family discord, psychological disorders, inadequate support systems, lack of safety of the familial environment, and difficulties with housing, education or employment.

Multi-systemic interventions with AOD-using parents can include interventions aimed at building parent resources to improve general functioning, interventions to decrease barriers to parents seeking help and interventions focused specifically on parenting skills (Dawe, 2007; Grella, Scott, & Foss, 2005).

Interventions to build family resources include helping parents to:

- access AOD treatments
- manage mental health and other personal problems and their impact on parenting (e.g. counselling, education, referral for medication)
- manage daily stresses associated with economic disadvantage
- seek and sustain support systems (e.g. family and social networks)
- access social services and community supports
- deal with relationship conflicts and family violence (e.g. couples counselling)
- work on self-protection or crime protection if at risk of assault
- access housing, employment, or courses for study and/or training.

Interventions aimed at reducing barriers for AOD-using parents accessing help include:

- building a solid therapeutic alliance
- making transport and childcare as accessible as possible
- linking parents with services that will attend the home
- helping clients access treatment services that include children<sup>28</sup>.

Interventions with a specific focus on parenting can include:

- enhancing parenting knowledge and specific skills with evidence-based parenting programs such as 'Triple P Positive Parenting' (see 'Triple P' website for resources)
- educating parents about attachment theory and how to provide children with a secure relationship characterised by sensitive and responsive care, as well as appropriate limits (see the Circle of Security website<sup>29</sup> for resources)
- providing direct parenting assistance with practical issues such as education, problem-solving, behaviour management, how to talk to children about their drug use
- building parenting confidence by focusing on parenting strengths (such as sense of responsibility to their children) as well as addressing parenting difficulties
- linking parents with services that will visit the family home to assist with parenting.

It is also important to consider the perspective of children living with parents who have AOD problems, as this is often neglected. Dawe et al. (2007) reviewed a small body of research which indicates that children generally know about parental AOD use earlier than the parents realise, do not say anything about it 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 AOD. Dawe et al. (2007) concluded that children need to be given the opportunity to talk about their experiences and helped to understand their parents' drug use in an age-appropriate manner.

<sup>28</sup> See 'Attach' ([www.unitingcarewest.org.au](http://www.unitingcarewest.org.au)), 'Women's Health & Family Services' ([www.whfs.org.au](http://www.whfs.org.au)), 'Saranna – Women's Residential Program' ([www.cyrenianhouse.com](http://www.cyrenianhouse.com)), and 'Women and Newborn Drug and Alcohol Service' (WANDAS).

<sup>29</sup> <https://www.circleofsecurityinternational.com/>

## Child protection issues – tip sheet

It is important to be aware of what constitutes abuse (physical, sexual, and psychological) and neglect and be aware of agency policies and procedures about child abuse and child protection. Training about child abuse and protection can also be beneficial for counsellors.

When a child is at immediate risk, counsellors have an ethical responsibility and duty of care to report this to Child Protection and Family Support. If a child is at risk of harm, confidentiality of client information relating to this risk does not apply.

AOD use does not necessarily result in poor parenting, but it is often a contributing factor, with children of AOD-using parents at greater risk of emotional, behavioural or social problems.

Issues of childcare 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. Establish whether the client has children in their care or has access visits to them. Structured assessment instruments can be used in conjunction with the assessment if risks to the child's safety are identified.

Parental factors associated with an increased risk of abuse or neglect for children include:

- history of abuse or neglect in childhood
- diagnosed mental health disorders
- history of criminal activities and/or family and domestic violence
- history of abuse towards another child
- prior involvement with child protection services
- disadvantaged background
- under 21 years of age
- poverty and/or transient lifestyle
- minimal social support/family isolation
- poor parent/child attachment
- punitive parenting style.

Assessing the potential risk of harm to a child when working with AOD-using parents can be done by exploring the following areas:

- the child's functioning
- the parents' functioning
- protective factors in the child's environment.

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.

Instruments such as the Signs of Safety assessment tool and the Risk Assessment Checklist for Parental Drug Use can be used to guide the assessment.

If the risk is assessed to be either immediate or possible, appropriate management strategies should be implemented. If it becomes necessary to involve a child protection agency 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.

## References

- Dawe, S., Frye, S., Best, D., Moss, D., Atkinson, J., Evans, C., ... Harnett, P. (2007). *Drug use in the family: Impacts and implications for children* (ANCD Research Paper 13). Canberra, ACT: Australian National Council on Drugs.
- Department for Child Protection. (2011). *The Signs of Safety Child Protection Practice Framework*. Perth, WA: Author.
- Department of Health, Western Australia. (2015). *Guidelines for Protecting Children 2015*. Perth, WA: Author.
- Grella, C. E., Scott, C. K., & Foss, M. A. (2005). Gender differences in long-term treatment outcomes in Chicago PETS. *Journal of Substance Abuse Treatment, 28*(2), S3-12. doi: 10.1016/j.jsat.2004.08.008
- Marsh, A., Towers, T., & O'Toole, S. (2012). *Trauma-informed treatment guide for working with women with alcohol and other drug issues*. Perth, WA: Women's Health & Family Services.
- Mental Health Commission, Western Australia (MHC). (2018). *Metro community alcohol & drug service and drug and alcohol youth service integrated service – child protection policy*. Perth, WA: Author.
- Solis, J. M., Shadur, J. M., Burns, A., & Hussong, A. M. (2012). Understanding the diverse needs of children whose parents abuse substances. *Current Drug Abuse Review, 5*(2), 135-147. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3676900/pdf/nihms-473560.pdf>
- Turnell, A. & Edwards, S. (1997). Aspiring to partnership: The Signs of Safety approach to child protection. *Child Abuse Review, 6*(3), 179-190. doi: 10.1002/(SICI)1099-0852(199708)6:3<179::AID-CAR324>3.0.CO;2-J
- Turnell, A. & Edwards, S. (1999). *Signs of Safety: A safety and solution oriented approach to child protection casework*. New York, NY: W. W. Norton & Company.

## 45. Gender and sexual diversity

When working with different genders, it is important to consider factors such as:

- sex – assigned at birth and determined by biological characteristics such as hormones, sexual organs and genes
- gender – a social and cultural construct of what constitutes being a ‘man’ or ‘woman’
- gender identity – how a person perceives their gender
- sexuality – includes sexual feelings, thoughts, attractions, preferences and sometimes behaviour.

Gender mediates the pharmacological impacts of AOD and in turn can influence behaviours. Sexual orientation and gender identity<sup>30</sup> can affect a client’s health and wellbeing in a variety of ways. An understanding of an individual’s identity and relevant behaviours can lead to more appropriate care, including harm reduction, counselling and targeted treatment and referrals. Care that is responsive to the unique needs of lesbian, gay, bisexual, transgendered and intersex (LGBTI)<sup>31</sup> people can enhance the client-worker relationship and help ensure that clients seek follow-up care.

### Gender differences in AOD use

While rates of AOD abuse are generally lower in women than in men (Becker & Hu, 2008), physiological differences between assigned-at birth males and females can alter the effects and specific risks associated with AOD use. Women are more vulnerable to experiencing negative medical consequences of AOD use and dependence (CSAT, 2009; Greenfield, et al., 2007). For example, female drinkers develop liver cirrhosis and heart muscle and nerve damage more quickly than males, and illicit drug use is associated with greater risk of liver and kidney diseases, bacterial infections and opportunistic diseases in females (CSAT, 2009).

### Working with female clients

Whilst research suggests the prevalence of substance use disorders in women in Australia is around half that in men (ABS, 2008), women are less likely to enter treatment (Greenfield et al., 2007). One barrier to women accessing treatment may be that they are more likely to be socially criticised as a result of their use/misuse, particularly when the drugs used are illegal (Thomas, 1997). Women are also more likely to have primary caregiving roles for their children, grandchildren, parents and other dependents; these roles may hinder women seeking help and fully engaging in treatment (CSAT, 2009).

The mental health profile of men and women who develop AOD disorders is different. Women with AOD issues are more likely to experience co-occurring mental health issues, such as mood disorders specific to depressive symptoms, agoraphobia with or without panic attacks, PTSD and eating disorders (CSAT, 2009; Marsh, Towers, & O’Toole, 2012). Additionally, women with AOD use issues are more likely than men to experience negative social and psychological consequences.

Treatment for female clients is likely to be successful if designed to be gender-sensitive and address gender-specific co-occurring issues and barriers to treatment. Service providers should endeavour to reduce barriers to access and have the capacity to address the client’s broad range of needs. These may include co-occurring mental health issues, access to childcare facilities and relevant referrals to a broad range of services (e.g. for health, family, economic and employment issues). Recent research undertaken in AOD treatment facilities in NSW found that 70–80% of the inpatient women had been victims of child sexual abuse, and 40% had experienced sexual assault as an adult. This study also demonstrated that when women could establish a link between their history of trauma and their current circumstances, they were able to contextualise their coping behaviours, enabling them to gain personal insight, reduce their own personal stigma and engage more meaningfully with their treatment (NADA, 2016).

Due to the high rates of trauma experienced by female clients presenting for AOD treatment, it is imperative for treatment settings to provide an environment in which female clients feel safe. Preferably, this should be a family-friendly

<sup>30</sup> Gender Identity refers to a person’s deeply held internal and individual sense of gender. Gender identity is the label or name someone uses to define and identify their gender. It refers to a sense of being male, female, neither, both or other, as well as our sense of gender, gender role, masculinity, femininity or androgyny (Living proud, n.d.).

<sup>31</sup> LGBTI: In Australia, the Commonwealth Government uses the initials LGBTI to refer collectively to people who are lesbian, gay, bisexual, transgender, and/or intersex. Many people and communities have additional ways of describing their distinct histories, experiences, and needs beyond the five letters in LGBTI (Ansara, 2013). LGBTQ is also a term that may also be used – the letter Q can refer to Queer or Questioning.

environment which is welcoming to children. Many women will prefer to see a female counsellor. Ideally, residential services should be welcoming to women and have female-dedicated facilities, such as showers, bathrooms and bedrooms separate to men's. 'Women only' groups are preferable for some women with AOD use issues, particularly women who are pregnant or primary caregivers (Greenfield et al., 2007) (see chapter on **Co-occurring trauma issues**).

Interventions to help manage strong emotions, such as relaxation training and other anxiety management skills, can help women with trauma or co-occurring mood disorders who are seeking AOD treatment (CSAT, 2009). Women are often focused on the needs of others, and rather than assuming that this is a barrier to treatment, skilled counsellors can use this as a tool in developing motivation for recovery (CSAT, 2009).

Social support is essential to both positive treatment outcomes and quality of life for women in recovery (Tracy et al., 2012). Therefore, if appropriate, treatment programs should link women to social support groups and expand their support networks. Importantly, women-only groups should be inclusive of transgender women, or 'transwomen'<sup>32</sup>.

## Working with male clients

Men generally consume harmful substances at higher rates than women (AIHW, 2017). Like women, men need co-occurring issues to be addressed as part of the AOD intervention. Men have better treatment outcomes when engaged with a service that provides a comprehensive treatment approach, including engagement with health, family, economic, legal, and employment services (Marsh, Cao, & D'Aunno, 2004).

There is a strong association between AOD use, in particular alcohol, and violence among men. If a client has an issues with aggression, the consequences of anger and violence (including family violence) as well as alternative ways of coping can be explored (see chapters on **Anger management and Assertiveness training**). Referral to specialist services and groups that deal with men who have issues with anger and violence can be provided.

Previous physical, emotional and sexual abuse is also prevalent among male clients seeking AOD treatment (Wu, Schairer, Dellor, & Grella, 2010). The experience of previous trauma can lead to feelings of shame, guilt and powerlessness, which are often compounded by the feelings associated with AOD dependency (see chapter on **Co-occurring trauma issues**). Treatment for men also needs to be trauma informed. However, it is understood that men and women may respond differently to trauma (CSAT, 2013). Treatment for men can focus on gender role deconstruction, particularly masculine gender role expectations and different ways to express masculinity, including emotional expression and how to be in relationships (CSAT, 2013). Some of the ways in which men are socialised – for example, to display emotional restraint and aggressiveness, fearlessness and invulnerability – may be counterproductive to recovery, so these and other behaviours that may be limiting the ways in which men can cope can be explored.

Males have high rates of suicide and are much more likely to choose lethal means for suicide attempts. There is a strong association between AOD, particularly alcohol, and suicide (Pompili et al., 2010). Be aware of this and explore suicidal ideation with clients, and when indicated, formally assess suicide risk and develop safety plans. Workers should always access supervision and/or consult with colleagues when dealing with suicidal clients (see chapters on **Assessment and Suicide assessment and management**).

## Working with Lesbian<sup>33</sup>, Gay<sup>34</sup>, Bisexual<sup>35</sup>, Transgender, Intersex<sup>36</sup> clients

An Australian study found that lesbian and bisexual women reported higher rates of cannabis and tobacco use than their heterosexual counterparts, and that lesbian and bisexual women were initiated into alcohol and tobacco use at an earlier age than heterosexual women (Roxburgh, Lea, de Wit, & Degenhardt, 2016). In the same study, gay and bisexual men had elevated rates of cannabis, ecstasy and methamphetamine use in the 12 months prior to the survey (Roxburgh et al., 2016).

32 Trans/transgender is an umbrella term used to describe a wide range of gender identities that differ from the perceived norms associated with biological sex (Living proud, n.d.). Currently in Australia, people are classified at birth as female or male. Female-classified children are raised as girls, male-classified children are raised as boys. A female-classified person who identifies as a boy or man might describe himself as a transman or simply as a man. Similarly, a woman classified as male might describe herself as a transwoman or simply as a woman. Some trans people identify trans as their gender. It is generally considered rude to assume that someone identifies as trans based on their history, or to call someone 'a trans', 'a transgender' or 'tranny' (Ansara, 2013).

33 Lesbian is a person who self-describes as a woman and who has experiences of romantic, sexual, and/or affectional attraction solely or primarily to other people who self-describe as women. Some women use other language to describe their relationships and attractions.

34 Gay is a person who self-describes as a man and who has experiences of romantic, sexual and/or affectional attraction solely or primarily to other people who self-describe as men. Some men use other language to describe their relationships and attractions.

35 Bisexual is a person of any gender who has romantic and/or sexual relationships with and/or is attracted to people from more than one gender. Some people who fit this description prefer the terms 'queer' or 'pansexual', in recognition of more than two genders. Although 'bi' technically refers to two, it is often used by people who have relationships with and/or attractions for people of more genders than just women or men (Ansara, 2013).

36 Intersex relates to congenital traits, when a person is born with physical or hormonal features which are not entirely male or female, or can be a combination of both (Living proud, n.d.).



Lesbian, gay, bisexual and other same-sex attracted young people have been shown to be at a higher risk of mental health problems, including depression, anxiety, suicidality, and AOD use than their heterosexual peers (Lea, de Wit, & Reynolds, 2014). Homophobia and stigma are often thought to underlie these differences between the wellbeing of LGBTI and heterosexual people. These stressors are said to have an additive effect on general psychosocial stressors and affect an individual's coping mechanisms, increasing the susceptibility of same-sex attracted people to develop problems with mental health and substance use (Hatzenbuehler, 2009).

Gay men and bisexual women are more likely to report suicidal ideation and suicide attempts than heterosexual men and women; bisexual women are also more likely to report non-suicidal self-injury (Swannell, Martin, & Page, 2015). Transgender and gender non-conforming people are also at higher risk of suicide attempts and suicidal ideation (Testa et al., 2017). Counsellors should ensure they conduct thorough risk assessments and consider the impact of discrimination, victimisation and minority status on the wellbeing of their LGBTI clients (see chapter on ***Suicide assessment and management***).

It is essential to avoid making assumptions about someone's gender or sexuality based on a person's appearance, voice, culture or name. Using appropriate pronouns when working with clients is also important. It is useful to ask clients how they would like to be addressed and referred to. Language used on intake forms and the way we collect information is an important first step when engaging LGBTI clients in a respectful way. Consider the use of the terms they/them/theirs as opposed to he/his/him or she/her/hers.

Although the acronym LGBTI is used as an umbrella term, each of these letters represents a distinct population with its own health concerns (Institute of Medicine (US) Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities, 2011) and its own inherent diversity. LGBTI people have many different ways of living their lives, and there is no single LGBTI community (Morris & Jacobs, 2016). Many LGBTI people do not feel comfortable with this acronym, and while it may be a useful term for workers to use when talking about gender diversity, it is important to treat people as individuals and, if appropriate, ask them about which groups – if any – they choose to identify with.

Since 2010, the National Drug Strategy Household Survey in Australia has consistently shown high rates of substance use among people who identify as homosexual (gay or lesbian) or bisexual (AIHW, 2017). The survey is yet to capture information on transgender or intersex people. The use of illicit drugs in the last 12 months, daily smoking and risky drinking were far more common among homosexual and bisexual people, with the largest differences in the use of ecstasy and methamphetamines (5.8 times higher in homosexual and bisexual people than heterosexuals). Homosexual/bisexual people were 3.7 times as likely to use cocaine, 3.2 times more likely to use cannabis and 2.8 times more likely to misuse pharmaceuticals.

Over one third of LGBTI people hide their sexuality or gender identity when accessing services, over 40% at social and community events, and nearly 40% at work due to the stigma and discrimination that LGBTI people experience (Australian Human Rights Commission, 2014). Having an LGBTI presence in a service can help LGBTI people to feel safe. Many clients have a history of trauma which can be gender triggered, so it is important for services to permit clients to choose the gender of their counsellor if possible. While it may be unrealistic to assume a service would have myriad lesbian, gay, bisexual and gender-diverse<sup>37</sup> counsellors to respond appropriately to the diverse client base, it is important for services to consider the gender diversity of their staff when hiring. Further, it is important to be aware of LGBTI counsellors, gender-specific and gender-diverse AOD services that are available for client referral.

Although most LGBTI Australians live healthy and happy lives, research has found that they are disproportionately affected by poor mental health. LGBTI populations are more likely to be diagnosed with a mental health disorder and face heightened risk of psychological distress, self-harm, suicidal ideation and attempts (Morris & Jacobs, 2016). These negative indices are not an inevitable result of a sexual minority status (Diamond, 2003) but are a likely consequence of the discrimination, marginalisation and isolation often associated with being LGBTI (Higa et al., 2014). Counsellors should consider co-occurring issues when working with gender-diverse clients and be sensitive to signs of self-harm and suicidal ideation. Being non-judgemental and working in a respectful and empathic way can counteract some of the negative effects of discrimination that clients may have experienced in other services.

37 Gender Diverse refers to someone who does not identify with the gender assigned at birth (Living proud, n.d.).

LGBTI youth, whilst facing the general challenges of adolescence, can also face challenges such as a lack of support or rejection from people close to them, such as family members (Higa et al., 2014), friends, and classmates, or from people in authority, such as teachers, and coaches. Many LGBTI youth are subject to bullying, harassment, threats, and violence (Australian Human Rights Commission, 2014); and have higher rates of eating disorders, STIs, school difficulties, sexual assault, homelessness, violence and suicide (Higa et al., 2014). It is important to be aware of increased risks and to provide appropriate education, harm reduction strategies, referrals, and resources where appropriate.

LGBTI elders share the same concerns about ageing as the rest of the population (see chapter on **Older people**). However, they have unique challenges and concerns, including fear of discrimination, stigma, and victimisation within health care systems. They may be isolated due to factors such as rejection from family, and, being less likely to have children, they may not have family or social supports (Abatiell & Adams, 2011). LGBTI elders in residential facilities may be particularly vulnerable when housed in unwelcoming, non-LGBTI-inclusive environments.

### Tip sheet – gender and sexual diversity

Women, men, transgender and gender nonconforming people face specific issues which may impact on their AOD use.

Previous trauma is common for female, male and LGBTI clients. Approach clients in a trauma-informed way to help them to feel safe, particularly when addressing trauma issues (see chapter on **Co-occurring trauma issues**).

Women may avoid treatment due to discrimination and caregiving commitments. View women's tendency to be other-focused as a strength and possible motivator for recovery.

Consider linking female clients into additional support services and groups, as they typically respond very well to engagement in support groups.

Where possible, offer a family-friendly service and options for women-only and men-only groups.

If an anger or violence issue is identified, encourage male clients to examine the consequences. Where appropriate, use anger management strategies and explore alternative coping strategies to AOD use. Refer to groups addressing anger management when available and appropriate (see chapter on **Anger management**).

**Be aware of the high rates of suicide in heterosexual men and LGBTI people when conducting suicide risk assessments, and always ask about suicide, suicidal ideation and non-suicidal self-injury** (see chapter on **Suicide assessment and management**).

Facilitate engagement with services to address co-occurring health, family, economic, employment and legal problems.

Create a welcoming environment inclusive of LGBTI people.

Learn and use people's preferred pronouns. Do not assume the pronouns or gender of someone based on their appearance, voice, culture or name.

Intake forms, posters, emails, and other forms of communication should use inclusive language.

Offer choices of counsellor, for example female, male, or where possible, non-binary gender.

Check that your service has inclusive forms and if needed, change policy and procedures to incorporate inclusive language to reduce barriers to access. Intake and assessment forms should allow blank space for people to record their own gender.

Ensure access to unisex bathrooms (or allow people to use the bathroom of their preferred gender).

Treatment should consider the social, cultural, and psychological context of AOD use, which is different for gender diverse people.

Be aware of the diversity amongst LGBTI groups and people. Be empathic and non-judgemental. Do not make assumptions.

Be aware of increased rates of mental health disorders and suicide among LGBTI people.

Develop partnerships with LGBTI services for referral.

## References

- Abatiell, P., & Adams, M. (2011). LGBTI aging: A question of identity. *The Gerontologist*, 51(6), 880-884. <https://doi.org/10.1093/geront/gnr113>
- Ansara, G. Y. (2013). *Inclusive language guide: respecting people of intersex, trans and gender diverse experience* [Fact sheet]. Retrieved from [https://lgbtihealth.org.au/sites/default/files/Alliance%20Health%20Information%20Sheet%20Inclusive%20Language%20Guide%20on%20Intersex%2C%20Trans%20and%20Gender%20Diversity\\_0.pdf](https://lgbtihealth.org.au/sites/default/files/Alliance%20Health%20Information%20Sheet%20Inclusive%20Language%20Guide%20on%20Intersex%2C%20Trans%20and%20Gender%20Diversity_0.pdf)
- Australian Bureau of Statistics. (2008). *National Survey of Mental Health and Wellbeing: Summary of Results*. (Cat. No. 4326.0). Canberra, ACT: ABS. Retrieved from <http://www.abs.gov.au/ausstats/abs@.nsf/mfi/4326.0>
- Australian Human Rights Commission. (2014). *Face the facts: Lesbian, gay, bisexual, trans and intersex people* [Brochure]. Retrieved from [https://www.humanrights.gov.au/sites/default/files/7\\_FTF\\_2014\\_LGBTI.pdf](https://www.humanrights.gov.au/sites/default/files/7_FTF_2014_LGBTI.pdf)
- Australian Institute of Health and Welfare (AIHW). (2017). *National drug strategy household survey 2016 - detailed findings* (Drug Statistics series no. 31. Cat. no. PHE 214). Canberra, ACT: Author.
- Becker, J. B. & Hu, M. (2008). Sex differences in drug abuse. *Frontiers in Neuroendocrinology*, 29(1), 36-47. doi: 10.1016/j.yfme.2007.07.003
- Center for Substance Abuse Treatment (CSAT). (2009). *Substance abuse treatment: addressing the specific needs of women* (Treatment Improvement Protocol (TIP) Series, No. 51). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment (CSAT). (2013). *Addressing the specific behavioural health needs of men* (Treatment Improvement Protocol (TIP) Series, No. 56). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Diamond, L. (2003). New paradigms for research on heterosexual and sexual minority development. *Journal of Clinical Child and Adolescent Psychology*, 32(4), 490-498. doi: 10.1207/S15374424JCCP3204\_1
- Greenfield, S. F., Brooks, A. J., Gordan, S. M., Green, C. A., Kropp, F., McHugh, R. K., & Miele, G. M. (2007). Substance abuse treatment entry, retention, and outcome in women: A review of the literature. *Drug and Alcohol Dependence*, 86(1), doi: 1-21. 10.1016/j.drugalcdep.2006.05.012
- Hatzenbuehler, M. L. (2009). How does sexual minority stigma "get under the skin"? A psychological mediation framework. *Psychological Bulletin*, 135(5), 707-730. doi: 10.1037/a0016441
- Higa, D., Hoppe, M. J., Lindhorst, T., Mincer, S., Beadnell, B., Morrison, D. M., ... Mountz, S. (2014). Negative and positive factors associated with the well-being of lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ) youth. *Youth & Society*; 46(5), 663-687. doi: 10.1177/0044118X12449630
- Institute of Medicine (US) Committee on Lesbian, Gay, Bisexual, and Transgender Health Issues and Research Gaps and Opportunities. (2011). *The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding*. Washington, DC: The National Academies Press.
- Lea, T., de Wit, J., & Reynolds, R. (2014). Minority stress in lesbian, gay, and bisexual young adults in Australia: associations with psychological distress, suicidality, and substance use. *Archives of Sexual Behaviour*, 43(8), 1571-1758. <https://doi.org/10.1007/s10508-014-0266-6>
- Living Proud. (n.d.). *Opening Closets Mental Health Training: Glossary of terms*. Retrieved from <http://www.livingproud.org.au/wp-content/uploads/2014/01/OCMH-Glossary-A5.pdf>
- Marsh, A., Towers, T., & O'Toole, S. (2012). *Trauma-informed treatment guide for working with women with alcohol and other drug issues*. Perth, WA: Women's Health & Family Services.
- Marsh, J. C., Cao, D., & D'Annunzio, T. (2004). Gender differences in the impact of comprehensive services in substance abuse treatment. *Journal of Substance Abuse Treatment*, 27(4), 289-300. doi: 10.1016/j.jsat.2004.08.004
- Morris, S., & Jacobs, R. (2016). *National LGBTI Mental Health and Suicide Prevention Strategy: a new strategy for inclusion and action* [brochure]. Retrieved from [https://lgbtihealth.org.au/wp-content/uploads/2016/12/LGBTI\\_Report\\_MentalHealthandSuicidePrevention\\_Final\\_Low-Res-WEB-1.pdf](https://lgbtihealth.org.au/wp-content/uploads/2016/12/LGBTI_Report_MentalHealthandSuicidePrevention_Final_Low-Res-WEB-1.pdf)
- Network of Alcohol and other Drugs Agencies (NADA). (2016). *Working with women engaged in alcohol and other drug treatment* (2nd ed.). Retrieved from [https://www.nada.org.au/wp-content/uploads/2017/10/working\\_with\\_women\\_engaged\\_in\\_aod\\_treatment\\_web.pdf](https://www.nada.org.au/wp-content/uploads/2017/10/working_with_women_engaged_in_aod_treatment_web.pdf)
- PASH.tm (2017). PASH.tm: *Position statement – data collection* [Fact sheet]. Retrieved from: [http://www.grunt.org.au/wp-content/uploads/PASH.tm-Data-Collection\\_Nov\\_2017.pdf](http://www.grunt.org.au/wp-content/uploads/PASH.tm-Data-Collection_Nov_2017.pdf)
- Pompili, M., Serafini, G., Innamorati, M., Dominici, G., Ferracuti, S., Kotzalidis, G.D., ... Lester, D. (2010). Suicidal behaviour and alcohol abuse. *International Journal of Environmental Research and Public Health*, 7(4), 1392-1431. doi: 10.3390/ijerph7041392
- Roxburgh, A., Lea, T., de Wit, J., & Degenhardt, L. (2016). Sexual identity and prevalence of alcohol and other drug use among Australians in the general population. *International Journal of Drug Policy*, 28, 76-82. <https://doi.org/10.1016/j.drugpo.2015.11.005>
- Slater, M., & Breckenridge, J. (2012). Gender, use and abuse: Sexually abused women in alcohol and drug treatment. In K. Nakray (Ed.), *Gender-based violence and public health: International perspectives on budgets and policies* (pp. 1-15). Oxford, United Kingdom: Routledge.
- Swannell, S., Martin, G., & Page, A. (2015). Suicidal ideation, suicide attempts and non-suicidal self-injury among lesbian, gay, bisexual and heterosexual adults: Findings from an Australian national study. *Australian & New Zealand Journal of Psychiatry*, 50(2), 145-153. doi: 10.1177/0004867415615949
- Testa, R. J., Michaels, M. S., Bliss, W., Rogers, M. L., Balsam, K. F., & Joiner, T. (2017). Suicidal ideation in transgender people: Gender minority stress and interpersonal theory factors. *Journal of Abnormal Psychology*, 126(1), 125-136. doi: 10.1037/abn0000234
- Thomas, S. (1997). Working with women. In S. Helfgott & S. Allsop (Eds.), *Helping change: The drug and alcohol counsellors' training program*. Perth, WA: Drug and Alcohol Office.
- Tracy, E. M., Laudet, A. B., Min, M. O., Kim, H., Brown, S., Jun, M. K., & Singer, L. (2012). Prospective patterns and correlates of quality of life among women in substance abuse treatment. *Drug and Alcohol Dependence*, 124(3), 242-249. doi: 10.1016/j.drugalcdep.2012.01.010
- Wu, N. S., Schairer, L. C., Dellor, E., & Grella, C. (2010). Childhood trauma and health outcomes in adults with comorbid substance abuse and mental health disorders. *Addictive Behaviors*, 35(1), 68-71. doi: 10.1016/j.addbeh.2009.09.003

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## 46. Culturally and linguistically diverse people

In Australia, culturally and linguistically diverse (CALD) is the term generally used to refer to groups and individuals who have religion, race, language and ethnicity that differs from those people of Anglo-Saxon/Celtic ancestry. Cultural norms, the shared rules and expectations that guide people's behaviour within social groups, consist of four cultural elements: values, norms, institutions and artefacts. Cultural norms are expressed differently within CALD groups. All cultures contain their own set of variances and subcultures; there is no single cultural norm (Supreme Court of Western Australia, n.d.). Cultural compliance, however, will vary between individuals from the same cultural background.

### Improving AOD treatment accessibility

Culturally and linguistically diverse clients are under-represented in AOD services. This under-representation can be attributed to service access barriers rather than a lack of need in CALD populations (Beyer & Reid, 2000). Examples of barriers include:

- stigma
  - shame and guilt around substance use
  - fear of judgement about accessing AOD treatment
- language and cultural differences
  - English being a second (or third, etc.) language
  - no interpreter or cultural liaison available through AOD services
  - perceived/real cultural differences between the client and worker
  - difficulty articulating expectations of service or needs
- AOD knowledge
  - lack of awareness or confusion around impacts of AOD use
  - low exposure to public health campaigns
  - confusion about AOD dependence
- AOD services
  - lack of awareness of existence/availability of AOD services
  - lack of awareness of referral processes
  - few culturally suitable AOD services available outside their community (being sought to maintain confidentiality/privacy)
  - workers at non-AOD services often have insufficient AOD knowledge.

(Drug and Alcohol Multicultural Education Centre [DAMEC], 2007; DAMEC, 2010)

## Improving client AOD treatment experience

The Victorian Alcohol and Drug Association (2016) identified nine best practice features for improving the treatment experience and outcome for CALD clients. Services and workers need to:

- take into account the person's ethnicity, cultural identity, and pre-migration and settlement experience
- pay special attention to engagement, address confidentiality concerns and promote safety (build rapport and trust)
- provide language service support (where required)
- address gaps in health literacy while focusing on the client's worldview and health perceptions
- be flexible in service delivery – tailor the intervention to match the clients' help-seeking behaviours
- customise the physical environment e.g. hang culturally appropriate pictures in the waiting room
- work in partnership with CALD community leaders, bi-cultural workers and other representatives
- use appropriate messaging and communication channels to reduce stigma and shame and improve the health literacy of community members requiring AOD support or treatment
- provide holistic and family sensitive care.

Suggestions for implementing some of these features are discussed in the remainder of this chapter.

### Ethnicity, cultural identity, pre-migration and settlement experience

Workers should bear in mind several basic but important considerations when working with CALD clients:

- ask the client how you should address them
- if they have a non-English name, learn to pronounce it
- explore the client's expectations of treatment and clarify what is realistic
- be aware of cultural taboos; many CALD clients experience acute embarrassment around issues that non-CALD clients engage with easily
- be clear, concrete and specific in what you say.

It is also essential for workers to understand their client's AOD use in the context of their cultural base (Houseman, 2003). This knowledge provides a platform for understanding how the client might be interpreting and feeling about their experiences with AOD use (Houseman, 2003). Using this approach in AOD treatment can help workers avoid making incorrect assumptions. Helping clients to place their AOD use in the context of background and experiences can reduce shame and increase self-compassion.

The relevant information to gather can be grouped into the following three categories (Marel et al., 2016):

- context of the migration
  - reason for leaving their country of origin
  - mode of travel to Australia
  - residency status
  - presence of migration trauma prior to leaving country of origin and/or after arrival in Australia
- subgroup membership
  - demographics of ethnicity, gender, sexual orientation, area in which they live
  - refugee or immigrant affiliation
  - religious affiliation
- degree of acculturation
  - traditional – if the client adheres completely to the beliefs, values and behaviours of their country of origin
  - bicultural – if the client has 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 to new ones
  - assimilated – if the client has completely given up their old beliefs, values and behaviours and adopted those of the new country.



## Engagement, confidentiality and building rapport and trust

Culturally and linguistically diverse clients may experience any number of stressors which can increase the challenges of adjusting to life in Australia. Many of these issues can become barriers to engaging and remaining engaged in AOD treatment and contribute to the perpetuation of AOD problems. Workers and services should be aware of these stressors and where possible, provide practical assistance or appropriate referrals (Brewer, 2009). Essentially, unless workers can be of practical help in reducing or managing stressors, they are likely to have little success in addressing the AOD use. Outlining measures for maintaining confidentiality can allay client concerns about their experience being shared with others. See chapter on **Confidentiality**.

## Language services support

The use of a professional interpreter, even for clients with English proficiency, can be a beneficial strategy for improving the client's treatment experience and outcomes. Client agreement should be sought before utilising an interpreter.

## Practical considerations for arranging and using an interpreter

- Ask whether the client would prefer a male or female interpreter
- Be aware that dialects can differ and ensure the interpreter speaks the client's dialect
- Check whether the client would accept an interpreter from a different ethnic group
- Allow at least twice the usual time for a session, because counselling activities tend to take longer when an interpreter is used
- Confidentiality needs to be addressed carefully, with both the interpreter and client
  - Some clients may be reluctant to disclose personal information in front of an interpreter who is not a trained counsellor
  - Some CALD clients are reluctant to use an interpreter in case the interpreter comes from their own community and/or is known to them, which can heighten shame.

(Mills et al., 2009)

Ensure the interpreter remains engaged in their own role and does not drift towards the counselling process.

## Gaps in health literacy while focusing on the client's worldview and health perceptions

Workers should use clear, unambiguous language (no acronyms) and regularly check that they and their clients understand each other. Cultures can have different understandings of psychological symptoms and what constitutes mental health disorders; clients may have a cultural interpretation of their experience. Workers should also be aware that signs and symptoms of psychological disorders may be described differently. For example, a non-CALD client who is experiencing psychosis might talk of being controlled by aliens, whereas a CALD client might refer to the same experience as 'black magic' (Mills et al., 2009).

It is important to remember that discussing some topics, such as sexual health/risks, with a worker of the opposite sex may be inappropriate or uncomfortable for the client (NADA, 2014). If appropriate, consider seeking information in the client's language or referring them to a same sex service provider.

## The physical environment

Importantly, the therapeutic environment should be culturally secure and gender sensitive (NSW Health & SA Health, 2006). Some strategies for creating a welcoming environment for CALD clients might include (NADA, 2014):

- increase the number of CALD workers within the agency
- using images representing the diversity of cultures in the local community/town/region
- use different CALD languages in signage.

## Partnership with CALD community leaders, bi-cultural workers and other representatives

AOD services and workers should collaborate with CALD-specific agencies in order to achieve the best treatment outcomes for CALD clients (DAMEC, 2007). This requires building internal and external relationships within the AOD agency and at worker levels, as well as between AOD services and CALD-specific agencies (DAMEC, 2010).



## Holistic and family sensitive care

If a CALD client has a strong collectivist world view, family involvement in their treatment process can be critical to improving their treatment outcomes. If appropriate, and with the client's permission, workers should build a sensitive collaboration with families (see chapter on **Working with significant others**). It is important the client decides who participates (Marel et al., 2016).

If the client does not want family involvement in their AOD treatment, workers may need to assist family members to access support and counselling of their own.

### Culturally and linguistically diverse – tip sheet

Improving AOD treatment accessibility for CALD clients requires building relationships internally and externally, at agency and worker levels, and with CALD agencies and communities (Marel et al., 2016).

Seek to understand the client's cultural base, such as the context of their migration, subgroup membership and degree of acculturation. How does their AOD use fit in with their cultural base?

Be aware of potential problems if considering using an interpreter, such as confidentiality, dialect-matching, and additional session time to accommodate for translation process.

Consider family-inclusive practice, particularly if the client has a collectivist background.

Provide CALD clients with practical help to manage stressors that may perpetuate AOD-related issues.

## References

- Beyer, L., & Reid, G. (2000). *Drugs in a multicultural community: An assessment of involvement*. Department of Human Services, Public Health Division, Melbourne
- Brewer, R. (2009). *Culturally and linguistically diverse women in the Australian Capital Territory. Enablers and barriers to achieving social connectedness*. Canberra, ACT: Women's Centre for Health Matters Inc.
- Drug and Alcohol Multicultural Education Centre (DAMEC). (2007). *Making treatment accessible for culturally and linguistically diverse clients with alcohol and other drug issues*. West Melbourne, VIC: Australian Drug Foundation. Retrieved from [www.druginfo.adf.org.au](http://www.druginfo.adf.org.au)
- Drug and Alcohol Multicultural Education Centre (DAMEC). (2010). *Making treatment services and prevention programs accessible for culturally and linguistically diverse clients*. West Melbourne, VIC: Australian Drug Foundation. Retrieved from [www.druginfo.adf.org.au](http://www.druginfo.adf.org.au)
- Houseman, D. (2003). *A framework for working with alcohol and other drug clients from diverse communities*. Elwood, VIC: Department of Human Services – Southern Metropolitan Region.
- Marel, C., Mills, K.L., Kingston, R., Gournay, K., Deady, M., Kay-Lambkin, F., Baker, A., & Teesson, M. (2016). *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*. Sydney, NSW: National Drug and Alcohol Research Centre. Retrieved from <https://comorbidityguidelines.org.au/>
- Mills, K., Deady, M., Proudfoot, H., Sannibale, C., Teesson, M., Mattick, R. & Burns, L. (2009). *Guidelines for the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*. Sydney, NSW: Centre of Research Excellence in Mental Health and Substance Use, National Drug and Alcohol Research Centre.
- Network of Alcohol and Other Drugs Agencies (NADA). (2014). *Working with diversity in alcohol and other drug settings*. Retrieved from [https://nada.org.au/wp-content/uploads/2017/06/nada\\_working\\_with\\_diversity\\_sept14.pdf](https://nada.org.au/wp-content/uploads/2017/06/nada_working_with_diversity_sept14.pdf)
- NSW Health & SA Health. (2006). *National clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn*. North Sydney, NSW: Ministerial Council on Drug Strategy, NSW Department of Health.
- Supreme Court of Western Australia. (n.d.). *Equality before the law*, Chapter 7. Retrieved from [https://www.supremecourt.wa.gov.au/\\_files/equality\\_before\\_the\\_law\\_chapter7.pdf](https://www.supremecourt.wa.gov.au/_files/equality_before_the_law_chapter7.pdf)
- Victorian Alcohol and Drug Association. (2016). *CALD AOD Project: Final report*. Collingwood, VIC: Author.

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## 47. Aboriginal clients, their families and communities

In Australia, Aboriginal communities are diverse and dynamic: they represent many language groups, hold unique cultural customs and share a rich history. Nationally, Aboriginal peoples<sup>38</sup> experience AOD problems at a disproportionately higher rate than non-Aboriginal Australians (Wilson, Stearne, Gray, & Saggars, 2010). It is important that non-Aboriginal workers have an understanding of the historical and social factors that contribute to problematic AOD use among Aboriginal people.

Contemporary AOD problems experienced by many Aboriginal peoples can be attributed to colonisation policies which sanctioned displacement from traditional lands; forcibly removed generations of children from families; and imposed compliance with foreign culture, religion and language (AIHW, 2016). Those colonisation strategies have resulted in poverty, marginalisation and disadvantage; high rates of AOD-related injuries requiring hospital admission and death; social problems such as family violence and child abuse/neglect; low educational achievement; high unemployment; and high levels of imprisonment (Wilson et al., 2010). Overall, the life expectancy of Aboriginal people is approximately 10 years less than that of non-Aboriginal Australians (AIHW, 2018).

### Culturally secure ways of working with Aboriginal clients

Despite the shock of colonisation, many Aboriginal knowledge systems have survived. Mainstream models of AOD practice have been developed within Western knowledge systems, and consequently ignore an Aboriginal world view or perpetuate intergenerational trauma caused by colonisation. Using models that don't match the cultural beliefs and values of Aboriginal clients may result in treatment/service disengagement. Culturally secure practices are required to respond to the strengths and needs of Aboriginal peoples and their communities.

The complexity of factors contributing to AOD problems among Aboriginal peoples means that culturally secure responses are needed at all levels of government, within agencies and throughout communities. Partnerships between Aboriginal and non-Aboriginal agencies and individuals are essential. Responses should also acknowledge the diversity within and between Aboriginal communities in remote, regional and metropolitan areas.

With guidance from Aboriginal agencies, evidence-based AOD models can be adapted to include an Aboriginal world view. In an effort to move away from a 'one size fits all' attitude, the following principles (Australian Government Department of Health and Ageing, 2007) can ensure models are redeveloped and framed within an Aboriginal context by Aboriginal peoples:

- acknowledge and incorporate an Aboriginal holistic concept of health and wellbeing
- understand the importance of Aboriginal historical factors (i.e. traditional life)
- recognise the impact and ongoing effect of colonisation
- strengthen Aboriginal family systems of care, control and responsibility
- address culturally secure approaches to harm reduction
- work with empowerment principles of self-determination.

The *Aboriginal Inner Spirit Model*<sup>39</sup> (Roe, 2000) illustrates the connection between self, country and community, and can be used to help Aboriginal clients improve their decision-making and support their behavioural change. With this model as a background, the Ways of Working with Aboriginal people (WOW) offers culturally secure strategies for working with Aboriginal clients, their families and communities (MHC, 2018). In a therapeutic setting, the Aboriginal Inner Spirit Model (Roe, 2000) and WOW constitute a useful framework for:

- understanding the structure of traditional Aboriginal life
- contextualising the impact of colonisation on contemporary life
- acknowledging the cultural disruption caused by AOD
- and exploring continuing systems of Aboriginal oppression.

38 There are national, regional and community differences in preferences for identifying as 'Aboriginal', 'Torres Strait Islander' and 'Indigenous' or by clan group (i.e. Noongar in South Western Australia). In Western Australia it is more common to use Aboriginal. It is recommended that you always ask clients how they prefer to describe their cultural heritage and community (Australian Government Department of Health and Ageing, 2007).

39 Different language groups give the Inner Spirit different names (e.g. Ngarlu or Liyan). Furthermore, not all Aboriginal clients subscribe to traditional spirituality and this concept may not resonate with them.

Additionally, the WOW expands on the 4Ls model (attributed to Roizen, 1983) of AOD-related harms (see chapter on **Harm reduction**) to include three additional 'Ls' representing Aboriginal values (MHC, 2018):

- **Liver** – health. Health in an Aboriginal context includes social and emotional wellbeing and is a holistic way of viewing health.
- **Lover** – family and community
- **Livelihood** – money and work
- **Aboriginal Law** – governance structures of traditional life, social and cultural obligations
- **Legal** – problems related to the mainstream Australian legal system
- **Loss** – grief and loss, both intergenerational and current, Stolen Generations, family in prison. Given the lower life expectancy of Aboriginal people, it is especially important to acknowledging competing family and cultural obligations during Sorry Time/funerals
- **Land** – maintaining connections to country and culture.

The WOW resources also provide culturally secure information about AOD use, dependence and harm reduction, the stages of change model (Prochaska & DiClemente, 1992) at an individual and community level, and relapse prevention and goal-setting.

## Mainstream theories to consider when working with Aboriginal clients

The following mainstream models are also worth considering when working with Aboriginal people.

Social Learning Theory (Bandura, 1977) acknowledges that to some extent drug use is learned from the environment in which people live. This is important in contextualising contemporary AOD issues and recognising that the dominant (non-Aboriginal) culture has modelled detrimental patterns of AOD use that did not exist in Aboriginal communities prior to colonisation. When Aboriginal families and communities adopt those patterns, they exacerbate colonisation's damage to social and emotional health and wellbeing.

Similarly, the social determinants of health (Wilkinson & Marmot, 2003) highlight the need to consider AOD use in the context of social, environmental and economic determinants of health. Complex interrelated physical, social, emotional, economic, educational and environmental inequalities influence harmful AOD use among Aboriginal people. It is important to recognise that many Aboriginal people experience poor environmental, social, and economic conditions, which are linked to higher rates of AOD use and health problems (Wilson et al., 2010).

When adapted in culturally secure ways, CBT works well with Aboriginal people (Bennett-Levy et al., 2014). With a focus on supporting clients to change the way they think and behave, this approach uses goal-setting strategies in assisting clients to manage complex problems. Importantly, it is considered a safe approach that doesn't retraumatise Aboriginal clients (Bennett-Levy et al., 2014) (see chapters on **Problem-solving**, **Goal-setting** and **Challenging unhelpful thinking**).

Given ongoing impact of colonisation policies and practices, and continued racism, violence and disadvantage consider a trauma-informed care and practice approach (see chapter on **Co-occurring trauma issues**) when working with Aboriginal clients.

## Implications for best practice when working with Aboriginal clients

Culturally safe practices are essential for AOD agencies and workers to best help their Aboriginal clients. Strategies for maintaining cultural security in AOD settings are listed below.

Acknowledgement of Aboriginal culture may be demonstrated at an agency level through some or all of the following:

- Implement cultural awareness practices in agency/organisational culture, such as:
  - offer an Acknowledgement of Country at business/social events
  - install or display Aboriginal and Torres Strait Islander flags
  - recognise significant dates/events for the local/national Aboriginal community (e.g. NAIDOC week)
  - form a Re/Conciliation Action Group and Action Plan
  - display Aboriginal artwork
  - appoint an Aboriginal Elder in residence

- Build organisational/staff capacity to respond effectively to AOD problems by establishing partnerships and collaboration with local Aboriginal services/individuals.
- Employ Aboriginal staff and provide them with training and resources to increase their effectiveness in working with Aboriginal communities:
  - many Aboriginal staff are also supporting family and community members dealing with AOD and mental health issues, and may require support to reduce professional burnout
  - consider the additional workload of staff if they become the cultural broker or agency expert on all things Aboriginal; they may need support to reduce professional burnout
- Ensure non-Aboriginal workers participate in cultural awareness training prior to working with Aboriginal clients.
- Ensure non-Aboriginal workers have ongoing cultural supervision from mentors who demonstrate competence in working with Aboriginal people.

Aboriginal client-centred practice may be achieved through some or all of the following:

- Offer Aboriginal clients additional support through referrals to Aboriginal-specific AOD services.
- Ask Aboriginal clients about – and if possible, accommodate – their preference for a male or female case worker:
  - AOD issues for Aboriginal clients may be related to men’s or women’s business or cultural obligations may make it uncomfortable for them to discuss their AOD use with a person of the opposite gender.
- Ask Aboriginal clients about – and if possible, accommodate – their preference for an Aboriginal or non-Aboriginal case worker:
  - Aboriginal clients may experience Shame as more than an emotion. For many, it may be a profound and disabling experience that is exacerbated by working with a non-Aboriginal counsellor or worker. Conversely, some clients may prefer a non-Aboriginal worker to ensure perceived confidentiality within their community.
- Acknowledge the strength of Aboriginal clients’ family systems; this may not necessarily be a nuclear, Western structure, and could include extended relatives:
  - with client permission, include family members in treatment plans as much as possible.
- A flexible approach is needed when working with Aboriginal clients, their families and communities. Consider the following adaptations:
  - meeting with clients in less formal settings (e.g. in a park)
  - repeated grief and loss in the lives of many Aboriginal people, families and communities; cultural or family obligations may take precedence over appointments (i.e. Sorry Time/funerals)
  - unresolved, intergenerational trauma warrants a trauma-informed care and practice approach (HealthInfoNet, n.d.).

### Working with Aboriginal clients, their families and communities – tip sheet

Culturally secure ways of working with Aboriginal peoples respect their rights, values and expectations. It is important to acknowledge the diversity within and between Aboriginal communities living in remote, regional and metropolitan areas.

There are many ways to improve the cultural security of an agency and create an Aboriginal client-centred practice. Implementing culturally secure practices:

- acknowledges Aboriginal and Torres Strait Islander people as first Australians and traditional custodians of their local lands and waterways
- incorporates an Aboriginal holistic concept of health and wellbeing
- recognises the continued impact of colonisation and intergenerational trauma in Aboriginal families, such as the overrepresentation of social disadvantage
- aims to strengthen Aboriginal family systems of care, control and responsibility
- uses Aboriginal values to approach harm reduction
- seeks to work within empowerment principles of self-determination.

## References

- Australian Government Department of Health and Ageing. (2007). *Alcohol treatment guidelines for Indigenous Australians*. Canberra, ACT: Author.
- Australian Institute of Health and Welfare (AIHW). (2016). *Australia's health 2016* (Australia's health series no.15. cat. no. AUS 199). Canberra, ACT: Author.
- Australian Institute of Health and Welfare. (AIHW). (2018). *Australia's health 2018*. Retrieved from: <https://www.aihw.gov.au/reports/australias-health/australias-health-2018/contents/indicators-of-australias-health/life-expectancy>
- Bandura, A. (1977). *Social learning theory*. Englewood Cliffs, NJ: Prentice Hall.
- Bennett-Levy, J., Wilson, S., Nelson, J., Stirling, J., Ryan, K., Rotumah, D., ... W., Beale, D. (2014). Can CBT be effective for Aboriginal Australians? Perspectives of Aboriginal practitioners trained in CBT. *Australian Psychologist*, 49. doi: 10.1111/ap.12025
- HealthInfoNet. (n.d.). *Trauma*. Retrieved from: <https://healthinfonet.ecu.edu.au/learn/health-topics/healing/trauma/>
- Mental Health Commission, Western Australia (MHC). (2018). *Strong Spirit Strong Mind – Aboriginal ways to reduce harm from alcohol and other drugs*. Making sense and supporting change: A guide for our people. Perth, WA: Author.
- Prochaska, J. O., & DiClemente, C. C. (1992). In search of how people change: applications to addictive behaviours. *American Psychologist*, 47(9), 1102-1114. <http://dx.doi.org/10.1037/0003-066X.47.9.1102>
- Roe, J. N. (2000). Ngarlu: A cultural and spiritual strengthening model. In: P. Dudgeon, D. Garvey & H. Pickett (Eds.), *Working with Indigenous Australians: A handbook for psychologists*. Perth, WA: Gunada Press.
- Roizen, R. (1983). Loosening up: General population views of the effects of alcohol. In R. Room & G. Collins (Eds.), *Alcohol and disinhibition: Nature and meaning of the link* (pp.236-257). Washington, DC: US Government Printing Office.
- Wilson, M., Stearne, A., Gray, D., & Saggars, S. (2010). The harmful use of alcohol amongst Indigenous Australians. *Australian Indigenous HealthBulletin*. Retrieved from [http://healthbulletin.org.au/wp-content/uploads/2010/06/alcohol\\_review\\_june\\_2010.pdf](http://healthbulletin.org.au/wp-content/uploads/2010/06/alcohol_review_june_2010.pdf)
- Wilkinson, R., & Marmot, M. (Eds.). (2003). *Social determinants of health: The solid facts*. (2nd ed.). Copenhagen, Denmark: World Health Organization.

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## 48. AOD use during pregnancy

AOD use during pregnancy is complex because it often occurs alongside factors such as poverty, stress, mental ill-health and domestic violence (Poole & Urquhart, 2010). Some reasons women use alcohol during pregnancy include not knowing they are pregnant, being unaware of the impact of AOD use on their unborn child, and AOD dependence.

There can be enormous stigma associated with AOD use during pregnancy, along with a range of barriers to accessing antenatal services for women who are AOD dependent (Roberts & Pies, 2011). These women may experience significant guilt about their drug use, as well as concern about the health of their child.

Prenatal AOD exposure can cause miscarriage, obstetric complications, and lifelong challenges for the unborn child resulting from deformities, growth deficiencies and functional deficits (CSAT, 2009; Preece & Riley, 2011).

### Alcohol and pregnancy

As a teratogen, alcohol is toxic to embryonic development and can cause birth defects. The teratogenic effects of alcohol vary depending on the amount consumed and the developmental stage of the fetus. For example, the central nervous system is teratogen sensitive for the entire pregnancy and alcohol exposure can result in lifelong intellectual and behavioural problems (O'Leary, 2002).

When alcohol enters the mother's bloodstream, it crosses the placenta into the fetus' bloodstream. The fetus' BAC quickly rises to match maternal levels. Additionally, amniotic fluid acts as a reservoir, prolonging alcohol exposure (Vaux & Chambers, 2016). These impacts may be increased by polydrug use.

Several factors can influence fetal vulnerability and resilience to the effects of alcohol:

- amount of alcohol consumed
- pattern of alcohol use
- timing of alcohol exposure during pregnancy
- maternal and fetal biological make up.

(Chudley et al., 2005; May & Gossage, 2011; Tunc-Ozcan et al., 2014)

It is important to note that not all children born to mothers who consumed alcohol during pregnancy will have foetal alcohol spectrum disorder (FASD). Nevertheless, frequent, high-level alcohol use of more than five standard drinks in one sitting during pregnancy can increase both the risk and severity of FASD (Elliott, Payne, Morris, Haan, & Bower, 2008).

Safe levels of alcohol exposure for foetal development are unknown. As such, the NHMRC (2009) recommends that **no alcohol** is the safest option during pregnancy, while planning a pregnancy, or breastfeeding.

### Fetal Alcohol Spectrum Disorder

Fetal alcohol spectrum disorder is the term used to describe a range of permanent physical and/or neurodevelopmental impairments caused by maternal alcohol consumption during pregnancy. The effects of prenatal alcohol exposure can include damage to the brain, major organs, facial structure and CNS.

Individuals who have FASD often experience secondary effects and social challenges, including mental health problems, disrupted school experience, AOD dependence, difficulties maintaining employment, and an inability to live dependently (Streissguth, Barr, Kogan, & Bookstein, 1997; Streissguth et al., 2004).



## FASD diagnosis

Obtaining a FASD diagnosis is a time-intensive process involving multiple health disciplines including occupational therapy, speech therapy, physiotherapy, psychology and paediatrics to confirm a combination of the following criteria categories (Dudley, Reibel, Bower, & Fitzpatrick, 2015; Reibel & Giglia, 2016):

- Prenatal alcohol exposure (confirmed OR unknown)
- Neurodevelopmental domains (severe impairment in at least 3 neurodevelopment domains)
  1. brain structure/neurology
  2. motor skills
  3. cognition
  4. language
  5. academic achievement
  6. memory
  7. attention
  8. executive function including impulse control and hyperactivity
  9. affect regulation
  10. adaptive behaviour, social skills or social communication
- Sentinel facial features (presence of 0–3 facial features):
  11. short palpebral fissure<sup>40</sup>
  12. smooth philtrum<sup>41</sup>
  13. thin upper lip.

## FASD prevention

Health service providers, including AOD counsellors, can play an important role in FASD prevention with women who are pregnant and using alcohol, as well as for other women of childbearing age. A national survey reported that 91% of women of childbearing age think health professionals should advise pregnant women to stop using alcohol during pregnancy (Peadon, O’Leary, Bower, & Elliott, 2008). BIs have proven to be an effective strategy in reducing alcohol consumption and related risk of harm (Gebara, Bhona, Ronzani, Lourenco, & Noto, 2013). The ‘Five A’s of FASD prevention’ (Alcohol and Pregnancy Project, 2009) as listed below have been identified as a helpful BI guide:

- **Ask** ALL women of childbearing age about their alcohol use
- **Assess** level of alcohol use by conducting an AUDIT-C (Foundation for Alcohol Research and Education [FARE], 2014)
- **Advise** women who are pregnant, planning a pregnancy or breastfeeding that no alcohol use is the safest choice (NHMRC, 2009). For women who have been using alcohol during this time, advise them that stopping or reducing use at any time will decrease future risk of harm to the developing fetus/baby. Note: Some clients may have consumed alcohol in earlier pregnancies with no apparent birth defects.
- **Advise** them there is no known safe amount and reiterate that any reduction or cessation in her alcohol use will be beneficial.
- **Assist** your client to explore their family and social support systems for reducing/stopping alcohol use.
- **Arrange** (with the client’s permission) culturally safe referrals for appropriate services as required. Note: If the client uses alcohol at a high-risk level, particularly frequently consuming more than 5 standard drinks in one sitting, arranging for her to attend a prenatal care service specialising in AOD use is strongly recommended.

It is estimated that as many as half of all pregnancies are unplanned (Colvin, Payne, Parsons, Kurinczuk, & Bower, 2007). Women who have unplanned pregnancies are less likely to access antenatal services in early trimesters than women who plan their pregnancy (Breen, Awbery, & Burns, 2014). Early antenatal support can help women identify successful strategies for reducing or stopping alcohol use during pregnancy. BIs around effective contraception or referrals to a sexual health service/GP for pregnancy planning may be useful FASD prevention strategies (Breen et al., 2014).

## FASD prevention among women who are drinking

Given the complexities associated with alcohol use during pregnancy, a non-judgemental, holistic, woman-centred approach is considered best practice (Leslie & Roberts, 2004; Poole, 2008). Adopt a harm-reduction approach: if the client is unable to stop drinking alcohol, reducing her alcohol use at any stage of pregnancy will be beneficial to her and her baby.

In the majority of cases alcohol consumption occurs in the early stages of pregnancy, prior to knowledge or confirmation of pregnancy (Colvin et al., 2007). As most women (75%) stop using alcohol when they know they are pregnant (AIHW, 2017), caution should be taken to avoid causing shame or undue concern around alcohol use during this time (NHMRC, 2009).

Prevention activities to address AOD use should be embedded within the context of broader efforts toward improving health and wellbeing during the client's pregnancies. Strategies that include family and friend support networks are more likely to improve outcomes (Pyett, Loughron, Waples-Crowe, & Williams, 2007).

## Access to treatment

Pregnant women using risky levels of alcohol should be supported to reduce/stop alcohol use by a multidisciplinary health care team, including AOD services, obstetric care and the client's GP (FARE, 2014). Appropriately matched therapeutic options may include BIs, CBT, group sessions and detoxification (NSW Health & SA Health, 2006). For more information, see the chapters on **Brief interventions** and on **Challenging unhelpful thinking**.

Clients should also be supported with medication, nutritional and vitamin supplements and access to appropriate maternal and fetal monitoring. Recent research indicates choline supplementation among heavy drinkers may reduce the impact of alcohol exposure on brain development (Jacobson et al., 2018). Importantly, the therapeutic environment should be culturally secure and gender sensitive (NSW Health & SA Health, 2006).

Optional extended hospitalisation for post-delivery help and support is suggested for women who are alcohol dependent. Assertive follow-up throughout the child's formative years may assist clients with healthcare, social services, housing and parenting support (Breen et al. 2014).

There is little research on safe alcohol pharmacotherapy treatments for use during pregnancy (Breen et al., 2014; Burns, Kingsbury, & Tudehope, 2006). For more information, see chapter on **Pharmacotherapies for AOD dependence**.

## Aboriginal and Torres Strait Islander women

It is impossible to ignore the historical context of alcohol use among Aboriginal women. Intergenerational trauma caused by colonisation policies of dispossession of land, culture, language, religion and the forced removal of children is akin to genocide. The contemporary overrepresentation of Aboriginal families in disadvantage and poverty is symptomatic of this history. Culturally secure approaches and resources can increase client engagement in FASD prevention. For more information on Cultural Security, see chapter on **Aboriginal clients, their families and communities**.

## Other drugs and pregnancy

Due to the stigma associated with illicit drug use and the fact that "pregnant women who use drugs are overrepresented among women who receive late, limited or no prenatal care" (Roberts & Pies, 2011, p. 333), counsellors have a unique opportunity in the prevention or reduction of maternal and fetal AOD-related harm by raising the issue and responding in a non-judgemental manner.

The scarcity of research on fetal exposure to illicit substances should not be mistaken for an absence of harm. The impacts of AOD on the developing fetus are further complicated by polydrug use, environmental and systemic factors. As with alcohol, the safest choice is not to use drugs during pregnancy.

40 The palpebral fissure is the space between the upper and lower eyelids

41 The philtrum is the vertical groove between the base of the nose and the border of the upper lip

In Victoria, The Royal Women's Hospital (2018) produced concise drugs and pregnancy fact sheets covering:

- Alcohol
- Amphetamines
- Benzodiazepines
- Buprenorphine
- Cannabis
- Tobacco
- Opiates
- Inhalants
- Methadone.

These resources outline the drugs' impact on foetal and newborn development and give counselling recommendations. They are available for download from [www.thewomens.org.au/health-information/pregnancy-and-birth/pregnancy-drugs-alcohol/drugs](http://www.thewomens.org.au/health-information/pregnancy-and-birth/pregnancy-drugs-alcohol/drugs).

In Western Australia, referral to a specialist AOD maternity service such as Women and Newborn Drug and Alcohol Services (WANDAS) at King Edward Memorial Hospital is recommended.

## AOD use and pregnancy – tip sheet

Alcohol (and other drugs) can cause birth defects. The NHMRC's *Guidelines to reduce health risks from drinking alcohol* (2009) recommend that no alcohol is the safest option during pregnancy, planning a pregnancy, or breastfeeding.

Fetal alcohol spectrum disorder is an umbrella term used to describe a range of birth defects caused by maternal alcohol consumption during pregnancy. These can include damage to the brain and major organs, growth deficiencies, facial structure and CNS abnormalities.

AOD counsellors have an important role to play in the prevention of FASD with all women of childbearing age.

Interventions should be culturally secure and family inclusive.

Women who have used drugs during pregnancy often experience guilt and fear about their drug-using behaviour and the possible effect on their baby. A non-judgemental approach is essential.

Pregnant women identified as consuming risky levels of alcohol should have priority access to alcohol treatment services. The need for withdrawal management is an indication for inpatient admission and treatment.

A collaborative inter-agency approach should be adopted for clients who are AOD dependent. Referral to a specialist AOD maternity service, for example Women and Newborn Drug and Alcohol Services (WANDAS), is recommended.

## References

- Alcohol and Pregnancy Project. (2009). *Alcohol and Pregnancy and Fetal Alcohol Spectrum Disorder: A Resource for Health Professionals (1st revision)*. Perth, WA: Telethon Institute for Child Health Research. Retrieved from [http://drugslibrary.wordpress.stir.ac.uk/files/2017/03/2009\\_Revised\\_Core\\_web.pdf](http://drugslibrary.wordpress.stir.ac.uk/files/2017/03/2009_Revised_Core_web.pdf)
- Australian Institute of Health and Welfare (AIHW). (2017). *National Drug Strategy Household Survey 2016: Detailed findings*. (Drug Statistics series no. 31. Cat. no. PHE 214). Canberra, ACT: Author.
- Breen, C., Awbery, E., & Burns, L. (2014). *Supporting pregnant women who use alcohol or other drugs: A review of the evidence*. Sydney, NSW: National Drug and Alcohol Research Centre.
- Burns, L., Kingsbury, A., & Tudehop, D. (2006). Alcohol and pregnancy. In NSW Department of Health (Ed.), *Background papers to the national clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn*. Sydney, NSW: NSW Department of Health.
- Center for Substance Abuse Treatment (CSAT). (2009). *Substance abuse treatment: Addressing the specific needs of women* (Treatment Improved Protocol (TIP) Series, No. 51). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Chudley, A. E., Conry, J., Cook, J. L., Looock, C., Rosales, T., & LeBlanc N. (2005). Fetal alcohol spectrum disorder: Canadian guidelines for diagnosis. *Canadian Medical Association Journal*, 172(5 Suppl), S1-S21. <https://doi.org/10.1503/cmaj.1040302>

- Colvin, L., Payne, J., Parsons, D., Kurinczuk, J. J., & Bower, C. (2007). Alcohol consumption during pregnancy in non-Indigenous West Australian women. *Alcoholism: Clinical and Experimental Research*, 31(2), 276-284. doi: 10.1111/j.1530-0277.2006.00303.x
- Dudley, A., Reibel, T., Bower, C., & Fitzpatrick, J. (2015). *Critical review of the literature: Fetal alcohol spectrum disorders*. Subiaco, WA: Telethon Kids Institute. Retrieved from <https://www.fasdhub.org.au/siteassets/pdfs/critical-review-of-the-literature-fetal-alcohol-spectrum-disorders-14jun2016.pdf>
- Elliott, E. J., Payne, J., Morris, A., & Bower, C. F. (2008). Fetal alcohol syndrome: A prospective national surveillance study. *Archives of Disease in Childhood*, 93(9), 732-737. doi: 10.1136/adc.2007.120220
- Foundation for Alcohol Research and Education (FARE). (2014). Information for health professionals on assessing alcohol consumption in pregnancy using AUDIT-C. Retrieved from [http://www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/0FF96125D3B433FDCA257CCF00055046/\\$File/FARE%20WWTK%20AuditC%20A4%20flyer%202017.pdf](http://www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/0FF96125D3B433FDCA257CCF00055046/$File/FARE%20WWTK%20AuditC%20A4%20flyer%202017.pdf)
- Gebara, C. F., Bhona, F. M., Ronzani, T. M., Lourenco, L. M., & Noto, A. R. (2013). Brief intervention and decrease of alcohol consumption among women: A systematic review. *Substance Abuse Treatment, Prevention and Policy*, 8(31). doi: 10.1186/1747-597X-8-31
- Jacobson, S. W., Carter, C. R., Molteno, C. D., Stanton, M. E., Herbert, J. S., Lindinger, N. M. ... Jacobson, J. L. (2018). Efficacy of maternal choline supplementation during pregnancy in mitigating adverse effects of prenatal alcohol exposure on grown and cognitive function: A randomized, double-blind, placebo-controlled clinical trial. *Alcoholism: Clinical and Experimental Research* 42(7), 1327-1341. <https://doi.org/10.1111/acer.13769>
- Leslie, M. & Roberts, G. (2004). *Nurturing change: Working effectively with high-risk women and affected children to prevent and reduce harms associated with FASD*. Retrieved from [http://www.mothercraft.ca/assets/site/docs/resource-library/publications/Nurturing\\_Change.pdf](http://www.mothercraft.ca/assets/site/docs/resource-library/publications/Nurturing_Change.pdf)
- May, P. A. & Gossage, J. P. (2011). Maternal risk factors for fetal alcohol spectrum disorders: Not as simple as it might seem. *Alcohol Research & Health*, 34(1), 15-26. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3860552/pdf/arh-34-1-15.pdf>
- National Health and Medical Research Council (NHMRC). (2009). *Australian guidelines to reduce health risks from drinking alcohol*. Canberra, ACT: Commonwealth of Australia.
- NSW Health & SA Health. (2006). *National clinical guidelines for the management of drug use during pregnancy, birth and early development years of the newborn*. North Sydney, NSW: Ministerial Council on Drug Strategy, NSW Department of Health.
- O'Leary, C. M. (2002). *Fetal alcohol syndrome: A literature review*. Canberra, ACT: National Expert Advisory Committee on Alcohol, Commonwealth Department of Health and Ageing.
- Peadon, E., O'Leary, C., Bower, C., & Elliott, E. (2007). Impacts of alcohol use in pregnancy – the role of the GP. *Australian Family Physician*, 36(11), 935-939. Retrieved from <http://citeseerx.ist.psu.edu/viewdoc/download?doi=10.1.1.525.7572&rep=rep1&type=pdf>
- Poole, N. (2008). *Fetal alcohol spectrum disorder (FASD) prevention: Canadian perspectives*. Ottawa, ON: Public Health Agency of Canada. Retrieved from <http://www.phac-aspc.gc.ca/hp-ps/dca-deal/prog-ini/fasd-etcaf/publications/cp-pc/pdf/cp-pc-eng.pdf>
- Poole, N. & Urquhart, C. (2010). *Mothering and substance use: approaches to prevention, harm reduction and treatment*. Gendering the National Framework Series (Vol. 3). Vancouver, BC: British Columbia Centre of Excellence for Women's Health. Retrieved from [http://bccewh.bc.ca/wp-content/uploads/2012/05/2010\\_GenderingNatFrameworkMotheringandSubstanceUse.pdf](http://bccewh.bc.ca/wp-content/uploads/2012/05/2010_GenderingNatFrameworkMotheringandSubstanceUse.pdf)
- Preece, P. M., & Riley, E. P. (2011). *Alcohol, drugs and medication in pregnancy: The long-term outcome for the child*. London, United Kingdom: Mac Keith Press.
- Pyett, P., Loughron, K., Waples-Crowe, P., & Williams, R. (2007). *Fetal alcohol syndrome: A literature review for the 'Healthy pregnancies, healthy babies for Koori communities' project*. Melbourne, VIC: Victorian Aboriginal Community Controlled Health Organisation.
- Reibel, T., & Giglia, R. (2016). *WA Health AUDIT-C Learning Guide*. Retrieved from <https://www.fasdhub.org.au/siteassets/pdfs/wa-health-audit-c-learning-guide-2016-web-version.pdf>
- Roberts, S. C., & Pies, C. (2011). Complex calculations: How drug use during pregnancy becomes a barrier to prenatal care. *Maternal Child Health Journal*, 15(3), 333-341. doi: 10.1007/s10995-010-0594-7
- Streissguth, A., Barr, H. M., Kogan, J., & Bookstein, F. L. (1997). Primary and secondary disabilities in fetal alcohol syndrome. In A Streissguth & J Kanter (Eds.), *The challenge of fetal alcohol syndrome: Overcoming secondary disabilities*. (pp. 25-40). Seattle, WA: University of Washington Press.
- Streissguth, A. P., Bookstein, F. L., Barr, H. M., Sampson, P. D., O'Malley, K., & Young, J. K. (2004). Risk factors for adverse life outcomes in fetal alcohol syndrome and fetal alcohol effects. *Journal of Developmental and Behavioral Pediatrics*, 25(4), 228-238.
- The Royal Women's Hospital. (2018). Pregnancy, drugs and alcohol. Retrieved from <https://www.thewomens.org.au/health-information/pregnancy-and-birth/pregnancy-drugs-alcohol>
- Tunc-Ozcan, E., Sittig, L., Harper, K. M., Graf, E. N., & Redei, E. E. (2014). Hypothesis: Genetic and epigenetic risk factors interact to modulate vulnerability and resilience to FASD. *Frontiers in Genetics*, 5(261). 10.3389/fgene.2014.00261
- Vaux, K. K., & Chambers, C. (2016). Fetal alcohol syndrome. Retrieved from <https://emedicine.medscape.com/article/974016-overview>

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## 49. Older people

Co-authored by Celia Wilkinson

Since the latter part of the twentieth century, population ageing has been a defining characteristic of all developed and many developing nations, including Australia (WHO, 2015). Not only has the size of the older Australian population grown, but significant numbers of older Australians are drinking at high-risk levels, the percentage using illicit drugs has increased (AIHW, 2017); as have numbers of older Australians presenting at AOD services (New South Wales Ministry of Health, 2015).

In Australia, the term 'older person' has generally been defined as anyone aged 65 years and over (ABS, 2008). However, as Aboriginal Australians have a low life expectancy in comparison to the general population, the term older Australian typically refers to an Aboriginal person once they reach 50 years of age (Department for Health and Ageing, Government of South Australia, n.d.). There is some contention about what constitutes 'older' heroin users (Carew & Comiskey, 2018) with some authors defining 'older' as those aged 40 and above (Crome, Sidhu, & Crome, 2009).

While many people reduce their use of AODs with age, and others continue with their usual level of use, some only commence AOD use late in life. This typology has been referred to as early-onset versus late-onset use (Nicholas, Roche, Lee, Bright, & Walsh, 2015); or early-onset 'survivors' versus late-onset 'reactors' (European Monitoring Centre for Drugs and Drug Addiction, 2008).

For example, early-onset drinkers are those individuals who have a long history of alcohol use, whereas late-onset drinkers commenced drinking or increased their drinking in older age, often in response to stressful life events such as loss of a spouse, or to cope with loneliness or sleeping problems, or as self-medication for pain (Wilkinson, Allsop, & Dare, 2015). Some of the reasons for drinking will also vary between 'social' drinkers and older 'problem' drinkers and between early-onset and late-onset drinkers. Some research suggests that as many as a third of alcohol-dependent older drinkers only develop problems after 45 years of age (Kist, Sandjojo, Kok, & van den Berg, 2014), and other research indicates that some people may not commence problematic drinking until after 60 years of age (Barrick & Connors, 2002).

While most research investigating the early-onset/late-onset typology has occurred with alcohol, there is also some suggestion that this typology applies to the misuse of pharmaceuticals, and to a lesser extent illicit drugs (Wu & Blazer, 2011). For example, there may be some older people who have a long history of misusing pharmaceuticals (early onset), while there may be more who only commence doing so later in life as a coping mechanism for the kinds of problems described above (Nicholas, Lee, & Roche, 2011).

While the levels of AOD use amongst older people are generally less than amongst younger people, AOD use amongst older people can present significant health risks as a result of physiological changes that occur with ageing that relate to pharmacokinetics (the way the body affects drugs) and pharmacodynamics (the way drugs affect the body). Consequently, it is important to be aware of the potential for physical and psychological comorbidities when working with older clients. Finally, many older people are likely to be taking prescription and over-the-counter medications, many of which interact with alcohol and illicit drugs in problematic ways (e.g. increasing the risk of falls, motor vehicle accidents and overdose) (Tanaka, 2003).

AOD use, which may be an attempt to self-treat or relieve mental health symptoms, can trigger the onset of mental health problems (including dementia) in susceptible individuals and then worsen or precipitate them (CSAT, 1998). Other mental health comorbidities among older people with AOD problems include depression, anxiety, sleep problems, self-harm and delirium (Nicholas et al., 2015).



## Risk Factors

Risk factors for AOD issues have been identified among older people:

- male gender (older men are more likely than older women to drink at risky levels; Moos, Schutte, Brennan, & Moos, 2009)
- loss of spouse
- other losses such as loss of occupation, financial support, skills or function, marriage or social networks (Royal College of Psychiatrists, 2011)
- co-occurring mental health conditions
- a family history of alcohol problems
- poly substance use.

## Other considerations

Older people can be vulnerable to exploitation, including financial abuse. This can be due to reasons including AOD-related disabilities resulting in dependence on carers and AOD-related cognitive loss reducing their ability to resist or detect coercion and fraud (Nicholas et al., 2015). As with all clients, it is good practice to consider the family situation of older AOD users while being aware of the potential for exploitation.

Amongst older Australian opioid users, health is a major concern (Australian Injecting and Illicit Drug Users League [AIVL], 2011). However, older opioid users report high levels of discrimination and considerable difficulty accessing health and welfare services (AIVL, 2011). Nevertheless, there is evidence that older opioid clients achieve better treatment outcomes than their younger counterparts, with women doing better than men (Carew & Cominskey, 2018).

## Assessment and Treatment

There is substantial evidence suggesting that substance use amongst older adults has been under-identified (Kuerbis, Sacco, Blazer, & Moore, 2014). There are many reasons for this, including the myth that older people do not use drugs, or that their AOD use history is so long that they will not respond to treatment (Kuerbis & Sacco, 2013). In terms of illicit drugs, people may not accept that older people use illicit substances. Indeed, research has largely overlooked illicit drug use among older populations (Wu & Blazer, 2011). Moreover, families, friends and workers may overlook concerns about older people's AOD use. It is therefore important to do a thorough assessment of all AOD use when working with older people.

Younger counsellors may find it difficult or intimidating to ask an older person about their AOD use. However, there is evidence that older Australians are very receptive to receiving AOD-related health information (Wilkinson et al., 2016), so it is important to have open, respectful clinical conversations with older clients.

The Royal College of Psychiatrists (2015) advised a non-judgemental and non-ageist approach should be taken when conducting assessments with older people and that underreporting of AOD use may occur due to stigma, lack of awareness or memory impairment. Rather than report their AOD use, an older person may present with AOD-related symptoms such as a lack of energy, depression or physical illness, or with AOD-related problems such as instability and falls, CI or problems associated with poor nutrition.

As part of a systematic AOD assessment, the Royal College of Psychiatrists (2015) suggested the following can be explored when working with older clients:

- medical history, including discussion of complications from AOD use, the effect of substances on any existing age-related impairment, and interactions with medications
- any history of sleep problems, risk of falls, isolation and financial abuse
- activities of daily living, for example are they being cared for, and if so, who by, as well as the level of support from formal and informal carers
- level of nutrition, including whether they cook for themselves.

With increasing age, communication barriers such as hearing loss, speech impairments, and slowed speed of cognitive processing can inhibit an older person's involvement in discussions about their AOD use (Bynum, Barre, Reed, & Passow, 2014). Therefore, counsellors may need to spend more time with elderly patients to ensure that they understand the information being communicated to them (Bynum et al., 2014).



AOD-related advice may be more effective when verbal counselling is delivered in conjunction with easy-to-read written information (Sadowski, 2011). In addition, companion involvement (should the client consent and agree), through the provision of informational support (i.e. such as asking questions, taking notes, and recalling information) may also be of benefit, and has been associated with improved understanding of medical advice (Laidsaar-Powell et al., 2013).

Some older people may experience social isolation and mobility issues that make it difficult for them to access services. Treatment tailored to older clients could include outreach or home-based care. Stigma can be a significant barrier to older people accessing treatment. There are no age-specific treatment programs such as withdrawal and rehabilitation services, and older people may avoid mixed-age treatment due to feelings of isolation and shame (Kuerbis & Sacco, 2013).

Thorley's (1980) model, which identifies three patterns of problematic AOD use (intoxication, regular use and dependence), is helpful when working with older people. Problems that may require assessment and treatment can be associated with intoxication (e.g. falls), regular use (e.g. health harms, impaired relationships or financial problems); or dependence (e.g. impaired control, AOD-centred behaviour or withdrawal) (Nicholas et al., 2015). Table 5 describes the appropriate intervention for the different levels of AOD use.

**Table 5: Tailoring the intervention to patterns of AOD harm experienced by older people (Babor & Higgins-Biddle, 2001; Heather, 2003 cited in Nicholas et al., 2015)**

Type of behaviour/problem	Intervention/response
<b>No use/low-risk</b>	Prevention activities, information about age-specific AOD-related risks and strategies to adopt if use becomes problematic
<b>Medium/high-risk</b>	Comprehensive medical assessment which includes assessment of concomitant AOD use and social and psychological functioning. BIs (e.g. BMI), discussion of harm reduction
<b>Dependence</b>	Intensive treatment, counselling, detoxification, maintenance therapy, relapse prevention

If someone is experiencing risky use or dependence, they may require intensive treatment.

A growing body of evidence shows that CBT approaches in relation to alcohol and benzodiazepine use with older people are effective (Kuerbis & Sacco, 2013; Morin et al., 2004; Satre, 2015). Research has also shown that pharmacotherapy and psychotherapy programs for substance use disorders and mental health problems have equivalent or more positive treatment outcomes amongst older people than their younger counterparts (Karlin, Trockel, Taylor, Gimeno, & Manber, 2013; Kuerbis & Sacco, 2013). There is also evidence that older patients are usually more compliant with treatment than younger patients (Gossop & Moos, 2008).

Older AOD users are a heterogeneous group and it is important that advice is tailored to each individual's circumstances and major risk factors, such as:

- concurrent medication use
- physical ill-health
- psychosocial factors.

If possible, co-occurring conditions should be approached in a holistic way. Referral pathways are important for all clients but particularly for older clients as co-occurring conditions are likely (see chapter on **Referral**). Clients may need referral to specialist agencies if they require management of intoxication, withdrawal, pain management, pharmacotherapy, or treatment of complex mental health or other co-occurring conditions.

Successful interventions for older clients with AOD problems, like all interventions, should be client-centred, empathic and non-judgemental. It is understood that social support for or against drinking greatly influences the drinking behaviour of older adults (Moos et al., 2010), so exploring social networks and, if possible, the inclusion of significant others in treatment, can be worthwhile.

While there are no services in Western Australia which are targeted specifically to the aged, all adult services should be inclusive and welcoming of older people. Meanwhile lessons can be learnt from the Older Wiser Lifestyles (OWL) Program (Nicholas et al., 2015) developed by Peninsula Health, Victoria as an age-specific service to address AOD-related harm among older adults.

## Older Wiser Lifestyles Program

The OWL program includes early intervention and treatment. Five core elements underpin the OWL program: comprehensive screening and/or assessment, engagement, harm reduction strategies, office-based and outreach support, and evidence-driven best practice. OWL uses the trans-theoretical model of change to tailor interventions to the client's readiness to change.

Treatment tips for working with older clients from the OWL Clinicians include the following:

- **Respect:** understanding the person has lived many years and their experience is valuable
- **Patience:** anecdotal evidence suggests that older people can change their habits but that it may take longer. Content may need to be reiterated a few times before it is absorbed
- **Rapport:** it is important to build rapport and trust. Find an age-relevant topic (hobbies, grandchildren, etc.)
- **Approach:** choose words carefully when raising AOD use. "Do you enjoy a drink?" may elicit a more honest answer than "Are you concerned about your drinking?"
- **Flexibility:** older adults will require a variety of interventions depending on the individual and their goals. Be willing to adjust goals as they may change due to client's current motivation and abilities
- **Boundaries:** older people may feel lonely and isolated; you may be the only regular contact in their life. While being aware of your boundaries, help older clients to find meaningful activities that can assist in their recovery
- **Thoroughness:** be as thorough as possible when assessing an older adult; gather information about mental and physical health, as well as social and family circumstances
- **Awareness:** have a good understanding of common issues at this stage of life, including retirement, identity and role changes, bereavement, loneliness, isolation and stigma. Be aware of your own beliefs and values regarding ageing and how these could affect your work with the client.

## Older People – Tip Sheet

AOD services will continue to see an increase in older clients as the population ages.

A thorough assessment of all drug use, not just the presenting AOD problem, is good practice with clients, including the elderly.

It is helpful to assess people for problems associated with intoxication, regular use and dependence.

As people age, their ability to metabolise drugs decreases and they are more susceptible to intoxication and related harm, such as falls. Older people are more likely to be on prescription medications, which may potentiate the effects of AODs, and increase the likelihood of intoxication and overdose.

Older people who use AOD are prone to co-occurring conditions; these can be physical and/or psychological.

Physical problems are likely to be experienced by people who are dependent or who have been using regularly for a long time. Psychological co-occurring conditions such as depression and anxiety are common.

Vulnerability to exploitation is also possible amongst the elderly. Stigma and social isolation may be barriers to older people seeking treatment and may prompt the need to consider outreach.

It is understood that older people in treatment for AOD problems do just as well as younger people and may do slightly better.

It is important for counsellors to be aware of their own attitudes towards AOD use in older people. When working with ageing clients, worker attitudes may be a barrier to effective treatment.

Research on older people and AOD use is scarce and it is therefore difficult to draw conclusions about which treatments are best. However, it is understood that the same models that are used to treat the general population can be used to treat older people. A growing body of evidence indicates that CBT approaches in relation to alcohol and benzodiazepine use with older people are effective.

Concurrent medication use, physical health and psychosocial context are all important issues to consider when planning treatment. Referral pathways for older people are very important.

Social support for or against AOD use greatly influences the drinking behaviour of older adults. Exploring social networks and the inclusion of significant others in therapy, if possible, can be useful.

Lessons learnt from the OWL program (an older age-specific service model developed in Victoria) included the importance of tailoring interventions towards the person's readiness to change. Tips from the OWL clinicians include working with respect and patience and the importance of building rapport with older clients. A non-judgemental approach coupled with flexibility and the importance of boundaries were underscored, as was a thorough assessment and a good understanding of stage-of-life issues.

## References

- Australian Bureau of Statistics (ABS). (2008). *Year Book Australia, 2008* (No. 1301.0). Retrieved from <http://www.abs.gov.au/ausstats/abs@.nsf/7d12b0f6763c78caca257061001cc588/0046daf21caa349bca2573d20010fe65!OpenDocument#>
- Australian Injecting and Illicit Drug Users League (AIVL). (2011). *Double jeopardy: Older injecting opioid users in Australia: AIVL Discussion Paper*. Canberra, ACT: Author.
- Australian Institute of Health and Welfare (AIHW). (2017) *Australia's welfare 2017* (Australia's Welfare Series no. 13. AUS 214). Canberra, ACT: Author.
- Babor, T., & Higgins-Biddle, J. (2001). *Brief intervention for hazardous and harmful drinking: A manual for use in primary care*. Geneva, Switzerland: World Health Organization.
- Barrick, C., & Connors, G. J. (2002). Relapse prevention and maintaining abstinence in older adults with alcohol-use disorders. *Drugs and Aging*; 19(8), 583-594. doi: 10.2165/00002512-200219080-00004
- Bynum, J. P., Barre, L., Reed, C., & Passow, H. (2014). Participation of very old adults in health care decisions. *Medical Decision Making*, 34(2), 216–230. doi: 10.1177/0272989X13508008
- Carew, A. M., & Comiskey, C. (2018). Treatment for opioid use and outcomes in older adults: A systematic literature review. *Drug and Alcohol Dependence*, 182, 48-57. doi: 10.1016/j.drugalcdep.2017
- Center for Substance Abuse Treatment (CSAT). (1998). *Substance abuse among older adults* (Treatment Improvement Protocol (TIP) Series 26). Retrieved from <http://adaiclearinghouse.org/downloads/TIP-26-Substance-Abuse-Among-Older-Adults-67.pdf>

- Crome, I., Sidhu, H., & Crome, P. (2009). No longer only a young man's disease—illicit drugs and older people. *Journal of Nutrition Health and Aging*, 13(2), 141-143. <https://doi.org/10.1007/s12603-009-0021-1>
- Department for Health and Ageing. (n.d.). *Elder abuse and people from an Aboriginal background*. Adelaide, ACT: Author.
- European Monitoring Centre for Drugs and Drug Addiction. (2008). *Drugs in focus – substance abuse among older adults: A neglected problem* (Report 18). Lisbon, Portugal: European Monitoring Centre for Drugs and Drug Addiction.
- Gossop, M., & Moos, R. (2008). Substance misuse among older adults: A neglected but treatable problem. *Addiction*, 103(3), 347-348. doi: 10.1111/j.1360-0443.2007.02096.x
- Heather, N. (2003). Brief intervention strategies. In R. Hester & W. Miller (Eds.), *Handbook of alcoholism treatment approaches: Effective alternatives* (3rd ed.). Needham Heights, MA: Allyn & Bacon.
- Karlin, B.E., Trockel, M., Taylor, C.B., Gimeno, J., & Manber, R. (2013). National dissemination of cognitive behavioural therapy for insomnia in veterans: Therapist- and patient-level outcomes. *Journal of Consulting and Clinical Psychology*, 81(5), 912-917. doi: 10.1037/a0032554
- Kist, N., Sandjojo, J., Kok, R. M., & van den Berg, J. F. (2014). Cognitive functioning in older adults with early, late, and very late onset alcohol dependence. *International Psychogeriatrics*, 26(11), 1863-1869. doi: 10.1017/S1041610214000878
- Kuerbis, A., & Sacco, P. (2013). A review of existing treatments for substance abuse among the elderly and recommendations for future directions. *Substance Abuse: Research and Treatment*, 7, 13-37. doi: 10.4137/SART.S7865.
- Kuerbis, A., Sacco, P., Blazer, D. G., & Moore, A. A. (2014). Substance abuse among older adults. *Clinical Geriatric Medicine*, 30(3), 629-654. doi: 10.1016/j.cger.2014.04.008
- Laidsaar-Powell, R., Butow, P., Bu, S., Charles, C., Gafni, A., Lam, W., ... Juraksova, I. (2013). Physician-patient-companion communication and decision-making: A systematic review of triadic medical consultations. *Patient Education and Counselling*, 91(1), 3-13. doi: 10.1016/j.pec.2012.11.007
- Moos, R. H., Schutte, K. K., Brennan, P. L., & Moos, B. S. (2010). Late-life and life history predictors of older adults' high risk consumption and drinking problems. *Drug and Alcohol Dependence*, 108(1-2), 13-20. doi: 10.1016/j.drugalcdep.2009.11.005
- Morin, C., Bastien, C., Guay, B., Radouco-Thomas, M., Leblanc, J., & Vallieres, A. (2004). Randomized clinical trial of supervised tapering and cognitive behaviour therapy to facilitate benzodiazepine discontinuation in older adults with chronic insomnia. *American Journal of Psychiatry*, 161(2), 332-342. doi: 10.1176/appi.ajp.161.2.332
- New South Wales Ministry of Health. (2015). *Older peoples Drug and Alcohol Project: Full report*. North Sydney, NSW: Author.
- Nicholas, R., Lee, N., & Roche, A. (2011). *Pharmaceutical drug misuse in Australia: Complex problems, balanced responses*. Adelaide, SA: National Centre for Education and Training on Addiction.
- Nicholas, R., Roche, A., Lee, N., Bright, S., & Walsh, K. (2015). *Preventing and reducing alcohol and other drug-related harm among older people: A practical guide for health and welfare professionals*. Adelaide, SA: National Centre for Education and Training on Addiction.
- Royal College of Psychiatrists. (2011). *Our invisible addicts*. Retrieved from [https://www.drugsandalcohol.ie/15373/1/RCP\\_Invisible\\_Addicts.pdf](https://www.drugsandalcohol.ie/15373/1/RCP_Invisible_Addicts.pdf)
- Royal College of Psychiatrists. (2015). *Substance misuse in older people: An information guide*. Retrieved from [https://www.rcpsych.ac.uk/pdf/Substance%20misuse%20in%20Older%20People\\_an%20information%20guide.pdf](https://www.rcpsych.ac.uk/pdf/Substance%20misuse%20in%20Older%20People_an%20information%20guide.pdf)
- Sadowski, C. (2011). Providing health information to older adults. *Reviews in Clinical Gerontology*, 21(1), 55-66. doi: 10.1017/S0959259810000316
- Satre, D. (2015). Alcohol and drug use problems among older adults. *Clinical Psychology: Science and Practice*, 22(3), 238-254. <https://doi.org/10.1111/cpsp.12104>
- Tanaka, E. (2003). Toxicological interaction involving psychiatric drugs and alcohol: An update. *Journal of Clinical Pharmacy and Therapeutics*, 28(2), 81-95. <https://doi.org/10.1046/j.1365-2710.2003.00459.x>
- Thorley, A. (1980). Medical responses to problem drinking. *Medicine*, 35, 1816-1822.
- Wilkinson, C., Allsop, S., & Dare, J. (2016). Alcohol, ageing and Australia. *Drug and Alcohol Review*, 35(2), 232-235. <https://doi.org/10.1111/dar.12301>
- Wilkinson, C., Dare, J., French, M., McDermott, M., Lo, J., & Allsop, S. (2016). Prescribing or dispensing medication represents the best opportunity for GPs and pharmacists to engage older people in alcohol-related conversations. *International Journal of Pharmacy Practice*, 24(5), 319-325. doi: 10.1111/ijpp.12255.
- World Health Organization (WHO). (2015). *World Health Statistics 2015*. Geneva, Switzerland: Author.
- Wu, L., & Blazer, D. (2011). Illicit and nonmedical drug use among older adults: A review. *Journal of Aging and Health*, 23(3), 481-504. doi: 1177/0898264310386224

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## 50. Pain management for dependent clients

Pain is a complex, subjective sensory and emotional experience (Pain Australia, 2010; Turk, Fillingim, Ohrbach, & Patel, 2016). The experience of pain is affected by psychological factors such as a person's beliefs about pain, anxiety, past experiences and fear, mood and genetics (Edwards, Dworkin, Sullivan, Turk, & Wasan, 2016).

### Pain mechanisms

Specialised peripheral sensory neurons (nociceptors) around the body send electrical signals to the CNS when they detect unpleasant stimuli such as extremes in temperature, pressure or inflammatory responses (Schug et al., 2015). Different groups of nociceptors detect specific unpleasant stimuli, and the types of nociceptors differ in parts of the body. For example, a large proportion of nociceptors in and around the internal organs respond to inflammation (Schug et al., 2015). Nociceptors can also send messages to the CNS without painful stimuli, such as when there is direct injury to nerves through physical trauma, or as a result of an illness. Additionally, neuroplastic changes in the brain and dysregulation of the pain modulation system can drive messages from nociceptors to the CNS (Schug et al., 2015).

Initially these signals are sent to the spinal cord and then travel up to the brain. After the electrical signals arrive in the brain they are “subjected to higher-order psychological and mental processing that integrates sensory information with previous learning history, appraisals, and emotional factors all within a socioenvironmental context to create the perception of pain” (Turk et al., 2016, p. T25).

There are four classifications of pain: nociceptive, inflammatory, neuropathic and pathological pain (Schug et al., 2015; Woolf, 2010).

- **Nociceptive and inflammatory pain:** part of the body's monitoring system, which locates and measures the intensity of painful stimuli and responds to that stimuli (Savage, Kirsh, & Passik, 2008).
- **Neuropathic pain:** pain caused by disease or injury to the somatosensory nervous system; it affects 7–10% of the population (Schug et al., 2015). Neuropathic pain can be acute or chronic and can include structural and functional changes across multiple points in the body's pain pathways that can alter the reception and transmission of pain signals. Neuropathic pain can have complex long-term psychobiological consequences (Savage et al., 2008).
- **Pathological pain:** pain which results from abnormal functioning of the nervous system. Pathological pain can occur after damage to the nervous system (neuropathic pain) but also in conditions that are unable to be linked reliably to pathophysiology (dysfunctional pain). Conditions in which pathological pain is a symptom include fibromyalgia, temporomandibular joint disease and interstitial cystitis (Woolf, 2010).

### Acute pain

Acute pain is functional, in that it draws the organism's attention to actual or potential tissue damage as well as motivating the organism to remove itself from the source of the pain (Tompkins, Hobelmann, & Compton, 2017). Acute pain also functions to promote coping behaviours that manage recovery from tissue damage, for example, limping on a sprained ankle. The experience of acute pain also facilitates learning and avoidance strategies which can minimise exposure to future damage, for example, knowing not to walk on sharp objects with bare feet (Schug et al., 2015). Acute pain tends to resolve once the injury is resolved (Tompkins et al., 2017).



## Chronic pain

Sometimes acute pain can progress to chronic pain. The probability of developing chronic pain is influenced by genetics, physiological factors and their interaction with social and psychological experiences of pain (Schug et al., 2015). Chronic pain is a disease in its own right, and while chronic pain may follow an episode of acute pain caused by tissue damage in the first instance, it is significantly different in physiological terms. Chronic pain arises due to neuroplastic changes in the CNS (Pain Australia, 2010). Chronic pain can be debilitating and chronic non-cancer pain (CNCP) can be complex to manage (Volkow, & McLellan, 2016). People with CNCP can experience stigma due to the invisibility and subjectivity of CNCP, which can reduce their self-efficacy and self-esteem and can delay diagnosis and appropriate treatment (Waugh, Byrne, & Nicholas, 2014). How acute pain becomes chronic is not well understood, and the time it takes for this to occur varies (Tompkins et al., 2017).

Edwards et al. (2016) stated that “the biopsychosocial approach describes pain and disability as a multidimensional, dynamic interaction among physiological, psychological, and social factors that reciprocally influence each other, resulting in chronic and complex pain syndromes” (p. T71). Psychosocial factors are the most consistent predictors of whether acute pain develops into chronic pain. Women are more likely to report chronic pain, as are people with a lower annual household income, and the prevalence of chronic pain increases with age (Tompkins et al., 2017). Childhood trauma is a risk factor for poor pain outcomes (Edwards et al., 2016). In recent research, women with histories of AOD issues and high levels of adverse childhood experiences showed high levels of anxiety and depression as well as chronic pain (Zlotnick, Lawental, & Pud, 2017).

Chronic pain is aggravated by a range of factors including acute and chronic stress (Tompkins et al., 2017). Depression, anxiety, negative affect and distress have a bidirectional relationship with pain, in that each increases the risk of the other (Edwards et al., 2016). People living with chronic pain also have high rates of co-occurring mental health conditions and functional impairment (Garland et al., 2017). PTSD and chronic pain commonly co-occur (Bilevicius, Sommer, Asmundson, & El-Gabalawy, 2018) and chronic pain is associated with an increased rate of personality disorders (Beitel et al., 2017). Campbell, Darke, Bruno, and Degenhardt (2015) found that chronic pain was associated with an increased risk of suicidality, and that 65% of people who attempted suicide had chronic pain.

## AOD use and pain

People who use AOD have a higher prevalence of CNCP than the general population (Voon et al., 2018). There are many causes of physical pain among people who use AOD, including pain caused by health conditions such as cancer, injury, arthritis, pain due to withdrawal, and pain that is unexplained by medical conditions.

Pain is often underestimated and undertreated amongst people with a history of opioid dependence and clinicians can be reluctant to prescribe pain medication to people on opioid substitution therapy (Lintzeris, 2015; NPS Medicinewise, 2016). People who are dependent on AOD can experience significant stigma, and this can be a barrier to them accessing effective treatment for pain (Quinlan, & Cox, 2017; Voon et al., 2018). This can, in turn, increase the risk of people who use AOD using more substances to try and manage their pain, which can increase the risk of harm.

There is an association between risky alcohol use and pain. Pain can be related to injuries received whilst intoxicated, or may be the result of nerve damage from long-term excessive alcohol use (Larance et al., 2016). Cigarette smokers are more likely to experience pain than non-smokers and pain is a potent motivator for smoking (Kosiba, Zale, & Ditre, 2018). Experiencing pain is also associated with using large amounts of cannabis (Sznitman, Baruch, Greene, & Gelkopf, 2018).

Opioid use can change how the CNS receives, processes and responds to pain and can result in decreased pain tolerance or increased sensitivity (opioid-induced hyperalgesia) (Wachholtz, Foster, & Cheatile, 2015). Intoxication and withdrawal both activate the sympathetic nervous system, which can also increase pain perception. Loss of social supports and interpersonal conflicts can often impair pain management (Savage et al., 2008).

Early opioid withdrawal features are often experienced as pain (Rieb et al., 2016). In addition to the pain exacerbation, opioid withdrawal will result in significant anxiety and insomnia, together with varying degrees of nausea, vomiting, diarrhoea, generalised musculoskeletal pain (Duong, Vytialingam, & O'Regan, 2018).



While it is true that people who use AOD experience pain and may struggle with adequate pain management, it is also true that people with pain may experience AOD dependence. Since 2000 the use of over-the-counter and prescribed pharmaceutical opioids in Australia has increased significantly. This increase has been associated with an increase in people who develop opioid dependence and a subsequent increase in the number of people requiring management of dependence and co-occurring chronic pain or other medical conditions (Lintzeris, 2015).

It is estimated that approximately 10% of people with CNCP treated with opioids meet the criteria for opioid dependence (Degenhardt et al., 2015). The diagnosis of dependence can be complex in people who are using prescribed opioids, and pain specialists sometimes don't consider tolerance and withdrawal as features of dependence in their patients (Lintzeris, 2015). Volkow and McLellan argue that tolerance and withdrawal are expected in longer-term opioid use for CNCP, but addiction requires changes in structure and function in the reward, inhibitory and emotional circuits of the brain, resulting in pronounced cravings, obsessive thoughts about the drug, inability to stop using the drug and compulsive drug use (Volkow, & McLellan, 2016).

People who have CNCP may use AOD to self-medicate pain, and stress from CNCP may increase the likelihood of harmful AOD use (Larance et al., 2016). Many people with CNCP experience co-occurring mental health disorders such as anxiety, depression and sleep disorders, which may also increase the risk of harmful AOD use (Larance et al., 2016; Severino et al., 2018). Adolescents are at risk of developing dependence on prescribed opioids due to the neuroplasticity of their brains and underdeveloped frontal cortex, which limits their self-control (Volkow, & McLellan, 2016).

Quinlan and Cox (2017) noted that people who experience chronic pain may present with “problem behavio[u]rs around seeking more opioid analgesia” (p. 1). However, they argued that this can be ‘pseudoaddiction’ and is the result of the under-treatment of pain rather than true dependence. Pseudoaddiction can be differentiated from dependence because the analgesia-seeking behaviours cease once the pain is treated effectively (Quinlan, & Cox, 2017).

Whether a person has developed dependence on opioids as a result of their initiation into their use for intoxication or for the treatment of pain, researchers have found that for some people opioids had the unanticipated capacity to provide a means of relief from life's distresses as well as co-occurring depression and anxiety, to make them feel ‘normal’ and more focused and energised, and that these qualities lead to the persistent use of opioids and eventually the development of a substance use disorder (Cicero, & Ellis, 2017).

## Pain management

There are a range of non-opioid strategies for the management of pain, including:

- medication such as non-steroidal anti-inflammatory drugs for musculoskeletal pain
- some antidepressants and anticonvulsants which are used primarily for neuropathic pain
- physical therapy such as hydrotherapy, exercise therapy and physiotherapy
- psychological therapies including CBT and mindfulness-based stress reduction
- complementary therapies, e.g. acupuncture and meditation
- peripheral procedures, e.g. steroid injections
- biofeedback
- spinal procedures – e.g. spinal cord stimulators, nerve block, epidural steroid injections.

(Volkow & McLellan, 2016)

Lintzeris (2015) described the principles of acute pain management in clients with AOD dependence as follows:

- provide adequate analgesia
- prevent withdrawal
- avoid worsening substance dependence.

Issues for consideration when working with a person who uses AOD and experiences chronic pain include:

- polydrug use – particularly CNS depressants such as opioids, benzodiazepines and alcohol and the risk of overdose, along with the risk of drug interactions
- presence of co-occurring mental health conditions
- increased risk of suicidality
- pain intensity can be a barrier to stopping or reducing AOD use
- pain may be undertreated
- risk of withdrawal from opioids

- increased tolerance to pain medications
- opioid dependence can decrease the effectiveness of opioids for pain management
- opioid dependence can increase pain sensitivity (hyperalgesia)
- people with CNCP treated with opioids are more prone to anhedonia
- risk of overdose when tolerance drops or opioid use increases
- client may experience stigma related to CNCP as well as their AOD use.

(Beitel et al., 2017; Lintzeris, 2015; Priddy et al., 2018; Quinlan, & Cox, 2017; Tompkins et al., 2017; Volkow, & McLellan, 2016; Voon et al., 2018)

The management of chronic pain involves comprehensive treatment planning and may involve coordination across multiple services. Treatment planning should involve the client and transparency regarding the risks and benefits of treatment options, side effects, costs and other aspects of treatment is necessary to ensure the client's informed consent (Lintzeris, 2015).

The counsellor should assist clients with chronic pain by arranging and facilitating referrals to relevant medical staff, and if necessary, a multidisciplinary pain clinic attached to a major public hospital. The information that follows is particularly relevant to helping clients manage chronic pain but can also be adapted to help clients to cope with acute pain.

Clients who have been treated with opioid monotherapy may exhibit reluctance to engage in non-medication treatment modalities (Becker et al., 2017). Exploring reasons for and managing such resistance is an important step in assisting individuals.

## Counselling and pain management

AOD counsellors can play an important role in facilitating appropriate treatment for people with AOD issues and chronic pain. Beitel et al. (2017) examined the barriers and facilitators of appropriate CNCP treatment for clients engaged in methadone maintenance treatment. AOD counsellors reported several barriers, including a lack of training about co-occurring chronic pain and opioid use disorders; a lack of expertise to respond effectively to the complexity of their client's issues; and concerns about objective pain assessment. Doctors report similar barriers (Baldacchino, Gilchrist, Fleming, & Bannister, 2010; Barry et al., 2010).

A thorough initial assessment is important in relation to understanding the impacts of and the relationship between AOD use and CNCP (see chapter on **Assessment**). Assessments should also be regular as treatment needs can change (Center for Substance Abuse Treatment, 2012). Re-evaluation of the individual's pain and subsequent impact on social circumstances, relationships, mental health and general function can assist in identifying specific needs as they arise.

Beitel et al. (2017) described the things that AOD counsellors did that facilitated better client engagement. These included expressing empathy about clients' experiences of CNCP and attempting to understand clients' lived experiences. Noticing small positive changes and witnessing client improvement created hope and fostered clients' resilience. Counsellors' self-reflection about their own experience of CNCP or the lack thereof assisted the engagement of the counsellor in the process of treatment.

The counsellor's role in the management of pain is to provide non-pharmacological strategies with an emphasis on helping the client improve their quality of life (Otis, Pincus, & Murawski, 2011). These can include addressing general psychosocial and/or pain specific psychosocial issues.

Cognitive behavioural therapy (Edwards et al., 2016) and narrative therapy<sup>42</sup> (Lintzeris, 2015) have both been shown to be helpful in the management of pain. Irrespective of the counsellor's theoretical perspective, counsellors can assist clients with pain to explore psychological and social factors that affect the client's experience of pain.

Beliefs, appraisals and thought processes can influence the experience of pain significantly, and changes in unhelpful beliefs and thoughts can affect the intensity and quality of pain, treatment responses and the level of disability (Turk et al., 2016). Assisting clients to address unhelpful thinking associated with pain can be beneficial (see chapter on **Challenging unhelpful thinking**).

<sup>42</sup> Narrative therapy is an approach to counselling which views people as the experts in their own lives. Problems are viewed as separate entities to the person and individuals are seen as having their own skills and strengths. See <https://dulwichcentre.com.au/what-is-narrative-therapy/>

Pain catastrophising, whereby the interpretation of actual or anticipated pain is exaggerated and the worst possible outcomes are assumed (Quinlan & Cox, 2017), has been shown to have a significant role in defining the pain experience and is predictive of pain severity, poor quality of life, pain-related disability and emotional distress (Turk et al., 2016). Cognitive restructuring can be helpful in assisting clients to challenge pain catastrophising. Encourage the client to monitor their pain and associated thoughts, feelings and behaviour and record them (see Appendix 25 for **Cognitive restructuring using the ABCDE model worksheet**). These records can be used to identify and challenge negative thoughts and underlying beliefs about the pain.

A sense of control or the perceived ability to manage pain and associated stress is important in determining how a person actually copes with pain (Turk et al., 2016). People with a greater sense of control have been shown to have better functioning, whereas helplessness is associated with greater pain and poorer adjustment in chronic pain (Turk et al., 2016). Strategies which assist clients to build their sense of control over pain and the stress related to pain can be beneficial. A sense of control is strongly related to the concept of self-efficacy.

Self-efficacy is the belief in one's own ability to achieve a desired outcome in a specific situation. Lower self-efficacy in chronic pain is related to greater disability and higher pain ratings (Edwards et al., 2016; Turk et al., 2016). Assisting clients to increase their sense of self-efficacy through problem-solving and goal-setting (see chapters on **Problem-solving** and **Goal-setting**) can assist clients to build their resilience and achieve outcomes such as decreased pain and disability (Edwards et al., 2016). Work with the client to collaboratively establish goals that are related to increasing general functioning and reducing the impact of the pain on functioning, rather than goals such as "experience less pain" (Otis et al., 2011). Goals such as increased activity levels need to be in small increments to avoid clients escalating their pain symptoms. Otis et al. (2011) suggested using "time-based pacing" of activities, which involves breaking down activities according to time intervals, not whether or not activities are completed. This method involves identifying with the client an important task that usually results in increased pain. Collaboratively estimate how long the client can perform this task before the pain increases (active time) and how long they will need to rest before becoming active again (rest time). The active–rest schedule should be used so that the task is manageable and the client's sense of self-efficacy and control over the pain increases. Using a fitness tracker or pedometer can assist in monitoring clients' actual activity levels, and recording activity levels can assist clients to see change as it occurs.

Expressing empathy in relation to a client's experience of pain, and attempting to understand the impact of pain on their life, can be helpful. Adjustment to chronic pain and related disability can provoke significant grief and loss over the client's loss of potential, ability, relationships, 'normalcy', activity, social life and sense of self<sup>43</sup> (see chapter on **Grief and loss**). People with CNCP who have higher levels of acceptance of their CNCP report lower pain intensity, decreased anxiety and avoidance, less depression and higher levels of functioning (Center for Substance Abuse Treatment, 2012).

Acceptance of chronic pain involves three important concepts:

- there is more to life than pain
- being completely free of pain is unrealistic
- being active is important, even if it causes an increase in pain.

(Center for Substance Abuse Treatment, 2012)

Mindfulness-based therapies have been shown to be as effective as CBT (Garland et al., 2017). Acceptance and commitment therapy (ACT) has also been shown to be effective in managing chronic pain (Beitel et al., 2017). Mindfulness-based strategies for pain teach acceptance of pain and decoupling of emotional reactivity from the pain experience (Garland et al., 2017). Mindfulness strategies (see **Mindfulness** chapter) can be tailored to suit working with clients with chronic pain to help them to learn a new way of attending to their experience without focusing on the pain. Instructions for mindfulness of breath and mindfulness of emotion are found in Appendix 21 and 22 respectively, and can be adapted to mindfulness of other aspects of a client's experience.

43 A useful resource is Transition into chronic illness: Grief and loss, which can be accessed from <http://www.chronicpinaustralia.org.au/files/Booklet%20-%20-%20Grief%20and%20Loss.pdf>

Acceptance and commitment therapy can be beneficial for people experiencing CNCP. The focus of an ACT approach to chronic pain is on improving functioning and decreasing the interference of the pain through acceptance and the pursuit of valued goals. Acceptance of pain can lead to increased pain tolerance and improved emotional, social and physical functioning (Wetherell et al., 2011). Core elements of an ACT approach to chronic pain includes establishing the client's values (e.g. what they care about and how they want to live their life), cognitive defusion (observing thoughts without buying into them), mindfulness, and committed action (encouraging action consistent with valued goals).

Explain that the opposite of avoidance is acceptance and abandoning the fight against pain. Empathise that this is not easy but that in doing so the client will be able to take action and engage in a life that is consistent with their values. Clarify that acceptance is not resignation, and acceptance allows full awareness of the pain and will empower the client to act rather than react to the pain. Point out that among AOD clients, a common way to react to the pain is to use AOD. It may be useful to explain to clients how avoiding physical pain can cause more suffering (Dahl & Lundgren, 2007). Enquire whether the pain-avoiding strategies, including AOD use, are causing undue suffering and costing the client the life that they want to be living.

Cognitive defusion is described in the chapter on **Mindfulness**. The term 'cognitive defusion' is used in ACT to describe the use of various strategies to gain distance from thoughts. Clients should be encouraged to adopt the viewpoint that 'A thought is just a thought' and to be mindful of thoughts without buying into them and becoming caught up in and upset by them. Cognitive defusion can help clients to drop their rope in the 'tug-of-war with pain' (Dahl & Lundgren, 2007). Acknowledge that cognitive defusion will not make the pain go away, but will enable the client to notice and have distance from their thoughts about pain so that they can make choices about their life (Dahl & Lundgren, 2007; see cognitive defusion worksheet in Appendix 23).

Given depression, anxiety and trauma have a high prevalence in people with CNCP and that these influence the experience of CNCP, assisting clients to manage their symptoms of these issues may help them manage their pain (see chapters on **Co-occurring AOD and depression disorders**, **Co-occurring anxiety** and **Co-occurring trauma issues**).

Strengthening social and interpersonal relationships can affect adjustment to living with chronic pain and associated disabilities. Sufficient social support also contributes positively to pain-related functioning and is associated with better pain outcomes across a range of conditions (Edwards et al., 2016). Engaging family and significant others in discussions about treatment (where appropriate) can assist the counsellor to understand the client's existing coping strategies and level of functioning. Additionally, family and significant others form important support networks for clients (see chapter on **Working with significant others**).

Assisting clients to develop strategies to cope with pain, other than AOD use, is essential. Coping strategies can include relaxation, pacing activities, positive thinking and a range of other strategies (Edwards et al., 2016). Clients and their experiences of pain are individual and coping strategies may need to be identified through a trial and error process.

Overdose is a risk for clients on opioid medications and using other substances such as benzodiazepines, alcohol or other opioids. Discussions around overdose prevention and management are important, and access to naloxone should be facilitated.

## Pain management for dependent clients – tip sheet

AOD use and pain frequently co-occur, and chronic pain is common amongst people who use AOD.

- Acute pain has a recent onset and an expected short-term period of duration. Acute pain can be caused by injury, illness, or AOD withdrawal.
- Chronic pain persists for longer than several months and can be caused by long-term illness or injury. Chronic non-cancer pain (CNCP) extends beyond the expected period of healing and is a disease process in itself. CNCP can be very debilitating and is associated with a range of co-occurring mental health conditions.

Biological, psychological and social factors influence the experience of chronic pain. Multidisciplinary approaches for chronic pain are most effective. The counsellor's role is to be empathic and provide strategies to help the client manage the pain and improve their quality of life.

Chronic pain can be difficult to diagnose and treat and clients often report feeling that others have not taken their experiences of pain seriously. Counsellors should adopt a stance in which they empathise with the client regarding their pain, the impact of the pain on their lives, and experiences of feeling invalidated and disbelieved.

Issues for consideration when working with a person who uses AOD and experiences chronic pain include:

- polydrug use – particularly CNS depressants such as opioids, benzodiazepines and alcohol and the risk of overdose, along with the risk of drug interactions
- presence of co-occurring mental health conditions
- increased risk of suicidality
- pain intensity can be a barrier to stopping or reducing AOD use
- pain may be undertreated
- risk of withdrawal from opioids
- increased tolerance to pain medications
- opioid dependence can decrease the effectiveness of opioids for pain management
- opioid dependence can increase pain sensitivity (hyperalgesia)
- people with CNCP treated with opioids are more prone to anhedonia
- risk of overdose when tolerance drops or opioid use increases
- client may experience stigma related to CNCP as well as their AOD use

It is important to liaise with other health professionals in helping a client to manage pain, particularly the client's GP who may not be fully aware of all biopsychosocial aspects impacting on the client and his/her family. Medical practitioners are likely to be highly appreciative and responsive to multidisciplinary approaches which improve outcomes for their patients.

Additional education regarding CNCP is recommended for counsellors who are working with clients who experience CNCP.

## References

- Baldacchino, A., Gilchrist, G., Fleming, R., & Bannister, J. (2010). Guilty until proven innocent: A qualitative study of the management of chronic non-cancer pain among patients with a history of substance abuse. *Addictive Behaviors*, 35(3), 270-272. doi: 10.1016/j.addbeh.2009.10.008
- Barry, D. T., Irwin, K. S., Jones, E. S., Becker, W. C., Tetrault, J. M., Sullivan, L. E., ... Fiellin, D. A. (2010). Opioids, chronic pain, and addiction in primary care. *The Journal of Pain*, 11(12), 1442-1450. <https://doi.org/10.1016/j.jpain.2010.04.002>
- Becker, W. C., Dorflinger, L., Edmond, S. N., Islam, L., Heapy, A. A., & Fraenkel, L. J. B. F. P. (2017). Barriers and facilitators to use of non-pharmacological treatments in chronic pain. 18(1), 41. doi: 10.1186/s12875-017-0608-2
- Beitel, M., Oberleitner, L., Kahn, M., Kerns, R. D., Liang, C., Madden, L. M., ... Barry, D. T. (2017). Drug counselor responses to patients' pain reports: a qualitative investigation of barriers and facilitators to treating patients with chronic pain in methadone maintenance treatment. *Pain Medicine*, 18(11), 2152-2161. doi: 10.1093/pm/pnw327
- Bilevicius, E., Sommer, J. L., Asmundson, G. J. G., & El-Gabalawy, R. (2018). Posttraumatic stress disorder and chronic pain are associated with opioid use disorder: Results from a 2012-2013 American nationally representative survey. *Drug and Alcohol Dependence*, 188, 119-125. doi: 10.1016/j.drugalcdep.2018.04.005
- Campbell, G., Darke, S., Bruno, R., & Degenhardt, L. (2015). The prevalence and correlates of chronic pain and suicidality in a nationally representative sample. *Australian & New Zealand Journal of Psychiatry*, 49(9), 803-811. doi: 10.1177/0004867415569795
- Center for Substance Abuse Treatment (CSAT). (2012). *Managing chronic pain in adults with or in recovery from substance use disorders* (Treatment Improvement Protocol (TIP) Series, No. 54). Rockville, MD: Substance Abuse and Mental Health Services Administration.



- Cicero, T. J., & Ellis, M. S. (2017). Understanding the demand side of the prescription opioid epidemic: Does the initial source of opioids matter? *Drug and Alcohol Dependence*, 173, S4-S10. <https://doi.org/10.1016/j.drugalcdep.2016.03.014>
- Dahl, J., & Lundgren, T. (2006). *Living beyond your pain. Using acceptance and commitment therapy to ease chronic pain*. Oakland, CA: New Harbinger Publications.
- Degenhardt, L., Bruno, R., Lintzeris, N., Hall, W., Nielsen, S., Larance, B., ... Campbell, G. (2015). Agreement between definitions of pharmaceutical opioid use disorders and dependence in people taking opioids for chronic non-cancer pain (POINT): A cohort study. *The Lancet Psychiatry*, 2(4), 314-322. doi: 10.1016/S2215-0366(15)00005-X
- Duong, T., Vytialingam, R., & O'Regan, R. (2018). *A brief guide to the management of alcohol and other drug withdrawal*. Perth, WA: Mental Health Commission.
- Edwards, R. R., Dworkin, R. H., Sullivan, M. D., Turk, D. C., & Wasan, A. D. (2016). The role of psychosocial processes in the development and maintenance of chronic pain. *The Journal of Pain*, 17(9), T70-T92. doi: 10.1016/j.jpain.2016.01.001
- Garland, E. L., Bryan, C. J., Finan, P. H., Thomas, E. A., Priddy, S. E., Riquino, M. R., & Howard, M. O. (2017). Pain, hedonic regulation, and opioid misuse: Modulation of momentary experience by Mindfulness-Oriented Recovery Enhancement in opioid-treated chronic pain patients. *Drug and Alcohol Dependence*, 173, S65-S72. <https://doi.org/10.1016/j.drugalcdep.2016.07.033>
- Kosiba, J. D., Zale, E. L., & Ditre, J. W. (2018). Associations between pain intensity and urge to smoke: Testing the role of negative affect and pain catastrophizing. *Drug and Alcohol Dependence*, 187, 100-108. <https://doi.org/10.1016/j.drugalcdep.2018.01.037>
- Larance, B., Campbell, G., Peacock, A., Nielsen, S., Bruno, R., Hall, W., ... Degenhardt, L. (2016). Pain, alcohol use disorders and risky patterns of drinking among people with chronic non-cancer pain receiving long-term opioid therapy. *Drug and Alcohol Dependence*, 162, 79-87. <https://doi.org/10.1016/j.drugalcdep.2016.02.048>
- Lintzeris, N. (2015). Treatment of patients with opioid dependence. *Medicine Today*, 16(6 Suppl), 10-15. Retrieved from [https://medicinetoday.com.au/sites/default/files/cpd/3-MT2015-06SUPPL-PRESCRIPTION\\_OPIOID\\_MISUSE-LINTZERIS.pdf](https://medicinetoday.com.au/sites/default/files/cpd/3-MT2015-06SUPPL-PRESCRIPTION_OPIOID_MISUSE-LINTZERIS.pdf)
- NPS Medicinewise. (2016). *Pain management in patients with a history of opioid dependence: Information for health professionals*. Surry Hills, NSW: Author.
- Otis, J. D., Pincus, B. P., & Murawski, M. E. (2011). Cognitive behavioural therapy in pain management. In M. Ebert & R. Kerns (Eds.), *Behavioral and psychopharmacologic pain management* (pp. 184-201). Cambridge, United Kingdom: Cambridge University Press.
- Pain Australia. (2010). *National Pain Strategy*. Retrieved from <https://www.painaustralia.org.au/improving-policy/national-pain-strategy>
- Priddy, S. E., Hanley, A. W., Riquino, M. R., Platt, K. A., Baker, A. K., & Garland, E. L. (2018). Dispositional mindfulness and prescription opioid misuse among chronic pain patients: Craving and attention to positive information as mediating mechanisms. *Drug & Alcohol Dependence*, 188, 86-93. doi: 10.1016/j.drugalcdep.2018.03.040
- Quinlan, J., & Cox, F. (2017). Acute pain management in patients with drug dependence syndrome. *PAIN Reports*, 2(4), e611. doi: 10.1097/pr9.0000000000000611
- Rieb, L. M., Norman, W. V., Martin, R. E., Berkowitz, J., Wood, E., McNeil, R., & Milloy, M. J. (2016). Withdrawal-associated injury site pain (WISP): a descriptive case series of an opioid cessation phenomenon. *Pain*, 157(12), 2865-2874. doi: 10.1097/j.pain.0000000000000710
- Savage, S. R., Kirsh, K. L., & Passik, S. D. (2008). Challenges in using opioids to treat pain in persons with substance use disorders. *Addiction Science & Clinical Practice*, 4(2), 4-25. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2797112/pdf/ascp-04-2-4.pdf>
- Schug, S. A., Palmer, G. M., Scott, D. A., Halliwell, R., Trinca, J., & APM:SE Working Group of the Australian and New Zealand College of Anaesthetists and Faculty of Pain Medicine. (2015). *Acute pain management: Scientific evidence* (4th ed.). Melbourne, VIC: Australian and New Zealand College of Anesthetists.
- Severino, A. L., Shadfar, A., Hakimian, J. K., Crane, O., Singh, G., Heinzerling, K., & Walwyn, W. M. (2018). Pain therapy guided by purpose and perspective in light of the opioid epidemic. *Frontiers in Psychiatry*, 9(119). doi: 10.3389/fpsy.2018.00119
- Sznitman, S., Baruch, Y. B., Greene, T., & Gelkopf, M. (2018). The association between physical pain and cannabis use in daily life: An experience sampling method. *Drug & Alcohol Dependence*, 191, 294-299. doi: 10.1016/j.drugalcdep.2018.07.014
- Tompkins, D. A., Hobelmann, J. G., & Compton, P. (2017). Providing chronic pain management in the "Fifth Vital Sign" Era: Historical and treatment perspectives on a modern-day medical dilemma. *Drug and Alcohol Dependence*, 173, S11-S21. <https://doi.org/10.1016/j.drugalcdep.2016.12.002>
- Turk, D. C., Fillingim, R. B., Ohrbach, R., & Patel, K. V. (2016). Assessment of psychosocial and functional impact of chronic pain. *The Journal of Pain*, 17(9), T21-T49. doi: 10.1016/j.jpain.2016.02.006
- Volkow, N. D., & McLellan, A. T. (2016). Opioid abuse in chronic pain--misconceptions and mitigation strategies. *New England Journal of Medicine*, 374(13), 1253-1263. doi: 10.1056/NEJMra1507771
- Voon, P., Greer, A. M., Amlani, A., Newman, C., Burmeister, C., & Buxton, J. A. (2018). Pain as a risk factor for substance use: A qualitative study of people who use drugs in British Columbia, Canada. *Harm Reduction Journal*, 15(1). doi: 10.1186/s12954-018-0241-y
- Wachholtz, A., Foster, S., & Cheatle, M. (2015). Psychophysiology of pain and opioid use: Implications for managing pain in patients with an opioid use disorder. *Drug and Alcohol Dependence*, 146, 1-6. <https://doi.org/10.1016/j.drugalcdep.2014.10.023>
- Waugh, O. C., Byrne, D. G., & Nicholas, M. K. (2014). Internalized stigma in people living with chronic pain. *The Journal of Pain*, 15(5), 550.e551-510. doi: 10.1016/j.jpain.2014.02.001
- Wetherell, J. L., Afari, N., Rutledge, T., Sorrell, J. T., Stoddard, J. A., Petkus, A. J., ... Atkinson, J. H. (2011). A randomized, controlled trial of acceptance and commitment therapy and cognitive-behavioral therapy for chronic pain. *Pain*, 152(9), 2098-2107. <https://doi.org/10.1016/j.pain.2011.05.016>
- Woolf, C. J. (2010). What is this thing called pain? *The Journal of Clinical Investigation*, 120(11), 3742-3744. doi: 10.1172/JCI45178
- Zlotnick, C., Lawental, M., & Pud, D. (2017). Double whammy: Adverse childhood events and pain reflect symptomology and quality of life in women in substance abuse treatment. *Social Work in Health Care*, 56(3), 189-201. doi: 10.1080/00981389.2016.1265629



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## 51. Residential settings

Residential rehabilitation allows people to live in while they complete a program that supports them to deal with AOD issues. Residential rehabilitation is voluntary. The programs may provide individual and group therapy, counselling, education and art and recreation activities. The average length of stay is 12–16 weeks, but some people stay for more than 12 months (MHC, n.d.).

Residential settings are a common context for AOD counselling. Residential services are 24-hour staffed programs that provide accommodation and offer intensive and structured interventions following AOD withdrawal (NSW Department of Health, 2007). Counselling in this setting involves a range of approaches described in this guide, usually including MI, goal-setting, problem-solving and relapse prevention, and often strategies to encourage clients to explore and challenge their ways of perceiving and reacting to things such as cognitive restructuring, relaxation, mindfulness, assertiveness training and anger management.

### Suitability for residential settings

Clients who meet the following criteria should be prioritised for long-term residential treatment (NSW Department of Health, 2007):

- severe and long-term AOD issues
- AOD issues persisting despite previous history of non-residential or short-term treatment
- home environment and social circumstances unresponsive to non-residential treatment approaches
- significant co-occurring AOD and mental health issues.

Note that some clients will relapse after completing a residential treatment program. This does not mean that they are unsuitable for a residential setting and should not preclude them from future engagement with this treatment.

The client's suitability should be assessed and the residential setting should have clear eligibility and exclusion criteria. At assessment, clients should be informed of the objectives of the program, treatment methods, rules, obligations and rights of residents, the role of the staff, available facilities, visiting rights, income support arrangements, fees (if applicable) and privacy policies (NSW Department of Health, 2007).

### Engaging clients into residential settings

If a residential setting seems suitable for a client, the AOD worker should help the client to engage with the agency and make an informed decision about pursuing this option by:

- providing the client with information and contacts
- addressing any concerns and misconceptions
- helping the client to work through ambivalence using MI
- highlighting the potential benefits of residential treatment given their circumstances
- encouraging the client to attend an information or assessment session with the agency before making an informed decision.

Note that the assessment process for residential settings is often thorough to ensure that the treatment is appropriate for the client and the client is at an appropriate stage of change. A speedy entry into a residential setting may not allow the client time to prepare and this can affect their ability to adapt to the program, which can increase the likelihood that they will cease treatment prematurely. It is important to prepare the client for the possibility of a lengthy assessment process and to support the client during their initial engagement and assessment with a residential setting.

Residential programs differ in various ways including:

- government and non-government managed
- therapeutic community as the primary service or a component of overall service
- supportive of involvement of significant others, or significant others may have limited opportunity for involvement
- emphasis on individual counselling, group work, or a combination
- mixed cohorts or modified to meet the needs of specific populations, such as Indigenous people, women, parents, young people, people with co-occurring mental health and AOD issues
- strict emphasis on ongoing abstinence (with the possible exception of prescription medication or tobacco) or supportive of harm minimisation and reduced use
- medium-term duration (e.g. 3 months) through to long-term duration (e.g. 12 months or more)
- located in inner city, outer metropolitan and regional areas
- bed capacity of fewer than 20 to more than 100.

## Therapeutic communities

Some AOD residential settings follow a therapeutic community model. This model is informed by the key principle that the therapeutic community is the intervention tool to foster and facilitate change. The treatment facility is itself a community, with an emphasis on self-management and mutual peer support as a vehicle for effecting change.

Therapeutic communities view long-term problematic AOD use as a disorder which affects the whole person and requires significant changes to lifestyle and identity (De Leon & Wexler, 2009). Residential settings, and therapeutic communities in particular, are the treatment of choice for clients with long-term and severe AOD issues (De Leon, 2010). Therapeutic community approaches are most effective when they incorporate a broad range of interventions to address the client's needs (NSW Department of Health, 2007). In addition, it is clear that outcomes are related to client retention: the longer the client remains actively involved in treatment, the greater the improvement at follow-up (De Leon & Wexler, 2009).

Despite the diversity in therapeutic communities in the AOD sector, there are shared concepts and similar practices among them. From a practical perspective, the social environment of a therapeutic community should resemble a community rather than an agency setting (De Leon, 2000). Residents participate in the management and operation of the community, which is the principal means of promoting change, and there is a focus on AOD use from the perspective of a social model of health (Gowing et al., 2002).

## Community as method

One of the pillars of therapeutic communities is that the community is seen as the method for change (De Leon, 2000). The goal of the community is to engage members' participation in the community so that they can achieve their goals. Some therapeutic communities rely almost exclusively on group work processes rather than individual counselling with a professional counsellor. The community usually includes rules of conduct and expectations for involvement in the community. The expectations are often learnt vicariously by observing and monitoring the participation of others.

As a community member moves through the program, it is expected that (De Leon, 2000):

- the member's roles and obligations in work, groups, meetings and recreation will increase
- responsibility and accountability will extend from self to immediate peers and eventually the entire community
- the member will improve their self-awareness of personal change issues
- the member will develop autonomy and initiate change without dependence on others.

## Staged approach

Stages of the therapeutic community process are in line with the expectations listed above. Members' responsibilities increase as they move through the stages to the extent that they eventually adopt a peer support role to newer residents. Involvement in a buddy system is usually part of a client's initial engagement in a residential setting. When a client enters a therapeutic community, they are often assigned a peer (buddy) who provides support and helps them to adjust to the community. As the client's mental health and general wellbeing improves they are encouraged, and indeed expected, to take on more responsibility and provide support to others, ultimately adopting a peer support role with newer residents.

Clients in recovery are encouraged to be supportive role models to others and involved in the counselling process. It can be helpful to have a mix of staff in a therapeutic community and staff members who have dealt with their own AOD lived experience can be a great addition to the environment. The length of the residential stay is usually dependent on the individual's requirements and their progression through distinct stages: assessment and orientation, treatment, transition and re-entry into the wider community.

### **Holistic and multidimensional**

Residential settings are often holistic and multidimensional and aim to address broad needs, such as occupational functioning and parenting skills, and provide services for a range of co-occurring issues.

## **Counselling**

Residential settings can help clients to work through problematic AOD use and co-occurring issues in a safe and supportive environment. Whilst residential programs may comprise both structured groups and individual therapy sessions, the degree of emphasis on group work versus individual therapy varies between services. Some therapeutic communities focus almost exclusively on group therapy, whilst others rely on individual counselling processes that complement and support the 'community as method' model. Informal learning through community recreation, relaxation, decision-making, problem-solving and empathy is also recognised as a vital part of therapy. Counselling in residential settings involves evidence-based approaches in line with the client's goals and facilitating the client's engagement and responsibility in the community.

The counsellor's broader role often includes participating in the operation of the community by taking part in daily activities, facilitating interactions between group members, and providing group sessions on relevant AOD issues and co-occurring issues. Counselling should be responsive to each client's stage of change and tailored to meet the client's particular psychosocial needs. In addition to reduced AOD use, important goals for clients in residential settings include improved general functioning and health, improved relationships, secure accommodation and the pursuit of important occupational and/or educational activities.

The focus of counselling will be largely dependent on the client's stage in the residential setting. Important issues to consider in the first phase of counselling in a residential setting include:

- helping the client to adjust to the residential setting
- assisting with orientation
- encouraging engagement with the therapy (if the setting is a therapeutic community, encouraging engagement with the buddy system)
- to improve retention, offering more intensive support within the first three weeks of admission (NSW Department of Health, 2007)
- addressing issues of retention in treatment and health outcomes
- discussing issues associated with staying in treatment and the client's concerns.

Following initial engagement, counselling typically involves helping the client through the provision of evidence-based approaches for presenting issues, using strategies such as MI, goal-setting, problem-solving and relapse prevention (see chapters on **Motivational interviewing**, **Goal-setting**, **Problem-solving** and **Relapse prevention and management**). In addition, the counsellor should be involved in case management and referral to address broad needs and co-occurring issues.

Important issues to consider in the final phase of counselling in a residential setting include:

- helping the client to manage transition and re-entry into the wider community
- facilitating the client's engagement with services to pursue employment, training, volunteering and/or leisure activities of interest to them
- establishing a basic 'exit package' with relevant information, telephone numbers and website addresses
- arranging referrals for continued community support
- scheduling follow-up sessions.

It is important for counsellors and AOD workers to maintain adequate supervision arrangements when working in a residential setting. This is particularly important as the counselling is often intense and a worker's role in this setting is complex.

## Residential setting – tip sheet

Clients who meet the following criteria should be prioritised for long-term residential treatment:

- severe and long-term AOD use issues
- persistent AOD use issues despite previous non-residential or short-term treatment
- home and social environment unsupportive of non-residential approaches
- significant co-occurring AOD and mental health issues.

Engaging clients into residential settings involves the following:

- providing the client with information and contacts
- addressing concerns and misconceptions
- helping the client to work through ambivalence
- highlighting the potential benefits of residential treatment
- encouraging the client to attend an information or assessment session.

Provide support to the client during their initial engagement and assessment with the residential setting. Inform them that it can be a lengthy process.

Residential settings in the AOD field are diverse. Some AOD residential settings focus on the formation of a therapeutic community. Therapeutic communities see the community itself as the primary method of change, follow a staged approach and are typically holistic and multidimensional.

The focus of counselling in a residential setting is dependent on the client's stage in the process. During the first few weeks after admission into a residential setting it is important to offer more intensive support to improve retention.

Important issues to consider in the first phase include:

- helping the client to adjust to the residential setting
- assisting with orientation
- encouraging engagement with therapy
- encouraging retention in treatment.

Following initial engagement, counselling in a residential setting will be dependent on the client's presenting issues. Counselling should follow an evidence-based approach and address broad needs and co-occurring issues.

Important issues to consider in the final phase include:

- helping the client with a gradual transition into the wider community
- facilitating the client's engagement with relevant services and community support
- establishing an 'exit package' with relevant information and contacts
- scheduling follow-up sessions.

## References

- De Leon, G. (2000). *The therapeutic community: Theory, model, and method*. New York, NY: Springer Publishing.
- De Leon, G., & Wexler, H. (2009). The therapeutic community for addictions: An evolving knowledge base. *Journal of Drug Issues*, 39(1), 167-178. <https://doi.org/10.1177/002204260903900113>
- De Leon, G. (2010). Is the therapeutic community an evidence-based treatment? What the evidence says. *Therapeutic Communities*, 31, 104–128. Retrieved from [https://www.researchgate.net/publication/277019069\\_De\\_Leon\\_G2010\\_Is\\_the\\_Therapeutic\\_Community\\_an\\_Evidence\\_Based\\_Treatment\\_What\\_the\\_Evidence\\_Says\\_International\\_Journal\\_of\\_Therapeutic\\_Communities\\_31\\_2\\_summer\\_104-128](https://www.researchgate.net/publication/277019069_De_Leon_G2010_Is_the_Therapeutic_Community_an_Evidence_Based_Treatment_What_the_Evidence_Says_International_Journal_of_Therapeutic_Communities_31_2_summer_104-128)
- Gowing, L., Cooke, R., Biven, A. & Watts, D. (2002). *Towards better practice in therapeutic communities*. Bungalow, NSW: Australasian Therapeutic Communities Association.
- Mental Health Commission, Western Australia (MHC). (n.d.). Residential rehabilitation for alcohol and other drugs. Retrieved from <https://www.mhc.wa.gov.au/getting-help/residential-rehabilitation-for-alcohol-and-other-drugs/>
- NSW Department of Health. (2007). *Drug and alcohol treatment guidelines for residential settings*. North Sydney, NSW: Author.

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## 52. Co-occurring AOD and anxiety

Anxiety symptoms may occur periodically in a person's life and are not always considered problematic. However, when a person's anxiety is frequent, intense and reduces their wellbeing and functioning, then their anxiety may be considered to be symptomatic of an anxiety disorder (CSAT, 2013).

People with anxiety disorders can experience intense feelings of fear, unease and panic, and may actively avoid the causes of their anxiety such as people, places or events (Royal Australian & New Zealand College of Psychiatrists, 2017). Symptoms of an anxiety disorder include poor concentration, inability to relax, sleep disturbances, depersonalisation, and physical symptoms such as dizziness, faintness, headaches, nausea, indigestion, loss of sexual pleasure, breathing difficulties, sweating, tension and muscle pain, and heart palpitations (Marel et al., 2016).

The DSM 5 (American Psychiatric Association, 2013) classifies anxiety disorders as follows:

- Generalised anxiety disorder (GAD)
- Panic disorder
- Agoraphobia
- Social anxiety disorder (SAD)
- Specific phobias.

(Marel et al., 2016)

### Generalised anxiety disorder

A GAD is marked by excessive anxiety about activities or situations for most of the time over a period of at least six months. The feelings of anxiety and worry are difficult to control and are associated with at least three of the following:

- restlessness or edginess
- being easily fatigued
- difficulty concentrating
- irritability
- muscle tension
- difficulty either falling or staying asleep, or restless sleep.

The symptoms lead to significant distress and/or interfere with a person's wellbeing and functioning, and are not due to the effects of a drug, medication or medical condition.

(CSAT, 2016)

### Panic disorder

A panic disorder involves the experience of at least one panic attack, an abrupt, quickly peaking (within 10 minutes) surge of intense fear accompanied by physical symptoms such as palpitations or pounding heart, sweating, sensations of shortness of breath, and chest pain or discomfort (CSAT, 2016). The diagnostic criteria include that the panic attack is followed by at least one month of persistent concern about having more panic attacks or their consequences, resulting in maladaptive changes in behaviour. Panic disorder can sometimes be accompanied by agoraphobia.

### Agoraphobia

Agoraphobia involves marked fear or anxiety about two or more of the following, for at least six months:

- using public transportation (e.g. buses, trains, taxis, planes)
- being in open spaces (e.g. parking lots, bridges)
- being in enclosed spaces (e.g. shops, movie theatres)
- standing in line or being in a crowd
- being outside the home alone.

(CSAT, 2016)

The person avoids these situations or undertakes them with severe distress or anxiety about having a panic attack, or requires a companion to undertake the activities. The situations that provoke symptoms of agoraphobia cause fear or anxiety that is out of proportion to the actual risk of danger posed (CSAT, 2016; Marel et al., 2016).

## Social anxiety disorder

Social anxiety disorder (formerly known as social phobia) is characterised by excess anxiety or worry about one or more social situations for at least six months, whereby the person perceives their actions may be analysed by others negatively or feel humiliated, embarrassed or rejected. A person with SAD will fear the situation to the point where their avoidance or anxiety causes significant distress and interferes with their ability to function (Marel et al., 2016).

## Specific phobias

Specific phobias are characterised by marked fear or anxiety about a specific object or situation (e.g. heights, spiders, flying) which persist for 6 months or more. The phobic object or situation provokes immediate fear or anxiety which is out of proportion to the actual danger posed. Phobic objects or situations are avoided or endured with significant distress. The phobia causes significant distress or impairment in social, occupational or other areas of functioning (CSAT, 2016).

## Working with co-occurring anxiety

Anxiety disorders are among the most common co-occurring mental health disorders experienced by people who use alcohol or other drugs. The prevalence for co-occurring anxiety disorders for people in AOD treatment in Australia ranges from 12% to 91%, depending on the treatment setting, with GAD and panic disorder being the most common (Kingston, Marel, & Mills, 2017). Anxiety is associated with more frequent use of alcohol and cannabis (Fatseas, Serre, Swendsen, & Auriacombe, 2018).

People with alcohol use disorders have more than twice the risk of an anxiety disorder compared to people without alcohol use disorders (Lai, Cleary, Sitharthan, & Hunt, 2015). People who use illicit drugs also have an almost three times greater risk of experiencing an anxiety disorder than those who do not use illicit drugs, and 50% of people who have been diagnosed with dependence on an illicit drug have also been diagnosed with an anxiety disorder (Lai, et al., 2015).

People who use AOD may experience some anxiety disorder symptoms without meeting all diagnostic criteria for an anxiety disorder (Marel et al., 2016). Others may meet the criteria for diagnosis of an anxiety disorder but have not been diagnosed. It is essential that a thorough assessment is undertaken with clients, including the history of any mental health conditions and their development. A screening tool such as the DASS, a 42-question screening tool (Lovibond & Lovibond, 1995) can be useful for differentiating between symptoms of stress, anxiety and depression (Antony, Bieling, Cox, Enns, & Swinson, 1998). A copy of the DASS is in Appendix 11. Alternatively, the client can be asked if they experienced these symptoms during periods of abstinence of 30 days or more (CSAT, 2013); this will assist in determining whether a client who plans to reduce or cease their AOD use has anxiety symptoms which are being masked by the AOD (see chapter on **Assessment**). If the anxiety symptoms have occurred during periods of extended abstinence or developed prior to heavy AOD use, they may have an underlying disorder which may require additional treatment (CSAT, 2013).

Individuals accessing AOD treatment services may experience anxiety while intoxicated or withdrawing (McHugh, 2015). Severe anxiety symptoms can become apparent during a withdrawal from benzodiazepines, and it can be difficult to tell if the symptoms are the result of withdrawal or an underlying anxiety disorder (Saunders et al., 2016). However, anxiety related to withdrawal is time-limited and generally improves in the first month after withdrawal, unlike the symptoms of an underlying anxiety disorder which, unless treated, will generally get worse during the month following withdrawal (Saunders et al., 2016). Approximately 15% of people will experience a protracted withdrawal from benzodiazepines, which can last a few weeks and sometimes months, and may include symptoms of anxiety (Manning et al., 2018).



An uncomplicated withdrawal from alcohol can mimic anxiety and panic disorder, but will respond to short-term treatment with benzodiazepines in combination with supportive care (Saunders et al., 2016). People may also experience a protracted post-withdrawal phase which can resemble an anxiety disorder once their initial withdrawal from alcohol is completed (see chapter on **Withdrawal management**). This protracted post-withdrawal phase can last 3–6 months and clients should be reassured that these symptoms will pass without medication. However, approximately 25% of clients will have an underlying anxiety disorder that preceded their heavy alcohol consumption (Saunders et al., 2016). These clients may require medication for the treatment of their anxiety disorder. Benzodiazepines are not recommended for ongoing treatment of anxiety disorders due to their potential for dependence (Saunders et al., 2016). Delirium tremens can also produce symptoms of anxiety (Manning et al., 2018).

Withdrawal from nicotine can produce symptoms of anxiety. As with other withdrawal, drug-related anxiety symptoms will generally improve over time (Manning et al., 2018).

Intoxication with stimulants such as methamphetamine can cause symptoms of anxiety which will wear off along with the other stimulant effects. Intoxication with hallucinogens such as lysergic acid diethylamide (LSD) or psilocybin (magic mushrooms) can also cause symptoms of anxiety as a result of the drug's stimulation and perceptual disturbance effects, especially in people who are less experienced with hallucinogens. This can also occur when people use hallucinogens alone, or in an unfamiliar or unpleasant setting (Saunders et al., 2016).

Anxiety and panic attacks are two to four times more common in people who are long-term users of cannabis than the general population (Saunders et al., 2016). Cannabis intoxication can cause symptoms of anxiety (Manning et al., 2018). Anxiety symptoms can present during cannabis withdrawal and may require short-term treatment with benzodiazepines (Manning et al., 2018).

People with opioid use disorders have high rates of co-occurring anxiety disorders and PTSD (Saunders et al., 2016). Additionally, people withdrawing from opioids can experience anxiety symptoms (Manning et al., 2018).

Anxiety and SUDs are associated with sleep-related problems, which have a strong relationship to concerns about the consequences of anxiety symptoms, also known as 'anxiety sensitivity cognitive concerns' (Dixon, Lee, Gratz, & Tull, 2018). Anxiety sensitivity is associated with depressive symptoms (Saulnier, Allan, Raines, & Schmidt, 2018).

People with SUDs and anxiety have a higher risk of relapse due to experiencing high craving intensity, which is associated with anxiety symptoms, particularly in relation to cannabis (Fatseas et al., 2018) (See chapter on **Relapse prevention and management**). Counsellors should work with clients on relapse prevention strategies as well as the management of a lapse/relapse (see relapse prevention worksheet in Appendix 16).

## Management of anxiety symptoms

While some people with AOD issues may require medication to treat their anxiety, counsellors can assist clients with anxiety to manage their anxiety symptoms through a range of strategies.

### Psychoeducation

Explaining about the nature of anxiety, including the activation of the body's 'flight or fight' or autonomic nervous system and subsequent physical symptoms of anxiety, can be helpful for clients. As such AOD counsellors should make themselves familiar with the symptoms of anxiety and their causes. Where possible, provide written information to clients so they can review it at a later date.

For services that wish to become 'dual diagnosis capable' (according to the Dual Diagnosis Capability in Addiction Treatment Toolkit Version 4.0), it is recommended that information about co-occurring disorders or specific common disorders such as anxiety are displayed in waiting room materials and provided in client information (SAMHSA, 2011).

The Centre for Clinical Interventions (CCI) has a range of information sheets for clients, including one on anxiety, which can be accessed via this website: <https://www.cci.health.wa.gov.au/Resources/Overview>

The following sections provide an overview of anxiety management techniques, most of which are detailed in other chapters within these guidelines. Strategies can be introduced during sessions with clients to allow them to try them out and provide the counsellor with feedback. Clients should be encouraged to practice their preferred strategy daily for 10–20 minutes to achieve the best results (Marel et al., 2016).

## Progressive muscle relaxation

Progressive muscle relaxation involves tensing and relaxing specific muscle groups. This exercise provides clients with a concrete focus, so it can facilitate distress reduction as well as increased relaxation (Marel et al., 2018) (see chapter on *Relaxation*).

## Controlled breathing

Controlled breathing or abdominal breathing can assist clients whose breathing is shallow and rapid, which can lead to hyperventilation or panic attacks (Marel et al., 2016). It is important to explain this process to clients and to assist them to practise controlled breathing until they can distinguish the difference between shallow and controlled breathing. If a client is very anxious when they are attempting it, they may not be able to control their breathing sufficiently and the counsellor may need to encourage them to practise when they are less anxious (Marel et al., 2016). A controlled breathing client handout is in Appendix 17.

## Visualisation

Visualisation encourages the client to create an imaginary relaxing and/or safe place for themselves using their hearing, smell, touch and vision, alongside breathing techniques. Not every client will find visualisation suitable, and clients should not use it if they find the process difficult or experience negative effects (Marel et al., 2016). A client handout for visualising a safe place is in Appendix 19.

## Grounding

Clients can use grounding strategies to manage overwhelming feelings, and they may be useful for clients who experience panic attacks or who have trauma histories (CSAT, 2013; Marel et al., 2016). These strategies, categorised as mental, physical or soothing, help clients with co-occurring AOD and anxiety issues to focus their attention onto the outside world rather than inward on traumatic memories or feelings of distress and anxiety (for more detail, see the chapter on *Grounding* and the client handout in Appendix 20). Grounding must be practised frequently to be most helpful (CSAT, 2013).

## Cognitive behavioural therapy

CBT is supported by the research evidence as an effective treatment for anxiety, and there is some evidence of its effectiveness as an integrated treatment for anxiety and SUDs (Morley et al., 2015; Springer, Levy, & Tolin, 2018; Wolitzky-Taylor et al., 2018). The CBT-based strategies that can be utilised when working with clients with co-occurring anxiety and AOD issues include:

- cognitive restructuring
- problem-solving
- goal-setting.

## Cognitive restructuring

Cognitive restructuring is based on the idea that our behaviours and feelings are a result of thoughts which happen so quickly that we are unaware of them happening (automatic thoughts), which in turn are related to our deeply held beliefs about ourselves, others and the world, also termed 'schemas' (core beliefs). It involves clients identifying and then challenging automatic thoughts, thereby challenging underlying core beliefs (CSAT, 2013) (see chapter on *Challenging unhelpful thinking*).

## Problem-solving

Problem-solving is a practical skill which can assist clients to develop achievable goals. The goal of problem-solving is not for the counsellor to solve the client's problems, but to teach clients to solve their own problems. Problem solving can be effective for clients with anxiety and AOD-related issues (Magill & Ray, 2009; Zhang, Park, Sullivan, & Jing, 2018) (See chapter on *Problem-solving* for more details).

## Goal-setting

Goal setting is a helpful strategy clients can use for both AOD treatment as well as the management of anxiety symptoms (Marel et al., 2016). It is important AOD workers remind clients that their goals need to be specific, measurable, achievable, realistic, and time-limited, described in positive terms and negotiated, or SMART goals (see chapter on Goal-setting for more detail).

## Acceptance and commitment therapy

One of the differences between ACT and CBT for anxiety is that CBT attempts to challenge the validity of the individual's unhelpful thoughts, whereas ACT's aim is for the client to accept the unhelpful thoughts (Barrera, Szafranski, Ratcliff, Garnaat, & Norton, 2016). According to a meta-analysis by Öst (2014), ACT is possibly efficacious in the treatment of anxiety and also possibly efficacious in the treatment of AOD dependence. Another meta-analysis found that ACT is more effective than 'treatment as usual' or placebo and that it may be as effective as some well-established psychological interventions (A-Tjak et al., 2015). Cognitive defusion is one strategy used in ACT which aims to allow an individual distance from their thoughts. For further information on cognitive defusion, see the chapter on **Mindfulness**.

## Mindfulness

The evidence for mindfulness-based treatments for common mental disorders in the acute phase is weak or non-existent (Hedman-Lagerlöf, Hedman-Lagerlöf, & Öst, 2018). Mindfulness-based interventions are not recommended for treating SAD (NICE, 2013). Mindfulness meditation programs have moderate evidence of improved anxiety in the short term, but are no more effective than other treatments (Goyal et al., 2014) (see the chapter on **Mindfulness**). Handouts on Mindfulness of breath, Mindfulness of emotions, and Mindfulness of thoughts: Cognitive defusion are in Appendices 21, 22 and 23 respectively.

## Other resources

Moodgym is an interactive self-help online program designed to assist people to identify and learn skills to cope with anxiety and depression. Moodgym was developed by the Australian National University; it is based on CBT and interpersonal therapy and has been extensively evaluated for its effectiveness. It can be accessed free of charge via: <https://moodgym.com.au/>

The Clinical Research Unit for Anxiety & Depression (CRUFAD), a joint facility of the University of New South Wales and St Vincent's Hospital in Sydney, provides a low-cost online education program for people with anxiety disorders. It can be located at the following website: <https://thiswayup.org.au/how-we-can-help/courses/>

The Centre for Clinical Interventions (CCI) is a Department of Health, Western Australia service that provides a specialist clinical psychology service specialising in psychological interventions for anxiety, mood and eating disorders. It has produced a range of worksheets for use with clients who are experiencing anxiety, which can be downloaded from the following website: <https://www.cci.health.wa.gov.au/Resources/Overview>

For further detail on the treatment of co-occurring AOD issues and anxiety, see <https://comorbidityguidelines.org.au/>, a website with online training and resources for AOD issues and co-occurring mental health disorders.

## Anxiety – tip sheet

Anxiety involving excessive fear or worry that is frequent, intense and reduces a person's wellbeing and functioning can be viewed as problematic.

Anxiety is a common co-occurring issue for people who use AOD.

Anxiety can be the result of intoxication or withdrawal from AOD, but anxiety may also be separate to AOD use. Anxiety which is the result of intoxication resolves as the drug effects wear off. Anxiety that is the result of withdrawal will generally resolve within a month without further treatment. Longer-lasting anxiety may require treatment with medication as well as psychological interventions.

Clients may also present with symptoms of anxiety but either have not been diagnosed with an anxiety disorder or may not meet the diagnostic criteria.

It is important to assess clients for co-occurring mental health conditions such as anxiety, and if possible determine whether their anxiety is substance induced or precedes their heavy AOD use, using the Depression, Anxiety Stress Scale (DASS) in Appendix 11.

The treatment of anxiety symptoms can involve a range of strategies, including:

- psychoeducation
- progressive muscle relaxation
- controlled breathing
- visualisation
- grounding
- problem-solving
- goal-setting
- mindfulness.

See chapters on **Relaxation, Grounding, Problem-solving, Goal-setting and Mindfulness**.

Additional resources for the treatment of co-occurring AOD issues and anxiety can be located at <https://comorbidityguidelines.org.au/>

## References

- Antony, M. M., Bieling, P. J., Cox, B. J., Enns, M. W., & Swinson, R. P. (1998). Psychometric properties of the 42-item and 21-item versions of the Depression Anxiety Stress Scales in clinical groups and a community sample. *Psychological Assessment, 10*(2), 176. doi: 10.1037/1040-3590.10.2.176
- A-Tjak, J. G., Davis, M. L., Morina, N., Powers, M. B., Smits, J. A., & Emmelkamp, P. M. (2015). A meta-analysis of the efficacy of acceptance and commitment therapy for clinically relevant mental and physical health problems. *Psychotherapy and Psychosomatics, 84*(1), 30-36. doi: 10.1159/000365764
- Barrera, T., Szafranski, D., Ratcliff, C., Garnaat, S., & Norton, P. (2016). An experimental comparison of techniques: cognitive defusion, cognitive restructuring, and in-vivo exposure for social anxiety. *Behavioural and Cognitive Psychotherapy, 44*(2), 249-254. doi: 10.1017/S1352465814000630
- Center for Substance Abuse Treatment (CSAT). (2013). *Substance abuse treatment for persons with co-occurring disorders* (Treatment Improvement Protocol (TIP) Series, No. 42). Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Center for Substance Abuse Treatment (CSAT). (2016). *Impact of the DSM-IV to DSM-5 changes on the National Survey on Drug Use and Health*. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Dixon, L. J., Lee, A. A., Gratz, K. L., & Tull, M. T. (2018). Anxiety sensitivity and sleep disturbance: investigating associations among patients with co-occurring anxiety and substance use disorders. *Journal of Anxiety Disorders, 53*, 9-15. <https://doi.org/10.1016/j.janxdis.2017.10.009>
- Fatseas, M., Serre, F., Swendsen, J., & Auriacombe, M. (2018). Effects of anxiety and mood disorders on craving and substance use among patients with substance use disorder: an ecological momentary assessment study. *Drug and Alcohol Dependence, 187*, 242-248. <https://doi.org/10.1016/j.drugalcdep.2018.03.008>
- Goyal, M., Singh, S., Sibinga, E. S., Gould, N. F., Rowland-Seymour, A., Sharma, R., ... Haythornthwaite J. A. (2014). Meditation programs for psychological stress and well-being: A systematic review and meta-analysis. *JAMA Internal Medicine, 174*(3), 357-368. doi: 10.1001/jamainternmed.2013.13018
- Hedman-Lagerlöf, M., Hedman-Lagerlöf, E., & Öst, L. G. (2018). The empirical support for mindfulness-based interventions for common psychiatric disorders: A systematic review and meta-analysis. *Psychological Medicine, 48*(13), 2116-2129. doi: 10.1017/S0033291718000259

- Kingston, R. E. F., Marel, C., & Mills, K. L. (2017). A systematic review of the prevalence of comorbid mental health disorders in people presenting for substance use treatment in Australia. *Drug and Alcohol Review, 36*(4), 527-539. doi: 10.1111/dar.12448
- Lai, H. M. X., Cleary, M., Sitharthan, T., & Hunt, G. E. (2015). Prevalence of comorbid substance use, anxiety and mood disorders in epidemiological surveys, 1990–2014: A systematic review and meta-analysis. *Drug and Alcohol Dependence, 154*, 1-13. <https://doi.org/10.1016/j.drugalcdep.2015.05.031>
- Lovibond, P. F., & Lovibond, S. H. (1995). The structure of negative emotional states: comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour Research and Therapy, 33*(3), 335-343. [https://doi.org/10.1016/0005-7967\(94\)00075-U](https://doi.org/10.1016/0005-7967(94)00075-U)
- Manning, V., Arunogiri, S., Frie, M., Ridley, K., Mroz, K., Campbell, S., & Lubman, D. (2018). *Alcohol and other drug withdrawal: practice guidelines* (3rd ed.). Richmond, Vic: Turning Point.
- Marel, C., Mills, K.L., Kingston, R., Gournay, K., Deady, M., Kay-Lambkin, F., Baker, A., & Teesson, M. (2016). *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*. Sydney, NSW: National Drug and Alcohol Research Centre. Retrieved from <https://comorbidityguidelines.org.au/>
- Magill, M., & Ray, L. A. (2009). Cognitive-behavioral treatment with adult alcohol and illicit drug users: A meta-analysis of randomized controlled trials. *Journal of Studies on Alcohol and Drugs, 70*(4), 516-527. Retrieved from <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2696292/pdf/jasad516.pdf>
- McHugh, R. K. (2015). Treatment of co-occurring anxiety disorders and substance use disorders. *Harvard Review of Psychiatry, 23*(2), 99-111. doi: 10.1097/HRP.0000000000000058
- Morley, K. C., Baillie, A., Leung, S., Sannibale, C., Teesson, M., & Haber, P. S. (2016). Is specialized integrated treatment for comorbid anxiety, depression and alcohol dependence better than treatment as usual in a public hospital setting? *Alcohol and Alcoholism, 51*(4), 402-409. doi: 10.1093/alcalc/agv131
- National Institute for Health and Care Excellence (NICE). (2013). Social anxiety disorder: Recognition, assessment and treatment: NICE clinical guideline 159. London, United Kingdom: NICE. Retrieved from [www.nice.org.uk/guidance/cg159](http://www.nice.org.uk/guidance/cg159)
- Öst, L.-G. (2014). The efficacy of acceptance and commitment therapy: An updated systematic review and meta-analysis. *Behaviour Research and Therapy, 61*, 105-121. <https://doi.org/10.1016/j.brat.2014.07.018>
- Royal Australian and New Zealand College of Psychiatrists. (2017). Anxiety disorders – your guide. Retrieved from <https://www.yourhealthinmind.org/getmedia/b9b7a719-5c48-4d8a-b7a8-c05a21a29aad/Anxiety-disorders-YHIM.pdf.aspx?ext=.pdf>
- Saulnier, K. G., Allan, N. P., Raines, A. M., & Schmidt, N. B. (2018). Anxiety sensitivity cognitive concerns drive the relation between anxiety sensitivity and symptoms of depression. *Cognitive Behavioural Therapy, 47*(6), 495-507. doi: 10.1080/16506073.2018.1469664
- Saunders, J., Conigrave, K., Latt, N., Nutt, D., Marshall, J., Ling, W., & Higuchi, S. (2016). *Addiction Medicine* (2nd ed.). Oxford, United Kingdom: Oxford Medical Publications.
- Springer, K. S., Levy, H. C., & Tolin, D. F. (2018). Remission in CBT for adult anxiety disorders: a meta-analysis. *Clinical Psychology Review, 61*, 1-8. <https://doi.org/10.1016/j.cpr.2018.03.002>
- Substance Abuse and Mental Health Services Administration. (2011). *Dual diagnosis capability in addiction treatment toolkit version 4.0* (HHS Publication No. SMA-XX-XXXX). Rockville, MD: Author.
- Wolitzky-Taylor, K., Niles, A. N., Ries, R., Krull, J. L., Rawson, R., Roy-Byrne, P., & Craske, M. (2018). Who needs more than standard care? Treatment moderators in a randomized clinical trial comparing addiction treatment alone to addiction treatment plus anxiety disorder treatment for comorbid anxiety and substance use disorders. *Behaviour Research and Therapy, 107*, 1-9. <https://doi.org/10.1016/j.brat.2018.05.005>
- Zhang, A., Park, S., Sullivan, J. E., & Jing, S. (2018). The effectiveness of problem-solving therapy for primary care patients' depressive and/or anxiety disorders: a systematic review and meta-Analysis. *Journal of the American Board of Family Medicine, 31*(1), 139-150. doi: 10.3122/jabfm.2018.01.170270



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## 53. Co-occurring AOD and depressive disorders

Depressive disorders are some of the most common mental health disorders worldwide (Rappeneau & Béro, 2017). The ABS (2015) 2014–2015 National Health Survey indicated that one in 11 people (8.9%) reported having depression or feelings of depression. Depressive disorders are common amongst people who access treatment for substance use disorders (SUD) (Hobden, Carey, Bryant, Sanson-Fisher, & Oldmeadow, 2017; Tolliver & Anton, 2015), with depression 3–4 times more prevalent among people diagnosed with SUD than the general population (Lai, Cleary, Sitharthan, & Hunt, 2015). Histories of alcohol use disorder and alcohol dependence are nearly twice as prevalent in people with a lifetime history of major depressive disorder (MDD) than people without MDD (Grant et al., 2016).

### Features of depressive disorders

Marel et al. (2016) stated that “the predominant feature of depressive disorders is the presence of sad, empty or irritable mood, accompanied by physical and cognitive changes that significantly impair an individual’s ability to function” (p. 32). This is different from feeling unhappy or sad in that a depressive disorder has persistent and severe symptoms.

A major depressive disorder is characterised by one or more major episodes in which five or more of the following symptoms are experienced nearly every day for at least two weeks, and at least one of the symptoms is either depressed mood or loss of interest or pleasure:

- depressed mood most of the day
- loss of interest or enjoyment in activities
- significant weight loss when not dieting, or weight gain, or changes in appetite
- sleeping problems (early morning waking, difficulty falling asleep, frequent waking, sleeping excessively)
- fatigue
- feelings of worthlessness or inappropriate guilt
- difficulty concentrating, diminished ability to think or make decisions
- recurrent thoughts of death, recurrent suicidal thoughts, attempts or plans.

(Marel et al., 2016)

Persistent depressive disorder (PDD – formerly dysthymia) is characterised by chronic low-level depression that may last longer than major depressive disorder. Briefly, PDD, as defined in the DSM 5 (American Psychiatric Association, 2013) represents a merging of two diagnostic categories from the earlier edition of the manual, namely dysthymic disorder and chronic major depressive disorder. PDD tends to have an early onset (before age 21 years) and is characterised by a duration of at least two years. Although dysthymia was considered less severe than major depression, PDD can result in severe functional impairment, increased impact on physical health through disease and increased risk of suicide (Halverson, 2015).

Symptoms of PDD include:

- A. depressed mood for most of the day, for more days than not
- B. presence while depressed, of two or more of the following:
  - poor appetite or overeating
  - sleep problems
  - fatigue
  - low self-esteem
  - poor concentration or difficulty making decisions
  - feelings of hopelessness.

(American Psychiatric Association, 2013)

Other depressive disorders featured in the DSM 5 include premenstrual dysphoric disorder, substance/medication-induced depressive disorder, depressive disorder due to a medical condition, other specified depressive disorder and unspecified depressive disorder.



## Substance/medication-induced depressive disorder

There have been reports of substance-induced mood disorders since the 1950s (Chandragiri, 2016). A substance or medication-induced depressive disorder is characterised by prominent and persistent changes in mood, clear signs of depression or a marked decrease of interest or pleasure in daily activities. These symptoms start when a substance or medication has been taken, or shortly thereafter and the symptoms can't be attributed to an existing depressive disorder or other diagnosis. In addition, the nature of the substance or medication must be taken into account (American Psychiatric Association, 2013). Drugs associated with substance-induced depressive disorder include alcohol, opioids and amphetamines.

Many clients' symptoms of depression may be experienced as part of their withdrawal and early periods of abstinence from substance use (Marel et al., 2016) (see chapter on **Withdrawal management**). Inform clients they may experience increased depression and that these symptoms should gradually decrease and resolve after a period of abstinence and monitoring (Gossop, 2003; Marsh & Dale, 2006). In some cases the symptoms may persist, which could indicate a pre-existing or underlying depressive disorder; assess whether such clients need further treatment.

Negative mood is often reported in the literature as a trigger for relapse (Marsh & Dale, 2006; Olsson, Cooper, Nugent, & Reid, 2016; Tate, Brown, Unrod, & Ramo, 2004). Therefore, addressing the depressive symptoms is an integral component of relapse prevention for AOD clients. CBT and mindfulness-based interventions have been shown to be effective in addressing negative affect in relapse prevention (Olsson, Cooper, Nugent & Reid, 2016) (see chapters on **Mindfulness** and **Relapse prevention and management**).

## Working with clients

Marel et al. (2016) stated that AOD workers should try to identify symptoms of co-occurring mental health conditions such as depression among their clients, so that symptoms can be incorporated into case formulations and treatment planning (see chapters on **Assessment, Case formulation and Treatment planning**). Clients may also present with symptoms that do not fully meet the diagnostic criteria of a depressive disorder. However, AOD counsellors should assist clients to manage these symptoms as they can have a significant impact on the client's wellbeing.

Several strategies have been found to be effective when working with AOD and depressive disorders, including cognitive restructuring, pleasure and mastery events scheduling, goal-setting and problem-solving (Marel et al., 2016). Marel et al. (2016) provided a detailed discussion of each of these strategies (also see chapters on **Challenging unhelpful thinking, Problem-solving** and **Goal-setting**).

### Pleasure and mastery events scheduling

Clients who experience depressive disorders may stop engaging in behaviours or activities that would normally give them a sense of pleasure, reward or achievement. This can lead to a cycle in which they become more inactive, perpetuating feelings of guilt or low mood and energy, which can cause further withdrawal from pleasurable events.

Strategies that use pleasure and mastery events scheduling help clients increase their levels of activity and give them a sense of pleasure, reward and achievement in a structured way. It can be challenging for clients to simply resume previous levels of activity, so this strategy enables them to use a weekly timetable in which they can schedule particular activities. AOD workers should encourage clients to start with activities that are simple and achievable.

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 vice versa. Thus, the aim is for clients to *gradually* begin experiencing the emotional and physical benefits of engaging in activities for pleasure and achievement; this can in time break the cycle of their low mood, lack of energy and feelings of guilt.

Therapies which address emotional regulation (e.g. schema therapy, CBT) have been shown to reduce emotional dysregulation and symptoms of a range of psychological difficulties, including depression and substance use (Sloan et al., 2017).

## Physical activity

Regular physical activity exercise has psychological benefits, with more active people reporting fewer depressive symptoms. Accordingly, the UK NICE Guidelines for depression recommend structured, supervised physical activity programs, three times a week (45 minutes to 1 hour duration) for at least 12 weeks (NICE, 2009). Cooney et al. (2013) undertook an extensive review of literature on physical activity (defined as aerobic, mixed, or resistance) and depression, and concluded that it was moderately more effective than control interventions for treating depression, with exercise equally as effective as psychotherapy or pharmacotherapy. A systematic review of the effect of exercise-based interventions on AOD use found exercise was associated with an overall improvement in depression. These findings indicate that although exercise may be a promising treatment option for people with co-occurring depression, further research is needed (Linke & Ussher, 2015).

Counsellors also need to be aware of the increased risk of suicide among clients with co-occurring AOD issues and depression. Marel et al. (2016) recommended regular suicide risk assessments for all clients presenting to AOD services. Refer to the chapter on ***Suicide assessment and management*** for further information.

AOD workers need to continue to work towards ensuring that their clinical efforts are focused on the provision of client-centred, evidence-based treatment, taking into account the client's needs and preferences, in a collaborative partnership.

The Centre for Clinical Interventions website includes lists of activities available for AOD workers to either recommend to clients or use with clients directly, for example, the 'Back from the Bluez' workbook – [www.cci.health.wa.gov.au/Resources/Looking-After-Yourself/Depression](http://www.cci.health.wa.gov.au/Resources/Looking-After-Yourself/Depression).

### Co-occurring AOD and depressive disorders – tip sheet

Many clients will present to AOD services with co-occurring AOD difficulties and symptoms of depression.

Because negative mood is often a trigger for relapse, treating depressive symptoms is also an integral component of relapse prevention.

Some CBT-based strategies that can be integrated with other counselling interventions are:

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

Counsellors also need to be aware of the increased risk of suicide among clients with co-occurring AOD difficulties and depression. It is recommended that all clients presenting to AOD services be assessed for suicide risk regularly (see chapter on ***Suicide assessment and management***).

AOD workers need to ensure that their clinical efforts are focused on the provision of client-centred, evidence-based treatment, taking into account the client's needs and preferences, in a collaborative partnership.

## References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Washington, DC: Author.
- Australian Bureau of Statistics (ABS). (2015). *National Health Survey: First results, 2014-15* (No. 4364.0.55.001). <http://www.abs.gov.au/ausstats/abs@.nsf/Lookup/by%20Subject/4364.0.55.001~2014-15~Main%20Features~Mental%20and%20behavioural%20conditions~32>
- Chandragiri, S. S. (2016). Substance-induced mood disorder. Retrieved from <https://emedicine.medscape.com/article/286885-overview>
- Cooney, G.M., Dwan, K., Greig, C.A., Lawlor, D.A., Rimer, J., Waugh, F.R., ... Mead, G.E. (2013). Exercise for depression. *Cochrane Database of Systematic Reviews*, 2013(9), 1-160. doi: 10.1002/14651858.CD004366.pub6.
- Gossop, M. (2003). *Drug addiction and its treatment*. Oxford, United Kingdom: Oxford University Press.
- Grant, B. F., Saha, T. D., Ruan, W., Goldstein, R. B., Chou, S.P., Jung, J., ... Hasin, D.S. (2016). Epidemiology of DSM-5 drug use disorder: Results from the national epidemiologic survey on alcohol and related conditions—iii. *JAMA Psychiatry*, 73(1), 39-47. doi: 10.1001/jamapsychiatry.2015.2132
- Halverson, J. L. (2015). Dysthymic disorder. Retrieved from <https://emedicine.medscape.com/article/290686-overview>
- Hobden, B., Carey, M., Bryant, J., Sanson-Fisher, R., & Oldmeadow, C. (2017). Clinician identification of elevated symptoms of depression among individuals seeking treatment for substance misuse. *Drug and Alcohol Dependence*, 181, 71-76. <https://doi.org/10.1016/j.drugalcdep.2017.09.013>
- Lai, H. M., Cleary, M., Sitharthan, T., & Hunt, G. E. (2015). Prevalence of comorbid substance use, anxiety and mood disorders in epidemiological surveys, 1990–2014: A systematic review and meta-analysis. *Drug and Alcohol Dependence*, 154, 1-13. <https://doi.org/10.1016/j.drugalcdep.2015.05.031>
- Linke, S. E., & Ussher, M. (2015). Exercise-based treatments for substance use disorders: evidence, theory, and practicality. *The American Journal of Drug and Alcohol Abuse*, 4(1), 7-15. doi: 10.3109/00952990.2014.976708
- Marsh, A. & Dale, A. (2006). *Addiction counselling: Content and process*. Melbourne, VIC: IP Communications.
- Marel, C., Mills, K.L., Kingston, R., Gournay, K., Deady, M., Kay-Lambkin, F., Baker, A., & Teesson, M. (2016). *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*. Sydney, NSW: National Drug and Alcohol Research Centre. Retrieved from <https://comorbidity.edu.au/sites/default/files/National%20Comorbidity%20Guidelines%202nd%20edition.pdf>
- National Institute for Health and Care Excellence (NICE). (2009). *Guidance on the use of electroconvulsive therapy: NICE Technology Appraisal Guidance 59*. London, United Kingdom: Author.
- Olsson, K. L., Cooper, R. L., Nugent, W. R., & Reid, R. C. (2016). Addressing negative affect in substance use relapse prevention. *Journal of Human Behavior in the Social Environment*, 26(1), 2-14. doi: 10.1080/10911359.2015.1058138
- Rappeneau, V., & Bérod, A. (2017). Reconsidering depression as a risk factor for substance use disorder: Insights from rodent models. *Neuroscience & Biobehavioral Reviews*, 77, 303-316. <https://doi.org/10.1016/j.neubiorev.2017.04.001>
- Sloan, E., Hall, K., Moulding, R., Bryce, S., Mildred, H., & Staiger, P. K. (2017). Emotion regulation as a transdiagnostic treatment construct across anxiety, depression, substance, eating and borderline personality disorders: A systematic review. *Clinical Psychology Review*, 57, 141-163. <https://doi.org/10.1016/j.cpr.2017.09.002>
- Tate, S. R., Brown, S. A., Unrod, M., & Ramo, D. E. (2004). Context of relapse for substance-dependent adults with and without comorbid psychiatric disorders. *Addictive Behavior*, 29(9), 1707-1724. doi: 10.1016/j.addbeh.2004.03.027
- Tolliver, B. K., & Anton, R. F. (2015). Assessment and treatment of mood disorders in the context of substance abuse. *Dialogues in Clinical Neuroscience*, 17(2), 181-190.

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## 54. Co-occurring severe mental health disorders

Mental health disorders are very common in clients in AOD treatment (Marel et al., 2016). As Minkoff and Cline (2005) noted, “dual diagnosis is the expectation, not the exception” for the AOD treatment sector (p. 71). For example, Australian research on clients in drug and alcohol residential settings indicated over 70% had a co-occurring mental health disorder (Mortlock, Deane, & Crowe, 2011). Severe mental health disorders are usually defined as such by their lengthy duration and disabling effects. For the purpose of this chapter, severe mental health disorders refers to disorders which feature psychotic symptoms such as schizophrenia and schizoaffective disorder, and severe forms of other disorders such as major depressive disorder and bipolar disorders. For details on the signs and symptoms of these disorders see <https://comorbidityguidelines.org.au/guidelines/>

The relationship between mental health disorders and AOD use is complex and dynamic. Due to the fact that long or short-term AOD use, as well as withdrawal, can cause clients to experience symptoms of mental health disorders, diagnosis is complicated and it is often difficult to clearly establish the causal connection between AOD issues and mental health 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 (Khantzian & Treece, 1985). In other cases, problematic AOD use may develop independently, with adverse consequences on mental health. It is widely accepted that causation is not all that important, as it is going to have little impact on treatment (Marel et al., 2016).

Because of the high prevalence of co-occurring disorders, it is crucial to screen for mental health disorders as part of a comprehensive AOD assessment. Counsellors should also attempt to identify severe mental health disorders (e.g. bipolar disorder, psychotic disorders and severe borderline personality disorder) that may benefit from psychiatric and specialist intervention. While a client may require psychiatric intervention, they may also need specialist AOD counselling and treatment. In the past it has been difficult for many clients with co-occurring disorders to receive the help they need due stringent service exclusion criteria. Some AOD services may exclude clients who have severe mental health issues, while some mental health services exclude clients with AOD issues. This siloed treatment has resulted in many clients with co-occurring disorders ‘falling through the gaps’ and unable to access appropriate treatment. If a client does require specialist mental health treatment, this is not a reason to disengage. Psychosocial interventions are effective for people with co-occurring severe mental health disorders and substance use disorders, but must be coordinated, multidisciplinary and provide long-term follow-up (Horsfall et al., 2009). Adopting a ‘no wrong door’ policy and consultation and collaboration with other service providers is key to providing effective care for people with co-occurring disorders (Marel, et al., 2016).

Basic guidelines for working with clients with severe mental health disorders in an AOD context are outlined below. For comprehensive guidelines, please see the National Comorbidity Guidelines (Marel et al., 2016) at <https://comorbidityguidelines.org.au/guidelines/>

### Engagement

#### The network of helping professionals

By the time clients with severe mental health issues come into contact with the AOD field, many will have had extensive experience, both positive and negative, with mental health specialists. Engagement can be assisted by exploring the client’s experiences of other helpers and identifying what the client has found helpful and unhelpful in their interactions with other professionals.

Clients may also remain engaged with other service providers. 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**). It is good practice, once you have the client’s consent, to contact other workers involved in the case to optimise the client’s care and ensure there is no overlap in the services you are providing. General practitioners are particularly important in providing care to people with co-occurring disorders, as they are often the first and most stable point of contact (Marel et al., 2016).

## **Bringing the family and significant others into the picture**

Families are often the major caregivers for clients with severe co-occurring mental health issues and AOD 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. Involving family members or caregivers in the assessment process can improve the quality of the formulation and long-term treatment plan (Wright, Turkington, Kingdon, & Ramirez Basco, 2008). This may be due to a collaborative recognition of areas of concern and insight into the relevance and viability of the therapy plan. Family involvement may also increase the chances that the client will adhere to the treatment plan and implement strategies, although it is important to clarify the role the family would like to assume in the treatment process. Inquiring about the impact of the issues on their lives, and on their experiences of supporting the client, acknowledges the efforts that the family members have made and supports them in their own right.

## **Exploring client's strengths and looking for exceptions**

Exploring clients' strengths is important for engagement and assessment and can be applied to both individual clients and relatives. Exceptions are those experiences in a client's life when the issue might have been expected to occur but somehow did not. Discovering times when the client has experienced a reduction or disappearance of psychiatric symptoms or AOD use introduces the possibility of change and helps to challenge the belief that situations are permanent and difficult.

## **Client's ways of coping**

A significant contributor to successful engagement with clients and their families is to consider the ways in which the client and family have coped with the twin issues of AOD use and serious mental health disorder. Questions that illuminate the ways in which the client copes with these issues shows acknowledgment of their efforts to change their lives and brings 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 (see chapter on **Assessment**) apply to the assessment of a client with a co-occurring severe mental health disorder. However, counsellors should be aware of the complex and dynamic interactions between AOD use, mental health disorders and prescribed psychiatric medications.

An assessment that pays attention to the relationships between stressors experienced by the client, mental health symptoms and AOD use can be of benefit. Similarly, exploring the influence of psychiatric medication on the level of drug use and vice versa and exploring the influence of AOD use on mental health symptoms is worthy of attention. The clarification that can emerge from this line of inquiry can contribute to a comprehensive treatment plan and appropriate goal-setting.

### **Adopting a holistic approach**

Clients with both AOD and severe mental health issues often experience many other difficulties, such as relationship problems, legal and financial difficulties, unstable accommodation and poor self-care. These difficulties in turn can reduce feelings of self-worth and contribute to the perpetuation of AOD use and mental health issues. Asking the client to rank their more pressing issues can help to distinguish the context and impact of each issue in the client's life and can form part of a collaborative assessment and intervention process. Networking with other professionals such as community and mental health workers, housing, employment and welfare services is good practice, as this can help you to empower your clients to engage meaningfully with the other services they require.

### **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

There is a strong link between stress and relapse of serious mental health symptoms. Giving up AOD use can further increase stress, especially if the substance is being used for 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 that aims to identify 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 the co-occurring AOD and mental health issues. Traditionally, most professional responses to families have involved 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 issue.

As a consequence, families may have experienced service providers as blaming and not sensitive to their diverse needs and situations. The importance of adopting a more family-inclusive model of working, which places importance on counsellors and agencies having a collaborative mindset toward families, is paramount (see chapter on **Working with significant others** for family-inclusive practice guidelines). This approach involves looking at current and previous solutions, evaluating their success and exploring alternatives that 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 effectively with families.

### Co-occurring severe mental health disorder – tip sheet

Co-occurring mental health disorder is extremely common among clients in AOD treatment settings.

It is often difficult to clearly establish the causal connection between AOD and mental health disorders.

Engage with the client by adopting a perspective that amplifies strengths and solutions and acknowledges their efforts to cope.

With client consent, involve families and caregivers early on. Be proactive in introducing family involvement with your client.

During assessment, explore the relationship between the client's AOD use, mental health disorder, current medication regime and stressors. If a mental health disorder is suspected, but not yet diagnosed, discuss with the client and liaise with mental health professionals if appropriate.

Explore what has been tried and what has worked.

Help with practical difficulties such as housing, finances, food, legal difficulties and self-care.

Consider linking clients into services and day centres that offer practical help and activities, particularly if they are unemployed or needing something meaningful to do during the day.

Explore stress reduction methods; there is a strong link between stress and relapse in mental health disorders. Giving up AOD use can increase stress, so explore ways that the client can reduce stress.

Psychiatric assistance should be sought for clients with severe co-occurring mental health disorders.

Liaise with appropriately trained medical and allied health personnel and mental health service providers.

## References

- Horsfall, J., Cleary, M., Hunt, G. E., & Walter, G. (2009). Psychosocial treatments for people with co-occurring severe mental illnesses and substance use disorders (dual diagnosis): a review of empirical evidence. *Harvard Review of Psychiatry, 17*(1), 24-34. doi: 10.1080/10673220902724599
- Khantzian, E. J., & Treece, C. (1985). DSM-III psychiatric diagnosis of narcotic addicts: Recent findings. *Archives of General Psychiatry, 42*(11), 1067-1071. doi: 10.1001/archpsyc.1985.01790340045007
- Marel, C., Mills, K.L., Kingston, R., Gournay, K., Deady, M., Kay-Lambkin, F., Baker, A., & Teesson, M. (2016). *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*. Sydney, NSW: National Drug and Alcohol Research Centre. Retrieved from <https://comorbidityguidelines.org.au/>
- Minkoff, K., & Ciine, C. (2005). Developing welcoming systems for individuals with co-occurring disorders: The role of the comprehensive continuous integrated system of care model. *Journal of Dual Diagnosis, 1*(1), 65-89. doi: 10.1300/J374v01n01\_06
- Mortlock, K. S., Deane, F. P., & Crowe, T. P. (2011). Screening for mental disorder comorbidity in Australian alcohol and other drug residential treatment settings. *Journal of Substance Abuse Treatment, 40*(4), 397-404. doi: 10.1016/j.jsat.2011.01.002
- Wright, J., Turkington, D., Kingdon, D., & Ramirez Basco, M. (2008). *Cognitive-behaviour therapy for severe mental illness*. New York, NY: American Psychiatric Publishing.



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## 55. Co-occurring trauma issues

Clients accessing AOD services frequently present with a history of traumatic events and symptoms related to trauma exposure, often stemming from childhood abuse and neglect (Bailey, Webster, Baker, & Kavanagh, 2012; Banducci, Hoffman, Lejuez, & Koenen, 2014a; Dore, Mills, Murray, Teesson, & Farrugia, 2012). Research suggests that risk of developing a substance use disorder increases with increasing exposure to traumatic events (Banducci, Hoffman, Lejuez, & Koenen, 2014b; Dore et al., 2012). In particular, exposure to direct forms of interpersonal violence (such as sexual and physical abuse) as well as indirect violence (such as witnessing parental domestic violence) have been found to increase the risk of developing substance use disorders in later life (Fuller-Thomson, Roane, & Brennenstuhl, 2016).

Specific groups of people seeking treatment for AOD-related issues may have particularly high rates of experiencing trauma. Very high rates of both trauma and mental health disorders have been documented in people seeking treatment for opioid, sedative and amphetamine use (Breckenridge, Salter, & Shaw, 2012; Hall, 1996; Mills, Teesson, Ross, & Peters, 2006). In addition, high rates of trauma exposure have been recorded in residential treatment settings (Breckenridge et al., 2010; Deane, Kelly, Crowe, Coulson, & Lyons, 2013) and in Aboriginal peoples (Breckenridge et al., 2010; The Bouverie Centre, 2013). Lesbian, gay, bisexual and transgendered people have higher rates of exposure to traumatic events and higher rates of PTSD than heterosexual people, and people with cognitive or physical disabilities are at higher risk of being victims of violence, abuse or neglect than people without disabilities (Substance Abuse and Mental Health Services Administration, 2014c).

While traumatic events can affect anyone at any stage of life, the effects of repeated or prolonged childhood trauma can impact on the health and wellbeing of an individual throughout their lifespan. Chronic exposure to trauma affects the cognitive, affective and physiological domains of functioning and the development of sense of self and relationships with others. Children who are traumatised in this way must invest their energies into survival rather than developmental competencies (Kinniburgh, Blaustein, Spinazzola, & van der Kolk, 2005).

The Adverse Childhood Experiences study (Felitti et al., 1998) and subsequent similar studies (Choi, DiNitto, Marti, & Choi, 2017) demonstrated that exposure to traumatic events in childhood is associated with a range of negative health outcomes which contribute to disability, disease, social problems and premature mortality. These studies have shown that adverse childhood experiences (ACEs) have a dose–response relationship with many health problems, meaning that the more ACEs a person experiences, the greater the likelihood that they will experience health, social or behavioural problems (including AOD use issues) during their life (Choi et al., 2017). Specifically ACEs impact on executive functioning (working memory, attention and inhibitory control) and self-regulation, as well as increased risk for AOD use and risk-taking in adolescence and adulthood (McClelland et al., 2018).

Exposure to childhood trauma can increase the risk of developing mental health conditions. Some individuals may develop symptoms of psychological disorders such as PTSD, but many more will experience brief subclinical symptoms (symptoms which do not meet diagnostic criteria) (Substance Abuse and Mental Health Services Administration, 2014c).

Exposure to childhood trauma is a risk factor for experiencing further trauma in adulthood. Child sexual abuse is associated with experience of sexual violence as an adult, while childhood physical abuse is associated to a lesser degree with experiencing sexual violence as an adult. Physical abuse during childhood is also associated with being a victim of interpersonal violence (for women) and a perpetrator of interpersonal violence (for men) (Substance Abuse and Mental Health Services Administration, 2014c).

### The relationship between AOD use and trauma

The cause and effect relationship between trauma and AOD use issues is not fully understood. Exposure to trauma in childhood increases stress reactivity (or threat sensitivity); this means that reactions to stressors tend to be immediate, intense and prolonged, a pattern of response which is a risk factor for the development of disease and substance use (Schlotz, 2013). Additionally exposure to trauma is associated with problems with emotion regulation resulting in “frequent intense and reactive negative emotional experiences” (Tull, Berghoff, Wheelless,

Cohen, & Gratz, 2018, p. 58). The self-medication (or self-soothing) theory proposes that clients manage their trauma symptoms, such as overwhelming emotional states or alexithymia<sup>44</sup>, with alcohol and other drugs (Breckenridge et al., 2010; Garland, Pettus-Davis, & Howard, 2013; Khantzian, 1997).

Garland et al. (2013) argue that the impacts of trauma create a feedback loop between AOD use and psychological symptoms that “may ultimately lead to the development of serious addictive behaviours and/or substance dependence” (p. 176). That is, the prolonged or repeated activation of the body’s stress systems as a result of trauma causes the body’s stress systems to be dysregulated. This dysregulation also results in negative affect and psychological distress, which may lead to the increased consumption of AOD, which can amplify affect dysregulation and increase the drive to use AOD (Garland et al., 2013).

Alcohol and other drug use may increase the risk of exposure to trauma through the pharmacological effects of the substances; for example, using alcohol increases the risk of being both a victim and a perpetrator of intimate partner violence (Laslett et al., 2015; Noonan, Taylor, & Burke, 2017). Additionally, some drug use and associated high-risk behaviours may expose people to higher risks of violence; for example, injecting drug users are more likely to engage in sex work and sex workers are at a higher risk of experiencing violence (Breckenridge et al., 2010). Given the relationship between AOD and trauma, it is recommended that AOD counsellors adopt a trauma-informed approach. This is also an approach that can be adopted at the service level. A trauma-informed approach does not mean that services should be specifically focused on addressing trauma, rather that trauma-informed principles are embedded into the way that clients are treated, irrespective of whether a trauma history is known. Underpinning all trauma-informed care and practice is the recognition and acknowledgement of the prevalence and impact of trauma amongst all staff and understanding of the relationship between AOD issues, mental health conditions and trauma.

The principles of trauma-informed care and practice (Kezelman & Stavropoulos, (2012) are as follows.

**Safety:** Trauma is often related to an absence of safety. Therefore, it is important to ensure the physical and emotional safety of clients, staff, and volunteers. This includes ensuring basic needs are met, safety measures are in place to respond to suicidality and service providers’ responses are predictable, consistent and respectful (Mental Health Coordinating Council (MHCC), 2013). Clients with trauma histories may be more likely to experience some dynamics, practices and procedures as negative, reminiscent of past trauma or retraumatising<sup>45</sup>. Examples of potentially retraumatising situations can include limited privacy or personal space, being seated away from an exit, being exposed to a client’s angry outburst.

**Trustworthiness:** Maximise trustworthiness through task clarity, consistency and maintenance of interpersonal boundaries. To maximise trustworthiness, counsellors should be transparent about the counselling process and decisions which relate to the client. For example, explaining about confidentiality, how case notes are kept and why information is collected and used. Additionally, counsellors should acknowledge when they are wrong or they don’t know an answer. Counsellors should maintain their interpersonal boundaries, which can assist the client to learn appropriate boundaries.

**Choice:** Maximise consumer choice and control. Provide opportunities for consumers to make decisions and create their own goals. Reassure the client that they have the right to make choices. For example; clients may not wish to engage with trauma specific or other services, particularly if they have already built a therapeutic relationship, therefore referral to other services should be discussed openly with the client, encouraging the client to make choices. The counsellor should also be mindful that the client may respond in a way that they think the counsellor wants them to, as they don’t want their choice to impact on the relationship with the counsellor.

**Collaboration:** Maximise collaboration and sharing of power between consumer and staff. This requires a shift from the viewpoint that the counsellor is the expert, to one that views the client and counsellor working in partnership and that the client is the expert on their own lives. Collaboration includes opportunities for clients/consumers to be represented in all aspects of development, planning and evaluation of services. Collaboration should also extend across organisations (Substance Abuse and Mental Health Services Administration, 2014b) (for example; shared case management).

44 Alexithymia is defined by difficulty identifying feelings and distinguishing between feelings and the bodily sensations of emotional arousal. It includes difficulty describing feelings to other people; constricted imaginal processes, as evidenced by a lack of fantasies; and a stimulus-bound, externally oriented cognitive style (Lumley, Neely, & Burger, 2007).

45 Retraumatising is defined as experiencing the feeling that past trauma is reoccurring in the present which can result in activation of trauma symptoms, or the situation is perceived as dangerous or unsafe to the extent of the previous traumas (Substance Abuse and Mental Health Services Administration, 2014b).

**Empowerment:** Prioritise empowerment and skill building. A sense of empowerment is critical to the client learning or regaining their sense of competence and autonomy. Collaboration and choice will assist clients to build their sense of empowerment, as will the acquisition of skills and knowledge. For example, trauma symptom management skills and using feedback-informed treatment where each session is evaluated by the client can be empowering for the client. (Miller, Hubble, Chow, & Seidel, 2015).

**Cultural, historical and gender issues:** Understand the influence of culture in the perception of and response to trauma, and the process of recovery. The counsellor is culturally sensitive and services offered are culturally appropriate. The counsellor recognises historical and/or intergenerational trauma and its impact on Aboriginal peoples, and other Indigenous peoples. Recognition of the gender-specific (including gender diverse) needs of clients and understanding of how gender can impact on the experience of trauma (Substance Abuse and Mental Health Services Administration, 2014a).

## Types of Trauma

The Mental Health Coordinating Council (2013) categorised the types of trauma as follows.

- **Single incident trauma** is related to an unexpected and overwhelming event such as an accident, natural disaster, a single episode of abuse or assault, sudden loss, or witnessing violence.
- **Developmental trauma** results from exposure to early, ongoing or repetitive trauma (as infants, children and youth) involving neglect, abandonment, physical abuse, sexual abuse, emotional abuse, witnessing violence or death, and/or coercion or betrayal. This often occurs within the child's care-giving system and interferes with healthy attachment and development.
- **Complex or repetitive trauma** is related to ongoing abuse, domestic violence, war or ongoing betrayal, often involving being trapped emotionally and/or physically.
- **Intergenerational trauma** describes the psychological or emotional effects that can be experienced by people who live with trauma survivors. Coping and adaptation patterns developed in response to trauma can be passed from one generation to the next.
- **Historical trauma** is a cumulative emotional and psychological wounding over the lifespan and across generations emanating from massive group trauma. Examples of historical trauma include slavery in the United States, colonisation in Australia, New Zealand, Canada and the United States.
- **Vicarious trauma**, also known as secondary traumatising, occurs when a worker experiences changes in their world view, and develops PTSD symptoms as a result of witnessing other people's trauma repeatedly (Pearlman, & Saakvitne, 1995) (see chapter on **Secondary traumatic stress, compassion fatigue, and vicarious trauma**).

In the immediate aftermath of trauma people can experience a wide range of symptoms across physical, behavioural, cognitive, existential and psychological domains (Substance Abuse and Mental Health Services Administration, 2014c). If symptoms persist and cause distress or impact on functioning, PTSD may be diagnosed.

## Posttraumatic stress disorder

Posttraumatic stress disorder is a diagnostic term describing symptoms associated with direct (e.g. experiencing or witnessing) or indirect (e.g. learning in the course of professional duties) exposure to a traumatic event. A traumatic event involves the person being exposed to death, threatened death, actual or threatened serious injury, or actual or threatened sexual violence.

The Diagnostic and Statistical Manual of Mental Disorders (DSM) 5 (American Psychiatric Association, 2013) classifies PTSD symptoms into four groups.

- **Intrusion:** repeated, involuntary memories; distressing dreams; or flashbacks of the traumatic event.
- **Avoidance:** Avoiding reminders of the traumatic event may include avoiding people, places, activities, objects and situations that bring on distressing memories.
- **Negative alterations in cognition and mood:** may include ongoing and distorted beliefs about oneself or others.
- **Alterations in arousal or reactivity:** such as being irritable and having angry outbursts; behaving recklessly or in a self-destructive way; being easily startled; or having problems concentrating or sleeping.

There are two sub-types of PTSD in the DSM 5.

- **Dissociative:** in addition to the symptoms above, the individual experiences high levels of derealisation – the experience of unreality, distance or distortion e.g. “things are not real” –in relation to trauma-related stimuli.
- **Delayed:** the full criteria for diagnosis is not met until at least six months after the trauma has occurred.

Symptoms must be present for more than one month and must cause distress or functional impairment in order for PTSD to be diagnosed.

(American Psychiatric Association, 2013)

## Complex PTSD

Several authors describe a condition they call complex PTSD, arguing that the standard diagnosis of PTSD insufficiently describes the symptoms and problems of people who experience prolonged, repeated or multiple forms of interpersonal trauma. This trauma is thought to occur in circumstances where escape is impossible due to physical, psychological, age-related, environmental or social constraints such as genocide, childhood sexual abuse, child soldiering, severe domestic violence, torture or slavery (Cloitre et al., 2012; Herman 1997). The symptoms of complex PTSD recognise that social, emotional, cognitive and psychological competencies have failed to develop properly due to the age at which the trauma occurs or have deteriorated due to exposure to the trauma. While complex PTSD is not included in the DSM 5, it is included in the International Classification of Diseases (ICD) 11 (World Health Organization, 2018).

According to the ICD 11, complex PTSD includes the symptoms of PTSD as described earlier, along with the following severe and persistent symptoms, which cause significant impairment in personal, family, social, education, occupational or other important areas of functioning:

- Problems with affect regulation:** difficulties managing, reducing and tolerating distressing emotions. Clients may present with rapidly shifting moods including intensive depressive episodes lasting a few hours, difficulties expressing or managing anger, and may experience extreme negative responses to minor events.
- Negative self-concept:** beliefs about oneself as diminished, defeated or worthless, accompanied by deep and pervasive feelings of shame, guilt or failure related to the traumatic event.
- Disturbances in relationships:** difficulties in sustaining relationships and in feeling close to others.

(World Health Organization, 2018)

## Recommended treatment approach

Research suggests that integrated treatments, which aim to address co-occurring trauma and AOD issues, are associated with better treatment outcomes (Ruglass et al., 2017). However, depending on the severity of the trauma and the impact on the client's developmental capacities, such as self-soothing ability, direct trauma-focused therapy may be contraindicated.

It was long assumed in trauma treatment that survivors or victims of trauma needed to talk about it and express all of their emotional responses in order to recover. More recent research indicates that this is not necessarily the case, so it is important that the individual's style of coping in the immediate aftermath of a traumatic event should be respected (Substance Abuse and Mental Health Services Administration, 2014c). In fact, in some instances, insisting that the survivor of a trauma relays the details of the traumatic event and their emotions associated with it can be particularly unhelpful as it can re-traumatise the person or trigger trauma symptoms (Vivekananda, 2002).

Vivekananda (2002) developed a framework for understanding the impacts of trauma and therefore the focus of trauma treatment (see Figure 5). The framework shows how different types of traumatic events can have different impacts depending on the:

- type of trauma
- severity of the trauma
- developmental capacities of the victim.

The post-trauma response is dictated by these factors and determines the approach that counselling should take. The earlier, more prolonged and repeated the trauma – especially attachment trauma – the more counselling needs to focus on safety and containment and the less it should focus directly on the trauma. The rehabilitation model of trauma treatment suggests that counselling should focus on psycho-education related to PTSD symptoms, self-care and self-management strategies, and on managing current life stressors and the impact of the trauma on the here and now, with little or no uncovering of traumatic material.

## Responding to disclosure<sup>46</sup>

If a client discloses a traumatic experience it is imperative that the counsellor's response conveys appropriate attitudes to the client. Many clients who have experienced trauma have felt as though they have not been believed when disclosing their experience to family, friends and workers. Quite often people who have experienced interpersonal trauma feel great shame and self-blame. If a client discloses trauma, it is important to:

- utilise the principles of trauma informed care and practice with a focus on the client's emotional and physical safety.
- listen – be respectful and compassionate
- validate – be non-judgemental
- convey belief – many clients who have disclosed previously have experienced denial and disbelief
- respond – assist the client to gain a sense of safety through being transparent and ensuring clients maintain as much control as possible over their treatment, including whether they are referred to a trauma-specific service
- discuss what your client will encounter if they choose to access a trauma-specific service.

(Australian Institute of Family Studies, 2016; Kezelman, & Stavropolous, 2018)

## Assessment

It is recommended that a trauma history is discussed as part of the AOD assessment process, including whether the client has experienced trauma and whether it continues to affect them. Clients should be told that they do not need to talk about any traumatic events in detail and reassured that they are in control of how much they disclose. It is unnecessary for a counsellor to know the details of the trauma in order to work with the impact of the trauma. Focus on how the trauma influences the present is recommended, particularly in relation to the impact on their AOD use.

As many people don't disclose a history of trauma even when asked (Substance Abuse and Mental Health Services Administration, 2014c), it is recommended that questions about trauma are delayed until after the first session, when some rapport with the client has been built. Even when rapport has been established, clients may not disclose their experience of trauma or the extent of the trauma. This can occur because clients do not perceive their experience as traumatic; do not see the connection between their experience of trauma and their AOD use; feel extreme self-blame and shame; or have experienced negative reactions when disclosing previously. Clients are also less likely to disclose if they are male, or when the perpetrator is a family member (Substance Abuse and Mental Health Services Administration, 2014c).

<sup>46</sup> The Sexual Assault Resource Centre (Perth) has an online learning package on responding to disclosure of sexual assault, available via <https://www.health.wa.gov.au/elearning/sarc/story.html>

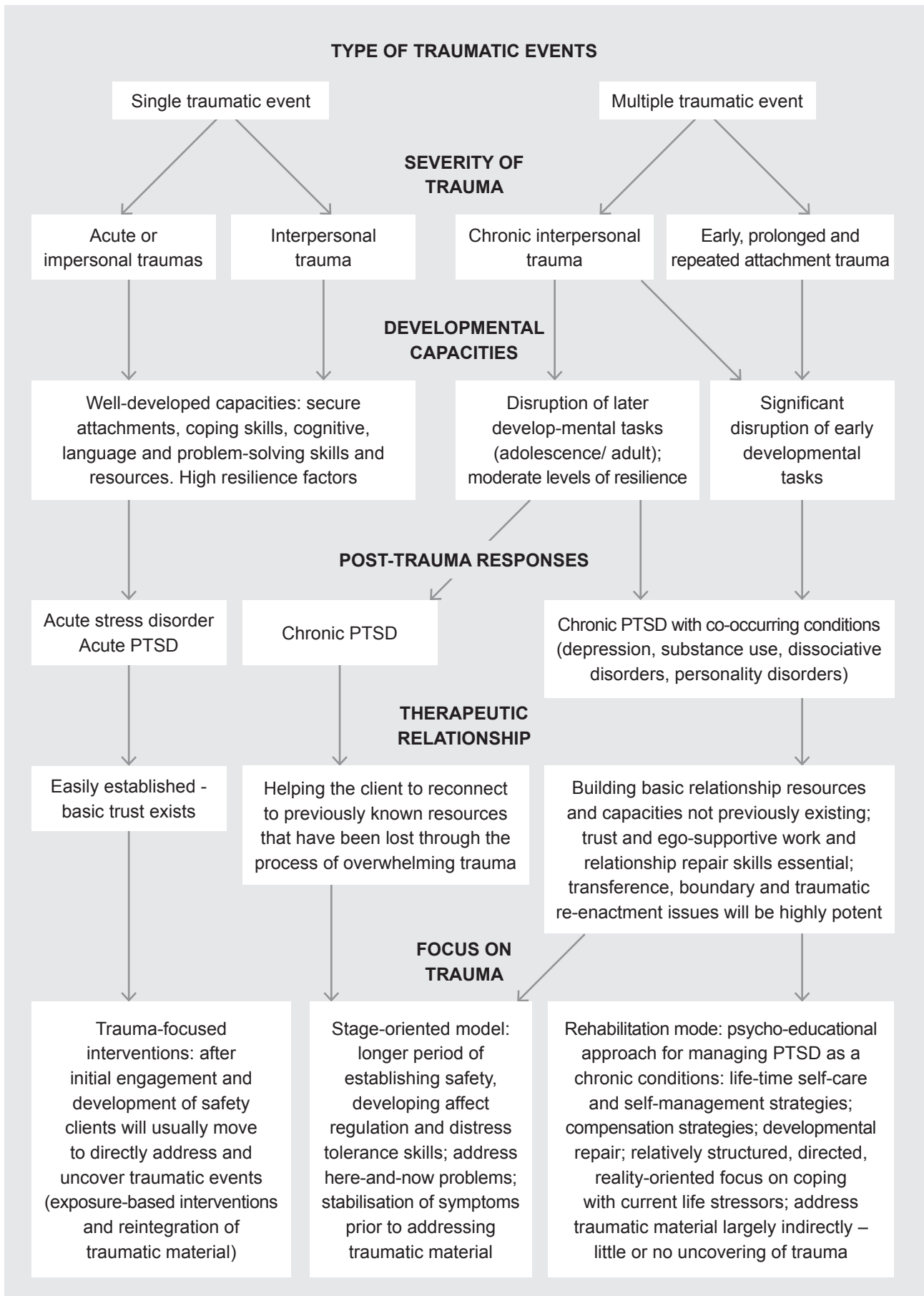


## AOD treatment and trauma

When working with clients, counsellors should take a universal precautions approach to trauma. That is, utilise the principles of trauma-informed care and practice with all clients, irrespective of whether they have indicated a history of trauma. The following general principles should be held in mind when working with clients who have a history of trauma.

- A positive therapeutic relationship is essential to positive client outcomes. This can be done using general counselling skills such as being warm, empathic, genuine, validating, consistent and setting appropriate limits.
- Clients with histories of attachment trauma in childhood may have difficulties in self-soothing, emotional regulation and developing and maintaining positive relationships. This may make it difficult for clients to tolerate emotional intensity. Counselling therefore needs to be very supportive and counsellors should be transparent about what they are doing and why.
- Clients can be vulnerable to suggestion and there have been cases where the clinician's utilisation of aggressive memory recovery techniques has resulted in false memories (Geraerts et al., 2007). Therefore, it is important not to attempt to assist clients to recover memories of trauma. However, it is now accepted that people can experience fragmented, disrupted or repressed memories of childhood trauma which they later recall (Substance Abuse and Mental Health Services Administration, 2014c).
- Explore what impact the trauma is having on the client in the present. Provide the client with psychoeducation regarding their trauma symptoms to assist in normalising and validating their experience.
- Explore the client's AOD use and any possible relationship to trauma symptoms (e.g. using alcohol to cope with insomnia). Clients may not be aware of the links between their AOD use and trauma symptoms.
- Organisational disruptions such as changing staff and agency practices can be detrimental to clients who have experience disrupted attachments (Breckenridge, 2010). The impacts of organisational changes should be minimised through providing a stable counsellor and active handover from the previous counsellor to a new counsellor or service, including providing a transition period where possible.
- Be transparent about the service being offered, including number of sessions, policy regarding changing counsellors, retention of case notes, confidentiality, non-attendance policy, and other processes and practices which may affect the client.
- Clients with a history of trauma have higher rates of suicide and self-harm and suicide risk assessment should be conducted regularly (see chapter on ***Suicide assessment and management***). The counsellor should also discuss self-harm with an aim of assisting the client to find alternative coping strategies.
- AOD use can be functional for people with trauma symptoms, and therefore reductions in AOD use need to occur slowly and monitored carefully for increased trauma symptoms. The likelihood of increased trauma symptoms should be discussed with clients prior to reduction taking place. Alternative strategies for managing trauma symptoms should be developed prior to significant reductions in AOD use.
- Treatment goals and steps towards them need to be realistic and involve small increments.
- General AOD treatment strategies, such as relapse prevention and management and harm reduction, should be utilised.
- MI, with its client-centred and collaborative focus, is appropriate for working with people who have experienced trauma.
- Encourage self-care and build coping skills such as problem-solving and goal-setting.
- Useful alternative coping strategies can include mindfulness, grounding, assertiveness, progressive muscle relaxation, controlled breathing (see the chapters on ***Mindfulness, Grounding, Assertiveness training, and Relaxation strategies***) and emotional regulation.
- Be aware of the possibility of re-traumatisation for those clients with trauma-related histories. If it occurs it is important to normalise it and develop strategies for managing the trauma symptoms.
- These alternative coping strategies should be explored and developed in relation to various situations in the client's life, including relationships, support networks, work, leisure, parenting, and getting out of family violence situations.
- Be aware that clients who have a trauma history are vulnerable to further trauma, including sexual assault and interpersonal violence. Their AOD use may also place them in situations which can increase their risk of further trauma.
- Counsellors should utilise clinical supervision and self-care strategies, and undertake training to assist them in working with clients and to minimise vicarious traumatisation (see chapter on ***Secondary traumatic stress, compassion fatigue, and vicarious trauma***).





**Figure 5: A framework for responding to trauma**

## Co-occurring trauma issues – tip sheet

The prevalence of exposure to traumatic events and subsequent trauma symptoms is higher in clients who use AOD than in the general population. Exposure to trauma is associated with a range of psychological difficulties, health and social problems and premature mortality, the risk of which increases with exposure to further trauma.

The impact of trauma and therapeutic approach is related to the type of trauma, the severity of the trauma and the developmental stage when the trauma occurred. Childhood abuse by an attachment figure (parent, caregiver) over a prolonged period of time can result in difficulties with emotional regulation, self-soothing, and difficulty forming and maintaining positive relationships, in addition to the symptoms of PTSD: alterations in arousal or reactivity, intrusion, negative alterations in cognition and mood, and avoidance.

A trauma-informed approach is recommended with all clients who access AOD services, and ideally this approach should be at the organisational and individual counsellor levels. Trauma-informed care and practice principles include:

- safety
- trustworthiness
- choice
- collaboration
- empowerment
- recognition of cultural, historical and gender issues.

Working effectively with clients who have experienced trauma in an AOD setting does not require direct focus on the trauma. A rehabilitation approach is recommended for clients with complex or early, prolonged and repeated attachment trauma. This approach is focused on psychoeducation for the management of trauma symptoms, self-care and self-management strategies, and coping with current life stressors.

General principles for working with people who have experienced trauma include:

- ensuring a positive therapeutic relationship through general counselling skills such as being warm, empathic, genuine, validating, consistent and setting appropriate limits
- utilise a supportive and transparent approach to counselling
- explore the impact the trauma is having on the client in the present. Provide the client with psychoeducation regarding their trauma symptoms to assist in normalising and validating their experience
- explore the client's AOD use and any possible relationship to trauma symptoms
- minimise the impact of organisational changes by providing a stable counsellor and an active handover and transition period when changing counsellors or services
- conduct regular suicide risk assessments and explore alternative strategies to self-harm
- develop alternative strategies for managing trauma symptoms prior to attempting significant reductions in AOD use
- formulate treatment goals and steps towards them that are realistic and involve small increments
- encourage self-care and build coping skills such as problem-solving and goal-setting
- be aware of the possibility of re-traumatisation for those clients with trauma-related histories
- be aware that clients who have a trauma history are vulnerable to experiencing further trauma
- access clinical supervision, practice self-care and access training.

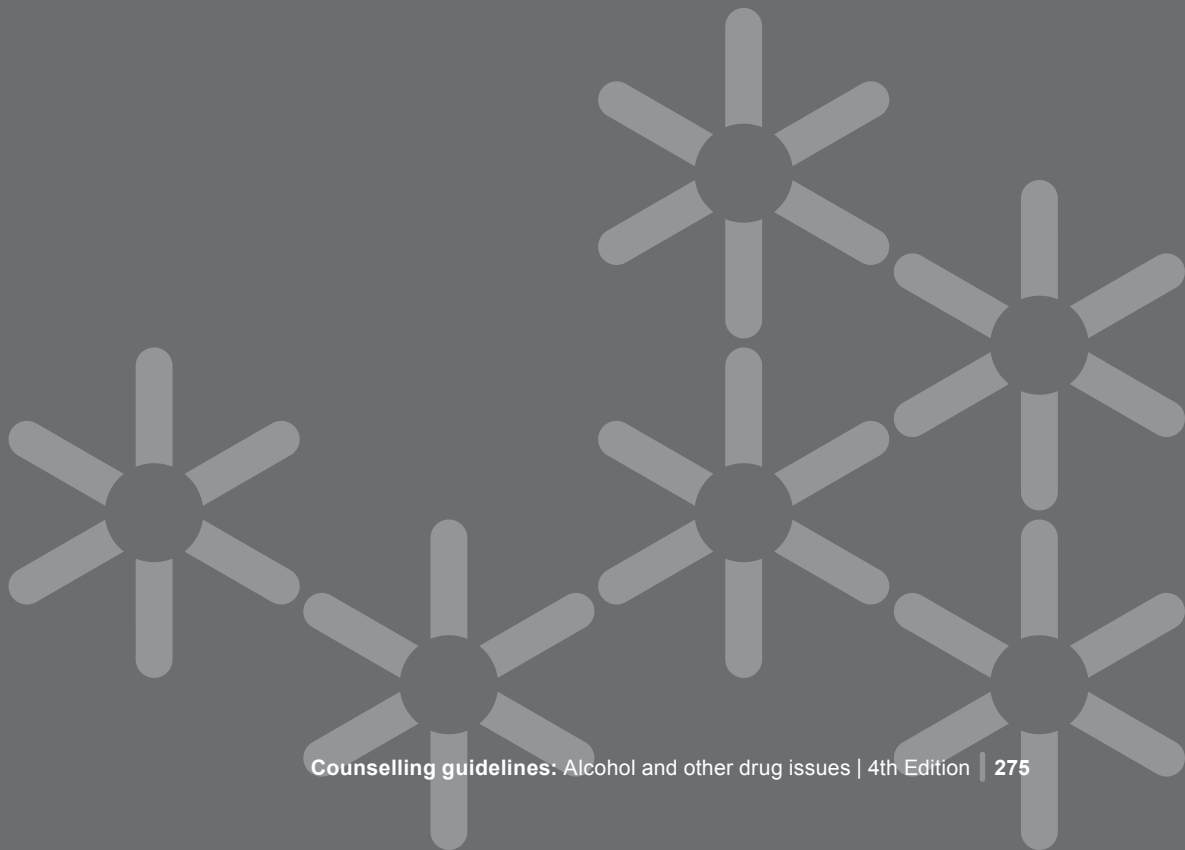
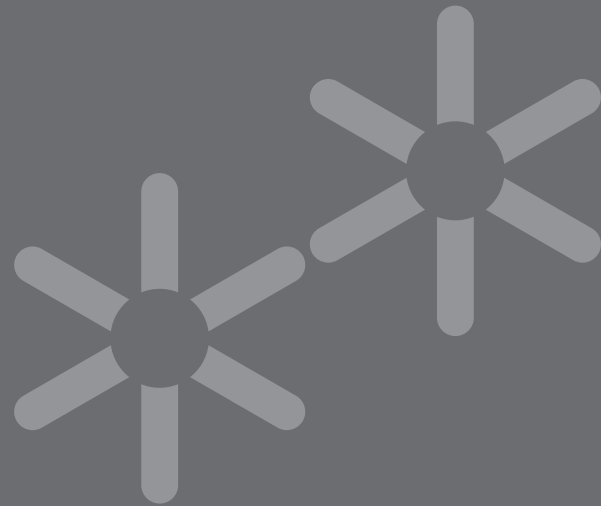
## References

- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (5th ed.)*. Washington, DC: American Psychiatric Association.
- Australian Institute of Family Studies. (2016). *Establishing the connection: Guidelines for practitioners and clinicians in the sexual assault and alcohol and other drug sectors*. Melbourne, VIC: AIFS.
- Bailey, K., Webster, R., Baker, A. L., & Kavanagh, D. J. (2012). Exposure to dysfunctional parenting and trauma events and posttraumatic stress profiles among a treatment sample with coexisting depression and alcohol use problems. *Drug and Alcohol Review, 31*(4), 529-537.
- Banducci, A. N., Hoffman, E. M., Lejuez, C. W., & Koenen, K. C. (2014a). The impact of childhood abuse on inpatient substance users: Specific links with risky sex, aggression, and emotion dysregulation. *Child Abuse & Neglect, 38*, 928-238. doi: 10.1016/j.chiabu.2013.12.007
- Banducci, A. N., Hoffman, E. M., Lejuez, C. W., & Koenen, K. C. (2014b). The relationship between child abuse and negative outcomes among substance users: Psychopathology, health, and comorbidities. *Addictive Behaviors, 39*(10), 1522–1527.
- Breckenridge, J. M. (2010). 'Use and abuse': Understanding the intersections of child abuse, drug use and mental health. Sydney: University of New South Wales.
- Choi, N. G., DiNitto, D. M., Marti, C. N., & Choi, B. Y. (2017). Association of adverse childhood experiences with lifetime mental and substance use disorders among men and women aged 50+ years. *International Psychogeriatrics, 29*(3), 359-372. doi: 10.1017/S1041610216001800
- Cloitre, M., Courtois, C. A., Ford, J. D., Green, B. L., Alexander, P., Briere, J., . . . Van der Hart, O. (2012). The ISTSS Expert Consensus Treatment Guidelines for Complex PTSD in Adults.
- Deane, F. P., Kelly, P. J., Crowe, T. P., Coulson, J. C., & Lyons, G. C. (2013). Clinical and reliable change in an Australian residential substance use program using the Addiction Severity Index *Journal of Addictive Diseases, 32*, 194-205.
- Dore, G., Mills, K., Murray, R., Teesson, M., & Farrugia, P. (2012). Post-traumatic stress disorder, depression and suicidality in inpatients with substance use disorders. *Drug and Alcohol Review, 31*(3), 294-302. doi: 10.1111/j.1465-3362.2011.00314.x
- Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., . . . Marks, J. S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventive Medicine, 14*(4), 245-258. doi: 10.1016/S0749-3797(98)00017-8
- Fuller-Thomson, E., Roane, J. L., & Brennenstuhl, S. (2016). Three types of adverse childhood experiences, and alcohol and drug dependence among adults: An investigation using population-based data. *Substance Use & Misuse, 51*(11), 1451-1461. doi: 10.1080/10826084.2016.1181089
- Garland, E. L., Pettus-Davis, C., & Howard, M. O. (2013). Self-medication among traumatized youth: Structural equation modeling of pathways between trauma history, substance misuse, and psychological distress. *Journal of Behavioral Medicine, 36*(2), 175-185. doi: 10.1007/s10865-012-9413-5
- Geraerts, E., Schooler, J. W., Merckelbach, H., Jelicic, M., J.A. Hauer, B., & Ambadar, Z. (2007). The reality of recovered memories: Corroborating continuous and discontinuous memories of childhood sexual abuse. *Psychological Science, 18*(7), 564-568. doi: 10.1111/j.1467-9280.2007.01940.x
- Hall, W. (1996). What have population surveys revealed about substance use disorders and their comorbidity with other mental disorders? *Drug and Alcohol Review, 15*, 157-170.
- Herman, J. (1997). *Trauma and recovery: The aftermath of violence – from domestic abuse to political terror*. New York: Basic Books.
- Karatzias, T., Cloitre, M., Maercker, A., Kazlauskas, E., Shevlin, M., Hyland, P., . . . Brewin, C. R. (2017). PTSD and Complex PTSD: ICD-11 updates on concept and measurement in the UK, USA, Germany and Lithuania. *European Journal of Psychotraumatology, 8*(sup7), 1418103. doi: 10.1080/20008198.2017.1418103
- Kezelman, C., & Stavropoulos, P. (2012). *Practice guidelines for treatment of complex trauma and trauma informed care and service delivery*. Retrieved from [http://www.blueknot.org.au/Portals/2/Practice%20Guidelines/Blue%20Knot%20Foundation%20Guidelines\\_WEB\\_Final.pdf](http://www.blueknot.org.au/Portals/2/Practice%20Guidelines/Blue%20Knot%20Foundation%20Guidelines_WEB_Final.pdf).
- Kezelman, C., & Stavropoulos, P. (2018). *Talking about trauma: Guide to conversations and screening for health and other service providers*. Blue Knot Foundation. Retrieved from [https://www.blueknot.org.au/Portals/2/Publications/Talking%20About%20Trauma%20Services\\_WEB.pdf?ver=2018-10-12-150504-710](https://www.blueknot.org.au/Portals/2/Publications/Talking%20About%20Trauma%20Services_WEB.pdf?ver=2018-10-12-150504-710)
- Khantzian, E. J. (1997). The self-medication hypothesis of substance use disorders: A reconsideration and recent applications. *Harvard Review of Psychiatry, 4*(5), 231-244. doi: 10.3109/10673229709030550
- Kinniburgh, K., Blaustein, M., Spinazzola, J., & van der Kolk, B. (2005). Attachment, Self-Regulation, and Competency: A comprehensive intervention framework for children with complex trauma. *Psychiatric Annals, 35*, 424-430. doi: 10.3928/00485713-20050501-08
- Laslett, A., Mugavin, J., Jiang, H., Manton, E., Callinan, S., MacLean, S., & Room, R. (2015). *The hidden harm: Alcohol's impact on children and families*. Canberra, ACT: Foundation for Alcohol Research and Education.
- Lumley, M., Neely, L. C., & Burger, A. J. (2007). The assessment of alexithymia in medical settings: Implications for understanding and treating health problems. *Journal of Personality Assessment, 89*(3), 230-246. doi: 10.1080/00223890701629698
- McClelland, M., Geldhof, J., Morrison, F., Gestsdóttir, S., Cameron, C., Bowers, E., . . . Grammer, J. (2018). Self-Regulation. In N. Halfon, C. B. Forrest, R. M. Lerner & E. M. Faustman (Eds.), *Handbook of Life Course Health Development* (pp. 275-298). Cham, Switzerland: Springer International Publishing.

- Mental Health Coordinating Council (MHCC). (2013). *Trauma-Informed Care and Practice: Towards a cultural shift in policy reform across mental health and human services in Australia, A National Strategic Direction, Position Paper and Recommendations of the National Trauma-Informed Care and Practice Advisory Working Group*. Authors: Bateman, J. & Henderson, C. (MHCC) Kezelman, C. (*Adults Surviving Child Abuse, ASCA*) Retrieved from [http://www.mhcc.org.au/media/32045/ticp\\_awg\\_position\\_paper\\_\\_v\\_44\\_final\\_\\_07\\_11\\_13.pdf](http://www.mhcc.org.au/media/32045/ticp_awg_position_paper__v_44_final__07_11_13.pdf)
- Miller, S. D., Hubble, M. A., Chow, D., & Seidel, J. (2015). Beyond measures and monitoring: Realizing the potential of Feedback-Informed Treatment. *Psychotherapy, 52*(4), 449-457.
- Mills, K. L., Teesson, M., Ross, J., & Peters, L. (2006). Trauma, PTSD, and substance use disorders: Findings from the Australian National Survey of Mental Health and Well-Being. *The American Journal of Psychiatry, 163*(4), 652-658. doi: 10.1176/appi.ajp.163.4.652
- Noonan, P., Taylor, A., & Burke, J. (2017). Links between alcohol consumption and domestic and sexual violence against women: Key findings and future directions: Australia's National Research Organisation for Women's Safety Limited (ANROWS).
- Pearlman, L. A., & Saakvitne, K. W. (1995). *Trauma and the therapist: Countertransference and vicarious traumatization in psychotherapy with incest survivors*. New York: W.W. Norton.
- Ruglass, L. M., Lopez-Castro, T., Papini, S., Killeen, T., Back, S. E., & Hien, D. A. (2017). Concurrent treatment with prolonged exposure for co-occurring full or subthreshold posttraumatic stress disorder and substance use disorders: A randomized clinical trial. *Psychotherapy and Psychosomatics, 86*(3), 150-161.
- Schlotz, W. (2013). Stress reactivity. In M. D. Gellman & J. R. Turner (Eds.), *Encyclopedia of Behavioral Medicine* (pp. 1891-1894). New York, NY: Springer New York.
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2014a). SAMHSA's concept of trauma and guidance for a trauma-informed approach. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2014b). *Trauma-informed care in behavioral health services*. (HHS Publication No. (SMA) 13-4801). Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from <https://store.samhsa.gov/shin/content//SMA14-4816/SMA14-4816.pdf>
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2014c). *Trauma-Informed Care in Behavioral Health Services. Treatment Improvement Protocol (TIP) Series 57*. (HHS Publication No. (SMA) 13-4801). Rockville, MD: Substance Abuse and Mental Health Services Administration Retrieved from <http://store.samhsa.gov/shin/content//SMA14-4816/SMA14-4816.pdf>
- The Bouverie Centre. (2013). Guidelines for trauma-informed family sensitive practice in adult health services. [http://www.bouverie.org.au/images/uploads/Bouverie\\_Centre\\_Guidelines\\_for\\_trauma-informed\\_family\\_sensitive\\_practice\\_in\\_adult\\_health\\_services.pdf](http://www.bouverie.org.au/images/uploads/Bouverie_Centre_Guidelines_for_trauma-informed_family_sensitive_practice_in_adult_health_services.pdf)
- Tull, M. T., Berghoff, C. R., Wheelless, L. E., Cohen, R. T., & Gratz, K. L. (2018). PTSD symptom severity and emotion regulation strategy use during trauma cue exposure among patients with substance use disorders: Associations with negative affect, craving, and cortisol reactivity. *Behavior Therapy, 49*(1), 57-70. <https://doi.org/10.1016/j.beth.2017.05.005>
- Vivekananda, K. (2002). Profound simplicity: Integrating frameworks for working with trauma. *Psychotherapy in Australia, 9*(1), 14-24.
- World Health Organization (WHO). (2018a). *International Classification of Diseases for mortality and morbidity statistics* (11th revision). Retrieved from <https://icd.who.int/browse11/l-m/en>
- World Health Organization (WHO). (2018b). ICD-11 for Mortality and Morbidity Statistics (ICD-11 MMS). Retrieved from <https://icd.who.int/browse11/l-m/en#/http://id.who.int/icd/entity/585833559>



# Appendices



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# Appendix 1: AOD and prevention resources

## AOD information

### Alcohol and Drug Foundation

The Alcohol and Drug Foundation (ADF) works in partnership with other agencies to support and create evidence-based policies and practice that prevent and minimise the harm associated with AOD. The ADF co-designs evidence-based programs with communities and supports them to build capacity to create change.

<https://adf.org.au/drug-facts/>

### Alcohol Think Again

The *Alcohol Think Again* education campaign is part of a comprehensive approach that aims to reduce the level of alcohol-related harm and ill-health in Western Australia. The campaign uses a mass reach social marketing strategy targeting the Western Australian community. The aims of the *Alcohol Think Again* education campaign are to: reduce the risk of alcohol-related harm over a lifetime; reduce the risk of injury on a single occasion of drinking; increase women's intentions to abstain from alcohol during pregnancy and when breastfeeding; and allow parents and young people to make informed choices about delaying initiation to alcohol use. *Alcohol Think Again* is managed by the Drug, Alcohol and Prevention Services Division, MHC.

<https://alcoholthinkagain.com.au/>

### A quick guide to drugs & alcohol (PDF)

The National Drug and Alcohol Research Centre in conjunction with the State Library of NSW & NSW Health have published *A quick guide to drugs & alcohol*. This resource is intended for anyone who wants accurate information about specific drugs and alcohol. It is not a medical or scientific book; it is set out in easy-to-read sections so that you can find the information that you require quickly. It is available via this link:

<https://yourroom.health.nsw.gov.au/publicationdocuments/quick-guide-ed3.pdf>

### AODElearning@MHC

Developed by the MHC, this online learning portal is aimed at professionals employed in the AOD and other human services and community sectors. Topics include an introduction to AOD, an introduction to fetal alcohol spectrum disorders, alcohol brief intervention, and needle and syringe programs.

<https://aodelearning.mhc.wa.gov.au/>

### Drug Aware

Drug Aware was established in 1996 as part of a state framework of educational strategies designed to address illicit drug use among young people in Western Australia. It was the first comprehensive ongoing program on illicit drug education undertaken in Australia.

<https://drugaware.com.au/>

### Drug Info

Drug Info provides a range of information on AOD, including an up-to-date A-Z drug index, information on working with communities and Aboriginal peoples, and latest news and articles pertinent to the AOD sector.

<https://druginfo.sl.nsw.gov.au/>



## **National Centre for Education and Training on Addiction**

The National Centre for Education and Training on Addiction (NCETA) is an internationally recognised research centre that works as a catalyst for change in the AOD field. NCETA offer information and access to a wide range of AOD resources and research.

<http://nceta.flinders.edu.au/>

## **National Drug and Alcohol Research Centre**

The National Drug and Alcohol Research Centre (NDARC) is an internationally recognised research institution in Sydney, Australia. NDARC's mission is to conduct and disseminate high-quality research and related activities that increase the effectiveness of treatment and other intervention responses to AOD-related harm.

<https://ndarc.med.unsw.edu.au/>

## **National Drug Research Institute**

The National Drug Research Institute (NDRI) is one of the largest centres of AOD research expertise in Australia. NDRI is based at Curtin University in Perth, Western Australia, with a satellite office in Melbourne, Victoria. NDRI is a WHO Collaborating Centre for the Prevention of Alcohol and Drug Abuse.

<http://ndri.curtin.edu.au/>

## **Volatile Substance Use in Western Australia**

This comprehensive website is a resource for front-line workers, service providers and other professionals working directly or indirectly with people affected by volatile substance use. It aims to bring together key documents and a wide range of literature and other resources to support an effective response in communities and state-wide.

<https://vsu.mhc.wa.gov.au/>

## **AOD Telephone and Online Support Services**

### **Alcohol and Drug Support Line (WA)**

The Alcohol and Drug Support Line is a confidential, non-judgemental telephone counselling, information and referral service for anyone seeking help for their own or another person's AOD use. The Alcohol and Drug Support Line is available 24 hours, 7 days a week.

The Alcohol and Drug Support Line also provides:

- interim support to individuals waiting for face-to-face counselling/treatment
- a free call back service to socially and geographically isolated clients
- support to health professionals working with individuals and families affected by AOD use.

Metropolitan area (08) 9442 5000

Country callers toll-free 1800 198 024\*

Email: [alcoholdrugsupport@mhc.wa.gov.au](mailto:alcoholdrugsupport@mhc.wa.gov.au)

Web: [www.alcoholdrugsupport.mhc.wa.gov.au](http://www.alcoholdrugsupport.mhc.wa.gov.au)

### **Parent and Family Drug Support Line**

The Parent and Family Drug Support Line is a confidential, non-judgmental telephone counselling, information and referral service for families and carers concerned about a loved one's AOD use. Professional counsellors are available via phone 24/7. In addition to professional counsellors, the Parent and Family Drug Support Line has a network of trained parent volunteers who have experienced their own child's AOD use. Parent volunteers are available via phone between 8 am and 10 pm each day (WST).

Phone: (08) 9442 5050

Country toll-free: 1800 653 203

Email: [alcoholdrugsupport@mhc.wa.gov.au](mailto:alcoholdrugsupport@mhc.wa.gov.au)

Website: [www.alcoholdrugsupport.mhc.wa.gov.au](http://www.alcoholdrugsupport.mhc.wa.gov.au)

## **Prevention resources**

### **Introduction to Alcohol and Other Drug Prevention Guidelines**

These guidelines provide valuable information to support professionals and services in the development and implementation of effective, evidence-based AOD prevention activity. Information contained in this document is drawn from the AOD and population health fields.

<https://www.mhc.wa.gov.au/media/2354/introduction-to-alcohol-and-other-drug-prevention-guidelines.pdf>

### **Western Australian Alcohol and Other Drug Prevention Core Knowledge and Skills Framework**

<https://www.mhc.wa.gov.au/media/1169/core-knowledge-and-skills-for-aod-prevention-workers.pdf>

### **The Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018-2025**

The *Western Australian Mental Health Promotion, Mental Illness, Alcohol and Other Drug Prevention Plan 2018 2025* (Prevention Plan) provides a guide for all stakeholders, including the MHC, for the development and implementation of evidence based and evidence-informed strategies to promote mental health and prevent mental illness and AOD-related issues amongst the Western Australian community.

<https://www.mhc.wa.gov.au/about-us/strategic-direction/the-western-australian-mental-health-promotion-mental-illness-alcohol-and-other-drug-prevention-plan-2018-2025/>

## Appendix 2: The termination checklist

Principle	Strategy	Completed/Plan?
Prepare explicitly for termination	Discuss what went well in therapy, consider what the ending will be like, and remind clients with the therapy will conclude	
Process feelings of client and therapist	Exploring the client's feelings about the treatment relationship, including the sense of loss about ending the sessions as well as both positive and negative reactions	
Reflect on client gains	Emphasise positive gains made, assess improvements, help the client understand the changes, and saying goodbye	
Express pride in client's progress and mutual relationship	Attribute gains to client's efforts, taking pride in the new skills achieved, acknowledging satisfaction in working together, and expressing some of the therapist's feelings about ending the therapeutic relationship	
Discuss client's future functioning and coping	Process risks for relapse, thinking about the future, and opening the door to possible return to therapy if needed. Discuss the client's development in therapy of new skills, capacities and tools for dealing with future stressors.	
Help client to use new skills beyond therapy	Discuss plans for continuing to practice in the "real world" new behaviours and understandings acquired in therapy. Emphasise that the client will continue to learn to master new problems as they apply what they learned	
Frame personal development as unfinished	Normalising the idea that problems are a natural part of life and the expectation that more will be learned by the patient is up ahead. It may also result in discussing resources that may be helpful with resolving future problems	
Anticipate post-therapy growth and generalisation	Point out that the treatment achievements are likely to carryover to symptom reduction and better functioning in other areas of life	

Adapted from: Norcross, J., Zimmerman, B., Greenberg, R., & Swift, J. (2017). Do all therapists do that when saying goodbye? A study of commonalities in termination behaviours. *Psychotherapy, 54*(1), 66-75. doi: 10.1037/pst0000097.

# Appendix 3: Clinical Institute Withdrawal Assessment Scale – Alcohol, revised (CIWA-Ar)

**Instructions:** This assessment for monitoring withdrawal symptoms requires approximately 5 minutes to administer. Circle the score that relates to each symptom. Add the score of each item to obtain the final score. Maximum score possible is 67.

<b>Patient:</b>	<b>Date:</b>	<b>Time:</b>
<b>Pulse or heart rate, taken for one minute:</b>		<b>Blood pressure:</b>

<p><b>Nausea and vomiting</b></p> <p>Ask “Do you feel sick to your stomach? Have you vomited?”</p> <p>Observation:</p> <p><b>0</b> no nausea and no vomiting  <b>1</b> mild nausea with no vomiting  <b>2</b>  <b>3</b>  <b>4</b> intermittent nausea with dry heaves  <b>5</b>  <b>6</b>  <b>7</b> constant nausea, frequent dry heaves and vomiting</p>	<p><b>Tactile disturbances</b></p> <p>Ask “Have you any itching, pins and needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?”</p> <p>Observation:</p> <p><b>0</b> none  <b>1</b> very mild itching, pins and needles, burning or numbness  <b>2</b> mild itching, pins and needles, burning or numbness  <b>3</b> moderate itching, pins and needles, burning or numbness  <b>4</b> moderately severe hallucinations  <b>5</b> severe hallucinations  <b>6</b> extremely severe hallucinations  <b>7</b> continuous hallucinations</p>
<p><b>Tremor</b></p> <p>Arms extended and fingers spread apart.</p> <p>Observation:</p> <p><b>0</b> no tremor  <b>1</b> not visible, but can be felt fingertip to fingertip  <b>2</b>  <b>3</b>  <b>4</b> moderate, with patient’s arms extended  <b>5</b>  <b>6</b>  <b>7</b> severe, even with arms not extended</p>	<p><b>Auditory disturbances</b></p> <p>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?”</p> <p>Observation:</p> <p><b>0</b> not present  <b>1</b> very mild harshness or ability to frighten  <b>2</b> mild harshness or ability to frighten  <b>3</b> moderate harshness or ability to frighten  <b>4</b> moderately severe hallucinations  <b>5</b> severe hallucinations  <b>6</b> extremely severe hallucinations  <b>7</b> continuous hallucinations</p>

<p><b>Paroxysmal sweats</b></p> <p>Observation:</p> <p><b>0</b> no sweat visible  <b>1</b> barely perceptible sweating, palms moist  <b>2</b>  <b>3</b>  <b>4</b> beads of sweat obvious on forehead  <b>5</b>  <b>6</b>  <b>7</b> drenching sweats</p>	<p><b>Visual disturbances</b></p> <p>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?”</p> <p>Observation:</p> <p><b>0</b> not present  <b>1</b> very mild sensitivity  <b>2</b> mild sensitivity  <b>3</b> moderate sensitivity  <b>4</b> moderately severe hallucinations  <b>5</b> severe hallucinations  <b>6</b> extremely severe hallucinations  <b>7</b> continuous hallucinations</p>
<p><b>Anxiety</b></p> <p>Ask “Do you feel nervous?” Observation:</p> <p><b>0</b> no anxiety, at ease  <b>1</b> mild anxious  <b>2</b>  <b>3</b>  <b>4</b> moderately anxious, or guarded, so anxiety is inferred  <b>5</b>  <b>6</b>  <b>7</b> equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions</p>	<p><b>Headache, fullness in head</b></p> <p>Ask “Does your head feel different? Does it feel like there is a band around your head?”</p> <p>Do not rate for dizziness or light-headedness. Otherwise, rate severity.</p> <p><b>0</b> not present  <b>1</b> very mild  <b>2</b> mild  <b>3</b> moderate  <b>4</b> moderately severe  <b>5</b> severe  <b>6</b> very severe  <b>7</b> extremely severe</p>
<p><b>Agitation</b></p> <p>Observation:</p> <p><b>0</b> normal activity  <b>1</b> somewhat more than normal activity  <b>2</b>  <b>3</b>  <b>4</b> moderately fidgety and restless  <b>5</b>  <b>6</b>  <b>7</b> paces back and forth during most of the interview, or constantly thrashes about</p>	<p><b>Orientation and clouding of sensorium</b></p> <p>Ask “What day is this? Where are you? Who am I?”</p> <p><b>0</b> oriented and can do serial additions  <b>1</b> cannot do serial additions or is uncertain about date  <b>2</b> disoriented for date by no more than 2 calendar days  <b>3</b> disoriented for date by more than 2 calendar days  <b>4</b> disoriented for place/or person</p>

**Total CIWA-Ar Score:**

**Rater’s Initials:**

**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.

Adapted from: Sullivan, J. T., Sykora, K., Schneiderman, J., Naranjo, C. A., & Sellers, E. M. (1989). Assessment of alcohol withdrawal: The revised Clinical Institute Withdrawal Assessment for Alcohol scale (**CIWA-Ar**). *British Journal of Addiction*, 84(11), 1353-1357.

## Appendix 4: Benzodiazepine Withdrawal Assessment Scale (CIWA-B)

<b>Client name:</b>	<b>Date:</b>
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	<b>0</b> Not at all	<b>1</b>	<b>2</b>	<b>3</b>	<b>4</b> Very much
Do you feel irritable?					
Do you feel fatigued?					
Do you feel tense?					
Do you have difficulties concentrating?					
Do you have any loss of appetite?					
Have you any numbness or burning in your face, hands or feet?					
Do you feel your heart racing? (palpitations)					
Does your head feel full or achy?					
Do you feel muscle aches or stiffness?					
Do you feel anxious, nervous or jittery?					
Do you feel upset?					
How restful was your sleep last night? (0 = very much so; 4 = not at all)					
Do you have any visual disturbances? (sensitivity to light, blurred vision)					
Are you fearful?					
Have you been worrying about possible misfortunes lately?					

<b>Subtotal:</b>
------------------



Clinician observations	0	1	2	3	4
Observe patient for sweating, restlessness or agitation	(none, normal activity)		(restless)		(paces back and forth, unable to sit still)
Observer tremor	(no tremor)	(not visible, can be felt in fingers)	(visible but mild)	(moderate with arms extended)	(severe with arms not extended)
Observe/feel palms	(no sweating visible)	(barely perceptible sweating, palms moist)	(palms and forehead moist, reports armpit sweating)	(beads of sweat on forehead)	(severe drenching seats)

**Subtotal:**

**Total:**

**Scoring:** Sum the score of each item's answer. Score range 0 - 80.

1 - 20 = Mild withdrawal

21 - 40 = Moderate withdrawal

41 - 60 = Severe withdrawal

61 - 80 = Very severe withdrawal

Adapted from Busto, U. E., Sykora, K., & Sellers, E. M. (1989). A clinical scale to assess benzodiazepine withdrawal. *Journal of Clinical Psychopharmacology*, 9(6), 412-416.

# Appendix 5a: The Short Opiate Withdrawal Scale (SOWS-Gossop)

**Instructions:** Put a tick in the box if you have suffered from any of the following conditions in the last 24 hours.

<b>Client name:</b>	<b>Date:</b>
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	None 0	Mild 1	Moderate 2	Severe 3
Feeling sick				
Stomach cramps				
Muscle spasms/twitching				
Feelings of coldness				
Heart pounding				
Muscular tension				
Aches and pains				
Yawning				
Runny eyes				
Insomnia/problems sleeping				
Subtotal				

<b>Total:</b>
---------------

**Scoring:** Score each item with a tick against it as follows:

None = 0, Mild = 1, Moderate = 2 and Severe = 3. Sum the total of each column for the total score.

The SOWS-Gossop total score ranges from 0 to 30, with higher scores indicating greater severity of withdrawal symptoms.

Adapted from: Gossop, M. (1990). The development of a short opiate withdrawal scale (SOWS).

*Addictive Behaviors*, 15(5), 487-490. [https://doi.org/10.1016/0306-4603\(90\)90036-W](https://doi.org/10.1016/0306-4603(90)90036-W)

# Appendix 5b: Clinical Opiate Withdrawal Scale (COWS)

**Instructions:** For each item, circle the number that best describes the patient's signs or symptom. Rate on just the apparent relationship to opioid withdrawal. For example, if heart rate is increased because the patient was jogging just prior to assessment, the increased pulse rate would not add to the score.

<b>Client's Name:</b>	<b>Date:</b>	<b>Time:</b>
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<p><b>Resting pulse rate</b> - <i>(record beats per minute) Measured after patient is sitting or lying for one minute</i></p> <p>0 - pulse rate 80 or below</p> <p>1 - pulse rate 81-100</p> <p>2 - pulse rate 101-120</p> <p>4 - pulse rate greater than 120</p>	<input type="checkbox"/>
<p><b>Sweating</b> - <i>Over past ½ hour not accounted for by room temperature or patient activity</i></p> <p>0 - no report of chills or flushing</p> <p>1 - subjective report of chills or flushing</p> <p>2 - flushed or observable moistness on face</p> <p>3 - beads of sweat on brow or face</p> <p>4 - sweat streaming off face</p>	<input type="checkbox"/>
<p><b>Restlessness</b> - <i>Observation during assessment</i></p> <p>0 - able to sit still</p> <p>1 - reports difficulty sitting still, but is able to do so</p> <p>3 - frequent shifting or extraneous movements of legs/arms</p> <p>5 - Unable to sit still for more than a few seconds</p>	<input type="checkbox"/>
<p><b>Pupil size</b></p> <p>0 - pupils pinned or normal size for room light</p> <p>1 - pupils possibly larger than normal for room light</p> <p>2 - pupils moderately dilated</p> <p>5 - pupils so dilated that only the rim of the iris is visible</p>	<input type="checkbox"/>
<p><b>Bone or Joint aches</b> - <i>If patient was having pain previously, only the additional component attributed to opioids withdrawal is scored</i></p> <p>0 - not present</p> <p>1 - mild diffuse discomfort</p> <p>2 - patient reports severe diffuse aching of joints/ muscles</p> <p>4 - patient is rubbing joints or muscles and is unable to sit still because of discomfort</p>	<input type="checkbox"/>
<p><b>Runny nose or tearing</b> - <i>Not accounted for by cold symptoms or allergies</i></p> <p>0 - not present</p> <p>1 - nasal stuffiness or unusually moist eyes</p> <p>2 - nose running or tearing</p> <p>4 - nose constantly running or tears streaming down cheeks</p>	<input type="checkbox"/>

<p><b>Gastrointestinal Upset - over last ½ hour</b></p> <p>0 - no gastrointestinal symptoms</p> <p>1 - stomach cramps</p> <p>2 - nausea or loose stool</p> <p>3 - vomiting or diarrhea</p> <p>5 - Multiple episodes of diarrhoea or vomiting</p>	<input type="checkbox"/>
<p><b>Tremor - Observation of outstretched hands</b></p> <p>0 - No tremor</p> <p>1 - tremor can be felt, but not observed</p> <p>2 - slight tremor observable</p> <p>4 - gross tremor or muscle twitching</p>	<input type="checkbox"/>
<p><b>Yawning - Observation during assessment</b></p> <p>0 - no yawning</p> <p>1 - yawning once or twice during assessment</p> <p>2 - yawning three or more times during assessment</p> <p>4 - yawning several times/minute</p>	<input type="checkbox"/>
<p><b>Anxiety or Irritability</b></p> <p>0 - none</p> <p>1 - patient reports increasing irritability or anxiousness</p> <p>2 - patient obviously irritable anxious</p> <p>4 - patient so irritable or anxious that participation in the assessment is difficult</p>	<input type="checkbox"/>
<p><b>Gooseflesh skin</b></p> <p>0 - skin is smooth</p> <p>3 - piloerection of skin can be felt or hairs standing up on arms</p> <p>5 - prominent piloerection</p>	<input type="checkbox"/>

**Total score** (sum of all 11 items):

**Score:**

5 - 12 = mild

13 - 24 = moderate

25 - 36 = moderately severe

more than 36 = severe withdrawal

Adapted from: Wesson, D. R., & Ling, W. (2003). The Clinical Opiate Withdrawal Scale (COWS).

*Journal of Psychoactive Drugs*, 35(2), 253–259.

## Appendix 6: Naloxone Brief Education Tool

Mental Health Commission, Western Australia. (2019). *Brief education tool: recognising and responding to opioid overdose*. Perth: WA: Author.

This brief education tool has been developed to support wider access to naloxone for people at risk of experiencing, witnessing and responding to overdose.

This tool will assist frontline workers who have direct contact with people who use opioids, to deliver a brief education session and deliver key messages before dispensing naloxone or linking to naloxone access.

In order to use this brief education tool, the worker must:

- be confident in the use of the Recognise and Respond audio visual resource
- have the ability to discuss and explore in depth, the signs and symptoms of opioid overdose, and how to effectively respond and administer naloxone
- have attended face-to-face naloxone training
- hold a first aid certificate
- be familiar with the use of naloxone formulations such as; Prenoxad™, Narcan™, and Nyxoid®

Target audience: who should use this brief education session tool?

- Naloxone project workers
- Alcohol and other drug workers (AOD)
- Needle Syringe Program workers (NSP)
- Frontline workers who have contact with people who use opioids

Target audience: who should receive the brief education session?

- People who use opioids
- People at risk of opioid overdose
- People who may be likely to witness opioid overdose
- Family, friends, significant others of those who use opioids

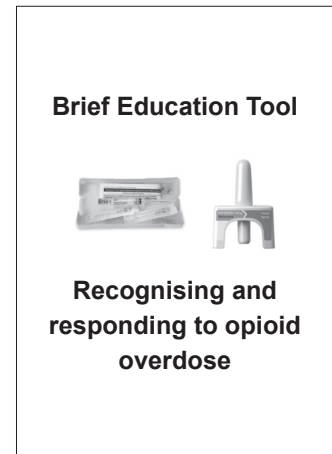
Upon completion of the brief education session first responders should be able to:

- recognise the signs and symptoms of opioid overdose
- respond to opioid overdose
- administer naloxone
- understand post-naloxone management
- supply naloxone or link people to naloxone access

### Background

In 2012 the World Health Organization (WHO) established a process to consider the use of naloxone and the resuscitation of people experiencing opioid overdose. As a result, in 2014 the WHO released guidelines entitled *Community Management of Opioid Overdose*<sup>47</sup>. In order to reduce the number of fatal overdoses and the harms and effects of non-fatal overdoses, the WHO guidelines recommend that those who are likely to witness an opioid overdose have access to naloxone and be given instruction in its administration. This will enable them to use naloxone for the emergency management of suspected overdose.

Take home naloxone projects have been operating in Australia since 2011. As part of ongoing intervention to reduce the rate of opioid overdose, wider naloxone access can be supported with appropriate BI.



47 World Health Organization (2014). *Community management of opioid overdose*. Retrieved from [http://www.who.int/substance\\_abuse/publications/management\\_opioid\\_overdose/en/](http://www.who.int/substance_abuse/publications/management_opioid_overdose/en/)

Key points on opioid overdose and naloxone:

- When a person has an opioid overdose, they lose consciousness and their breathing can slow and eventually stop. This results in damage to the brain and other organs and, finally, death. Most overdose deaths occur more than an hour after last injection and other people, such as friends or family, are usually nearby. Tragically however, in most fatal cases, there is no intervention before death. This is primarily because most people are ill-equipped to respond<sup>48</sup>.
- Naloxone is a medicine that temporarily reverses the effects of heroin and other opioid drugs. If a person overdoses on heroin or prescription opioids, naloxone can help bring them around and potentially save their life. Naloxone has a very specific action in reversing the effects of opioid intoxication. It does not produce any intoxication itself and has no effect on people who do not have opioids in their system<sup>49</sup>.
- For over 40 years naloxone has been used in medicine to reverse the effects of heroin and other opioids. In this capacity it has been shown to be safe, reliable and effective. In Australia, as elsewhere, naloxone is widely used in hospital emergency departments and most ambulance services as a key response to opioid overdose<sup>50</sup>.
- Opioid overdose can be managed by monitoring the person, maintaining their airway, providing ventilation (with rescue breathing), basic life support and calling an ambulance. Naloxone administration can greatly assist in reversing overdose by helping to quickly restart normal breathing<sup>51</sup>.
- There is no evidence that wider availability of naloxone leads to riskier or more widespread drug use<sup>52</sup>.
- Naloxone is sometimes confused with Naltrexone. Naltrexone is used to treat dependence on alcohol, heroin and other drugs.

### **Offering a brief education session on recognising and responding to opioid overdose including the use of naloxone**

Using the following 10 step process:

1. Explain the process will take approximately 20-25 minutes.
2. Discuss the audio-visual scenario, noting that it contains images of injecting, drugs, drug paraphernalia, overdose and fatal overdose; which may be a trigger for use, relapse, grief and loss.
3. Let them know there is a quiz component and why i.e. 'to assess knowledge, it is not a test'.
4. Watch the audio-visual resource.
5. After viewing, administer the quiz. (*Note: consider the literacy level of the participant; the worker can assist by asking and recording answers, working side by side with the person or it can be self-completed*).
6. Discuss the person's responses and clarify areas that require additional education.
7. Reinforce the following key messages:
  - tolerance, purity, poly-drug use and using alone increase the risk of overdose
  - symptoms of overdose include: blue lips, pale, clammy skin, shallow breathing, non-responsive, not breathing, snoring, gurgling sounds, 'on the nod'
  - never leave someone to 'sleep off' and overdose
  - call an ambulance immediately on (triple zero) 000
  - administer naloxone intramuscularly
  - stay with the person until help arrives
  - naloxone wears off in around 90 minutes, the person could drop again
  - it is safe to administer more naloxone at any time
8. Dispense naloxone or link the person to naloxone access.
9. Give the person a Recognise and Respond (opioid/blue) fold out resource.
10. Check in with the person. Remind them of self-care, as the images and discussion may raise some issues for them at a later time. Where possible provide links to support, debrief and/or counselling opportunities/services.

48 Green, T. C., Heimer, R., & Grau, L. E. (2008). Distinguishing signs of opioid overdose and indication for naloxone: an evaluation of six overdose training and naloxone distribution programs in the United States. *Addiction*, 103(6), 979-989. 10.1111/j.1360-0443.2008.02182.x.

49 Lenton, S., & Dietze, P. (2015). Explainer: what is naloxone and how can it help save drug users who overdose? *The Conversation*. Retrieved from <https://theconversation.com/explainer-what-is-naloxone-and-how-can-it-help-save-drug-users-who-overdose-48812>

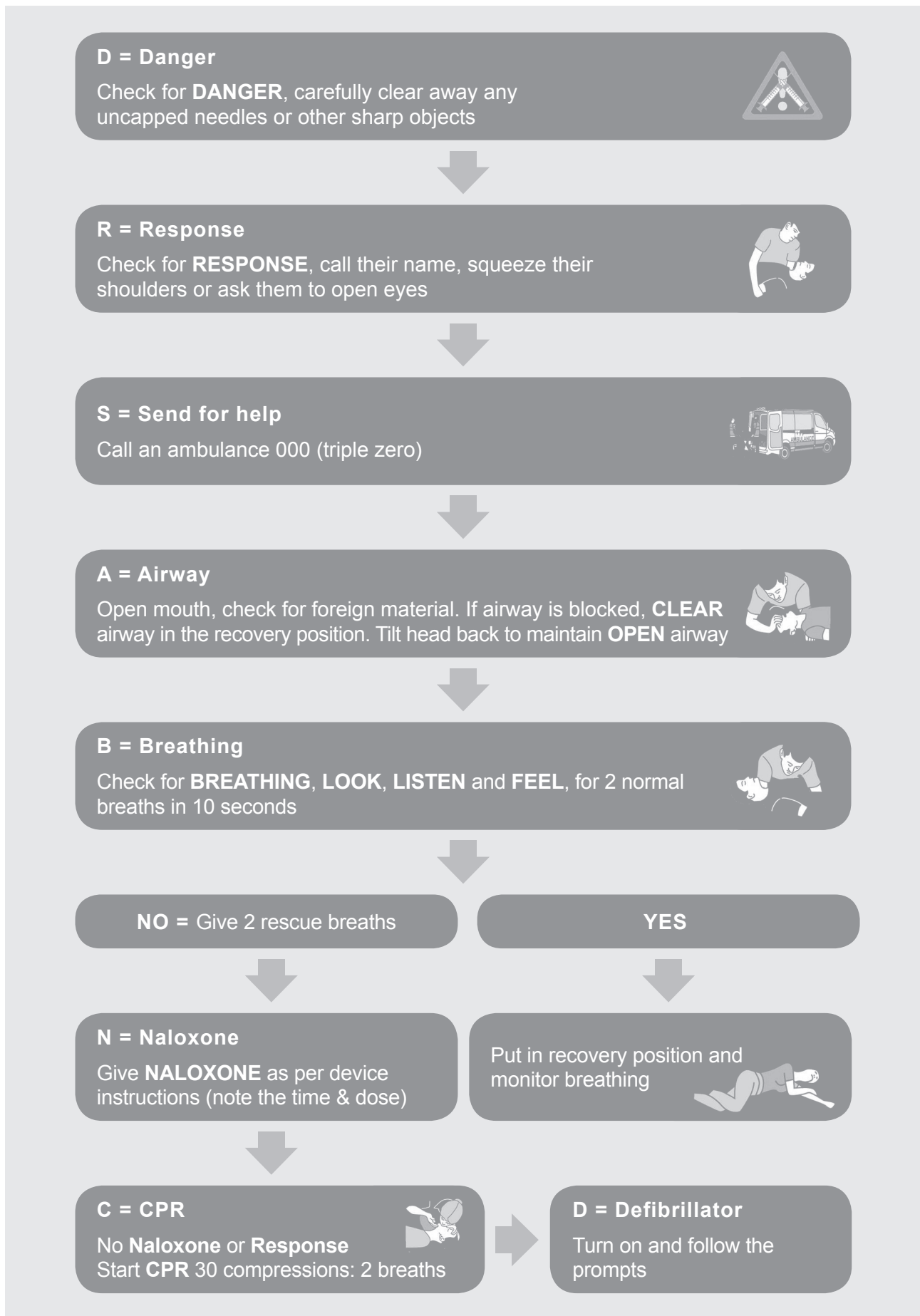
50 Narcan. (n.d.). Retrieved October 2, 2016 from <http://www.rxlist.com/narcan-drug/clinical-pharmacology.htm>

51 Australian Resuscitation Council (n.d.). *The Australian Resuscitation Council Guidelines*. Retrieved from <http://resus.org.au/guidelines/>

52 Piper, T.M., Stancliff, S., Rudenstine, S., Sherman, S., Nandi, V., Clear, A., & Galea, S. (2008). Evaluation of a naloxone distribution and administration program in New York City. *Substance Use and Misuse*, 43(7), 858-870. 10.1080/10826080701801261



## Responding to Opioid Overdose – Flow Chart



## Printable quiz: Recognising and responding to opioid overdose and naloxone administration

*(tick all that apply)*

### Which of the following can increase the risk of an opioid overdose?

- using too much heroin
- change in purity
- using heroin with other drugs (e.g. alcohol, benzos)
- using heroin alone
- change in tolerance (e.g. haven't used in a while, after detox, prison)
- using in unfamiliar places, with unfamiliar people

### Which of the following may be signs of an opioid overdose?

- slow shallow breathing
- blue lips
- loss of consciousness, won't wake up
- snoring, gurgling sounds
- pinned pupils
- clammy skin
- nodding in and out of conversation and sleep

### What would you do in the event of an overdose?

- call an ambulance, triple zero, 000
- stay with the person until they come round
- walk the person around the room
- inject saline, salt water
- give stimulants (e.g. amphetamines, coffee)
- slap or shake the person
- splash the person with cold water
- place the person in a bath or running shower
- perform mouth to mouth resuscitation
- place the person in the recovery position
- give naloxone (Prenoxad™, Narcan™ or Nyxoid®)
- stay with the person until the ambulance arrives

### What is naloxone used for?

- to reverse opioid overdose (e.g. heroin, methadone)
- to reverse amphetamine overdose
- to reverse alcohol overdose
- to reverse any drug overdose
- to reverse benzodiazepines 'benzos' overdose
- not sure

### In an overdose situation, what is the recommended way to administer take-home naloxone?

*(tick all that apply)*

- intra-muscular injection (inject into the muscle)
- intra-venous (inject into the vein, IV)
- oral consumption, swallow (tablet or liquid)
- nasal spray (spray into the nose)
- subcutaneous injection (inject under the skin)

**What is the preferred location for injection?**

- outer thigh
- buttock
- arm
- vein
- subcutaneous tissue
- not sure

**How long does naloxone take to start working?**

- 2 - 5 minutes
- 5 -10 minutes
- 10 - 20 minutes
- other:
- not sure

**How long does naloxone last?**

- less than 20 minutes
- 1 – 6 hours
- 60 minutes
- 90 minutes

**How long before another dose of naloxone can be given?**

- 3 minutes
- 10-20 minutes
- 1 hour
- anytime is ok
- not sure

**What are the steps when giving intranasal naloxone?**

- place the person on their back
- squirt the naloxone into the persons mouth
- spray all of the naloxone into one nostril
- test-pump the nasal spray

## Printable answer sheet: Recognising and *responding to opioid overdose*

### Which of the following can increase the risk of an opioid overdose?

- using too much heroin
- change in purity
- using heroin with other drugs (e.g. alcohol, benzodiazepines)
- using heroin alone
- change in tolerance (e.g. haven't used in a while, after detox, prison)
- using in unfamiliar places, with unfamiliar people

### Which of the following may be signs of an opioid overdose?

- slow shallow breathing
- blue lips
- loss of consciousness, won't wake up
- snoring, gurgling sounds
- pinned pupils
- clammy skin
- nodding in and out of conversation and sleep

### What would you do in the event of an overdose?

- call an ambulance, triple zero, 000
- stay with the person until they come round
- walk the person around the room
- inject saline, salt water (*has no overdose reversal effect*)
- give stimulants (e.g. amphetamines, coffee) (*giving stimulants may increase health complications and does not reverse the effects of overdose*)
- slap or shake the person
- splash the person with cold water
- place the person in a bath or running shower (*may create drowning risk, makes the person difficult to handle if wet and in an area of danger, i.e. hard, sharp surfaces*)
- perform mouth to mouth resuscitation
- place the person in the recovery position
- give naloxone (Prenoxad™, Narcan™ or Nyxoid®)
- stay with the person until the ambulance arrives

### What is naloxone used for?

- to reverse any drug overdose
- to reverse opioid overdose (e.g. heroin, methadone) (*naloxone only reverse the effects of opioid overdose*)
- to reverse amphetamine overdose
- to reverse alcohol overdose
- to reverse benzodiazepines 'benzos' overdose
- not sure

**In an overdose situation, what is the recommended way to administer take home naloxone?**

*(tick all that apply)*

- intra-muscular injection (inject into the muscle)
- intravenous (inject into the vein, IV)
- oral consumption, swallow (tablet or liquid)
- nasal spray (spray into the nose)
- subcutaneous injection (inject under the skin)

**What is the preferred location for injection?**

- buttock
- outer thigh
- arm
- vein
- subcutaneous tissue
- not sure

**How long does naloxone take to start working?**

- 2 - 5 minutes
- 5 -10 minutes
- 10 - 20 minutes
- other:
- not sure

**How long does naloxone last?**

- Less than 20 minutes
- 1 – 6 hours
- 60 minutes
- 90 minutes

**How long before another dose of naloxone can be given?**

- 3 minutes
- 10-20 minutes
- 1 hour
- anytime is ok
- not sure

**What are the steps when giving intranasal naloxone?**

- place the person on their back
- squirt the naloxone into the persons mouth
- spray all of the naloxone into one nostril
- test-pump the nasal spray

**Discuss responses, reinforce key messages; Recognise, Respond, Stay**

Note: this quiz was adapted from the OOKS Scale<sup>53</sup>.

# Appendix 7: Amphetamine Cessation Symptom Assessment Scale (ASCA)

**Instructions:** This scale can be completed by self-report. Questions refer to the past 24 hours only. Please circle one response to each question.

<b>Name:</b>	<b>Date:</b>
--------------	--------------

	Score	0	1	2	3	4
1	Have you had difficulty concentrating? (e.g. on reading, conversation, tasks, or making plans)	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 them?	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

<b>Total score:</b>
---------------------

**Scoring:** Add the scores for each item for a final score. A higher total score reflects more severe symptoms. Adapted from: McGregor, C., Srisurapanont, M., Mitchell, A., Longo, M. C., Cahill, S., & White, J. M. (2008). Psychometric evaluation of the Amphetamine Cessation Symptom Assessment. *Journal of Substance Abuse Treatment*, 34(4), 443-449. doi: 10.1016/j.jsat.2007.05.007



## Appendix 8: Cannabis Withdrawal Scale

**Instructions:** This version of the Cannabis Withdrawal Scale (CWS) asks about symptoms experienced over the last 24 hours, and can be administered by an interviewer OR by self-report.

The following statements describe how you have felt over the last 24 hours. Please **circle the number** that most closely represents your personal experiences for each statement. For each statement, please rate its negative impact on normal daily activities on the same scale (0=Not at all to 10=Extremely), writing the number in the right hand column.

		Not at all			Moderately				Extremely				Negative Impact on daily activity (0 – 10)
		0	1	2	3	4	5	6	7	8	9	10	
1	The only thing I could think about was smoking some cannabis	0	1	2	3	4	5	6	7	8	9	10	
2	I had a headache	0	1	2	3	4	5	6	7	8	9	10	
3	I had no appetite	0	1	2	3	4	5	6	7	8	9	10	
4	I felt nauseous (like vomiting)	0	1	2	3	4	5	6	7	8	9	10	
5	I felt nervous	0	1	2	3	4	5	6	7	8	9	10	
6	I had some angry outbursts	0	1	2	3	4	5	6	7	8	9	10	
7	I had mood swings	0	1	2	3	4	5	6	7	8	9	10	
8	I felt depressed	0	1	2	3	4	5	6	7	8	9	10	
9	I was easily irritated	0	1	2	3	4	5	6	7	8	9	10	
10	I had been imagining being stoned	0	1	2	3	4	5	6	7	8	9	10	
11	I felt restless	0	1	2	3	4	5	6	7	8	9	10	
12	I woke up early	0	1	2	3	4	5	6	7	8	9	10	
13	I had a stomach ache	0	1	2	3	4	5	6	7	8	9	10	
14	I had nightmares and/or strange dreams	0	1	2	3	4	5	6	7	8	9	10	
15	Life seemed like an uphill struggle	0	1	2	3	4	5	6	7	8	9	10	
16	I woke up sweating at night	0	1	2	3	4	5	6	7	8	9	10	
17	I had trouble getting to sleep at night	0	1	2	3	4	5	6	7	8	9	10	
18	I felt physically tense	0	1	2	3	4	5	6	7	8	9	10	
19	I had hot flashes	0	1	2	3	4	5	6	7	8	9	10	

**Scoring:** Score by summing each item's value to a maximum withdrawal score of 190 (you can derive two scores from the scale: one for withdrawal intensity and one for the negative impact of withdrawal – each separate score has a theoretical maximum of 190).

Adapted from: Allsop, D. J., Norberg, M. M., Copeland, J., Fu, S., & Budney, A. J. (2011). The cannabis withdrawal scale development: Patterns and predictors of cannabis withdrawal and distress. *Drug and Alcohol Dependence*, 119(1-2), 123-129. doi: 10.1371/journal.pone.0044864.t001

# Appendix 9: Session Rating Scale (SRS) and Outcome Rating Scale (ORS)

## Session Rating Scale (SRS V.3.0)

Name:		
Age (years):	Gender:	Date:
ID#:	Session#:	

Please rate today's session by placing a mark on the line nearest to the description that best fits your experience.

**ATTENTION CLINICIAN:** TO ENSURE SCORING ACCURACY, PRINT OUT THE MEASURE TO INSURE THE ITEM LINES ARE 10 CM IN LENGTH. ALTER THE FORM UNTIL THE LINES PRINT THE CORRECT LENGTH. THEN ERASE THIS MESSAGE.

	<b>Relationship</b>		
I did not feel heard, understood, and respected	_____		I felt heard, understood, and respected.
	<b>Goals and Topics</b>		
We did not work on or talk about what I wanted to work on and talk about.	_____		We worked on and talked about what I wanted to work on and talk
	<b>Approach or Method</b>		
The therapist's approach is not a good fit for me.	_____		The therapist's approach is a good fit for me.
	<b>Overall</b>		
There was something missing in the session today.	_____		Overall, today's session was right for me.

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## Scripting for Oral Administration of Session Rating Scale

I'm going to ask some questions about our session today, including how well you felt understood, the degree to which we focused on what you wanted to talk about, and whether our work together was a good fit. Each of these questions is based on a 0 to 10 scale, with 10 being high (or very good) and 0 being low (or very bad).

Thinking back over our conversation, how would you rate:

1. On a scale of 0–10, to what degree did you feel **heard and understood today**, 10 being completely and 0 being not at all?
  - a. If the client gives you two numbers, you should ask, “which number would you like me to put?” or, “is it closer to X or Y?”
  - b. If the client gives one number for heard and another for understood, then go with the lowest score.
2. On a scale of 0–10, to what degree did we **work on the issues that you wanted to work on** today, 10 being completely and 0 being not at all?
  - a. If the client asks for clarification, you should ask, “did we talk about what you wanted to talk about or address? How well on a scale from 0 – 10?”
  - b. If the client gives you two numbers, you should ask, “which number would you like me to put?” or, “is it closer to X or Y?”
3. On a scale of 0–10, how well did the approach, the **way I /we worked, make sense and fit for you?**
  - a. If the client gives you two numbers, you should ask, “which number would you like me to put?” or, “is it closer to X or Y?”
  - b. If the client gives one number for make sense and then offers another number for fit, then go with the lowest score.
4. So, given your answers on these specific areas, how would you rate how things were in today's session overall, with 10 meaning that the session was right for you and 0 meaning that something important that was missing from the visit?
  - a. If the client gives you two numbers, you should ask, “which number would you like me to put?” or, “is it closer to X or Y?”

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## Outcome Rating Scale (ORS)

Name:		
Age (years):	Gender:	Date:
Session#:		
Who is filling out this form? Please check one: <input type="radio"/> Self <input type="radio"/> Other:		
If other, what is your relationship to this person?		

Looking back over the last week, including today, help us understand how you have been feeling by rating how well you have been doing in the following areas of your life, where marks to the left represent low levels and marks to the right indicate high levels. *If you are filling out this form for another person, please fill out according to how you think he or she is doing.*

**ATTENTION CLINICIAN:** TO ENSURE SCORING ACCURACY, PRINT OUT THE MEASURE TO INSURE THE ITEM LINES ARE 10 CM IN LENGTH. ALTER THE FORM UNTIL THE LINES PRINT THE CORRECT LENGTH. THEN ERASE THIS MESSAGE.

**Individually**  
(Personal wellbeing)

\_\_\_\_\_

**Interpersonally**  
(Family, close relationships)

\_\_\_\_\_

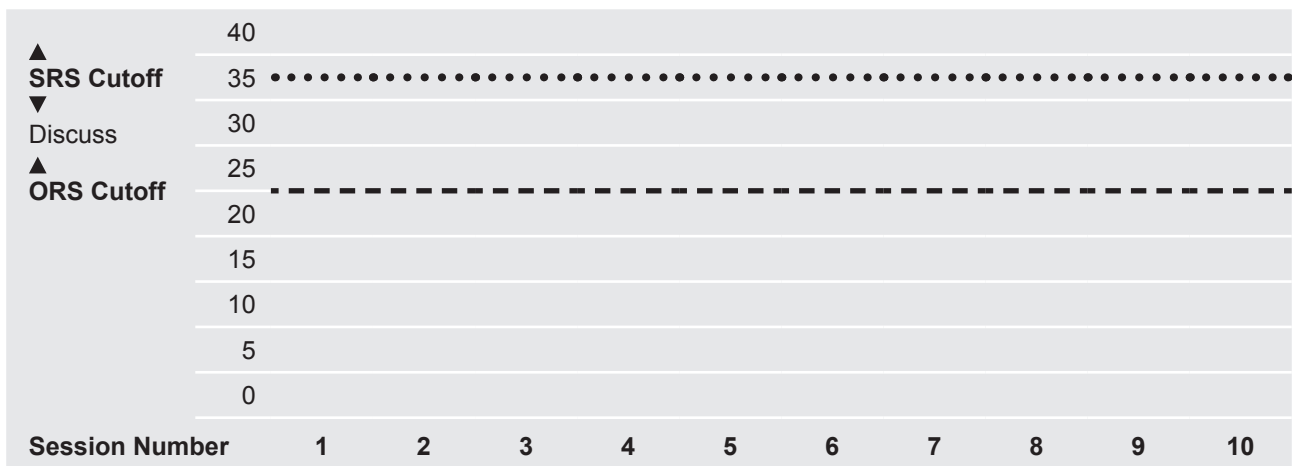
**Socially**  
(Work, school, friendships)

\_\_\_\_\_

**Overall**  
(General sense of wellbeing)

\_\_\_\_\_

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## Scripting for Oral Version of the Outcome Rating Scale

I'm going to ask some questions about four different areas of your life, including your individual, interpersonal, and social functioning. Each of these questions is based on a 0 to 10 scale, with 10 being high (or very good) and 0 being low (or very bad).

Thinking back over the last week (or since our last conversation), how would you rate:

2. How you have been doing **personally**? (On the scale from 0 to 10)
  - a. If the client asks for clarification, you should say "yourself," "you as an individual," "your personal functioning."
  - b. If the client gives you two numbers, you should ask, "which number would you like me to put?" or, "is it closer to X or Y?"
  - c. If the client gives one number for one area of personal functioning and offers another number for another area of functioning, then go with the lowest score.
3. How have things been going in your **relationships**? (On the scale from 0 to 10)
  - a. If the client asks for clarification, you should say "in your family," "in your close personal relationships."
  - b. If the client gives you two numbers, you should ask, "which number would you like me to put?" or, "is it closer to X or Y?"
  - c. If the client gives one number for one family member or relationship type and offers another number for another family member or relationship type, then go with the lowest score.
4. How have things been going for you **socially**? (on the scale from 0 to 10)
  - a. If the client asks for clarification, you should say, "your life outside the home or in your community," "work," "school," "church."
  - b. If the client gives you two numbers, you should ask, "which number would you like me to put?" or, "is it closer to X or Y?"
  - c. If the client gives one number for one aspect of his/her social functioning and then offers another number for another aspect, then go with the lowest score.
5. So, given your answers on these specific areas of your life, how would you rate how things are in your life **overall**?

The client's responses to the specific outcome questions should be used to transition into counseling. For example, the counselor could identify the lowest score given and then use that to inquire about that specific area of client functioning (e.g. if the client rated the items a 7, 7, 2, 5, the counselor could say, "From our responses, it appears that you're having some problems in your relationships. Is that right?) After that, the counseling proceeds as usual.

# Appendix 10: Mental State Examination (MSE)

Adapted from Marel et al., (2016), pp. 229-230.

## Mental State Examination (MSE) form

<b>Client name:</b>	<b>Date:</b>
Appearance. Physical appearance? (posture, grooming, signs of AOD use, nutritional status)	
Behaviour. General behaviour? Reaction to situation and clinician? (angry/hostile, uncooperative, withdrawn, inappropriate, fearful, hypervigilant)	
Speech. Rate, volume, tone, quality and quantity of speech?	
Language (form of thought). Incoherence/illogical/irrelevant thinking? Amount? Rate?	
Mood and affect. How does the client describe their emotional state (mood)? What do you observe about the person's emotional state (affect)? Are these two consistent and appropriate?	
Thought content. Delusions, suicidality, homicidality, depressed/anxious thoughts?	
Perception. Hallucinations? Depersonalisation? Derealisation?	
Cognition. Level of consciousness? Attention? Memory? Orientation? Abstract thoughts? Concentration?	
Insight and judgement. Awareness? Decision-making?	



# Mental State Examination (MSE): Guidelines for describing mental state

(Adapted from Marel et al., 2016, p.66-69)

## Appearance

Consider: posture (tense, slumped, bizarre, relaxed); grooming (dishevelled, make-up inappropriately applied, poor personal hygiene, well groomed); clothing (bizarre, inappropriate, dirty); nutritional status (significant weight loss/gain, not eating properly, heavy, thin); evidence of AOD use (intoxicated, flushed, dilated/ pinpoint pupils, track marks).

## Behaviour

How is the client behaving? Consider: motor activity (immobile, restless, pacing); abnormal movements (tremor, jerky/slow movements, abnormal walk); bizarre/odd/unpredictable actions.

How is the client reacting to the current situation and counsellor? Consider: angry/hostile/overfamiliar/inappropriate/seductive/uncooperative/withdrawn/fearful/guarded/hypervigilant.

## Speech and language

How is the client talking? Consider: rate, tone/volume, quality, anything unusual? How does client express themselves? Consider: incoherent/illogical thinking; unrelated/unconnected ideas, shifting from one topic to the next; loosening of associations; absence/retardation of, or excessive thoughts and rate of speech; thought blocking (abrupt interruption to the flow of thoughts).

## Mood and Affect

Mood: how does the client describe their emotional state? Note: a 'normal' non-depressed, non-anxious mood can be described as 'euthymic'.

Affect: what do you observe about the client's emotional state? Consider: flat; anxious; irritable; labile; inconsistent with content; excessively happy/animated. Note: refer to 'appropriate' affect when affect is consistent with mood and content of the conversation.

## Thought Content

What is the client thinking about? Consider: delusional thoughts; preoccupations; thoughts of harm to self or others; client believing that their thoughts are broadcast to others or that others are disrupting their own thoughts.

## Perception

Is the client experiencing misinterpretations of sensory stimuli? Consider: presence of hallucinations; do you observe the client responding to unheard sounds, voices, or unseen people or objects; other perceptual disturbances (feeling one is separated from the outside world, feeling one is separated from one's own physicality, heightened or dulled perception).

## Cognition

Level of consciousness? Consider: is the client alert to time and place; is the client attentive during interview; does the client's attention fluctuate; does the client present as confused; is the client's concentration impaired (can they count backwards from 100; say months of year backwards).

Orientation? Consider: does the client know who they are; where they are; why they are with you now; the day of the week, time, month, year. Memory? Consider: can the client remember why they are with you (immediate); what they had for breakfast (recent); what they were doing this time last year (remote); can they recall recent events.

## Insight and judgement

Consider: how aware is the client of what others think to be their current difficulties; is the client aware that any symptoms might appear bizarre; is the client able to make judgements about their situation?

# Appendix 11: Depression, Anxiety and Stress Scale (DASS)

<b>Name:</b>	<b>Date:</b>
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Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you <i>over the past week</i> . There are no right or wrong answers. Do not spend too much time on any statement.					
<i>The rating scale is as follows:</i>					
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					
<b>1</b>	I found myself getting upset by quite trivial things	0	1	2	3
<b>2</b>	I was aware of dryness of my mouth	0	1	2	3
<b>3</b>	I couldn't seem to experience any positive feeling at all	0	1	2	3
<b>4</b>	I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)	0	1	2	3
<b>5</b>	I just couldn't seem to get going	0	1	2	3
<b>6</b>	I tended to over-react to situations	0	1	2	3
<b>7</b>	I had a feeling of shakiness (e.g. legs going to give way)	0	1	2	3
<b>8</b>	I found it difficult to relax	0	1	2	3
<b>9</b>	I found myself in situations that made me so anxious I was most relieved when they ended	0	1	2	3
<b>10</b>	I felt that I had nothing to look forward to	0	1	2	3
<b>11</b>	I found myself getting upset rather easily	0	1	2	3
<b>12</b>	I felt that I was using a lot of nervous energy	0	1	2	3
<b>13</b>	I felt sad and depressed	0	1	2	3
<b>14</b>	I found myself getting impatient when I was delayed in any way (e.g. lifts, traffic lights, being kept waiting)	0	1	2	3
<b>15</b>	I had a feeling of faintness	0	1	2	3
<b>16</b>	I felt that I had lost interest in just about everything	0	1	2	3
<b>17</b>	I felt I wasn't worth much as a person	0	1	2	3
<b>18</b>	I felt that I was rather touchy	0	1	2	3

19	I perspired noticeably (e.g. 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
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 (e.g. 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 (e.g. in the hands)	0	1	2	3
42	I found it difficult to work up the initiative to do things	0	1	2	3

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	Scoring Template
S	
A	
D	
A	
D	
S	
A	
S	
A	
D	
S	
S	
D	
S	
A	
D	
D	
S	
A	
A	
D	

**Scoring:**

Apply template to both sides of sheet and sum scores for each scale:

D = depression, A = anxiety, S = stress.

Adapted from: Lovibond, S. H., & Lovibond, P. F. (1995). *Manual for the Depression Anxiety Stress Scales*. Sydney NSW: Psychology Foundation.

## Appendix 12: Psychosis Screener

### Psychosis Screener

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

#### Scoring:

Score each item marked with a 'yes' response as 1 and items marked with a 'no' response as 0.

Total maximum score = 7.

A score of more than 3 has been found to be indicative of a possible psychotic disorder.

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

# Appendix 13: Suicide Risk Screener

<b>Name:</b>	<b>D.O.B.:</b>	<b>Date:</b>
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<b>1</b>	In the past four weeks did you feel so sad that nothing could cheer you up? <input type="radio"/> All of the time <input type="radio"/> Most of the time <input type="radio"/> Some of the time <input type="radio"/> A little of the time <input type="radio"/> None of the time
<b>2</b>	In the past four weeks, how often did you feel no hope for the future? <input type="radio"/> All of the time <input type="radio"/> Most of the time <input type="radio"/> Some of the time <input type="radio"/> A little of the time <input type="radio"/> None of the time
<b>3</b>	In the past four weeks, how often did you feel intense shame or guilt? <input type="radio"/> All of the time <input type="radio"/> Most of the time <input type="radio"/> Some of the time <input type="radio"/> A little of the time <input type="radio"/> None of the time
<b>4</b>	In the past four weeks, how often did you feel worthless? <input type="radio"/> All of the time <input type="radio"/> Most of the time <input type="radio"/> Some of the time <input type="radio"/> A little of the time <input type="radio"/> None of the time
<b>5</b>	Have you ever tried to kill yourself? <input type="radio"/> Yes <input type="radio"/> No <b>If Yes</b> a. How many times have you tried to kill yourself? <input type="radio"/> Once <input type="radio"/> Twice <input type="radio"/> 3+ b. How long ago was your last attempt? <input type="radio"/> in the last 2 months <input type="radio"/> 2-6 months ago <input type="radio"/> 6-12 months ago <input type="radio"/> 1-2 years ago <input type="radio"/> more than 2 years ago Have things changed since? <input type="radio"/> Yes <input type="radio"/> No
<b>6</b>	Have you gone through any upsetting events recently? (tick all that apply) <input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Family breakdown <input type="radio"/> Trauma <input type="radio"/> Other (specify): <input type="radio"/> Loss of a loved one <input type="radio"/> Impending legal prosecution <input type="text"/> <input type="radio"/> Child custody issues <input type="radio"/> Chronic pain/illness <input type="text"/> <input type="radio"/> Relationship problem <input type="radio"/> Conflict relating to sexual identity <input type="text"/>
<b>7</b>	Have things been so bad lately that you have thought about killing yourself? <input type="radio"/> Yes <input type="radio"/> No <b>If Yes:</b> a. How often do you have thoughts of suicide? <input type="text"/> b. How long have you been having these thoughts? <input type="text"/> c. How intense are these thoughts when they are most severe? <input type="text"/> d. How intense have these thoughts been in the past week? <input type="text"/> <b>If No:</b> Skip to 10
<b>8</b>	Do you have a current plan for how you would attempt suicide? <input type="radio"/> Yes <input type="radio"/> No <b>If Yes:</b> a. What method would you use? (access to means? <input type="radio"/> Yes <input type="radio"/> No) <input type="text"/> b. Where would this occur? (have all necessary preparations been made? <input type="radio"/> Yes <input type="radio"/> No) <input type="text"/> c. How likely are you to act on this plan in the near future? <input type="radio"/> Very likely <input type="radio"/> Likely <input type="radio"/> Unlikely <input type="radio"/> Very unlikely



<b>9</b>	What has stopped you from acting on these suicidal thoughts? <input type="text"/> <input type="text"/>
<b>10</b>	Do you have any friends/family members you can confide in if you have a serious problem? <input type="radio"/> Yes <input type="radio"/> No a. Who is/are this/these person/people? <input type="text"/> b. How often are you in contact with this/these person/people? <input type="radio"/> Monthly <input type="radio"/> Less than once a month
<b>11</b>	What has helped you through difficult times in the past? <input type="text"/> <input type="text"/>

<b>Client presentation/statements</b> (tick all that apply)	
<input type="radio"/> Agitated	<input type="radio"/> Disoriented/confused
<input type="radio"/> Intoxicated	<input type="radio"/> Delusional/hallucinating
<input type="radio"/> Self-harm	<input type="radio"/> Other: <input type="text"/>
NOTE: If client presents as any of the above and is expressing thoughts of suicide, risk level is automatically <b>ACUTE</b>	
Worker rated risk: <input type="radio"/> Low <input type="radio"/> Escalating <input type="radio"/> Acute	

Risk	Suggested response
<b>Low:</b> <ul style="list-style-type: none"> <li>• No plans or intent</li> <li>• No prior attempts</li> <li>• Few risk factors</li> <li>• Identifiable protective factors</li> </ul>	<ul style="list-style-type: none"> <li>• Monitor and review risk frequently</li> <li>• Identify potential supports/contacts and provide contact details</li> <li>• Consult with a colleague or supervisor for guidance and support</li> <li>• Refer client to safety plan and keep safe strategies should they start to feel suicidal</li> </ul>
<b>Escalating:</b> <ul style="list-style-type: none"> <li>• Suicidal thoughts of limited frequency, intensity and duration</li> <li>• No plans or intent</li> <li>• Some risk factors present</li> <li>• Some 'protective' factors</li> </ul>	<ul style="list-style-type: none"> <li>• Request permission to organise a specialist mental health service assessment as soon as possible</li> <li>• Refer client to safety plan and keep safe strategies as above</li> <li>• Consult with a colleague or supervisor for guidance and support</li> <li>• Remove means where possible</li> <li>• Review daily</li> </ul>
<b>Acute*:</b> <ul style="list-style-type: none"> <li>• Frequent, intense, enduring suicidal thoughts</li> <li>• Clear intent, specific/well-thought-out plans</li> <li>• Prior attempt/s</li> <li>• Many risk factors</li> <li>• Few/no protective factors</li> </ul> <b>*or highly changeable</b>	<ul style="list-style-type: none"> <li>• If the client has an immediate intention to act, ensure that they are not left alone</li> <li>• Remove means where possible</li> <li>• Call an ambulance/police if the client will not accept a specialist assessment, or the crisis team is not available</li> <li>• Consult with a colleague or supervisor for guidance and support</li> </ul>

Adapted from: The National Drug and Alcohol Research Centre's Suicide Assessment Kit. For more information and a guide to using this document please click on this link: <https://ndarc.med.unsw.edu.au/suicide-assessment-kit>.



## Appendix 15: Goal-setting worksheet

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 obstacles 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...

Don't forget to make your goals SMART:

- **Specific** – clear, not vague
- **Measurable** – can be measured in quantity or time
- **Achievable** – able to be attained
- **Realistic** – can be attained along with other commitments
- **Time-limited** – achievable within a specific time frame

## Appendix 16: Relapse prevention worksheet

### 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 no.*

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 you say to yourself that make you want to use alcohol or other drugs.

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.



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## Appendix 17: Controlled breathing

Shallow, rapid breathing goes hand in hand with feelings of anxiety, stress and panic.

First, learn to recognise the difference between shallow breathing and controlled 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 controlled breathing. Follow the instructions below.

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

1. Place one hand on your abdomen right beneath your rib cage.
2. Inhale slowly, taking the air deeply into your lungs. If you are breathing from your abdomen you should feel your hand rise. You don't need to take a big breath, just a deep one.
3. 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.
4. Do 10 slow abdominal breaths. Breathe in slowly counting to four, before exhaling to the count of four.  
Repeat this cycle 10 times.
5. Now re-rate your level of anxiety and see if it has changed.

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 use.



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## Appendix 18: Progressive muscle relaxation

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.

1. Take 3 deep abdominal breaths, exhaling slowly each time, imagining the tension draining out of your body.
2. Clench your fists. Hold for 10 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 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.

Adapted from: Bourne, E.J. (1995). *The anxiety and phobia workbook*. California, New Harbinger Publications. pp. 75-76

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## Appendix 19: Creating an imaginary safe place

This involves remembering or imagining a 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 your skin?*

*What does the atmosphere smell like?*

*What can you see around you?*

*What can you hear?*

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## Appendix 20: Grounding

Grounding involves detaching yourself from emotional pain by focusing 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 everyday 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 names.
- Jump up and down.
- Change your posture to a more upright one.
- Stretch.
- As you breathe say "in" and "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 animals.
- 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

- Practise 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.

Adapted from Najavits, L. (2002). Detaching from emotional pain (grounding). In L. Najavits (Ed.), *Seeking safety: a treatment manual for PTSD and substance abuse* (pp. 125-136). New York: Guildford Press.

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## Appendix 21: Mindfulness of breath

Being able to focus on physical sensations associated with breath will take time. Try to practise mindful breathing for several minutes each day and gradually build the time up to about 15 minutes, even if the 15 minutes is made up of several shorter mindful breathing episodes. Doing this can help many people to reduce their basic stress levels.

Read the following instructions and then try the exercise for a couple of minutes to start with. When you do this exercise, either close your eyes or focus your eyes softly on the floor or your lap.

- For a few minutes, bring your attention to your breathing. Notice the air as it comes in through your nostrils... down to the bottom of your lungs...and flows back out ... Follow your awareness of the sensations that you feel as the air goes in.... and out ... Notice how it is slightly cooler as it goes in and slightly warmer as it goes out ... You may also notice the rise and fall of your chest or the expanding of your abdomen. Focus on the changing pattern of physical sensations that you find most vivid.
- You might notice that thoughts arise and your mind wanders away from the focus on the physical sensations of breathing. Whatever the thoughts going through your mind, whether they are pleasant or unpleasant, just gently acknowledge their presence and return your attention to your breathing.... Don't get caught up in your thoughts or judge them as good or bad, just allow them to come and go. You might even like to imagine putting the thoughts on a leaf and letting them float down a stream.
- Time and time again you may notice that your attention has wandered and that you have become caught up in a train of thoughts. This is normal; it is just what our mind does. The important thing is to try not to judge your thoughts or yourself. Just gently notice where your mind has been and bring your focus back to your breath going in... and out... of your nostrils..., or the rise... and fall... of your chest .... If you find yourself thinking that the exercise is boring or you can't do it, just gently acknowledge these thoughts, without judging them, and return your attention to the breath.... Simply acknowledge the thoughts that enter your mind, let them be, and refocus on your breath ...

54 If you are likely to become overwhelmed by your emotions, which is often the case when you are feeling trauma-related emotions, use grounding strategies instead of focusing on your emotions.

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## Appendix 22: Mindfulness of emotions<sup>55</sup>

It takes time to be able to be mindful of your emotions. The advantage of doing so is that you gradually become able to tolerate stronger and stronger emotions without becoming overwhelmed. Take opportunities as they arise to practise being mindful of emotions that are mild to moderate in intensity, not with emotions that are very distressing or overwhelming, or likely to become overwhelming. For these very intense emotions you should use grounding.

The key to being mindful of emotions is to be non-judgemental as you observe, describe, and allow yourself to experience an emotion.

- Observe the emotion that you are feeling. Be attentive to it; don't try to push it away or cling to it. Just stay in the moment and notice the emotion come and go. Stand back from the emotion and acknowledge it but don't judge it. Put words on your emotion. Say to yourself, "I notice that I feel sadness" or "I notice that I'm agitated."
- Stay in the moment and learn as much about the emotion as you can. Notice the emotion come and go and change in intensity. Notice the sensations associated with the emotion. You might notice physical sensations; some may be uncomfortable. Look for the strongest sensation, perhaps the one that bothers you the most. For example, it may be a lump in your throat, flushed face, nausea, heaviness in the chest, butterflies or a knot in the stomach, or a hot wave. Notice any actions associated with the emotion, such as withdrawing, crying, or laughing. Perhaps you can also notice urges to perform an action, such as to hit, run or hug. Notice the sound quality or temperature associated with the emotion as well as any images, thoughts, and smells.
- Just allow the emotion to be as it is. Don't make it more or less than it is, don't judge it. Just acknowledge its presence and gently accept it. Be aware that you are not your emotion. The part of you that observes the emotion is separate from the emotion. Think of times when you have felt different emotions from this one. Don't automatically act on your emotion – decide whether to act or not. Take as long as you need to gently accept your emotion.

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## Appendix 23: Mindfulness of thoughts: cognitive defusion

Cognitive defusion describes the use of various strategies to gain distance from thoughts. The idea of cognitive defusion is 'look at' rather than 'look from' thoughts, and to adopt the viewpoint that "a thought is just a thought." That is, to be mindful of thoughts without, 'buying into' them and becoming caught up in and upset by them.

Some ways to do this are:

- say to yourself: *"I'm having the thought that..."*
- say to yourself: *"Thank you mind"*
- say to yourself: *"There goes that thought that ... again"*
- hearing thoughts in cartoon voices
- naming the story: e.g. *"That's the 'I'm a loser' story"*
- hearing thoughts sung to *"Happy Birthday"* or other tunes
- using imagery to pop thoughts onto leaves floating down a stream, or onto clouds and letting them float away
- say to yourself *"There goes my (self-critical, worry etc.) spot again."*

Adapted from: Harris, R. (2007). *The happiness trap*. Auckland, New Zealand: Exisle Publishing Ltd. Chapter 4, pp. 49-58.



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## Appendix 24: Common unhelpful thinking styles

Some common unhelpful thinking styles are listed below. There are some overlaps between thinking styles.

### **Mental filter**

Interpreting events based on what has happened in the past.

*I can't trust men, they only let you down.*

### **'All or none' or 'black and white' thinking**

*If I fail one test it means I am a total failure.*

### **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.*

### **Jumping to conclusions**

Consistently jumping to incorrect negative conclusions, including mind reading and predictive thinking.

Mind reading assumes a conclusion based on the idea we know what people are thinking.

Predictive thinking occurs when negative conclusions are drawn about what will happen in the future.

*I know that exam is going to be awful and I'll probably fail.*

### **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.*

### **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.*

### **Should, must and ought**

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.*

### **Labelling**

Global statements about ourselves or others which are based on behaviour in a specific situation.

*I tried to give up drugs once before and relapsed. I will never be able to give up.*

### **Emotional reasoning**

When views of a situation, oneself or others are based on the way a person is feeling at the time.

This confuses feelings for facts.

*I feel like a failure, so therefore I am a failure.*

### **Magnification and minimisation (disqualifying the positive)**

Minimisation is when positive things happen; people discount them and insist that they don't count.

At the same time, positive attributes of others are magnified.

*I avoided using drugs because I didn't run into any of my using mates.*

## Appendix 25: Cognitive restructuring using the ABCDE model worksheet

	A	B	C	Challenge negative thoughts		
	Activating event/trigger	Beliefs/ thoughts	Consequences: feelings/ behaviours			
Date	What happened?	What were you thinking?	What were you feeling? What did you do?	What is the evidence for and against your thoughts?	Is there any other way of looking at this situation?	What do you think now?

Adapted from: Marel, C., Mills, K. L., Kingston, R., Gournay, K., Deady, M., Kay-Lambkin, F., ... Teesson, M. (2016). *Guidelines on the management of co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings*. Sydney, Australia: Centre of Research Excellence in Mental Health and Substance Use. Retrieved from <https://comorbidityguidelines.org.au/>

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## Appendix 26: Bill of Assertive Rights

Adapted from: Jarvis, T. J., Tebbutt, J., Mattick, R. P., & Shand, F. (2005). *Treatment approaches for alcohol and drug dependence* (2nd ed.). Chichester, United Kingdom: Wiley.

### **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 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.







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