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The Drug and Alcohol Office is pleased to publish the third edition of the Western Australian evidence-based practice materials, following their original publication in 2000 and their revision in 2007.

These materials are evidence-based consistent with Evidence-Based Medicine (EBM), in which best existing research evidence is integrated with clinical wisdom and expertise, as well as client circumstances and expectations (Gambrill, 1999). A cognitive behavioural approach in the counselling strategies described has been adopted because it has a good evidence base. However, other approaches to counselling may be just as effective but are less researched. The strategies described in this guide can also be integrated into other counselling approaches. These guidelines should be used in addition to agency policies and procedures.

The first edition published in 2000 was based on materials 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, 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). This 3rd edition also benefited from advice and editing by Sue Helfgott (Drug and Alcohol Office) and the addition of a chapter on AOD use and pregnancy by Judi Stone (Drug and Alcohol Office) and a chapter on prevention by Sara Rouwenhorst (Drug and Alcohol Office).

In previous editions, there were three documents: a literature review, a summary of evidence-based indicators for AOD interventions, and a counsellor guide. In this edition, these three documents have been combined into one counsellor guide: the Counselling guidelines: Alcohol and other drug issues, which explores some of the key skills needed to work at an individual level with people who have AOD problems. The guide assumes the reader has a basic understanding of the development of AOD problems and already possesses basic counselling skills.

Managers, supervisors and counsellors are encouraged to use this guide as a reference, an educational tool and as an aid to quality management and professional supervision.

2013

1. Addiction is complex and affects brain function and behaviour. These changes can persist long after drug use ceases, which might account for the long-lasting risk of relapse. Addiction is treatable.
2. No single treatment is appropriate for everyone.
3. 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. Treatment early in a using career is associated with more positive outcomes.
4. Effective treatment attends to the multiple needs of the individual, not just his or her drug use problems. Effective treatment addresses medical, psychological, vocational and legal problems in addition to the AOD use.
5. Remaining in treatment for an adequate period of time is critical. Although the optimal length of time in treatment varies from person to person, research suggests that people need at least 3 months in treatment to make significant changes to their AOD use, and that treatment of longer duration is more successful. Because 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.
6. 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.
7. 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.
8. An individual’s treatment plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs.
9. Many individuals with AOD problems also have other 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.
10. Medically assisted withdrawal is only 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. Strategies to enhance motivation for change and motivation to continue with treatment after withdrawal, when begun at initial intake, can improve treatment engagement.
11. 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.
12. Drug use during treatment must be monitored continuously, as lapses during treatment do occur. Monitoring can assist clients in their efforts to change and can also provide an early indication of a return to drug use, signalling a possible need to adjust the treatment plan.
13. Treatment programs should assess patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis and other infectious diseases as well as provide targeted risk-reduction counselling to help clients modify or change behaviours that place them at risk of contracting or spreading infectious diseases.
A well known model in the AOD area is Prochaska and DiClemente’s (1992) transtheoretical model of behaviour change, commonly referred to as the ‘Stages of change model’. The model was originally developed through an examination of the process of self change in smokers and suggests that individuals attempting to change behaviour move through a number of stages of change: precontemplation, contemplation, preparation, action and maintenance.

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

![Figure 1: Stages of Change (Prochaska, DiClemente and colleagues)](image)

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

### 2.1 Precontemplation

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

For clients in this stage it is best to provide harm reduction information and where possible negotiate less risky methods of using.

### 2.2 Contemplation

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

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

### 2.3 Preparation
2. Stages of change

During this stage of change the client has made a decision to change and is planning how to put it into effect. Counsellors can help the client to confirm their decision to change (motivational interviewing) as well as initiating goal-setting, planning, and problem-solving. The client will need to consider some of the actions they will take to change their behaviour as well as recognising those things that will tempt them to relapse.

2.4 Action

Clients in the action stage are in the process of changing their behaviour. They are generally putting a lot of energy into abstinence and/or reduced drug use and developing new interests and activities to replace AOD-related activities. Early on in this stage people may be going through withdrawal symptoms, and even after withdrawals are over they often get bored and disillusioned before they have new and interesting things in place to replace their previous lifestyle. They usually have to deal with cravings to use. Clients in the action stage can feel very isolated and anxious and can find it very difficult to relate to the ‘non-using’ world.

Counsellors can assist with motivational interviewing to reinforce reasons for change, relapse prevention and management skills, act as cheerleaders by reinforcing the positive changes clients have made and continue to help clients to find alternative rewards. Clients should also be encouraged to think about longer-term goals and general life style issues such as study, work and leisure activities.

2.5 Maintenance

During the maintenance stage, clients are focused on maintaining the positive changes they have made to their lifestyle. For the changes to remain worthwhile, they need to experience post change rewards. Counsellors can continue to reinforce the positive changes that have been made and encourage clients to begin working towards their longer-term lifestyle goals.

It should be noted that clients are likely to relapse from any stage of change to a previous one. For example, a client may move from the action stage back to the preparation stage (see Chapter 15 Relapse prevention and management).

---

Stages of change – tip sheet

The stages of change model suggests that individuals attempting to change behaviour move through a number of stages, though not necessarily in an orderly fashion.

1. Precontemplation – not interested in changing AOD use. Provide harm reduction information and where possible negotiate less risky methods of using.
2. Contemplation – feel two ways about their use. Starting to think about changing their behaviour. Motivational interviewing is useful for clients in this stage.
3. Preparation – a decision to change has been made. The client is now thinking about putting it into effect. Motivational interviewing, goal-setting, planning, identifying triggers for relapse and problem-solving 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. Motivational interviewing is useful in this stage.
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.

Clients may relapse from any stage of change to previous one. See Chapter 15 Relapse prevention and management.
In this chapter we provide a brief overview of a number of issues that are 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 comorbidity
- terminating treatment sensitively
- professional development and supervision.

### 3.1 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; Meier et al., 2005):

- The strength of the therapeutic alliance is consistently predictive of positive outcomes, including engagement and retention of clients in the treatment process.
- The link between alliance and outcome is independent of 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 without this, the therapeutic endeavour is doomed to failure. A sound therapeutic relationship provides an avenue to communicate respect, understanding, warmth, acceptance, commitment to change and a corrective emotional experience (Teyber, 2006). By ‘corrective emotional experience’ we mean that the counsellor responds to the client in empathic and helpful ways that are different from previous hurtful experiences they have had with others, particularly in their family of origin. A sound therapeutic relationship is collaborative, with both counsellor and client working as partners to help the client achieve his or her goals.

A number of counsellor qualities impact on the therapeutic alliance. Therapist qualities and techniques found to make a positive contribution to the therapeutic alliance, taken from Ackerman and Hilsenroth (2003, p.28) are listed below.

#### Personal attributes:
- flexible
- experienced
- honest
- respectful
- trustworthy
- confident
- interested
- alert
- friendly
- warm
- open.

#### Techniques:
- exploration
- depth
- reflection
- supportive
- notes past therapy success
- accurate interpretation
- facilitates expression of affect
- active
- affirming
- understanding
- attends to client’s experience.

Other tips for increasing the therapeutic alliance, adapted from Macneil et al. (2009) include the following:

- Tailor interventions to the client’s readiness for change.
- Ask about previous treatment experiences, positive and negative, as this can help guide your counselling.
- See the whole person: explore their strengths as well as their difficulties.
- Understand how the client sees their issues and experiences, as this will form the basis for goals the client will be able to feel comfortable with.
3. Ingredients of effective treatment

- Avoid labels where possible and 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 – they can be valuable learning experiences for clients.
- Put in the effort to manage the ongoing therapeutic relationship.

The ability to help the client anticipate potential problems and assist them to develop ways of dealing with them before they arise is also associated with better alliance and better outcomes (McLellan et al., 1998).

A number of client factors also influence the therapeutic alliance and therapeutic outcomes. These include the degree to which clients are open about their issues and personal information (Macneil et al., 2009).

3.2 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 problems and gaining an understanding of how these problems fit within the context of their history and current circumstances (See Chapter 4 Assessment).
- Case formulation involves integrating the information gathered from an assessment into a proposed explanation, using a theoretical framework, of how the client’s presenting problems 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 will need to be addressed in a treatment plan to help the client resolve their presenting problems (see Chapter 6 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 would include strategies to address AOD issues such as counselling or perhaps referral for withdrawal or long-term rehabilitation, and also strategies to address issues in other areas of a person’s life such as psychological, social, health, legal, accommodation and financial problems (see Chapter 10 Treatment planning).

3.3 Effective case management

Case management involves the coordination of resources and services to help clients address the range of issues that they present with, so as to assist them to overcome their AOD problems. Case management prolongs treatment retention and increases client 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: to link 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 11 Case management).

3.4 Specific interventions

Counselling works: this is supported by evidence in the general psychotherapy and the addiction literature. However, there is no evidence that any particular theoretical approaches to counselling are better than others (e.g. Andrews, 2001). Some theoretical approaches, such as cognitive behaviour therapy and interpersonal therapy, however, have been more researched and therefore have a better evidence base.
3. Ingredients of effective treatment

All theoretical orientations to counselling advocate the use of certain techniques, and these techniques play a limited, but important, role in successful intervention. Counselling techniques strengthen the client’s expectations of change by heightening the credibility of counselling, provide a rationale and strategies for change, and diminish the client’s sense of hopelessness and despair.

There is also some limited evidence that particular types of treatments suit some clients with some problems better than others (see Chapter 10 Treatment Planning). In considering what approach to adopt with a client, counsellors should operate from an ‘evidence-based’ approach. An evidence-based approach assumes that the treatment approach adopted with a particular client should be guided by an integration of:

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

Most clients will need basic AOD interventions such as motivational interviewing and relapse prevention and others will also need withdrawal management, pharmacotherapies, or admission to a therapeutic community. Clients with co-occurring psychological and AOD issues need to have both addressed in their treatment plans for optimal AOD intervention outcome (Mills et al., 2009). Interventions that target beliefs and thoughts that cause people difficulties are important, and can be based in cognitive behaviour therapy, schema therapy, interpersonal therapy, narrative therapy and other approaches. There is also recent interest in incorporating mindfulness-based interventions into AOD counselling as preliminary research results are promising (Zgierska et al., 2009). All clients need a focus on internal and external resources as well as problems, and many will need linking to other services while they are engaged in counselling.

Other interventions might include assistance with problem-solving, conflict resolution, assertion, anger management, grief processing, parenting skills, employment or accommodation. Other clients, particularly young people, may benefit from the inclusion of key significant others in treatment. Evidence to support particular interventions for particular clients is outlined throughout this treatment guide.

3.5 Addressing comorbidity

Many AOD clients present with diagnosable mental health disorders that 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 interfere with client functioning and AOD treatment progress and outcome (Mills et al., 2009). 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 for example Chapters 21, 35, 36, 37 on Mindfulness, Co-occurring depression, Co-occurring anxiety and Co-occurring trauma issues).

3.6 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 and differences to past experiences. Essentially, the key principles of ending 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.
3. Ingredients of effective treatment

In situations when a client is nearing completion of a counselling program it can also 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 also important to review and highlight improvements made by clients, how they’ve achieved these changes and therefore what they can use to maintain them or to deal with lapses, and their strengths. Clients should also be encouraged to recontact the agency (or clinician if appropriate) in future if necessary, if agency policy allows for this.

3.7 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 51 Clinical supervision).

<table>
<thead>
<tr>
<th>Ingredients of effective treatment – tip sheet</th>
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<td>Effective AOD counselling requires:</td>
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<td>• a strong therapeutic alliance</td>
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<td>• assessment, case conceptualisation and treatment planning</td>
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Assessment

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 16 and 17 Harm reduction and Brief intervention).

A good assessment paints a thorough and detailed picture of the client’s AOD problems and how they fit in the context of his or her life. In formulating how and why a client has developed problematic AOD use, it is useful to consider Zinberg’s (1984) ‘Interaction model’. This model suggests that there are three factors that influence whether AOD use becomes problematic: 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 conceptualisation, which provides the foundation for an individually tailored treatment plan and effective AOD counselling.

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, which have preferably been 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.

4.1 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 drug use, which in turn may facilitate the desire for change
- helping the client to link their current problems with their drug 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 initial idea of the client’s treatment needs. The next session or two tend to be primarily devoted to coming to understand the client’s current difficulties in the context of their experiences throughout their life, presenting this understanding, or ‘case conceptualisation’ to the client, seeking their feedback and modifying your understanding as necessary and, as a result, developing with the client a plan to meet their treatment needs.

The assessment interview should take the form of a semi-structured narrative and evaluate a number of different areas including:

- 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)
- alcohol and other drug use including:
  - current pattern(s) of use, AOD use history and periods of abstinence
  - the impacts of AOD use, including impacts on health (including 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

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1 For a very thorough explanation of assessment, including many useful examples of how to ask particular questions, see the ‘Alcohol and other drugs assessment clinician’s booklet’ (2013) produced by the Drug and Alcohol Office of WA.
4. Assessment

- 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 Mills et al. (2009, p.152–153):

- Appearance. Physical appearance? (posture, grooming, signs of AOD use, nutritional status)
- 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?
- Insight and judgement. Awareness? Decision-making?

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

A mental state examination (MSE) form and guidance for describing mental state are included in Appendix 2. 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 from the internet.

Note that it is not uncommon 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 39 Cognitive impairment). These impairments are not always obvious upon presentation and may require a formal assessment through referral to a neuropsychologist. The majority of 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 Korsakoff’s syndrome, which consists of severe memory and learning impairments, inability to plan activities and comprehend abstract information.
4. Assessment

Illicit drug use can also be associated with cognitive impairments with evidence of deficits in memory and executive functioning for people who have used large amounts of amphetamines, ecstasy, cannabis, cocaine and opioids (Cooper, 2011). For example, long-term methamphetamine use may result in deficits in memory, executive functions, processing speed, as well as motor, verbal and visuospatial skills (Scott et al., 2007). In addition to the direct effects of drug use, many people involved in the drug using lifestyle are exposed to violence and/or accidents resulting from intoxication, which can also result in head injuries and cognitive impairments.

As part of assessing mental state, counsellors should make observations regarding any indications of poor cognitive functioning, such as difficulty concentrating and comments from clients about poor memory or difficulties organising their lives. If cognitive impairment is suspected, a referral to a neuropsychologist is recommended, if possible. Although these problems may be related to the effects of the drug using lifestyle, such as a lack of sleep, they can reflect cognitive impairment, in which case treatment strategies may need to be adapted. For more information, see Chapter 39 Cognitive impairment chapter.

Presenting issues

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

Alcohol and other drug use

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

- Liver (health)
- Lover (relationships)
- Legal (the law)
- Livelihood (e.g. finances, housing, work).

It is also necessary to highlight that harmful AOD use is not exclusive to dependence. Thorley (1982) provides a broader perspective of what constitutes harmful AOD use by identifying that a range of problems are associated with intoxication, regular use and dependence, and there may be overlap between these AOD-related problems. Commonly referred to as ‘Thorley’s balls’, the model is shown in Figure 2.

![Figure 2: ‘Thorley’s balls’ model of drug-related harms (adapted from Thorley, 1982)]
4. Assessment

There are numerous harms associated with intoxication including: 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.

Problems associated with regular use include numerous health problems, 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 use include strained relationships, criminal activities and financial problems.

Dependence occurs when a person becomes physically dependent on the drug to function. In particular, neuroadaptation occurs: cells of the body adapt to repeated exposure to the drug and eventually require the drug in order to function. There are widespread harms associated with dependence, including the physical and psychological experience of tolerance and withdrawal.

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

It is also 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 start to develop a picture of what needs to be included and avoided in the counselling process and whether referral to or liaison with other agencies is needed.

Readiness to change
Readiness to change can be assessed by exploring the perceived pros and cons of continuing or changing their drug use. This is best done using a motivational interview, 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 7 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, the provision of harm reduction information is a more appropriate treatment strategy for a client in the precontemplation stage whereas goal-setting, problem-solving and relapse prevention are more appropriate for clients in the action stage.

Mental health issues and treatment history
Clients should be asked about current and past mental health problems, diagnoses and treatment, and the context for mental health problems (e.g. stress, AOD use). They should also be asked what worked well and what was ineffective in previous mental health treatment.

Physical health and medical history
Clients should be asked briefly about physical health issues and medical history, particularly as they are 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 children in client’s care. See Chapter 5 Suicide assessment and management, as well as the format for suicide risk assessment included in Appendix 1.
4. Assessment

For clients engaging in sex with casual partners or involved in sex work, sexual practices should be evaluated for risk in terms of blood-borne virus 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, drug use will have been central to them being able to manage very distressing emotions and memories, often stemming from adverse childhood experiences. For such clients, talking with the counsellor about how important drug use has been to them can help them to develop compassion and understanding for themselves. Exploring these areas can also help the client make links between the impact of drug use and their current life situation.

The following areas should be enquired into:

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

See section 4.1.1 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 issues such as 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 behaviour technique (Beck, 1995). When a client voices a negative belief about something, such as ‘I can’t stop using drugs’, the counsellor can ask: ‘What does that mean about you?’

This will help to identify core beliefs, such as defectiveness:
‘It means there’s something wrong with me, I’m hopeless.’

Or failure:
‘It means I’m a complete failure.’

Or entitlement:
‘I shouldn’t have to stop using drugs, what business is it of my partner anyway?’

Young’s Schema questionnaire\(^2\) can also be used to guide the assessment of client’s core beliefs or ‘schemas’ about themselves, others and the world.

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\(^2\) Young’s Schema questionnaire (Jeffrey Young) is available from http://www.schematherapy.com
4. Assessment

Strengths and weaknesses
Identify current strengths and weaknesses. These usually emerge from collecting information about the client’s life throughout the assessment interview, though some direct enquiry can also be included when appropriate. Current strengths can be used during the course of therapy to help the client achieve their goals.

4.1.1 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. In order to raise these issues sensitively, the following should be considered:

- 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
- 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 problems
- 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 brief interventions should use clinical judgement in relation to raising sensitive issues. It may not be appropriate for the counsellor to work with clients on some sensitive issues and referral to a more appropriate agency or counsellor with the necessary knowledge and experience may be required.

4.1.2 A note on trauma
Many AOD clients have had traumatic experiences, often childhood physical and/or sexual abuse (Plant et al., 2004; Watson, 2006). Although it is important to know whether a client has had these experiences, it is even more important to avoid further traumatising a client. Counsellors should establish a safe environment and a strong therapeutic relationship prior to 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 childhood sexual abuse by explaining that you only need a broad overview of the client’s history. Cloitre et al. (2006) suggest 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 37 Co-occurring trauma issues).

Some clients will volunteer information about traumatic experiences in the first session. If a client starts going into enormous detail, it may be necessary to ‘protectively interrupt’, i.e. 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 all right 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 as it is easy for them to be overwhelmed when thinking or talking about traumatic experiences.

Other clients will not volunteer information on traumatic experiences at all and counsellors will need to seek permission from the client to enquire about trauma, then ask broad questions, but make it clear that great details are unnecessary and that the client can stop the process whenever they wish.
4. Assessment

For example:

‘It’s important that I know whether you’ve had traumatic experiences as it helps place your drug use into a broader context, but I don’t need details. However I don’t want to ask any questions right now that will be too distressing for you – it’s important that you only give me this information when you feel ready. How would you feel about me asking you a few 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 Chapter 20 Grounding).

4.2 Standardised assessment

AOD agencies all have standard procedures that are used 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.

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

Standardised assessment tools aim to achieve the following:

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

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 may have access to the results. Discuss how long the assessment is expected to take before asking whether the client is willing to complete the assessment. It is important that informed consent is given willingly and that clients do not feel under any obligation to complete assessment instruments.

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

Key areas for standardised assessment

Screening instruments are suggested for the following areas:

- AOD problems
- co-occurring mental health issues
- general well-being
- client satisfaction with treatment.

Assessment instruments should be selected depending on the client’s presenting AOD issues and related problems. For a detailed review of standardised assessment tools that may be relevant to DAO 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 on the internet.
4. Assessment

**AOD problems.** Measures that assess AOD use problems and are freely available on the internet include the Alcohol Use Disorders Identification Test (AUDIT) (Saunders et al., 1993) and the Drug Abuse Screening Test (DAST) (Skinner, 1982). Measures of withdrawal from heroin, alcohol, benzodiazepines, amphetamines and cannabis are included in Appendices 3–7. The measurement of withdrawal syndromes where 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 Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) scale (Metcalfe et al., 1995) and the Objective Opiate Withdrawal Scale (OOWS) (Handelsman et al., 1987). However, withdrawal scales for those syndromes where symptoms are subjective and no objective signs have been identified (such as scales for benzodiazepine, amphetamine and cannabis withdrawal) may be less useful. Given the subjective nature of withdrawal symptoms for benzodiazepine, amphetamine and cannabis withdrawal, scales can only be used as a general guide to treatment.

**Co-occurring mental health issues.** Screening instruments can alert the clinician to possible psychological difficulties such as depression, anxiety, psychosis, dissociation or posttraumatic stress disorder (PTSD). An instrument with demonstrated reliability and validity, the Depression Anxiety Stress Scale (DASS) (Lovibond & Lovibond, 1995) has been included in Appendix 8. The Psychosis Screener (Degenhardt et al., 2005), which was developed to screen for psychosis in the general population, rather than just in the presence of psychosis, is in Appendix 9. This instrument may be useful to assess for the presence of psychotic symptomatology in users of drugs such as amphetamines. If indicated, the PTSD Checklist (PCL) (Weathers et al., 1991) can be used to assess for symptoms of PTSD.

**General well-being.** A short 4-item scale – The Outcome Rating Scale (ORS) – has been developed by Miller and Duncan (2000) to assess outcome and progress in terms of ‘well-being’ from session to session. It assesses several areas: personal sense of well-being; interpersonal well-being in terms of family and other close relationships; social well-being in terms of work, school and social networks; and overall sense of well-being. The scale is available from Scott Miller’s website: http://scottdmiller.com.

**Treatment satisfaction.** Treatment services often have their own preferred treatment satisfaction scales. Another option is a short (4-item) and easy to use scale – the ‘Session Rating Scale (SRS) – that has been produced by Miller and Duncan (2000) to measure 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 available from Scott Miller’s website: http://scottdmiller.com.

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.

Assessment of the safety of children should also be made when working with parents with substance use problems (see Chapter 44 Child protection issues). If a level of suspicion exists as a result of the assessment interview, structured assessment instruments can be used to explore child safety in more detail. An instrument to assist with assessing parenting and child safety in the context of parental drug use, including violence and exposure to potential risk, is the Risk Assessment Checklist for Parental Drug Use.³ This instrument is freely available on the internet and does not require training, however it has not been evaluated for reliability and validity.

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 et al., 2000). Situations in which self-reported behaviour could be misleading include those in which clients may receive negative sanctions for accurate reporting, such as when they are involved in the criminal justice system, feel shame and embarrassment, or fear disappointing the counsellor. There are various ways to increase the accuracy of the data in these situations.

4. Assessment

For example for clients involved in the criminal justice system, urine tests can provide information that clients may not be prepared to divulge. In situations when clients fear telling the counsellor, normalising the issues being asked about (e.g. relapse) can help.

Contrary to the concerns of some practitioners regarding the impact of administering standardised assessment measures, the literature and anecdotal evidence indicates that when conducted appropriately the process of standardised assessment can be a source of rapport building (Marsh & Dale, 2006). It is acknowledged, however, that it can be difficult for counsellors to administer numerous assessment instruments in addition to the general intake questions and interview. 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 drug use, crime, depression etc. These ratings can be compared from start to finish of treatment to gain an idea of change, or they can be rated, for example from 1 (much worse) to 5 (much better).

Interpretation of assessment results

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

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

Outcome measures

By administering the same standardised assessment tools used during a formal assessment 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 a number of key areas.

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

4.3 Documenting the assessment

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

Recording in the client’s file

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

Reports for third parties

Assessment reports are often requested by third parties 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. When writing an assessment report for an external party the following should be considered:

- include only relevant and important information
- be concise – no one will read an overly long report
- write in a clear, simple and objective writing style
4. Assessment

- avoid value statements
- do not use any ambiguous terms
- avoid jargon
- eliminate any biased terms or wording from the report
- always cite the source of the information. For example
  ‘Betty reported that …’; ‘The court assessment service revealed that …’
- consider all sources of information in your 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 prior to 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.)

4.4 Treatment matching

The main purpose of assessment (as well as building rapport) is to formulate the client’s problems (see Chapter 6 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 problem severity

Clients who present with high levels of AOD dependence and other problems may be more likely to benefit from intensive, highly structured treatment programs, residential treatment and more frequent outpatient sessions and linking with other relevant services (Chen et al., 2006; Timko & Sempel, 2004). Clients enmeshed in the AOD-using lifestyle and associating primarily with other AOD users will require more intensive treatment. Conversely, those with a social network supportive of abstinence or moderate AOD use will require less intensive treatment.

For alcohol dependent clients, controlled drinking goals are more appropriate for clients with a lower severity of dependence and who believe that controlled drinking is possible (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.

Cognitive factors

Cognitive deficits often result from AOD use and can hold significant implications for the process and outcome of treatment. Clients with some degree of cognitive damage may be more likely to benefit from highly structured residential treatment. When working with clients who have cognitive damage, interventions should be tailored accordingly. For clients with moderate to severe cognitive deficits, treatment should include a strong life skills component addressing issues of finance, accommodation, domestic duties and involvement in a non-AOD using community. See Chapter 39 Cognitive impairment for more information on tailoring interventions.

Co-occurring problems

Co-occurring problems 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 problems and parenting difficulties.
4. Assessment

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 (Subutex®, Suboxone®, which have opioid effects, are effective treatment options for long-term users with severe opioid dependence who are not motivated to be completely drug free. Naltrexone treatment is likely to be successful for those clients who are highly motivated for abstinence and who have a social network supportive of abstinence. See Chapter 30 Pharmacotherapies for AOD dependence.

Prochaska and DiClemente's (1992) transtheoretical model of behaviour change is also relevant to matching specific counselling strategies in terms of client motivation. Tailoring clinical interventions to stages of change has been found to significantly enhance outcome (Prochaska & Norcross, 2001). See Chapter 2 Stages of change in this guide for recommended interventions for clients at each stage.

Other client characteristics
Other client characteristics that should be considered include age, gender, financial, physical and emotional security, cultural issues, degree of coercion for treatment and the nature and severity of mental health issues. See Chapters 40, 43, 45, 46, 48 and 49 of this guide, such as Coerced clients, Young people, Parenting interventions, Gender issues, Culturally and linguistically diverse people, Aboriginal people, 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 of core performance indicators should be conducted at treatment entry, exit and follow up to enable treatment evaluation and research.

Assessment interview
The assessment interview should cover:
• source of referral
• presenting issues
• drug use history and related harms
• readiness to change AOD use (use motivational interviewing)
• 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)

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5 Suboxone® Reckitt Benckiser.
4. Assessment

Assessment – tip sheet

- how clients view themselves, others and the world
- strengths and weaknesses
- presentation and mental state.

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

*Standardised assessment*

Standardised assessment:
- should complement the assessment interview
- provides an objective view of the client’s difficulties and current life situation
- increases the accountability of both services and clinicians by providing an objective measurement of treatment success, comparability between treatment approaches and comparability between clients accessing treatment services
- should 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.
Suicide assessment and management

Clients presenting for AOD treatment are at a greater risk of suicidal behaviours (Schneider, 2009). Do not ignore any suspicions of 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 as appropriate. For clients who acknowledge current suicidal ideation or intent, a thorough assessment of level of risk should be conducted. The assessment of suicide risk used by Next Step Drug and Alcohol Service and Community Drug Services in Western Australia is included in Appendix 1.

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

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

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

- talk to the client alone – without any family or friends present
- allow sufficient time
- discuss limits of confidentiality
- introduce suicide in an open, yet general way
- link it to presenting concerns and problems
- be non-judgemental and empathic
- use non-threatening prefices.

Counsellors may wish to use one of the following questions to introduce the issue of suicide.

‘When things get really bad for people, they often start to think about finding a way out. Have you ever felt so bad that you’ve thought about suicide?’

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

‘Because of the high rates of suicide, I ask all my clients about whether they have ever had any suicidal thoughts. I am wondering if you have felt so bad that you have thought about suicide?’

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

5.1 Assessing suicide risk

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

Current thoughts of suicide
Presence of suicide ideation.
5. Suicide assessment and management

Nature of suicidal thinking:
  *Frequency* (e.g. ‘How often do you think about suicide?’)
  *Intensity* (e.g. ‘Could you rate the intensity of your suicidal thoughts?’)
  *Duration* (e.g. ‘When did you first have these thoughts?’) (Bryan & Rudd, 2006)

What does death mean to the person?

What recent experience of suicide has the person had (in relation to self or close others)?

**Suicide plan and method**

‘Have you thought about how you would kill yourself?’

The more detailed and feasible the plan, the greater the risk.

Assess the lethality of the plan and access to lethal means.

**Availability**

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

**Rescue**

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

**Active behaviours**

Consider behaviours associated with planning, such as getting finances in order or writing a suicide note (e.g. ‘Have you taken any steps to prepare for suicide?’).

**Previous attempts or threats of suicide**

History of previous attempts.

How the client feels about the results of the attempt.

Assess the context of the suicide attempt (e.g. ‘What was going on at that time in your life?’).

Assess the circumstances, intent, lethality of the contemplated previous attempt (e.g. ‘Why did you choose that particular method? Did you think it would be enough to successfully commit suicide?’).

What was the meaning or goal of the attempt?

Have other people close to the client ever attempted suicide?

**Alcohol and other drug use**

Use of AOD is associated with an increased risk. Suicide often occurs in the context of acute intoxication, possibly due to reduced inhibition (Bryan & Rudd, 2006).

**Depression**

Use a depression measure such as the DASS (Appendix 8) to assess levels of depression and presence of hopelessness.

**Protective factors**

Is there anything in the client’s life that can act as a deterrent to the suicidal behaviour?

Consider areas such as social support, religious commitment, active participation in therapy, presence of hopefuifulness (Bryan & Rudd, 2006). Explore each of these factors in detail. Where suicidal ideation is present, encourage the client to talk about their ambivalence: why they want to die and why they want to live. This will give the client insight into the functionality of the suicidal thoughts, as well as providing an avenue for exploring ways of delaying the suicide attempt.
5. Suicide assessment and management

Determine the suicide risk of the client on the basis of the suicide assessment (see Appendix 1). If the client is at moderate risk, has acknowledged that there are things preventing them from committing suicide and does not have a well developed plan, discuss appropriate strategies with the client to help them to manage suicidal thoughts and to have a clear plan of how to remain safe if their suicidal thoughts increase in intensity. Provide the client with various helpline and emergency telephone numbers.

Note that there is no reliable evidence to support the use of ‘no-suicide contracts’ (Rudd et al., 2006). Indeed, the use of a pseudo-legal contract between client and counsellor may reduce the counsellor’s clinical assessment of risk due to a false sense of security.

If you determine that the client is of high suicide risk, consult your supervisor or a mental health professional immediately. Consider hospitalisation (see below ‘Chronic suicidality’) and contact your local hospital or a mental health emergency phone line. Do not leave highly suicidal people unattended. Thoroughly document all steps taken to explore the suicidal thoughts and the action taken. Always provide even mildly suicidal people with helpline and emergency phone numbers.

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.

5.2 Chronic suicidality

AOD clients who have experienced complex trauma, particularly in childhood, are often chronically suicidal, with the intensity of their suicidality varying over time. The difficulty for counsellors is to determine when to become alarmed and intervene. Because things can change very quickly for traumatised clients it is not possible to estimate 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 gain the best estimate they can of suicide risk (National Health and Medical Research Council (NHMRC), 2012).

The notion of chronic versus acute suicidality is a useful one for clinicians to be familiar with, because chronic suicidality should be managed differently from acute suicidality. The following points are taken from NHMRC (2012):

- 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.

Figure 3 is taken from NHMRC (2012) and 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 pattern of risk behaviour: in frequency, type or severity.

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6 This section is adapted from Marsh et al. (2012) Chapter 6 ‘Suicide and self-harm’
5. Suicide assessment and management

NHMRC (2012, p.56) describes factors that might be used to help determine when the risk of suicide on 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, and
- recent adverse life events (e.g. breakdown or loss of an important relationship, legal problems, employment problems or financial problems).’

In terms of responding to the estimated levels of risk as shown in Figure 3, NHMRC (2012) makes 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 and counselling should focus on issues that will improve their quality of life and risk should be regularly assessed.
- If a client at chronic low risk starts to use more lethal methods of self-harm on a long-term basis, they become at chronic high risk of suicide (top left-hand quadrant of Figure 3). Hospitalisation is probably not appropriate 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 low chronic 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.
5. Suicide assessment and management

- If a client who is at high chronic 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 initial assessment, as well as ongoing assessment. When raising the issue of suicide:

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

**Suicide risk assessment**

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

- current thoughts of suicide
- suicide plan and method including availability, rescue and active behaviours
- previous attempts or threats of suicide
- alcohol or other drug use
- depression
- protective factors.

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 the suicide risk of the client.

**Actions in relation to assessed suicide risk are outlined in Appendix 1.**

If the client is not considered to be of high risk, has acknowledged that there are things stopping them from committing suicide and does not have a well developed plan, discuss appropriate strategies with the client to help them to manage suicidal thoughts. Develop a clear plan with the client as to how to remain safe if their suicidal thoughts increase in intensity. Provide the client with various helpline and emergency telephone numbers.

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

- consult your supervisor or mental health professional immediately
- consider hospitalisation (see page 25 ‘Chronic suicidality’)
- do not leave suicidal people 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 with the client 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.
5. Suicide assessment and management

Suicide management – tip sheet

**Chronic suicidality**

Chronic suicidality needs a different response from acute suicidality. NHMRC (2012) note that:

- 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 problems driving the suicidal ideation.
- 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.
Case formulation

Developing a case formulation entails integrating the information gathered from an assessment into an explanation, using a theoretical framework, of how the client’s presenting problems are caused and maintained. This is a proposed explanation (hypothesis) to be adjusted as more information becomes apparent. A clear case formulation indicates the causal and maintaining factors that will need to be addressed in a treatment plan to help the client address their presenting issues.

A case formulation should be developed after the initial assessment is completed and prior to developing a treatment plan.

6.1 Format of a case formulation

A case formulation differs somewhat according to theoretical approach and model of therapy. A case formulation usually includes a summary of the presenting issues, an examination of these presenting issues in terms of their development and maintenance within the context of the client’s life, as well as a summary of the client’s strengths. A simple model covering this information is the ‘5Ps’ model:

- **Presenting issues.** Briefly summarise the problems the client identifies as bringing them into treatment, as well as any other problems that are identified during the assessment. Presenting issues are usually broader than just AOD problems and can include issues in any area of a person’s life, such as psychological, social, health, legal, accommodation and financial problems.

- **Predisposing factors.** These are issues in the client’s childhood, adolescence and adulthood that predispose them towards experiencing AOD, mental health 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.

- **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 resources.

6.2 Example of a case formulation

Karen presented seeking help to stop daily dependent use of cannabis. She also described symptoms of depression and anxiety, relationship difficulties which she saw as being caused by her cannabis use, and lack of self-worth. Her DASS (Depression Anxiety Stress Scale) results also indicated very 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, and a father who worked long hours and was emotionally unavailable even when he was around because he had an alcohol problem. 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. The 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.

Perpetuating factors for Karen’s cannabis use include the assistance it provides her in the short term with managing her emotions and lack of self-worth. Karen’s cannabis use is also perpetuated by her lack of any other strategies to manage her 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.

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7 This chapter is adapted from Marsh et al. (2012) Chapter 7 ‘Case formulation’.
6. Case formulation

6.3 Feedback of the case formulation to clients

Assessment results should be presented to clients in the form of the case formulation so as to help them make sense of their difficulties. This helps clients to gain a broad perspective on how their problems developed and are maintained, which can also encourage them to develop compassion and empathy for themselves. 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 contributing to perpetuating these difficulties. This provides hope for the client and direction for the future (Marsh & Dale, 2006).
- It should focus on strengths as well as weaknesses. A focus on strengths contributes to building hope, particularly if these strengths are framed as factors that can help the client to overcome their problems.
- The feedback should be presented in easy-to-understand language, which takes account of the client’s level of education and vocabulary.
- When questionnaires have been used a numerical score will mean nothing to a client. Therefore results should be explained in terms of their meaning in the context of the overall pattern of assessment results.
- 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.

It can be useful to draw a diagram of the case formulation, go through this with the client and make any adjustments on the page as you go through it. Clients may want to take a copy of the formulation away with them. A useful diagrammatic format is shown below.

![Diagram of case formulation]

8 The case formulation diagram shown is from Kate Hadden, Clinical Psychologist, Vietnam Veteran’s Counselling Service, Applecross, Western Australia.

6.4 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 headings. It is also useful to include the diagrammatic copy of the formulation that was presented to the client in the file.
6. Case formulation

Case formulation – tip sheet

A case formulation is an explanation of how the client’s presenting problems are caused and maintained. The format will differ according to theoretical approach and model of therapy. A simple model covering this information is the ‘5Ps’ model:

- **Presenting issues.** Briefly summarise the problems the client identifies as bringing them into treatment, as well as any other problems that are identified during the assessment. Presenting issues are usually broader than just AOD problems and can include issues in any area of a person’s life, such as psychological, social, health, legal, accommodation and financial problems.

- **Predisposing factors.** These are issues in the client’s childhood, adolescence and adulthood that predispose them towards experiencing AOD, mental health 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.

- **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 resources.

Assessment results should be presented to clients in the form of the case formulation so as to help them make sense of their difficulties. A case formulation diagram can be useful.

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.
Motivational interviewing (MI), first described by Miller (1983), is a counselling technique based on the belief that all behaviour is motivated. Thus, AOD use is a motivated behaviour, with many drug users being more motivated to keep using than to give up. Motivational interviewing aims to evoke and enhance ‘client change talk’, which in turn has been found to be associated with enhanced behaviour change (Miller, 2013).

Motivational interviewing has been found to be associated with behaviour change in many different areas of health, such as diet, exercise, management of cardiovascular disease, gambling and HIV risk behaviour (Rollnick et al., 2008). It appears to increase treatment retention and reduce relapse rates (Burke et al., 2003; Hetteama et al., 2005), and foster positive change and deepen engagement (Lundhal et al., 2010). Outcomes are similar to those for other specific treatments, but motivational interviewing probably achieves positive results in a shorter time (Lundhal et al., 2010).

Results tend to be less good when counsellors follow a manual (Lundhal et al., 2010). This highlights the need to implement any counselling strategy flexibly, and ensure that it does not take precedence over responding to the client’s reactions and issues, and to what is occurring within the therapeutic relationship. For example, traumatised clients often feel so bad about themselves and their AOD use that highlighting and amplifying their concerns about their AOD use, which is part of motivational interviewing, can be counter-productive and make them so distressed that they feel like using to cope. Instead counsellors need to adapt the motivational interview by engaging in less exploration of the problems associated with the AOD use and perhaps highlighting any achievements clients have made in terms of reducing use and exploring how they achieved this and how they felt as a result. Counsellors might also need to interrupt a motivational interview if a client becomes distressed and engage the client in distress reduction strategies, such as grounding or controlled breathing (Chapters 19 and 20 Relaxation strategies and Grounding).

Motivational interviewing and exploring decisional balance have been considered synonymous. However Miller (2013) has recently made a clear distinction between them. Miller notes that decisional balance, where a client explores the pros and cons of change (or continuing to use) in a balanced fashion, is an assessment of the extent to which a client is motivated to stay the same or change. It can therefore be useful as part of an assessment. A balanced exploration of the pros and cons of change for people who have not yet made a decision to change (in precontemplation or contemplation stages) appears to NOT increase commitment to change, though it may do for people who have already made a decision to change (in preparation for action and action stages) (Miller, 2013). Miller (2013) therefore argues that there is no reason to engage clients in exploring decisional balance if you want to encourage clients to make a decision to change.

Motivational interviewing, however, is focused on evoking and enhancing change talk (Miller, 2013). Motivational interviewing can also contribute to the development of the therapeutic relationship as it assists clients to articulate their own thoughts and feelings about AOD use as opposed to having the counsellor’s opinions and judgements imposed upon them. The overall goal of motivational interviewing is for the client to explore their feelings and thoughts about their AOD use and convince themselves of the need to change. The psychological law underpinning motivational interviewing is ‘As I hear myself talk I learn what I believe’ (Miller & Rollnick, 2002, p.21).

Miller and Rollnick (2013) describe motivational interviewing as being based on four broad processes: engaging (building a therapeutic relationship), focusing (deciding on a focus for counselling), evoking (eliciting and exploring the client’s reasons for change), and planning (setting goals and planning how to achieve them). Miller and Rose (2009) place these four broad processes within two components of an emerging MI theory.

The first component is relational and refers to the engaging and focusing aspect of MI. The second component is technical and refers to the differential evoking and reinforcing of client change talk, followed by planning. The relational component of MI is central to all good counselling, as is the planning aspect of the technical component. It is the differential evoking and reinforcing of client change talk that is unique to MI, but cannot exist in isolation. The relational component is central to MI as a whole intervention as it lays the foundation for the unique process of evocation. Depending on the client, the final planning process may or may not be necessary.
7. Motivational interviewing

7.1 The relational component of MI

Within the relational component of MI – engaging and focusing – it is useful to explore the ‘good’ and the ‘less good’ aspects of a client’s drug use.

7.1.1 The ‘good things’ about AOD use (sustain)

Miller and Rollnick (2013) suggest that counsellors do not ask clients about the pros of their behaviour – the things that ‘sustain’ it. They argue that clients will volunteer any important sustaining reasons and that engaging clients in ‘sustain talk’ can weaken motivation for change. Our clinical experience, however, suggests that there are some very good reasons for asking clients about the benefits – the functionality – of their AOD use. This promotes an atmosphere of non-judgemental acceptance of the client and can assist the client to be more compassionate towards him or herself. Some clients believe they are either mad or bad to use drugs, and exploring their reasons for using can help them to see their use as a rational choice. It can also engender hope that counselling can help them find other ways to meet their needs. It is important that clinicians steer the conversation to ‘change talk’ as the motivational interview progresses, and that reasons for change are explored in more detail.

Some clients will respond to the term ‘good things’, others will say there is nothing good about it. In the latter instance, ask what keeps the client using, or what the AOD use does for them.

It can be useful to provide clients with a rationale for exploring the good things about their AOD use such as ‘It’s important for us to get clear about what you get out of using, what has kept you doing it. Only by getting clear on what the using does for you can we work out other ways for you to meet these needs. Unless we do this it can be difficult for you to change your drug use.’

The good things about drug use can be explored by asking some open-ended questions such as:
‘Can you tell me some of the good things about using heroin?’
‘What does the alcohol do for you?’
‘What are some of the things you like about using speed?’

Before moving on, acknowledge each of the good things and ask the client if there are any other benefits they neglected to mention. Emphasise the importance of getting a comprehensive list of the positives in order to understand the importance of the drug use. Briefly summarise the good aspects of AOD use.

Note that when setting goals and planning strategies to achieve the goals, the good things about AOD use may need to be explored in greater detail so that clear goals and plans for alternative ways for clients to meet needs can be devised.

7.1.2 Less good things (change)

Next, ask the client about the less good things about their AOD use, the things that promote change, and ensure you explore these in detail, in terms of why they are of concern to the client and how they motivate the client to change. Try to avoid using negative words such as the ‘bad things’ or ‘problems’. The counsellor can ask questions such as:
‘So we have talked about some of the good things about using drugs. Now could you tell me some of the less good things?’
‘What are some of the things that you don’t like about your drug use?’
‘What are some of the less good things about using?’
‘Can you tell me about what makes you think about changing your drug use?’

The less good things need to be explored in detail to evoke and enhance the client’s change talk, as these are central to motivation for change. It is important to explore the client’s perspective of the less good things and to avoid jumping in with your own ideas unless the client has previously mentioned some less good things about AOD use that he or she fails to mention now. The counsellor can ask follow up questions such as:
‘How does this affect you?’
‘What don’t you like about it?’
7. Motivational interviewing

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

‘Could you tell me a little more about that?’
‘Could you give me a recent example of when that happened?’

Many counsellors make the mistake of assuming that just because the client acknowledges a less good thing about AOD use, then the client acknowledges that this concern is directly related to them. For example, an illicit drug user might mention the financial cost of using, but when asked about the extent to which that concerns them might say ‘not at all’ because they are dealing to support their habit and so are not spending anything.

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

For example:

‘Does that concern you?’
‘How do you feel about that?’
‘Is that a problem or does that worry you in any way?’
‘On a scale of 1 to 10 where 10 is very concerned, how much does that concern you?’
‘Why is that such a concern for you?’
‘What’s so important about that?’

Counsellors should never suggest that an issue should be of concern, nor put any value judgement on the beliefs of the client by saying something like ‘Don’t you think that overdosing twice is a bit of a problem?’ The success of motivational interviewing depends on the counsellor’s ability to facilitate client exploration of their AOD use and the good and less good effects that it has on them.

7.1.3 Summary

Following this exploration of the client’s perspective on their AOD use, the counsellor should summarise all of the major points discussed. For example:

‘It seems that on one hand you feel that the drug use helps you because … and on the other it causes difficulties including … These difficulties concern you because … and make you think that you really need to change your drug use.’

Ensure that you finish the summary by highlighting the reasons for change and why the AOD use is of concern to the client. Finally, always ask the client for their opinion of your summary.

7.2 The technical component

Once the motivational interview has progressed to the stage where the counsellor begins to evoke and reinforce the client’s own change talk, it is considered counter productive to the change process to give equal focus or emphasis to the client’s sustain talk. At this point, if the client begins to use more sustain talk than change talk language, it is an indication that they are feeling ambivalent. It is essential that the counsellor listens and responds appropriately to the client by returning to the relational components of MI (engaging and focusing). In MI, it is the client that guides the counsellor’s interventions. This is why MI is referred to as a client-centred counselling approach.
7. Motivational interviewing

7.2.1 Evoking and enhancing client change talk
Miller and Rollnick (2013) note that change tends to occur when people become aware of a discrepancy between their values and goals and their current situation and behaviour. Becoming aware of a discrepancy causes discomfort with the behaviour, which increases motivation for change. There are several ways in which counsellors can attempt to increase discomfort about continuing the AOD use. Take care not to leave the client overcome by hopelessness and despair when you increase psychological discomfort about using. Be empathic and non-judgemental, acknowledge any feelings of hopelessness, and then focus on the fact that while it is difficult, the client can make choices that will result in changes to their current and future life circumstances. The second option below, ‘looking forward’, is the safest in terms of the level of hopelessness some clients might feel.

Exploring values and goals
Exploring values (what clients care about, believe in, find meaningful and live for) and goals (what they want to achieve), and encouraging them to evaluate their situation while using in comparison to these values and goals 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.

Looking forward
The counsellor explores with the client how they expect the future to be if they continue using as they are. For example:
‘What would you like to be doing in two years time?’
‘What do you think will happen if you keep using?’
‘How do you feel about that?’

With young people the time frame for looking forward should be kept short, weeks or months rather than years.

Looking back
The counsellor explores with the client how past expectations differ from their current situation. The counsellor can ask questions such as:
‘When you were fifteen what did you imagine that you would be doing now?’
‘How is that different from what you are doing now?’
‘How do you think that your use of … has influenced things?’
‘How do you feel about that?’

Self versus user
Another strategy to increase cognitive dissonance is to encourage the client to examine the discrepancy between their idea of self as a substance user, versus self as a person. For example:
‘How would your friends describe the good things about you?’

Explore in more detail before asking:
‘How would you describe yourself as a … user?’

Again, explore in more detail before asking:
‘How do these things fit together?’

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

7.3 The decision

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

The counsellor could ask the following questions:

‘Where does this leave you now?’

‘What does this mean for your drug use?’

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

Whatever goal the client sets, it is important that it is specific, achievable, short-term and concrete (see Chapter 9 Goals of intervention).

Motivational interviewing has a variety of applications and can be used to examine almost any issue, particularly those that clients are ambivalent about such as whether to take a particular job, leave a relationship, or take up a sport. In some situations there will not be a particular side of the argument that the client eventually wants to adopt as there is with most AOD use (most clients eventually want to either quit or reduce their AOD use). When there is no clear side of the argument, counsellors should help clients to explore both sides in detail. Counsellors are also encouraged to use it throughout the therapeutic process.

Motivational interviewing – tip sheet

Motivational interviewing aims to evoke and enhance ‘client change talk’, which in turn has been found to be associated with enhanced behaviour change.

Motivational interviewing is distinct from simply exploring the pros and cons of a behaviour (exploring decisional balance) in that it evokes and explores the cons of the behaviour and the reasons for change in far more detail than the pros of the behaviour.

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

Components of motivational interviewing include:

- Relational component: explore the good things and less good things about drug use, focusing more on the less good things by asking for examples, how much of a concern they are and why they are of concern.
- Technical component: evoking and enhancing client change talk:
  - exploring client’s values and goals and how using fits with these
  - looking forward – compare what the client would like to be doing in the future compared to what they think they will be doing if they keep using
  - looking back – how do past expectations compare with the current situation
  - explore the discrepancy between the client as a user, compared to the client as a non-user.
- Summarise all of the above and ask the client how it all fits together.
- Encourage the client to make a decision about their drug use before moving to goal-setting.

If the client does not want to change, explore harm reduction strategies where appropriate.
Encountering and successfully negotiating problems is a part of everyday life. When clients are attempting to change their AOD use, encountering problems that threaten changes that are being made 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 reinforce with clients 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 are beneficial when teaching clients problem-solving skills. Verbal instruction, written information and skill rehearsal can all be useful. People with cognitive impairment may find problem-solving a difficult exercise and can require a lot of practice and simple, easy-to-follow information. For suggestions on techniques to use with cognitively impaired clients, see Chapter 39 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 by which they can solve their own problems. Problem-solving steps, based on D’Zurilla and Goldfried (1971) are outlined in the following.

### 8.1 Orientation

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.

### 8.2 Define the problem

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

### 8.3 Brainstorm solutions

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

### 8.4 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. With the remaining list of solutions, work with the client to evaluate the probable negative and positive outcomes of each. Is the strategy possible? Is it likely to be effective? What are the possible short and long-term consequences? Following evaluation of potential solutions, the client (not the counsellor) should choose a solution.
8. Problem-solving

8.5 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? 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 may identify some of the problems that the client may encounter, as well as increasing clients’ confidence about implementing the strategy. After rehearsing the strategy it is important to evaluate how effective it was. Did it work? Can it be improved? Should another strategy be considered? For further information, see Chapter 9 on Goals of intervention.

8.6 Putting the plan into action and evaluating the outcome

The client should then put the plan into action and in the next session client and counsellor should evaluate how it went and if necessary adjust the plan for next time.

There is a problem-solving practice sheet for clients in Appendix 10.

**Problem-solving – tip sheet**

Teaching problem-solving skills is an integral part of any AOD treatment program. Give written information (see client information in Appendix 10), verbal instruction and skill rehearsal.

Problem-solving steps:
- **Orientation** – step back from the problem.
- **Define the problem** – be specific.
- **Brainstorm solutions** – anything goes.
- **Decision-making** – consider pros and cons of each solution, choose a solution, consider how to put the solution into action.
- **Implementation** – rehearse the strategy, evaluate its effectiveness and then try it out.
Goals of intervention

Goal-setting entails using the information gathered during the assessment to develop a plan for the direction of treatment that is mutually agreed upon by both client and counsellor. Goal-setting:

- provides directions for counselling
- clarifies the client’s expectations of counselling
- clearly establishes for both the counsellor and client 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 that 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 also allow counsellors to determine whether their skills and ways of working are appropriate for working with a particular client towards their goals. The particular AOD use goals a client has are also relevant to the suitability of a particular service, treatment approach, or counsellor. For example, if a client’s goal is controlled use or an opioid pharmacotherapy then an abstinence-based program will not be suitable.

9.1 Issues to consider when setting goals
Counsellors should consider the following issues, adapted from Allsop and Helfgott (2009a), when they assist their clients to set goals. Goals should be:

9.1.1 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.

9.1.2 Negotiated
Goals should be client directed, as this ensures that the client is committed to the goals. At the same time counsellors should guide clients to choose 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 overrule the client and insist on a more realistic goal. Instead, agree to the client’s goal and negotiate with the client 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 untenable, then counsellor and client agree to review the goal.

9.1.3 Specific and achievable
Goals need to be defined in clear, specific and achievable terms. As an example, Allsop and Helfgott (2009a, p.2) suggest that the goal of ‘to be nice to my partner’ is ambiguous. A more specific goal might be to ‘say three positive things to my partner this week’ or ‘to go to the movies with my partner once per week’. Goals also need to be achievable. For example, instead of the client committing to abstinence, it may be more realistic for the client to initially aim for two alcohol-free days per week. It is important that the client begins to gain a sense of mastery by achieving his or her goals.

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

9.1.5 Described in ‘presence’ rather than ‘absence’ terms
The importance of focusing on skill acquisition, rather than behaviour reduction, has a long history in psychology and related disciplines. Where possible, therefore, goals should be phrased in terms of someone doing something (presence), rather than someone 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’.

9.1.6 Not necessarily limited to drug use
In most situations a number of different goals may be considered. These might include:
- reduction in drug use
- improved physical health
- improved mental health
- improved social adjustment and functioning
- reduced harm associated with drug use
- reduction in criminal behaviour.

9.2 SMART goals
A useful acronym for setting goals is SMART. Goals should be:
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-framed – worked within a specific time frame.

9.3 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 11.
9. Goals of intervention

**Goal-setting – tip sheet**

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

When setting goals consider the following:

- Goals should be geared towards a client’s stage of change.
- Goals should be negotiated between counsellor and client.
- Goals should be defined in clear, specific and achievable terms, e.g. I will have three alcohol-free days per week.
- Goals should be short term. Set an overall goal for therapy and then break it down into its smallest components. Small goals should be set on a weekly basis.
- Goals should ideally be described in presence not absence terms. They should focus on skill acquisition, e.g. 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
  - criminal behaviour.

Note: there is a goal-setting worksheet in Appendix 11.
A treatment plan is a detailed overview of the planned intervention, much akin to a road map for therapy. The primary purpose of treatment planning documentation is to ensure individuality and continuity and consistency of care for clients and to enhance communication between clinicians involved in the client’s care, the client and management (National Treatment Agency for Substance Misuse UK, 2006). Treatment plans ensure that counselling covers the concerns relevant to the client and provide hope by planning ways to help clients address these concerns.

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

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 (e.g. formal or informal measures of change in symptoms and drug use, whether referrals were successful, whether client remains engaged in treatment).

If evaluation of the client’s progress indicates the need for the renegotiation of the treatment plan, this should be done explicitly and together with the client to ensure that client and counsellor have the same aims.

### Treatment planning – tip sheet

Treatment plans keep counselling focused.

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

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.
Case management is a process that coordinates the acquisition and delivery of services to meet the individual client’s needs. It facilitates a holistic approach to client care. Case managers are not expected to provide all the necessary services themselves, but instead to refer to and facilitate engagement with appropriate agencies. Substance users generally present with a myriad of additional issues that need to be addressed during the course of treatment, including problems with general health, accommodation, mental health, employment, education, the legal system and family situations. Failing to address these concomitant issues as part of AOD treatment may impede the client’s progress in relation to their AOD goals. Indeed, evidence-based treatments for clients with AOD issues do not focus exclusively on the substance use; they also aim to address concomitant 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 client retention in treatment. Case management is effective in increasing client use of community-based services, improving quality of life, increasing client satisfaction and prolonging treatment retention (Vanderplasschen et al., 2007). Retention in treatment, in turn, has been consistently associated with better treatment outcomes among AOD populations (Vanderplasschen et al., 2007).

Core elements of case management include:
- assessment of the health and social service needs
- planning and coordination of these services
- monitoring to ensure the client is receiving the services
- client advocacy.

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

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.

(Siegel, 1998)

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

### 11.1 Primary case management

Primary case management involves one case manager who personally establishes a series of separate relationships with other professionals or services as required. The case manager retains full and autonomous control over the case and is responsible only to the parent agency (Siegal, 1998).

For example, a child protection worker working with a young clinically depressed drug-using mother and her two children may refer the client to a clinical psychologist for help with the AOD and depression issues, and engage parenting help for the client. In this example, each specialist is responsible to the child protection worker who has ultimate responsibility to ensure that the client’s overarching needs are addressed.
11. Case management

11.2 Shared case management

Shared case management involves several professionals (often inter-agency) who work collaboratively as a team to provide multiple services for clients on a case-by-case basis (Siegal, 1998). There is some evidence to suggest that this model of case management is associated with a higher level of 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 coordinate services in response to the client’s needs. The responsibility for meeting the client’s needs is shared, although accountability for the provision of each service remains with the relevant agency or individual.

For example, a mental health service and an AOD treatment service may work together to meet the needs of a client with 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 impeding 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 drug counsellors working with sexual abuse counsellors, medical practitioners, corrections services and schools.

Case management, whether primary or shared, 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 case management approach that includes time allocated to functions such as goal-setting, client advocacy and service coordination (Miller et al., 2011).

Important components for a high standard of structured case management and service coordination also include:

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

Case management – tip sheet

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

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

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<thead>
<tr>
<th>Case management – tip sheet</th>
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<tr>
<td>Case managers should:</td>
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<tr>
<td>• identify clients’ treatment and service needs</td>
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<td>• obtain written informed consent from the client prior to sharing any client-related information with associated professionals or otherwise</td>
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<tr>
<td>• locate service options</td>
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<td>• link clients with appropriate services</td>
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<td>• monitor clients’ progress in treatment</td>
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<td>• evaluate services provided to clients</td>
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<td>• advocate for the client as necessary.</td>
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Effective case management involves:

• clear and open communication between the professionals involved
• clarification of the requirements and boundaries of each specialist
• clear establishment of the boundaries of confidentiality and what will be communicated with the case manager (or team)
• knowledge of other professionals involved and the nature of their involvement in the case
• having a contract (written or verbal) that outlines the expectations and boundaries of service provision.
In designing a treatment plan for a client it is often necessary to consider referral to other services or counsellors. This can be for additional services or because the counsellor finds the client’s presenting problems 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. Referral is an ethical practice that can help to ensure that the client receives appropriate treatment. Consider the possible need for referral early on in the counselling process to avoid delays for the client in this regard (Nelson-Jones, 2005). In addition, seek supervision and support when considering the need to refer a client to another counsellor or service.

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 problems and history to a new person. Be clear about the reasons for the referral and explain that the suggested agency or professional is more 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. With written permission from the client, the counsellor should make contact with the proposed agency and if possible the clinician to whom they are referring the client. Continue to support the client until an appointment with the new agency can be arranged. Some clients may require several sessions in preparation for referral (Hodges, 2011). In addition, referral is not always an either/or matter (Nelson-Jones, 2005), and 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 should be posted rather than faxed where possible.

**Referral – tip sheet**

In designing a treatment plan for the 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 appropriate treatment? Referring clients to appropriate services or counsellors is at the heart of client-centred and ethical practice. Consider the possible need for referral early on in the counselling process and seek supervision in this regard.

The process of referral should aim to ease the transition for the client:
- Referral needs to be managed sensitively because many people are lost to treatment in the referral process.
- Consider a more appropriate service or counsellor for the client.
- 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.
- Continue to support the client until an appointment with the new agency can be arranged.
- If the client expresses concern about attending appointments with a new counsellor, it may be beneficial to initially work collaboratively with another counsellor.
- Some clients may wish counsellors to accompany them to their first session with the new counsellor.

Practical considerations, pertaining to the release of confidential information, may arise during the referral process. When case notes are requested by the new agency, always obtain written permission from the client to release this information, and avoid faxing confidential information about a client.
Waitlist management and follow up

Despite the difficulties of following up clients, mainly due to the transient nature of this population, the practice of follow up has great utility. Follow up can provide a forum for brief intervention to diminish the build up of crises that often result in clients re-seeking treatment. It provides clients with a sense of care and commitment from the service provider and may result in the client being more likely to re-engage in treatment should the need arise. Follow up is also an important part of evidence-based practice and can provide useful information regarding treatment efficacy, effective components of treatment and relapse rates. Follow up is a relevant issue for clients at all stages of therapeutic engagement: from clients on the waitlist to clients who have concluded counselling.

It is important to follow up with clients who have been added to the waitlist for counselling. Being on a waitlist is perceived as a barrier among clients seeking treatment and the longer the waiting period, the less likely clients are to follow through with the appointment (Redko et al., 2006). 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, can substantially improve attendance (Downer et al., 2005).

Assertive attempts to re-engage the client should be made for clients who do not attend an initial appointment and for clients who do not attend a scheduled appointment. Clients who fail to attend appointments are more likely to perceive a number of barriers to attending (Collins et al., 2003). Follow up with clients who miss appointments can include helping clients to address barriers to attending and brief interventions over the phone to boost the client’s motivation to attend counselling (National Treatment Agency for Substance Misuse, 2009).

For clients who have attended counselling, the importance and possible format of follow up should be explained prior to the cessation of treatment. Follow up procedures should address issues of continued support, re-engagement with the service (if necessary), or appropriate referral. Follow up should be discussed while the client is still engaged in treatment. If face-to-face or by telephone, appointments should be scheduled. Reminder phone calls can also help to keep track of clients, as well as increasing the chance of clients attending the follow up appointments.

Client should be re-contacted for short-term follow up within one to three months following the conclusion of treatment. It is also recommended that follow up is conducted with clients in the long-term between six and twelve months after treatment. Follow up with clients 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. Where face-to-face or telephone contact is not possible, a written method of follow up may include a simple evaluation questionnaire and a prepaid envelope (Hodges, 2011). Another option is agency-wide group follow up procedures that can have the added benefit of providing clients with a support network.

**Waitlist management and follow up – tip sheet**

It is important to follow up with clients who are on waitlists for counselling.

Clients who have been in treatment, regardless of whether or not they have relapsed, should be followed up within one to three months at the conclusion of treatment. Long-term follow up between six and twelve months is also recommended.

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

Preference should be given to face-to-face or telephone contact, however written contact or agency-wide group follow up is also sufficient. If face-to-face or by telephone, sessions should be scheduled with the client prior to discharge from treatment.

Follow up provides clients with 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.
Maintaining concise and up-to-date case notes is an important means of tracking client progress. Counsellors should inform clients about the rationale of maintaining case notes, the presence of case files, where the files are stored and who has access to them. Such an explanation and rationale might be 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 me keep a track of where we are up to and helps me 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, in which case I have no option but to release them. I am careful about what I record and only record the most important information. If you would like to read your case notes, please discuss this with me.’

This explanation will vary according to agency policies and procedures. When clients request to view their case notes, allow them to view the ones you have written but not those of other staff without seeking their permission. If a client wishes to have copy of their whole file, most agencies have procedures 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. Note that clients can ultimately gain access to their file notes through Freedom of Information Acts even if agency staff do not wish them to.

### 14.1 Principles of client record documentation

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

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

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

Avoid transporting case files or client notes where possible. This runs the risk of breaching confidentiality if, for example, your car or house is broken into. If supervision arrangements or agency liaison require you to transport client notes, use a locked briefcase or transport de-identified photocopies of the original documents.

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

**Examples**

‘Susan said she had not used but her pupils were dilated and she was perspiring noticeably, leading me to suspect that she had used methamphetamines recently.’

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

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

**Example**

‘Betty reported that in 1978 she was committed to Graylands Hospital and diagnosed by the attending psychiatrist with paranoid schizophrenia.’
14. Case notes

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

**Example**

‘Betty explained that she fights with her husband when coming down off amphetamines.’

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

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

**Example**

‘Betty expressed thoughts about wanting to die. I explored this further, whereby Betty reported that she does not have a plan for suicide and stated that she is not seriously considering suicide as an option. She stated that when life seems difficult, sometimes it seems like the easy option. However, Betty stated that she has too much to live for, with her sons to raise and husband to look after. When asked on a scale of one to 10 (10 being definitely wanting to die and one being just a fleeting thought with no intent behind it), how much Betty 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 *Alcohol and other drugs assessment clinician booklet* produced by Workforce Development Branch and Next Step Drug and Alcohol Services, Drug and Alcohol Office.

14.2 Incident reports

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

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

Most agencies have policies and procedures for recording information regarding critical incidents. Also see Chapter 28 *Critical incidents* for further information.

14.3 Recording information related to liaison

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

- who supplied the information (name, title, agency, position in the agency, their relationship to the client)
- how the information was supplied (letter, face-to-face, fax, email, phone)
- why the information was supplied (who asked for it and why)
- if any action is planned as a result of the liaison, what is the action, who is responsible for its implementation and by when it should be completed
- whether your client (the agency, or others) is at risk and what steps are to be taken to minimise that risk.
14. Case notes

Case notes – tip sheet

- Always maintain clear and up-to-date case notes.
- Always tell clients about the presence of client files, where they are stored, who has access to them and why files are maintained.
- Avoid transporting case files or client notes where possible. This runs the risk of breaching confidentiality if, for example, your car or house is broken into. If supervision arrangements or agency liaison require you to transport client notes, use a locked briefcase or transport de-identified photocopies of the original documents.
- Clients have the right to access their files under the Commonwealth and State Freedom of Information acts. Record notes with the assumption that clients will read them.
- Any written information may be subpoenaed and required as evidence in court. Avoid any statements of opinion, judgements or value statements about the client.
- Only record information that is considered important to treatment.
- Notes should be written in pen, signed and dated. Do not use correction fluid; if you make a mistake cross it out. If you make alterations to notes at a later date, sign and date the alteration.
- Write what you observe. If you must record interpretations and opinions, provide the evidence that led to the conclusions.
- Don’t record suspected psychological or psychiatric diagnosis unless qualified to do so, or unless the client reports past psychological or psychiatric assessments and diagnoses. If the diagnosis is recorded, clearly state how you gained this information.
- When you write about what a client has said to you, make it clear where the information came from. For example: ‘Betty reported that …’, ‘Betty explained that …’, ‘Betty said that …’
- Avoid naming other people in the notes where possible and appropriate.
- When a client expresses suicidal ideation or self-harming thoughts or behaviours, carefully record all of the steps taken to ensure the client’s safety.
Relapse prevention and management

It is estimated that up to 90% of individuals will lapse (at least one drink or one occasion of other drug use after a period of abstinence) within the first year (Allsop, 2009). A lapse frequently turns into a relapse (a return to pre-treatment AOD use levels) and research indicates that between 40% and 60% of clients will end up relapsing (National Institute on Drug Abuse, 2009). Consequently, the probability of client relapse is high and needs to be considered with all clients.

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

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

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 (Marlatt & Witkiewitz, 2005):

- 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.

Stages in relapse prevention training are outlined below.

### 15.1 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, the client can resume treatment as quickly as possible.

### 15.2 Enhancing the commitment

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

### 15.3 Identifying high-risk situations

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

15.4 Developing coping responses
During the early stages of change, clients may find it easier to avoid high-risk situations. As it is not always possible to avoid high-risk situations the client needs to develop a plan to cope with them when they arise. Problem-solving techniques can be useful and should be 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 Chapter 8 Problem-solving.

Common themes often underlie high-risk situations. For example, a client may be particularly likely to use when stressed or angry, when something goes wrong 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 Chapters 18, 19, 20 and 21 Cognitive restructuring, Relaxation strategies, Grounding and Mindfulness.

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

After a lapse clients are often heard saying ‘I don’t know how it happened, it just did’. They often fail to see the choices that they made in relation to their lapse and therefore 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.

15.6 Preparation for a lapse
Harm reduction strategies should be explored as part of preparation for a lapse. Due to the period of abstinence generally preceding a lapse, the client’s tolerance to their drug of choice will have reduced. Furthermore, many clients use alone due to issues of shame and not wanting others to know about a lapse. These circumstances make drug use more dangerous in relation to overdose and therefore exploring harm reduction is critically important. For further detail, see Chapter 16 Harm reduction.

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

15.7 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.
15. Relapse prevention and management

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.

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

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

Note: A Relapse prevention worksheet for clients is in Appendix 12.
The goal of harm reduction is primarily to reduce the harm associated with AOD use rather than to reduce AOD use per se. Harm reduction is based on the assumption that AOD use is part of society and will never be eliminated and that people who use AOD need strategies to keep them as free from harm as possible.

Harm reduction strategies aim to reduce problems associated with continuing AOD use or relapse, such as:
- overdose (e.g. avoid mixing drugs or using alone)
- bloodborne virus transmission (e.g. use clean injecting equipment)
- family violence (e.g. avoid using when feeling angry or aggressive, go to a sobering up shelter rather than going home to the family)
- unsafe sex when intoxicated (e.g. motivational interviewing around the consequences of getting an STD, assertion practice around insisting on use of condoms)
- driving under the influence of alcohol and other drugs (e.g. think about alternative methods of transport)
- fights (e.g. avoid drinking heavily with people with whom you have conflict, limit drinking in potentially inflammatory situations)
- harm that can arise from polydrug use, particularly mixing depressant drugs (e.g. avoid or minimise mixing depressant drugs).

### 16.1 Harm reduction and AOD treatment

When clients have goals of controlled use of alcohol or other drugs, assisting them to think through potential risks and the sorts of harm reduction strategies to manage these risks is essential. For clients in abstinence-based AOD treatment, relapse occurs so frequently that harm reduction strategies should also be covered as part of treatment. Harm reduction strategies should be introduced to clients in the context of potential relapse. Clients should be encouraged to think through the potential risks that might arise in a relapse and problem-solve harm reduction strategies to minimise these risks. Harm reduction strategies are also a key aspect of brief interventions.

A useful framework for conceptualising the harms associated with drug use involves Roizen’s (1983) 4Ls model. Using such a framework, the main harms associated with drug use can be conceptualised as follows.
- **Liver** – health problems (e.g. liver damage, hepatitis C, overdose).
- **Lover** – social and relationship problems (e.g. domestic violence, family breakdowns, loss of friends).
- **Livelihood** – financial and occupational harm (e.g. job loss, debt, lack of interest in leisure or study activities).
- **Law** – legal problems (e.g. from using or selling illegal drugs, road traffic crashes or fights while intoxicated).

### 16.2 Negotiating less risky using

There can be barriers that prevent clients from engaging in less risky using practices (e.g. the ‘using’ ritual). These barriers will often relate to the purpose served by unsafe using practices. Explore these constraints with the client – their relevance to the client and their reality. When working with clients who, due to these constraints, are not willing to implement harm reduction strategies which are deemed ‘best’, counsellors should ‘negotiate safety’ (Dear, 1995) with their clients. This goes beyond the simple dissemination of information and involves attempting to work with the client to find strategies that are acceptable and that they are willing to put into practice.

Motivational interviewing can be used to enhance a client’s motivation to engage in less risky behaviour (especially in relation to the constraints that the client identifies about less risky using). Explore the following in a motivational interview:
- The good things about continuing to use in the current fashion (e.g. sharing needles, using large amounts of the substance, mixing drugs, unsafe sex).
- The less good things about continuing to use in the current fashion, with a thorough exploration of why and how much the client is concerned about their using practices.
16. Harm reduction

- Ways of enhancing discrepancy between the client’s current using practices and their values and goals. For example, ask how the client sees their risky using practices fitting with their own goals or values, or what the client thinks the future will hold if they continue to use in the present fashion and how that fits with what they want it to hold.

- After summarising what the client has said, encourage them to consider whether they want to change anything (‘so where does that leave you?’), and what compromises can be drawn to decrease the risk in their using behaviours.

(See Chapter 7 Motivational interviewing.)

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

All counsellors should make sure that they thoroughly assess the areas in which clients are at risk of experiencing harm and ensure that clients have the information and resources necessary to reduce as much harm as possible. Information on AOD-related harm and harm reduction strategies is available from user groups, AIDS councils and Hepatitis councils.

Harm reduction – tip sheet

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

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

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

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

Motivational interviewing can be used to formulate and negotiate the implementation of appropriate harm reduction strategies. Explore the following:

- The good things about continuing to use in the current fashion (e.g. sharing needles, using large amounts of the substance, mixing drugs, unsafe sex).
- The less good things about continuing to use in the current fashion, with a thorough exploration of why and how much the client is concerned about their using practices.
- Ways of enhancing discrepancy between the client’s current using practices and their values and goals. For example, ask how the client sees their risky using practices fitting with their own goals or values, or what the client thinks the future will hold if they continue to use in the present fashion and how that fits with what they want it to hold.
- After summarising what the client has said, encourage them to consider whether they want to change anything (‘so where does that leave you?’), and what compromises can be drawn to decrease the risk in their using behaviours.

After a list of possible harm reduction strategies has been negotiated make a contract with the client and help them strengthen their resolution about implementing the agreed-upon harm reduction strategies.
Brief intervention was originally developed around tobacco use in the form of the 5As model:

- Ask – about AOD use.
- Assess – ask questions or administer screen to assess extent of AOD use.
- Advise – provide information/feedback about risk associated with the client’s AOD use.
- Assist – brief motivational interview.
- Arrange – referral if required.

Brief interventions can range from one to five or so contacts and can be as brief as five to 30 minutes. They have been shown to produce greater reductions in a range of types of AOD use than no intervention at all (NSW Department of Health, 2008).

Brief interventions can include:

- assessment of the client’s AOD use
- feedback from the assessment
- advice or information about how to reduce AOD-related harms (by quitting use, reducing use, or using more safely)
- assessment of and feedback about the client’s readiness to change (motivational interview)
- problem-solving
- goal-setting
- relapse prevention
- follow up.

If a brief intervention consists of only one contact, it should at least include some feedback from information gathered about the client’s AOD use, along with advice on how to reduce AOD-related harm. The provision of self-help materials is also useful as part of a brief intervention.

Brief interventions need to be delivered in a sensitive and non-judgemental manner as clients may not previously have considered their AOD use as problematic. Motivational interviewing can be very useful to help clinicians maintain this stance (NSW Department of Health, 2008).

Brief interventions are useful for clients:

- presenting at a general health setting and who are unlikely to seek or attend specialist treatment
- with a low to moderate dependence on alcohol, amphetamines, opioids or cannabis
- who are dependent on nicotine
- who are resistant to the idea of treatment (Bernstein et al., 2005; Peterson et al., 2006)
- as a first step to engaging a client in more intensive intervention (Tait et al., 2004)
- when contact time and/or resources are limited.

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

Brief interventions are not considered suitable for clients with more complex issues such as additional mental health issues, severe dependence, poor literacy skills, or difficulties related to cognitive impairment. In these cases, more intensive intervention is recommended.

Brief interventions can be a good way to communicate and implement harm reduction strategies (Tait et al., 2004).
17. Brief intervention

**Brief intervention – tip sheet**

Brief intervention was originally developed around tobacco use in the form of the 5As model:
- **Ask** – about AOD use.
- **Assess** – ask questions or administer screen to assess extent of AOD use.
- **Advise** – provide information/feedback about risk associated with the client’s AOD use.
- **Assist** – brief motivational interview.
- **Arrange** – referral if required.

Brief interventions range from one to five contacts and each contact can typically last from five to 30 minutes.

If brief intervention consists of only one contact, it should include:
- feedback from assessment of the client’s AOD use
- information and advice on how to reduce AOD-related harm.

Multiple sessions could include:
- motivational interview
- problem-solving
- goal-setting
- relapse prevention
- follow up.

Self-help materials should be provided whenever possible.

Brief intervention is recommended for clients:
- presenting at a general health setting and who are unlikely to seek or attend specialist treatment
- with a low to moderate dependence on alcohol, amphetamines, opioids or cannabis
- with dependence on nicotine
- as a first step to engaging a client in more intensive intervention
- when contact time and/or resources are limited.

Brief interventions are not recommended for clients with severe dependence, cognitive impairment, complex issues, or poor literacy levels.
Cognitive restructuring rests on the notion that our behaviours and feelings are a result of our automatic thoughts (those thoughts which happen so quickly that we are unaware of them happening), which in turn are related to our core beliefs (deeply held beliefs about ourselves, others and the world, also termed ‘schemas’). Relapse, anxiety, feeling depressed and other life problems are considered to be linked to core beliefs, which can be inferred through our feelings, actions and automatic thoughts. Note that whether clinicians wholeheartedly agree with this perspective or not, it is hard to argue with the notion that what we say to ourselves at least influences our feelings and behaviours.

Cognitive restructuring is a cognitive-behavioural therapy (CBT) technique and involves identifying and challenging automatic thoughts and the underlying core beliefs that result in negative feelings and problematic behaviours. As automatic thoughts are challenged and disputed, their ability to cause problems, negative feelings and problematic behaviours is weakened. Automatic thoughts are commonly based on incorrect beliefs which can be challenged by using cognitive restructuring exercises.

18.1 Common thinking errors

The list of thinking errors below is adapted from Beck (1995).

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

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

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

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

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

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

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

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

Note: a client handout listing these common thinking errors is included in Appendix 13.
18. Cognitive restructuring

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 where thoughts can really influence 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. For one minute, your client is not to think at all.
- Ask your client if they managed to stop thinking. We are willing to bet 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.

Example

Sally had been clean 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 as well. She does use and enjoys herself thoroughly. The next morning, she wakes up and remembers that she used the night before. She remembers the fun that she had and tells herself that it was simply a lapse. That she had been out with her friends and because she had been drinking, she was not thinking clearly enough to say no. She thinks ‘Oh well’, renews her commitment to not using and stays clean.

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

These stories demonstrate that our interpretation of events greatly influence 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. There are often events that will 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 remaining clear that the person who assaulted them was the one at fault, they can feel more distressed because of the shame.

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.
18. Cognitive restructuring

18.2 The ABCDE model

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, a body sensation that reminds one of a past experience). For example: a friend offering a taste, someone stealing your parking space, dropping a bowl of sugar, or thinking of a past experience of failure.

B Beliefs about the event
These are the automatic thoughts or what we say to ourselves. These automatic thoughts might be related to the situation, for example: ‘I can’t turn down a free taste’. 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 assist clients to 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 now.

C Consequences
What we do, or how we feel as a result of what we are saying to ourselves. For example, using, getting into a fight, feeling irritable, depressed, 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 just had one hit because I was out with my mates and had too much to drink.’ Another important step, suggested by the example given earlier in which John continued to beat himself up for his lapse and relapsed, whereas Sally moved on, is to move on. We can refer to this as F, Forging ahead.

F Forging ahead
Once the issue is resolved, it is important to move on rather than continue to keep going back over the situation time and time again. The client cannot change yesterday, only tomorrow. Note: cognitive defusion exercises, which are described in Chapter 21 *Mindfulness*, can assist with moving on.

During counselling sessions, help clients to use the model to think through situations of their own before setting homework tasks that require the client to practise challenging their thoughts. There is a client handout sheet listing common thinking errors in Appendix 13, which clients can use as a basis for identifying dysfunctional thoughts to be challenged. If clients are keen to write things down, a table can be drawn up for them with five columns corresponding to A, B, C, D and E above.

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

### Cognitive restructuring – tip sheet

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

Relapse, anxiety, depression and other life problems are often linked to core beliefs, which can be inferred through our feelings, actions and automatic thoughts.

Automatic thoughts are often based on common thinking errors.

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

**ABCDE model**

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

B Beliefs about the event – the automatic thoughts 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 the automatic thoughts.

E Alternative explanation – rational alternative thoughts.

F Forging ahead – once the issue is resolved move on rather than continuing to review it and beat oneself up about it. Cognitive defusion (see Chapter 21 *Mindfulness*) can help with this.

Practise using this model during sessions.

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

Note: A list of Common thinking errors is included in Appendix 13.
There is a strong association between drug use and feelings of anxiety and stress. People often begin to use drugs to reduce these feelings. However, over time these feelings become triggers for drug use and are strongly associated with relapse. Consequently, relaxation training can play an important role in a client’s treatment program. Clients who suffer significantly high levels of anxiety and stress may find relaxation training particularly beneficial.

Note that traumatised clients can have unpredictable and at times negative reactions to relaxation strategies, so when introducing such strategies these clients must be given permission to halt the process if feeling uncomfortable. Grounding strategies (see Chapter 20) can be more useful for some traumatised clients and are particularly useful for all traumatised clients in moments of extreme distress.

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

19.1 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.

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

• Next, teach clients 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. Some clients will always have trouble with this. The following are instructions for the client:
  1. Rate your level of anxiety on a scale from 1 to 10.
  2. Place one hand on your abdomen right beneath your rib cage.
  3. Inhale 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 ten times.
  6. Now re-rate your level of anxiety and see if it has changed.
• Clients should be encouraged to practise this for between 10 and 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 situations or high-risk situations when they are tempted to lapse.

19.2 Progressive muscle relaxation

Progressive muscle relaxation, originally developed by Jacobson (1938), involves tensing and relaxing different muscle groups in succession. This technique can be particularly useful for clients who have trouble using their imagination or tend to dissociate, as it is very directed and focused.

Before starting, make sure clients are sitting in a quiet and comfortable place. Ask clients that when they tense a particular muscle group, they do so strongly and hold the tension for 10 seconds. Encourage clients to concentrate on the feelings in their body and on the feelings of tension and release.
19. Relaxation strategies

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, p.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. Clench your fists and tighten your biceps by drawing your forearms up towards your shoulders. 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.
19. Relaxation strategies

19.3 Visual imagery to create a safe place

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

The following instructions are adapted from Gawain (1982, p.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?
- How does the air feel against you skin?
- What does the atmosphere smell like?
- What can you see around you?
- What can you hear?

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

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

Appendices 14, 15, and 16 contain information for clients on the relaxation techniques described above.

Relaxation – tip sheet

There is a strong association between drug use and feelings of anxiety and stress. Various relaxation strategies can play an important role in a client’s treatment program. Clients who suffer significantly high levels of anxiety and stress may find relaxation training particularly beneficial.

Note that traumatised clients can have unpredictable and at times negative reactions to relaxation strategies, so when introducing such strategies these clients must be given permission to halt the process if feeling uncomfortable. Chapter 20 Grounding strategies can be more useful for some traumatised clients and are particularly useful for all traumatised clients in moments of extreme distress.

There are a number of different relaxation techniques. Several of the most popular are controlled breathing, progressive muscle relaxation and creating a safe place.

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

The majority of clients in AOD treatment have experienced trauma, with most research finding at least 25–35% of clients meet criteria for current posttraumatic stress disorder (PTSD) (Mills et al., 2003). Trauma reactions such as flashbacks, intrusive memories, panic, fear and dissociation can be prompted very easily in clients with PTSD, even by seemingly innocuous things such as a particular smell in the room, practising a breathing exercise, or the colour of the counsellor’s jacket. Relaxation strategies are not effective in these situations. Instead, ‘grounding strategies’ should be used to help clients focus their attention onto the outside world rather than inward on the traumatic memories. Grounding can also stop dissociation. Grounding is also referred to as distraction or healthy detachment (Najavits 2002).

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

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

The following points should be considered when introducing grounding.

- Grounding can be described to the client as ‘strategies to use for extreme emotional distress which distract you from that distress and focus you outside yourself’.
- It is useful to ask clients whether they have strategies they already use that help with extreme emotional distress.
- Introduce the grounding handout for clients in Appendix 17. Go through the handout with the client, asking them to note any strategies that particularly appeal to them. Counsellor and client can also use their imaginations to come up with other helpful grounding strategies that are more personal.
- Ask the client if they’d be prepared to practise a couple of strategies from the list in session. Assist them with this and ask for feedback.
- Ask them to look over the list at home and add strategies that already work for them, try out more of the new strategies and highlight those that work with highlighter pen or ticks.

Clients should practise the strategies, and reminders to use them in various places (such as a note in a diary, or a note stuck in their car or on the fridge) can also be helpful. Particularly useful grounding strategies can be listed on these reminder notes, along with a reminder to start 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, as this will encourage them to use them more often.

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

- having a picture on the wall to direct a client’s attention to and ask them to describe it in great detail
- 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 17.
20. Grounding

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.
Mindfulness is a form of awareness that emerges from ‘paying attention on purpose, in the present moment, and non-judgementally’ to on-going 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 mindful driving, mindful reading, or mindful eating.

21.1 Formal mindfulness strategies

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. Traumatised 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 traumatised 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.

21.1.1 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 18, illustrate the key themes of mindfulness of the breath and can be modified to suit the client’s needs.

Either close your eyes or gaze with a soft focus at the ground/your lap, whichever you prefer.

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.

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.

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 …

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9 This section is adapted from Marsh et al. (2012) Chapter 13 ‘Mindfulness’
21. 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 18.

21.1.2 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 that 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.

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’.

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.

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.
21. Mindfulness

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 19.

21.1.3 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 20.

21.2 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 www.actmadesimple.com.

21.3 Making up simple mindfulness strategies for clients

Germer (2005) describes 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 or drinking.
21. Mindfulness

- Ask clients to mindfully observe themselves when they use 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 returning their attention to the ocean.

21.4 Mindfulness and cognitive behaviour therapy

Mindfulness is considered to be part of cognitive behaviour therapy, but it is a very different way of dealing with difficult thoughts and feelings than cognitive restructuring. Instead of challenging dysfunctional thoughts as in cognitive restructuring, the idea of mindfulness is to acknowledge but not ‘buy into’ dysfunctional thoughts.

Some clients find that challenging problematic thoughts is more useful, whereas others 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 using thoughts initially, and then use cognitive defusion to not buy into them from then on. As an example of how the two approaches might be used at different times by a client, 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 on his responses, rather than becoming caught up in his anxiety about being seen as boring.

21.5 The therapeutic relationship and mindfulness

While little research has been done in this area, there are preliminary indications that therapist mindfulness is associated with better therapeutic alliance and client outcomes (Hick & Bien, 2008). By increasing their awareness of the ‘here and now’ counsellors can increase their ability to demonstrate skills in attentiveness and empathy, and to manage their emotional responses and enhance awareness of and hence ability to effectively manage countertransference reactions towards clients (Shapiro & Carlson, 2009).
21. Mindfulness

**Mindfulness – tip sheet**

Mindfulness is a form of awareness that emerges from paying attention to the present moment on purpose and non-judgementally. It entails observing and accepting thoughts, feelings and sensations without reflecting on their implications or trying to change them. It can help clients become less reactive to thoughts and emotions.

It is not suitable for trauma-related thoughts, feelings and distress that are overwhelming for the client – use grounding strategies instead.

**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 as they 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 focusing 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 thoughts 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 (CBT)**

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.

For further information and resources on mindfulness refer to Harris’s book *ACT Made Simple* (2009) or website http://actmadesimple.com/free_resources.
Anger management

Many clients experience difficulties related to anger management. Anger is a normal and adaptive human emotion, whereas maladaptive or dysfunctional anger is harmful to the client and their relationships. It can cause significant personal distress, such as feeling out of control, guilty and ashamed (Deffenbacher, 2011). Dysfunctional anger, and associated damaging behaviours, can also lead to adverse consequences such as strained relationships, difficulties in the workplace and legal issues. Problematic anger is often linked to previous experiences that have left people feeling powerless, lacking in self-worth, or threatened by others. Problematic anger is included in the diagnostic criteria of a number of psychological disorders, including PTSD and borderline personality disorder. Learning how to manage anger can be an end in itself for clients, and it can also be part of learning how to manage emotions so that counselling can safely address issues underlying the anger.

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 goal they would like to work towards. Motivational interviewing can be a very useful technique for clients who demonstrate ambivalence about their anger management.

It is important to normalise the client’s experience of anger, which is a common and often appropriate and understandable emotional reaction. This can reduce the client’s sense of shame about their anger problem, and encourage them to discuss the intensity and frequency with which they experience anger, and behaviours associated with anger. The client’s difficulties with 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).

22.1 Anger management steps

Step 1 Recognition

Clients often fail to recognise signs of anger until their anger has escalated to an explosive level. Helping clients to learn the signs that they are becoming angry is therefore very important. When anger is provoked there are not only strong emotions but also physical symptoms. The following is a list of physical symptoms commonly associated with anger.

- hot or flushed face
- tight, acid or painful stomach
- clenched fists
- grinding teeth, clenched jaw
- pounding heart
- shaking
- eye tension or twitching
- dry mouth or throat, voice quivering
- butterfly stomach, nausea
- shallow, rapid breathing
- skin rashes
- back or neck ache
- headaches.
22. Anger management

Step 2 Identify triggers
Next, it is important to teach clients to recognise the triggers associated with outbursts of anger. An effective way of doing this is to ask them to monitor their anger for up to a week. A written record is desirable, however a mental record will suffice. Identifying triggers entails exploring high-risk situations (see Chapter 15 *Relapse prevention and management*) and identifying anger-provoking situations, people, places, thoughts and emotions. Clients should also be encouraged to examine the role of alcohol and other drug use in provoking anger and making managing it difficult. For example, the use of alcohol or amphetamines can directly contribute to difficulties with anger management.

Step 3 Identify and challenge anger-inducing thoughts
Explore links between thoughts and 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 blame-worthy (Deffenbacher, 2011) so consider these themes in reviewing the client’s thoughts. Once the thoughts that result in anger outbursts have been examined, they can be challenged in terms of their accuracy and validity given the situation (see Chapter 18 *Cognitive restructuring*).

Step 4 Reduce levels of anger
Once clients learn to recognise anger and associated high-risk situations, a number of 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.

*Controlled breathing*
As anger levels increase, breathing tends to become more rapid and shallow. The controlled breathing technique (see Chapter 19 *Relaxation strategies*) can be an effective means of reducing immediate levels of tension.

*Backwards counting*
Silently counting backwards at an even pace, from 20 to 1 can provide time for some of the anger to dissipate and to think of a rational response to the situation.

*Pleasant imagery*
If anger is not too intense, imagining a peaceful and pleasant scene can be calming. This is too difficult to do when high levels of anger are being experienced.

*Time out*
If intense anger is experienced during interpersonal conflict, the ‘time out’ technique can be helpful. 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 they are becoming angry, they will signal that they require ‘time out’ but that they will return to discuss the situation once they have calmed down.

Step 5 Find alternative ways to express anger
In the event that the strategies outlined in step 4 do not help the client to reduce their levels of anger, it is necessary to help them find ways of expressing their anger when they are intensely angry, that do not result in negative consequences for themselves or others (e.g. vigorous exercise). It is important to find strategies that are suited to the individual client. Problem-solving can be a useful way of exploring possible strategies.
22. Anger management

Step 6 Differentiate aggression from assertiveness
Clients with anger problems usually need to learn ways to express their needs and perspectives appropriately. Assertiveness is typically referred to as the expression of needs, wants and opinions in a direct manner that does not involve hostility or rudeness (Jarvis et al., 2005). For tips on assertiveness training see Chapter 23 Assertiveness training.

Step 7 Relapse prevention and management
The process of preventing the return to the problematic expression of anger and effectively managing situations in which this does occur is not dissimilar to the process of relapse prevention and management used to address drug use (see Chapter 15 Relapse prevention and management).

The above steps should be effective in reducing anger outbursts and helping clients gain control over their anger. However, counsellors need to remain mindful 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

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

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

Step 3: Identify and challenge anger-producing thoughts, use the cognitive restructuring techniques discussed in Chapter 18 Cognitive restructuring.

Step 4: Reduce levels of anger by teaching the following strategies:
  • controlled breathing
  • backwards counting – counting backwards from 20 to 1
  • pleasant imagery – imagine a peaceful and pleasant scene if not too intensely angry
  • ‘time out’ technique for situations of interpersonal conflict.

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

Step 6: Differentiate aggression from assertiveness and teach assertive communication.

Step 7: Consider ways of preventing and managing relapse to problematic expression of anger.

Note: a Bill of Rights list is included as a client handout in Appendix 21.
Assertiveness training can be helpful for clients who tend to communicate in either an overly passive or overly aggressive manner.

### 23.1 Steps in assertiveness training

**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).

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 become hostile.

**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 with the client what they perceive to be 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).

**Discuss beliefs about assertiveness**

Spend some time discussing beliefs that the client may have about assertiveness (Jarvis et al., 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 deeper issues linked to experiences (often adverse) in people’s family of origin or previous relationships and can take time to work through.

It is also important to address common misconceptions about assertiveness. For example, some clients may believe that they should be assertive in all situations. On the contrary, 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 is threatened (McKay et al., 2009).

**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) provides 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
23. Assertiveness training

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

It is useful to adapt this handout to your client’s situation (Jarvis et al., 2005). Note: this list is included as a client handout in Appendix 21.

**Assertive communication skills**

In order to be assertive clients may benefit from 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).

**Example**

‘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!’)

**Practise challenging situations**

Clients should have the opportunity to practise assertive responses in challenging situations by role-playing in session, if they feel comfortable. 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 using behaviour is now in the past.’

**Dealing with requests**

Some clients may find it difficult to decline in response to a request. ‘Empathic assertion’ can be helpful when refusing requests in an assertive manner. This involves stating the refusal clearly while also indicating an understanding for the other person’s circumstances.
23. Assertiveness training

Fred is good at fixing computers and his friends are always asking him to come over and fix his computer at home for free. Fred’s brother has asked Fred to fix his computer, however 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.’

## Assertiveness training – tip sheet

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
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<tbody>
<tr>
<td>1.</td>
<td>Explain the difference between aggressive, passive and assertive communication.</td>
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<tr>
<td></td>
<td>- 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.</td>
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<tr>
<td></td>
<td>- 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.</td>
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<tr>
<td></td>
<td>- 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.</td>
</tr>
<tr>
<td>2.</td>
<td>Discuss the advantages of assertiveness and develop ‘assertiveness goals’.</td>
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<tr>
<td>3.</td>
<td>Explore beliefs and common misconceptions about assertiveness.</td>
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<tr>
<td>4.</td>
<td>Encourage clients to think more assertively. Use the ‘Bill of Rights’ included in Appendix 21. 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.</td>
</tr>
<tr>
<td>5.</td>
<td>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.</td>
</tr>
<tr>
<td></td>
<td>E.g. You-statement: ‘You make me so angry!’</td>
</tr>
<tr>
<td></td>
<td>E.g. I-statement and observer comment: ‘I feel angry when you’re late to pick me up from work.’</td>
</tr>
<tr>
<td>6.</td>
<td>Practise assertive communication. Use role-plays of challenging situations, such as responding to criticism or requests.</td>
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</table>
Group work is a common and useful form of therapy in the AOD field. There are many different types of groups, including support groups, task-focused and educative groups and therapeutic communities. The intricacies of group work are beyond the scope of this guide. Therefore this chapter will provide an overview of the broad issues underpinning basic group work and information applicable to group work in general.

Group therapy can be highly effective and provides many benefits including:

- providing peer support
- offering inspiration
- enhancing motivation
- reducing feelings of isolation and inadequacy
- providing role models of people who have overcome similar problems
- offering opportunities for clients to practise communication skills.

Yalom and Leszcz (2005) identified ‘therapeutic factors’ leading to therapeutic change in group therapies, some of which are outlined below:

**Instillation of hope**

The instillation 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, 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 provides clients with an opportunity to be helpful to another person and this can help them to feel better about themselves.

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

It is important that group members share a common goal. Conflict can arise when group members have discordant goals (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 as this allows the larger group to be broken down into subgroups for certain activities. Group size restrictions may not apply to education groups and may be influenced by the nature of the group or type of group members (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 et al., 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).
24. Group work

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 that are placed on the nature of the group work. Ground rules might include the following.

- The minimum number of sessions that the client is expected to attend.
- The expectation of punctuality. Clients should give advance notice when they are unable to attend.
- Clients should not attend the group under the influence of alcohol or 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 does occur try to contact the group member before the next group meeting. Discuss any concerns or shame that they may be experiencing about their intoxicated behaviour and coming to the next session). If you have a co-facilitator, it can be useful to take the intoxicated person 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; however group members should only discuss their own personal experiences, 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 (Gillaspy et al., 2002). Encouraging group alliance and cohesion is a crucial task of group facilitators. There are numerous ways that this can be facilitated, 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 with each other by talking to each other and asking each other questions.

Example

‘Fred it sounds like you agree with Freda about how difficult it is not to relapse. Does 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 further builds a sense of togetherness and group cohesion. Simply acknowledging any words of support, concern or encouragement offered by group members can do this.

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.

24.1 Stages of group development

Groups tend to go through five stages as they develop. The following description is drawn from Tuckman (1965) and Tuckman and Jensen (1977):

1. Forming: The group comes together and gets to know one other. They tend to look to group leaders for guidance and avoid serious feelings and topics.
2. Storming: Group members experience conflict and competition as they work out leadership and control, who is responsible for what, and what the group rules are.
3. Norming: This stage is characterised by group cohesion as agreement is reached on how the group operates.
24. Group work

4. Performing: This stage is not reached by all groups, but when it is, there is true interdependence among group members and the group is able to problem-solve and work effectively on meeting its objectives.

5. Adjourning: The process of dissolving the group once the tasks are completed, and disengaging from group relationships. There should be recognition of participation and achievement and opportunity for group members to say their goodbyes.

<table>
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<th>Group work – tip sheet</th>
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<td>Group work is an effective component of AOD treatment.</td>
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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. There are a number of important factors that can influence the success of the group. These include the following:
- Group members working towards a common goal.
- Group size – optimal numbers are six to nine participants.
- Gender makeup of the group – single-sex 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:
  - 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
  - confidentiality – any issues discussed during the group should remain 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 go through five stages: forming, storming, norming, performing, and adjourning.
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). Residential settings vary in approach. Counselling in this setting involves a range of approaches described in this guide, usually including motivational interviewing, 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.

25.1 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 use issues
- history of unsuccessful non-residential or short-term treatment
- home environment and social circumstances unsupportive of non-residential treatment approaches
- significant co-occurring issues.

Note that a number of clients will relapse after completing a residential treatment program. This does not mean that they are not ‘suitable’ for a residential setting and should not preclude them from future engagement with a residential setting.

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).

25.2 Engaging clients into residential settings

If a residential setting seems suitable for a client, the counsellor 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 relevant contacts
- addressing any concerns and misconceptions
- helping the client to work through ambivalence using a decisional balance approach
- highlighting the potential benefits of residential treatment given their circumstances
- encouraging the client to attend an information or assessment session with the relevant 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 support the client during their initial engagement and assessment with a residential setting and to prepare them for the possibility of a lengthy assessment process.

Residential programs may differ in a number of ways including:

- government and non-government managed
- therapeutic community as the primary service or a component of overall service
- involvement of significant others or strict boundaries in this regard
- emphasis on individual counselling, group work, or a combination
25. Residential settings

- 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+)
- located in inner city, outer metropolitan and regional areas
- varied bed capacity from less than twenty to over a hundred.

25.3 Therapeutic communities

AOD residential settings often centre on the formation of a therapeutic community to facilitate change. The treatment facility is a community itself with the emphasis on self-help and mutual support as a vehicle for effecting change.

Therapeutic communities view long-term problematic AOD use as a disorder that affects the ‘whole person’ and requires significant changes to lifestyle and identity (De Leon & Wexler, 2009). Residential settings, and therapeutic communities in particular, are recognised as the ‘treatment of choice’ for clients with long-term and severe AOD issues (De Leon, 2010). Therapeutic community approaches are most effective when a broad range of interventions are incorporated to address the client’s needs (Timko et al., 2000). 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). The residents participate in the management and operation of the community, which is the principal means of promoting change, and there is a focus on substance use from a social model of health perspective (Gowing et al., 2002).

Community as method

One of the fundamental views 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 the member’s 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 members move through the program the community has a number of expectations of what will unfold (De Leon, 2000):
1. The community members’ roles and obligations in work, groups, meetings and recreation will increase.
2. Responsibility and accountability will extend from self to immediate peers and eventually the entire community.
3. The member will improve their self-awareness of personal change issues.
4. The member will develop autonomy and initiate change without dependence on others.

Staged approach

There are different stages of a therapeutic community in line with these expectations. Members’ responsibilities increase as they move through the stages to the extent that they eventually adopt a peer support role to newer residents. Part of a client’s initial engagement in a residential setting is the use of a ‘buddy’ system. When a client enters a therapeutic community they are often assigned a peer who provides support and helps them to adjust to the community.
25. Residential settings

As the client’s mental health and general well-being improves they are encouraged, and indeed expected, to take on more responsibility and provide support to others. 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 issues 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.

25.4 Counselling
Residential settings can help clients to work through problematic AOD use and co-occurring issues in a safe and supportive environment. While 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 while others have established individual counselling processes that complement and support the ‘community as method’ model. Informal learning through community recreation, relaxation, decision-making, problem-solving and empathy are 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 therapeutic 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 problems. 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 problems of 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 motivational interviewing, goal-setting, problem-solving and relapse prevention. 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
25. Residential settings

- establishing a basic ‘exit package’ with relevant information, telephone numbers and websites
- arranging referrals for continued community support
- scheduling follow-up sessions.

It is important for counsellors to maintain adequate supervision arrangements when working in a residential setting. This is particularly important as the counselling is often intense and the counsellor’s role in this setting is complex.

### Residential settings – tip sheet

Clients who meet the following criteria should be prioritised for long-term residential treatment:
- severe and long-term AOD use issues
- history of unsuccessful non-residential or short-term treatment
- home and social environment unsupportive of non-residential approaches
- significant co-occurring issues.

Engaging clients into residential settings includes the following:
- providing the client with information and relevant contacts
- addressing concerns and misconceptions
- helping the client to work through ambivalence
- highlighting potential benefits of a 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.

There are diverse residential settings in the AOD field. 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 of 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
- addressing issues of retention in treatment.

Following initial engagement, counselling in a residential setting will be dependent on the client’s presenting problems. Counselling should follow an evidence-based approach and should 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.
Managing intoxicated clients

It is likely that a counsellor working with alcohol and other drug users will at some stage have to manage a client who is intoxicated. Intoxicated clients can behave inappropriately and become verbally and/or physically abusive to counsellors, staff, or other clients.

If the client is not heavily intoxicated or incapacitated, it may be beneficial to have a time-limited session. Do not overlook 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 alcohol or other drugs. It is important that counsellors establish boundaries concerning acceptable levels of intoxication. This will depend on the agency, the client, the goal of therapy and the client’s behaviour while intoxicated.

If a client presents in a heavily intoxicated state, the counsellor should usually 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. In addition, depending on the client’s behaviour and appearance, the counsellor may need to arrange medical attention for the client (Glidden-Tracey, 2009). This may be achieved through the client contacting an appropriate friend or family member to make arrangements for medical attention. Alternatively, the counsellor may need to call a hospital emergency department.

If a client is heavily intoxicated they need to be oriented to what your role is and where they are. Intoxicated clients may find it difficult to understand what the counsellor says and they may take offence if they believe you are condescending.

Clients who present with methamphetamine intoxication may display symptoms of psychosis, including paranoia, delusions (of grandiosity, control and persecution), misperceptions and hallucinations. When clients are exhibiting symptoms of psychosis, consider how odd thoughts might relate to drug use and withdrawal, explore whether the symptoms are transient, episodic or prolonged, and assess whether the client has any insight into their symptoms.

26.1 How to approach intoxicated clients

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

26.2 Some general guidelines for managing intoxication

- Breathe (don’t panic).
- Assess the situation including your safety, client safety and the safety of others. Enlist other staff to help you manage the situation if necessary.
- Where possible, identify the substances that have caused the intoxication to assess levels of risk and anticipated behaviour.
- Duty of care. Consider your responsibility to your client’s safety (e.g. try to stop very intoxicated clients from driving or leaving alone).
- Limit the duration of the session. Don’t overlook the fact that the client has made an effort to attend the appointment. Listen to the client and explain that being intoxicated interferes with counselling. Negotiate that they will be less intoxicated for next session.
- Avoid being judgemental.
26. Managing intoxicated clients

26.3 Managing methamphetamine intoxication

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

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

Managing intoxicated clients – tip sheet

How to approach intoxicated clients.

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

Some general guidelines for managing intoxication:

- Breathe (don’t panic).
- Assess the safety of the situation and enlist other staff if necessary.
- Where possible, identify the substances that have caused the intoxication to assess levels of risk and anticipated behaviour.
- Duty of care. Consider your responsibility to your client’s safety.
- Limit the duration of the session. Explain that being intoxicated interferes with counselling. Negotiate that they will be less intoxicated for next session. Avoid being judgemental.
Managing aggressive clients

Aggressive behaviour is not uncommon in AOD services. If a client’s behaviour becomes particularly aggressive, and potentially violent, then it is important to act in line with the policies and procedures of the service. In general, aggressive episodes are triggered by an initial event, which may include circumstances that render the client feeling threatened or frustrated (Mills et al., 2009).

27.1 Avoid triggering an aggressive episode

To avoid triggering an aggressive episode, consider the client’s personal space, avoid standing over the client (i.e. sit if they are sitting) and keep your body posture non-threatening (Mills et al., 2009). On a practical level, maintain a non-stimulating environment and inform the client of any potential delays.

27.2 Managing safety with an aggressive client

If a client has become 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 level of 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 are willing to enter a counselling room with an aggressive client, either leave the door open or make sure that both of you have an easy exit. Ensure that there is easy access to help, be it through a telephone, emergency button, duress alarm, or yelling. If you are enlisting the help of other people, request that they stand at the periphery as crowding may lead to further escalation (Mills et al., 2009). It is also important to consider that the presence of an appropriate friend or family member may help to calm an aggressive client (Mills et al., 2009).

27.3 Communicating with an aggressive client

The following guidelines may be helpful in communicating with an aggressive client in order to avoid escalation:

- Remain calm and speak slowly and gently.
- Listen actively to the client and reassure them that you want to hear what they have got to say.
- Acknowledge the problem, validate the client’s feelings and empathise with them (e.g. ‘I understand that you are angry and frustrated right now’).
- Indicate possible alternatives to alleviate the anger-provoking situation (e.g. ‘I want to be able to understand what is really going on and how we can sort it out’).
- Do not make any sudden movements or behave in ways that could be interpreted as threatening.
- Don’t take the client’s comments or behaviour personally.
- Be non-judgemental and avoid confrontation as well as anything the client can interpret as insincerity and ridicule (this may include smiling).

Managing intoxicated or aggressive clients can be a harrowing and traumatic experience for counsellors. Make sure that you debrief to another member of staff or your supervisor after an incident (refer Chapter 28 Critical incidents).
# Managing aggressive clients

**Managing aggressive clients – tip sheet**

If a client has become aggressive, consider safety issues:
- Assess the client’s aggression and the level of risk. If you are concerned about the level of risk, do not confine yourself to a room alone with an aggressive client.
- If you are willing to enter a counselling room with an aggressive client, leave the door open or ensure that you have an easy exit and access to help.
- If you are enlisting the help of other people, request that they stand at the periphery (crowding can lead to further escalation).
- Also note that the presence of an appropriate friend or family member may help to calm an aggressive client.

The following are some basic guidelines to consider in communicating with an aggressive client in order to avoid escalation:
- Remain calm and speak slowly and gently.
- Listen actively to the client and reassure them that you want to hear what they have to say.
- Acknowledge the problem, validate the client’s feelings and empathise with them.
- Indicate possible alternatives to alleviate the anger-provoking situation.
- Do not make any sudden movements or behave in ways that could be interpreted as threatening.
- Don’t take the client’s comments or behaviour personally.
- Be non-judgemental and avoid confrontation.
Critical incidents

Critical incidents are sudden unexpected events that can be perceived as psychologically or physically threatening, such as verbal threats or physical assaults. These events often make overwhelming demands on the person’s ability to cope in the short-term and can result in strong emotional and physiological reactions. People react to stressful events differently. Following a critical incident, some people may find it extremely difficult to function normally in the workplace. Note that agencies will have different policies and procedures in place to manage 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, may have a negative impact on recovery (Rosen & Frueh, 2010). 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 (Devilly & Annab, 2008). As outlined below, social support is an important factor in the aftermath of a crisis situation. Consequently, debriefing may be offered to an individual following a critical incident; however it is strongly recommended that the process should not be mandatory.

The principles of Psychological First Aid (Brymer et al., 2006) should be considered in helping people to recover from a critical incident in the workplace. If a staff member continues to have difficulties following a critical incident then it is appropriate to encourage a formal intervention, such as counselling or psychotherapy.

28.1 Principles of psychological first aid

Psychological First Aid is an evidence-informed supportive approach that aims to foster normal recovery in the aftermath of a traumatic event (Brymer et al., 2006). The central themes of this approach should be considered in helping people to recover from critical incidents in the workplace. The approach is non-intrusive, practical and aimed at building upon available social supports and adaptive coping skills.

The Psychological First Aid approach outlines some behaviours to avoid in talking with someone following a critical incident. Of note, do not assume that someone who has experienced a critical incident will be traumatised. In addition, avoid ‘pathologising’ and referring to PTSD or labelling normal reactions as ‘symptoms’. If a co-worker has experienced a critical incident, be calm and supportive to help the person to feel safe, but avoid being intrusive or assuming that your colleague will want to talk to you about it.

28.2 Support

A consistent finding in the literature is that social support can buffer the impact of a traumatic event (Rosen & Frueh, 2010). Recovery from traumatic events is associated with the amount of quality social supports an individual has access to, as well as their inclination to utilise supports. Following a critical incident it is important that practical and immediate support be provided to those who are distressed. Encourage connection with primary supports, such as a partner or close friend, in the aftermath of a critical incident (Brymer et al., 2006). In addition, a co-worker who was not involved in the event may help to provide informal support and assistance to a colleague who has experienced a critical incident. Offering support to someone who has experienced a critical incident is not counselling, however confidentiality should still be adhered to.

Some guidelines for offering support include the following.

- Be available to those affected. Initiate contact but avoid intruding.
- Accept the response you get from the person under stress. Don’t judge their feelings or make interpretations about motives. Don’t take their anger or feelings personally.
- Be interested in the person, not just the situation.
- Be supportive in a practical way – make them a cup of tea.
- Listen to what is being said. Most people feel reassured and assisted by just having someone to talk to.
28. Critical incidents

- Give choices and options for consideration. Share ideas on what you think would help, or what has worked for you and others you know.
- Don’t tell the person that they are lucky it wasn’t worse, or that they are better off than some people.
- Remember that you are not responsible for how the person handles the situation or incident.
- Don’t expect to always have the answers to questions, or to be able to fix the person’s problems.
- Know your limits. Be aware of any ongoing problem behaviours, declining emotional condition, or other reactions that indicate that the person may need professional help.
- Diffusing. This involves listening to the affected person’s problems and concerns and acknowledging that they may be having difficulties. You can tell them what the organisation can offer to support them and what options they can consider and encourage them with a positive comment or validation for the way that they managed the critical incident.

If you find that the person who experienced the critical incident continues to have difficulties such as excessive anxiety at work, 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.

28.3 Documenting critical incidents

In the event of a critical incident it is important to record the following:
- when it occurred (date and time)
- where it occurred
- what happened (observations only, not opinions)
- who was involved in the incident and who was present
- in the event of injuries, the person’s condition before and after the injuries
- action taken by staff
- whether the incident was reported and if so, to whom (name, position and agency).

28.4 Self-care

It is important to consider self-care strategies in the event that you are involved in a critical incident. Looking after yourself can lessen the impact of the incident. Self-care strategies may include:
- knowing reactions and what to expect from yourself
- accept stress reactions
- exercise
- adequate rest and sleep
- relaxation and meditation.
28. Critical incidents

### Critical incidents – tip sheet

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

People react differently to stressful events; there is no right or wrong way to respond to a critical incident. Formal debriefing interventions may have a negative impact on recovery. It is clear from the literature that social support can buffer the impact of a traumatic event. Following a critical incident it is important that practical and immediate support is provided to those affected. 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.

If you are involved in a critical incident ensure that you consider self-care, such as allowing time for relaxation and adequate rest and sleep.

#### 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.

- Be available to those affected. Initiate contact but avoid intruding.
- Accept the response you get from the person under stress.
- Be interested in the person, not just the situation.
- Be supportive in a practical way – make them a cup of tea.
- Listen to what is being said. Most people feel reassured and assisted by just having someone to talk to.
- Give advice and share ideas on what you think would help or what has worked for you and others you know. Give choices and options for consideration.
- Don’t tell the person that they are lucky it wasn’t worse, or that they are better off than some people.
- Remember that you are not responsible for how the person handles the situation or incident.
- Don’t expect to always have the answers to questions, or to be able to fix the person’s problems.
- Know your limits. Be aware of any ongoing problem behaviours, declining emotional condition, or other reactions that indicate that the person may need professional help.
- 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.
Withdrawal from drug dependence entails the experience of physical and psychological reactions as the person adjusts to not having the drug present in their body. Withdrawal can be managed in an inpatient or home setting and may be medicated or non-medicated. Medication is often used to help manage withdrawal symptoms, complications, and concomitant medical conditions.

Clients should be provided with education and support throughout the withdrawal process (Mills et al., 2009), and be encouraged to consider strategies to help them to manage withdrawal symptoms and avoid relapse. Important components of preparing a client for withdrawal are:

- providing information about what to expect for both the client and their support people
- helping the client develop a plan to cope with the withdrawal
- ensuring the availability of appropriate support
- organising access to medication, as needed, by linking the client with a doctor or a home-based withdrawal service
- helping the client to plan follow up support and treatment.

Clients can fear withdrawal and have concerns about the setting, physical consequences, medication and 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 and should also be provided with written information. There are also various self-help booklets for clients about what to expect from withdrawal, tips for managing the process, and help with relapse prevention. For example, Turning Point Alcohol and Drug Centre in Victoria produces a range of small booklets for clients to assist them with giving up alcohol, amphetamine, heroin and methadone.

A comprehensive assessment is essential in order to arrange the appropriate withdrawal treatment approach for the client. The course of the withdrawal process, and hence the appropriate treatments and supports needed, depend upon:

- the drugs being used
- the severity of dependence and hence the degree to which neuroadaptation must be reversed
- co-existing medical and mental health issues
- past history and experience of withdrawal
- psychosocial factors, such as the physical environment, support, expectations, motivation and fears
- the client’s reasons for withdrawing
- the client’s motivation for abstinence.

(Allen et al., 2005; NSW Department of Health, 2008; Saunders et al., 2002)

Matching the appropriate withdrawal treatment to the client should take account of the client’s safety, the likelihood of successful withdrawal, and the client’s preference based on the information presented to them. 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 use
- previous attempts to detoxify as an outpatient have been unsuccessful
- there is a lack of social support
- the client is pregnant.

(Saunders et al., 2002)

Outpatient withdrawal is most appropriate when:

- the client is not severely dependent
- there have been no previous complicated withdrawals
29. Withdrawal management

- there are no significant complicating medical or mental health issues
- there is no significant polydrug use
- the person has a stable home environment
- a non-using carer is present to provide support, monitor progress and control medications
- the client is strongly motivated for abstinence.

(Saunders et al., 2002)

As medical assistance is often required for outpatient withdrawal, clients should be linked with a home-based withdrawal service wherever possible.

Several other issues of note:
- Managing withdrawal for clients with polydrug dependency requires careful consideration. The literature supports a gradual or stepped withdrawal approach whereby clients withdraw from one drug at a time, typically starting with the substance associated with the potential for a moderate or severe withdrawal (NSW Department of Health, 2008).
- Attempt to engage non-using significant others as supports for the client.
- Ideally, treatment to manage withdrawal should be a gateway to further treatment, including a link to ongoing treatment services or relapse prevention pharmacotherapies. Commitment to ongoing treatment should not, however, be a prerequisite for admission to a withdrawal management program.
- Inpatient withdrawal management should never be insisted upon. For example some women may feel unsafe in an inpatient environment (Swift & Copeland, 1998), particularly if they have a history of sexual abuse. In such instances premature discharge can occur.
- Pregnant women should always be referred to specialist drug and alcohol services and linked with antenatal obstetric services. Withdrawal management should usually occur as an inpatient as some withdrawal symptoms can place the pregnancy at risk.

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

29.1 Alcohol

Clients who regularly drink beyond recommended limits should be assessed for withdrawal symptoms and previous symptoms of withdrawal. A scale to assess alcohol withdrawal symptoms (CIWA-Ar) has been included in Appendix 3 to assist counsellors. People who regularly drink large amounts of alcohol (over 8–10 standard drinks a day) are at risk of experiencing withdrawal symptoms and should be referred to a doctor.

Typically, the onset of withdrawal is 6–24 hours after the last drink and duration is 2–3 days without treatment, but can last up to 10 days (NSW Department of Health, 2008). Withdrawal symptoms include sweating, tachycardia, hypertension, tremor, fever, lack of appetite, nausea, vomiting, upset stomach, diarrhoea, poor concentration, anxiety, psychomotor agitation, disturbed sleep and vivid dreams. Severe withdrawal symptoms include dehydration and electrolyte disturbances, seizures, hallucinations or perceptual disturbances and delirium.

Alcohol withdrawal seizures are experienced by 2–9% of people who are alcohol dependent, they typically occur within 6–48 hours after the cessation of drinking, and a history of alcohol withdrawal seizures predicts an increased risk of experiencing seizures during subsequent alcohol withdrawals (Haber et al., 2009).

Wernicke-Korsakoff’s syndrome is another issue for counsellors to be aware of, as it is greatly under-diagnosed (Haber et al., 2009). Wernicke’s encephalopathy is a form of acute brain injury found in some alcohol dependent clients caused by thiamine (vitamin B1) deficiency. Symptoms include confusion or mental impairment, ataxia and unusual eye movements (nystagmus or ophthalmoplegia) and clients can exhibit some or all of these symptoms. Wernicke’s encephalopathy is initially reversible with large doses of intravenous thiamine, but if left untreated leads to permanent cognitive impairment termed ‘Korsakoff’s syndrome’ in which there is short-term memory loss, impaired ability to acquire new information, and compensatory lying
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and invention (Haber et al., 2009). As a preventive measure, all heavy drinkers should be encouraged to take oral thiamine.

Residential medical withdrawal is indicated when there is a high probability of the client experiencing a severe withdrawal syndrome. The following factors are likely to predict greater withdrawal severity:

- chronic heavy alcohol consumption (e.g. more than 150 g or 15 standard drinks a day)
- onset of withdrawal symptoms upon waking that are relieved with morning drinking
- past history of severe alcohol withdrawal syndrome (anxiety, seizure, delirium, hallucinations)
- concomitant physical or psychiatric conditions
- heavy or regular use of other drugs (opioids, benzodiazepines, stimulants).
(Haber et al., 2009)

Other factors that might indicate the need for residential withdrawal include repeated failure at home-based withdrawal, an unsuitable home environment (other people using AOD, no appropriate supportive adult), or an unclear AOD history (Haber et al., 2009).

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


29.2 Benzodiazepines

The onset of withdrawal from benzodiazepines is typically 1–10 days after last use and the duration of withdrawal is 3–6 weeks, depending upon the benzodiazepine (NSW Department of Health, 2008). For clients dependent on benzodiazepines, the sudden cessation of benzodiazepines can be dangerous. In rare cases, abrupt discontinuation of benzodiazepines can lead to full tonic-clonic seizures and even death. The more common withdrawal symptoms include anxiety, restlessness, agitation, headaches, sensitivity to light and sound, palpitations, delirium, visual hallucinations, paranoid thoughts, muscle spasms.

The assistance of a medical practitioner should be secured as withdrawal from benzodiazepine dependence usually entails switching the client from short- to long-acting benzodiazepines (usually diazepam) and then gradually reducing the dose. A slow outpatient withdrawal regime under medical supervision is usually recommended and is quite safe.

29.3 Opioids

Withdrawal symptoms from cessation of dependent opioid use usually start 6–24 hours after the last dose and persist for approximately 5–10 days, depending upon the opioid (NSW Department of Health, 2008). Withdrawal from opioids results in a number of flu-like symptoms, including irritability, restlessness, nausea, vomiting, diarrhea, insomnia, muscular and abdominal pains, hot/cold sweats, runny nose and ‘goose flesh’. These symptoms can be managed effectively in both inpatient and outpatient settings, depending upon a client’s medical, psychiatric and social functioning and support.


29. Withdrawal management

The management of withdrawal symptoms may be medicated or non-medicated. Opioid agonist pharmacotherapies (methadone and buprenorphine) and clonidine hydrochloride can help relieve withdrawal symptoms and can be used on an inpatient or outpatient basis. However, the effects and pattern of symptoms observed with opioid pharmacotherapies as opposed to clonidine hydrochloride are different, with unpleasant side effects more likely with clonidine, but a longer withdrawal period with opioid agonist pharmacotherapies. Clonidine reduces blood pressure and is not suited to some clients.

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

29.4 Amphetamines

The onset of withdrawal from amphetamines is 12–24 hours after the last dose and the withdrawal is defined by three phases (crash, withdrawal, and extinction) over the course of several months. Typically the symptoms of amphetamine withdrawal can include dysphoria, lethargy, poor concentration, hunger, anxiety, depression, irritability or restlessness and sleeping difficulties (long but disturbed sleep or insomnia). Generally the acute symptoms of withdrawal last for 1–2 days, with some symptoms lasting for a period of months (e.g. sleeping and mood difficulties).

As the symptoms of amphetamine withdrawal are rarely life-threatening, withdrawal management does not need to occur in an inpatient setting. However, a client’s medical, psychiatric and social functioning needs to be considered when making this decision.

While medication is not always necessary, clients may benefit from individualised symptomatic prescription of benzodiazepines, antidepressants or antipsychotics, though evidence regarding the efficacy of pharmacological treatments of amphetamine withdrawal is limited (Pennay & Lee, 2011).

29.5 Cannabis

The onset of withdrawal from cannabis is within 24 hours after the last dose and the withdrawal usually takes 1–2 weeks, with different withdrawal symptoms peaking at different times (NSW Department of Health, 2008). Many symptoms have, however, been found to last in mild form for longer, with anger, irritability and physical tension persisting for up to a month for some people (Kouri & Pope, 2000). Symptoms of cannabis withdrawal can include restlessness, physical tension, insomnia, sweating, upset stomach, loss of appetite, tremors, irritability, anxiety and depressed mood. These symptoms tend to be milder than those for other drugs because cannabis leaves the body slowly.

To date there are no medications approved specifically for treating cannabis dependence and withdrawal and there is a need for controlled clinical trials of candidate pharmacotherapies (Weinstein & Gorelick, 2011). However, depending upon the severity of the symptoms and the other physical or mental health issues the client has, medication for symptomatic relief can at times be useful. Inpatient withdrawal treatment is rarely appropriate for cannabis dependence.

29.6 Scales for assessing withdrawals

The measurement of withdrawal syndromes where 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 Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) scale (Reoux & Miller 2000) and Objective Opiate Withdrawal Scale (OOWS) (Handelsman et al., 1987). However, withdrawal scales for those syndromes where symptoms are subjective and few objective signs have been identified (such as benzodiazepines, amphetamine and cannabis withdrawal) may be less useful.

Withdrawal scales for alcohol, opioids, benzodiazepines, amphetamines and cannabis are included in Appendices 3 to 7 of this guide. Of note, all these scales have research evidence indicating reliability and validity.
29. Withdrawal management

29.7 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 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.

For more detailed information on assisting clients with withdrawal see: NSW Department of Health (2008) *Drug and Alcohol Withdrawal Clinical Practice Guidelines*.

###Withdrawal management – tip sheet

Withdrawal involves various physiological and psychological reactions as a person adjusts to not having a drug present in their body. Several factors impact on the course, intensity, and duration of withdrawal, including:

- type of drug(s) used
- severity of dependence and tolerance
- co-existing 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 be with or without medication depending on the severity of dependence and client choice.

In general residential withdrawal is suggested by:

- severe dependence
- history of complicated withdrawals
- unstable home environment
- concurrent psychiatric or health problems
- lack of non-drug using supports.

In general outpatient or home withdrawal is suggested by:

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

Attention should be given to the following issues.

- When clients are considering withdrawal options always tell them what to expect and discuss problem-solving coping strategies and relapse prevention. It is useful to provide self-help booklets.
- If clients are wishing to undergo home-based withdrawal, provide information regarding what to expect to both the client and their support people, and involve a home-based withdrawal service if desired and appropriate.
- Attempt to engage non-using significant others as supports for the client.

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29. Withdrawal management

Withdrawal management – tip sheet

- 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.
- For clients with polydrug dependency, withdrawal from one substance at a time may be most successful.

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

Alcohol
- Chronic heavy alcohol consumption, past severe withdrawal symptoms, and concomitant substance use and medical or psychiatric conditions increase the risk of severe withdrawal.
- 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 and risk of relapse.
- Withdrawal from benzodiazepines should involve swapping from a short- to a long-acting benzodiazepine (usually diazepam) and a gradual reduction in dose as sudden cessation can result in seizures.
- A medical practitioner should always be engaged to assist with managing withdrawal from benzodiazepines.

Opioids
- Symptomatic treatment with clonidine or a short course of buprenorphine are the preferred medications to treat opioid withdrawal.
- Opioid withdrawal should not be encouraged during pregnancy. Methadone or buprenorphine maintenance is recommended instead.

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

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

Pharmacotherapies should not be seen as standalone treatments but are optimally used in conjunction with other psychosocial interventions for most drugs of dependence. Counsellors need a basic understanding of addiction pharmacotherapies 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 in Australia by medical practitioners who have undergone a training program to become approved prescribers. Any medical practitioner can prescribe other addiction pharmacotherapies.

### 30.1 Pharmacotherapies for opioid dependence

Pharmacotherapies for opioid dependence generally 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’. They have a longer duration of action than the drugs of dependence, thereby delaying the onset of opioid withdrawals and reducing frequency of use and hence reducing drug-related disruptions to daily life. Drug substitution 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. Agonists include methadone and buprenorphine.

The aims of substitution treatment are to:

- reduce illegal drug use
- improve physical and mental health
- reduce criminal activities
- reduce risk of opioid overdose
- reduce sharing of injecting equipment and hence transmission of blood-borne viruses.

Once a stable dose is achieved, and if the client is not using other drugs (particularly 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.

#### 30.1.1 Methadone

Methadone is a long-acting synthetic opioid (mean half-life with ongoing dosing is 24 hours) usually administered in liquid form. Methadone results in cross tolerance and reduces heroin withdrawal symptoms, the desire to use heroin and the euphoric effect when heroin is used.

Initially the aim of treatment is usually maintenance but there can be a longer-term goal of abstinence. Methadone is effective in retaining clients in treatment, reducing heroin use, criminal activity, overdose deaths and risk of HIV transmission. During induction on to treatment there is an increased risk of overdose death and clients need to be inducted slowly and monitored regularly during this period. Once the dose is stabilised (about 2 weeks) the risk of death from overdose is considerably lower than prior to methadone treatment. Withdrawal symptoms from methadone are usually more protracted but less intense than withdrawal symptoms from heroin.

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13 This section is adapted from information in Gowing et al. (2013) National policy and guidelines for medication-assisted treatment of opioid dependence.
30. Pharmacotherapies for AOD dependence

Clients describe more sedation, opioid-like effects and impact on cognition with methadone compared with buprenorphine. This can be useful for clients experiencing psychological distress.

Methadone is generally taken orally under supervision on a daily basis. Some take-home doses are made available with increased time on the treatment and demonstrated client stability.

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

30.1.2 Buprenorphine

Buprenorphine (Subutex, Suboxone) is an opioid analgesic with partial agonist effects and high receptor affinity. Its action is similar to that of full agonist drugs such as methadone, except that increases in dose have progressively less effect as receptor sites become saturated. The partial agonist effect of buprenorphine means that its respiratory effect reaches a ceiling and further addition of 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 and 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 which is a sublingual tablet consisting of a combination of buprenorphine and naloxone. Naloxone is an opioid antagonist that when absorbed into the bloodstream precipitates withdrawals 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. A film preparation containing buprenorphine and naloxone has also become available in Australia as of 2012.

The reduced sedation, opioid effects, and impact on cognition that clients report with buprenorphine in comparison to methadone make it suitable for many clients. Withdrawal symptoms from cessation of long-term buprenorphine treatment typically emerge 3–5 days after the last dose and persist at a mild level for several weeks. Withdrawal symptoms may be milder than those for other opioids including heroin and methadone.

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

Buprenorphine is not currently fully approved for use in pregnancy though it appears to be effective and safe. Many pregnant women continue buprenorphine knowing its effects are still being researched. Pregnant women taking buprenorphine should be on Subutex as it does not contain the added drug naloxone. Babies born to mothers on buprenorphine experience a milder neonatal abstinence syndrome than babies born to mothers on methadone.
30. Pharmacotherapies for AOD dependence

30.1.3 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 withdrawals and 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 a minority of clients report headaches, sedation or nausea.

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

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-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 pregnant women, and clients with major mental health issues, renal problems and multiple drug dependence.

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

30.2 Pharmacotherapies for alcohol dependence\(^{14}\)
Common pharmacotherapies for alcohol dependence include naltrexone, acamprosate 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 problems if they have not benefited from psychosocial interventions (Lingford-Hughes et al., 2012).

30.2.1 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 on an ‘as-needed’ basis when cravings occur or when a client is facing a potentially heavy-drinking situation. There is no evidence that it prolongs abstinence.

Naltrexone is usually taken orally though depot and implantable forms are being investigated. It is safe to take while clients are still drinking and the most common side effects are nausea and sedation. Naltrexone should be taken for at least 6 months and preferably longer.

30.2.2 Acamprosate
Acamprosate (Campral) normalises alcohol-induced abnormalities in neurotransmission. It increases abstinence and many but not all reviews find that it can reduce heavy drinking during relapse. It should be started during withdrawal and be prescribed for at least a year. Positive benefit seems to persist 3–12 months after ceasing treatment.

\(^{14}\) This section is adapted from information in Lingford-Hughes et al. (2012)
30. Pharmacotherapies for AOD dependence

Acamprosate is taken 3 times a day with food, a regime that some clients can struggle to maintain. It is usually well tolerated and the most common side effect is gastrointestinal disturbance (nausea, diarrhoea).

30.2.3 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 and hence disulfiram is used with caution. It can only be started once a client has been alcohol-free for 24 hours and there can potentially be a reaction with alcohol for up to 7 days after stopping it.

Disulfiram appears to be effective if clients are motivated for abstinence and administration is supervised.

30.3 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. 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).

There is no evidence to date that any pharmacotherapy for amphetamine, cocaine or cannabis dependence can reduce relapse (Lingford-Hughes et al., 2012).

There are several pharmacotherapies for nicotine dependence including nicotine replacement therapies (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 but are optimally used 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 compared with 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.
### Pharmacotherapies for AOD dependence – tip sheet

**Naltrexone**
- Naltrexone is an opioid antagonist that displaces opioids from the receptors in the brain and has no opioid effect. When opioids are taken in the presence of naltrexone they 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 for abstinence.
- Oral naltrexone is associated with increased risk of fatal overdose should the tablets be ceased and heroin used, due to markedly reduced tolerance.
- Implantable or depot forms of naltrexone may be more successful in treatment of opioid dependence and research is underway.

**Pharmacotherapies for alcohol dependence**

**Naltrexone**
- Naltrexone blocks the functioning of the endogenous opioid system in the brain, and as a result appears to reduce the pleasurable effects from alcohol consumption and hence reduces heavy drinking should a lapse occur. It can therefore be used on an ‘as-needed’ basis when cravings occur or when a client is facing a potential heavy-drinking situation.
- There is no evidence that it prolongs abstinence.

**Acamprosate**
- Acamprosate (Campral) normalises alcohol-induced abnormalities in neurotransmission.
- It increases abstinence and many but not all 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 and therefore disulfiram is used with caution.
- Disulfiram appears to be effective if clients are motivated for abstinence and administration is supervised.

Either acamprosate or naltrexone should be offered to all alcohol-dependent clients and to all non-dependent clients with problems 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.

There is no evidence to date that any pharmacotherapy for amphetamine, cocaine or cannabis dependence can reduce relapse.

Pharmacotherapies for nicotine dependence include nicotine replacement therapies (gum, lozenges and patches), varenicline and bupropion.
31.1 Acute and chronic pain

A prerequisite to helping a client manage pain is to clarify the nature, cause and impact of the client’s pain. 
- Acute pain has a recent onset and an expected short-term period of duration which is dependent on the healing time of the underlying condition (WA Drug and Alcohol Office, 2009). For example, within the AOD context, acute pain may be caused by injury, illness, or withdrawal with a short-term expected duration. 
- Chronic pain persists for longer than several months and can be caused by long-term illness, which may be malignant, or injury. Non-malignant chronic pain extends beyond the expected period for healing. Chronic pain is recognised as involving biological, psychological and social factors (WA Drug and Alcohol Office, 2009). 

Identifying the causes of chronic physical pain should form part of the assessment and may involve liaison with other health professionals to establish a collaborative formulation. Given that pain is so often difficult to diagnose or treat, it is of therapeutic importance that the counsellor empathises with the client for their pain and the impact of the pain on their lives. 

Some clients present with physical symptoms that suggest a physical illness or injury but are unexplained by a medical condition, effects of substance use or are in excess of what is expected for a medical condition. In this case, when the physical complaints result in treatment seeking, persist over several years and cause significant impairment in functioning before the age of 30 years, the client may be diagnosed with one of a number of somatoform disorders (e.g. somatisation disorder, conversion disorder, hypochondriasis). A diagnosis of a somatoform disorder should only be made by a qualified professional. It is important to recognise that a diagnosis of a somatoform disorder does not mean that the client’s physical pain is feigned or intentionally produced for attention. 

Counsellors should also be aware that chronic pain is common in trauma survivors. There can be pain from injuries resulting from the trauma, for example pelvic and gastrointestinal problems for people who were sexually abused. There may also be chronic pain with no medical explanations as a result of dissociated trauma memories. It is thought that clients might re-experience the pain associated with the abuse on a physical level, but because of the enormity of the trauma, have dissociated the memories at a behavioural, image, affect and meaning level (Towers, 2008). Chronic pain, particularly in the pelvic area, is common in clients who have been sexually abused. 

31.2 Multidisciplinary management of chronic pain

Chronic pain is influenced by biological, psychological and social factors and the literature clearly indicates that multidisciplinary treatments for chronic pain are most effective (Scascighini et al., 2008). Multidisciplinary approaches typically include counselling and education, medication, physiotherapy and occupational therapy.
31. Pain management for dependent clients

Once a counsellor has established that the client’s pain is chronic then it is necessary to establish a coordinated and multidisciplinary approach by arranging referrals and facilitating the client’s engagement with medical personnel and, if necessary, specialist pain management centres that exist in many major public hospitals. The information that follows is particularly relevant to helping clients manage chronic pain but can also be adapted to help clients cope with acute pain.

The counsellor’s role in the management of pain is to provide non-pharmacological strategies with an emphasis on managing the pain to help the client improve their quality of life. Not surprisingly, mental health issues such as co-occurring depression and anxiety are also common among clients with chronic pain and would need to be addressed during therapy (Otis et al., 2011).

31.3 Cognitive-behavioural approaches for pain management

Both cognitive-behaviour therapy (CBT) and acceptance and commitment therapy (ACT) approaches are recognised as empirically supported treatments for chronic pain (Wetherell et al., 2011). Counselling for AOD clients with pain should help to target psychological and social problems that have emerged because of the pain. For example, clients who experience pain, particularly chronic pain, often explain that their activity levels have reduced and they have withdrawn socially. Both CBT and ACT approaches emphasise facilitating increased activity levels and functioning and encouraging lifestyle changes (Otis et al., 2011).

Regardless of which therapeutic approach a counsellor decides to use, it is critical that the counsellor demonstrates empathy towards clients with chronic pain. Acknowledge the impact that the pain is having on the client’s life and, particularly for clients who experience pain without a recognised cause, acknowledge that the pain is real. Particularly if the pain is a chronic condition, the counsellor should work with the client to establish that the emphasis is on managing the pain not curing it. In addition, provide hope by explaining that there are many strategies that can improve their ability to cope with pain (Otis et al., 2011).

Key components of CBT for chronic pain

The focus of a CBT approach to chronic pain is on reducing the psychological distress associated with the pain by modifying unhelpful thinking and maladaptive behaviours. It entails identifying pain-related thoughts and behaviours that contribute to a sense of helplessness and reinforce unhelpful behaviours. Core elements of a CBT approach to chronic pain include psychoeducation about pain, cognitive restructuring, graded homework assignments, relaxation training and activity scheduling (Otis et al., 2011).

Cognitive restructuring

The counsellor should facilitate the client’s insight into how their thoughts about the pain impact their experience of the pain (see Chapter 18 Cognitive restructuring). Many clients find that when they are distressed the pain seems to intensify, whereas when they’re feeling hopeful the pain is less noticeable. The counsellor should use examples to illustrate how thoughts, feelings and behaviours interact and influence one another, and demonstrate how pain can be influenced by thoughts and behaviours. Help the client to identify common thinking errors and how they apply to pain. For example, catastrophic thoughts following increased pain such as ‘now the rest of the day is going to be ruined’ are common among clients with chronic pain. Similarly, clients may think in black and white terms such as ‘I can’t do anything until the pain is gone’.

The client should be encouraged to monitor their pain and associated thoughts, feelings and behaviours. These records can be used to identify and challenge negative thoughts and underlying beliefs about the pain.

Activity scheduling

Some clients with chronic pain may feel helpless and put their life on hold until there is a ‘cure’ for their pain. The counsellor should 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). For example, goals might include ‘increasing social activity’ which could be broken down into manageable weekly goals such as phoning a friend, having lunch with significant others, working on a shared project.
31. Pain management for dependent clients

Inactivity and helplessness among clients with chronic pain can be maintained by perceived ‘failures’ in social and occupational functioning. For example, a client with pain might push themselves to achieve a goal, leading to a flare up in pain, giving up and the belief that they cannot cope. Otis et al. (2011) suggest 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.

Key components of ACT for chronic pain

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 include 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).

Acceptance

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

Cognitive defusion is described in Chapter 21 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 it 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).

Cognitive defusion techniques described in Appendix 20 include the following (Harris, 2007).

- 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 causing them distress. For example, a client who is preoccupied with worrying about pain could be encouraged to say to themselves ‘oh there goes my worrying about pain spot again’ when the distressing thoughts arise.
31. Pain management for dependent clients

**Mindfulness**

Mindfulness is also a key component of management of chronic pain. Mindfulness strategies (see Chapter 21 *Mindfulness*) 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 getting caught up in the pain.

The key is to guide the client to become mindfully aware of what is predominant in their moment-to-moment experience. Encourage the client to become aware, purposefully and intentionally, of the focus that their mind is repeatedly drawn to. This may be thoughts, feelings and physical sensations associated with pain. Encourage the client to notice the physical sensations in an accepting rather than a reactive way. Explain that pushing the pain away will ensure that it has a strong pull on their attention and instead it is helpful to start to notice, observe and accept the experience.

In completing mindfulness of the breath exercises, clients with pain may notice that their attention is repeatedly pulled towards their pain. Encourage the client to become mindfully aware of the nature of the pain and to say to themselves: ‘It’s OK. Whatever it is, it’s OK. Let me feel it’ (Segal et al., 2002). Encourage the client to stay aware of the sensations and their relationship to the sensations and let them be.

Instructions for mindfulness of breath and mindfulness of emotion are found in Appendix 18 and 19 respectively, and can be adapted to mindfulness of other aspects of a client’s experience.

**Committed action**

In clarifying values and lifestyle goals it may be useful to ask the client how their lives would be different if they were free of pain. Encourage the client to paint a picture of what this would look like. They might begin to identify changes related to relationships, employment, activities and recreation, such as ‘I’d go out more’ and ‘I’d be able to spend more time with my kids’. Encourage the client to commit to acting in ways that are consistent with their valued goals.

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**Pain management for dependent clients – tip sheet**

As part of a comprehensive assessment, clarify the nature, cause and impact of pain on the client’s life.

- 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. Non-malignant chronic pain extends beyond the extended period of healing.

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 their experiences of pain have not been taken seriously by others. 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.

Both CBT and ACT approaches are empirically supported treatments for chronic pain.

General points in working with clients with pain include:

- empathise with the client’s experience of acute or chronic pain, even when the pain is unexplained by a medical condition
- acknowledge the impact that the pain is having on the client’s life
- provide hope by explaining that strategies can be used to improve the client’s ability to cope
- for clients with chronic pain, 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’.

It is important to liaise with other health professionals in helping a client to manage pain.
A number of issues are of concern when working with clients who regularly use methamphetamine. The immediate and long-term management of methamphetamine-dependent clients is proving to be particularly challenging for counsellors. The following issues should be considered when working with this client group.

32.1 Managing intoxication

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

- Reduce environmental stimuli as much as possible, including removing the person to a quieter environment.
- Avoid confrontations or arguments while allowing the client to satisfy their need to talk.
- Approach the person slowly and with a sense of confidence and relay to them the fact that the situation is under control.
- Reassure the client that the symptoms will resolve with time.
- Encourage supportive friends or relatives to stay with the client, or contact appropriate sources of support.
- Monitor vital signs and mental state.
- Encourage the client to maintain a steady intake of fluids.
- Remove the client to a cool place and suggest that they remove any restrictive clothing.

Given that aggressive or hostile behaviour is also a common effect of methamphetamine intoxication it is recommended that counsellors be aware of strategies for managing extreme hostility or agitation. See Chapter 27 Managing aggressive clients or specific guidelines to avoid escalation. Always consider your personal safety, as well as the safety of the client and others. If you are enlisting the help of other people, request that they stand at the periphery as crowding may lead to further escalation (Mills et al., 2009).

- Remain calm and speak slowly and gently.
- Listen to the client.
- Do not make any sudden movements or behave in ways that could be interpreted as threatening.
- Don’t take the client’s comments or behaviour personally.
- Be non-judgemental and avoid confrontation.
- Gently remind the client of the effects of methamphetamine on their thoughts, behaviours, and physical reactions.

32.2 Managing psychosis

Amphetamine-induced psychosis is common with prolonged heavy methamphetamine use. Recreational methamphetamine use is also associated with an increased risk of psychotic symptoms (McKetin et al., 2010). Common symptoms of psychosis include paranoia, hallucinations (particularly auditory), delusions and misperceptions. Sub-clinical psychotic symptoms, such as hostility, suspiciousness, paranoia, and disordered thought processes, are also common in regular users. Clients who have experienced repeated amphetamine-related psychotic episodes are at risk of experiencing further psychotic episodes. Further psychotic episodes can occur in relation to non-specific stressors and even if the client has consumed a lower dose of amphetamine. Psychotic symptoms associated with methamphetamine use tend to be much longer lasting than with the less potent amphetamine, often requiring antipsychotic medication.

Due to the increased likelihood that clients who regularly use methamphetamine will experience persistent psychotic symptoms it is recommended that these clients be screened for psychotic disturbances. Various tools to assist with screening for psychotic symptoms are available. The Psychosis Screener (Degenhardt et al., 2005) has adequate psychometric properties and has been used with community and drug and alcohol populations (Deady, 2009). It is an interview-style questionnaire that should be administered by the AOD worker and is included in Appendix 9.
32. Methamphetamine

It contains seven questions relating to features of psychosis: delusions of control, thought interference, delusions of reference/persecution, and grandiose delusions. The final item indicates whether the client has ever been diagnosed with schizophrenia. It is also important to ask whether the client has ever received a diagnosis of psychosis or been prescribed antipsychotic medication.

When screening for psychotic symptoms counsellors should:
• ask how any odd thoughts relate to drug use and withdrawal
• check on whether the symptom(s) are transient, episodic, or prolonged
• assess the client’s insight into their experience of psychosis.

Counsellors should also give clients information about amphetamine-related psychosis and about repeated psychotic episodes lowering the threshold for further episodes.

When managing a client with acute psychotic symptoms, always consider your personal safety, as well as the safety of the client and others, and consider the following (adapted from Mills et al., 2009):
• ensure that the room is well lit in order to reduce the risk of perceptual ambiguities
• maintain a non-stimulating environment (e.g. reduce noise and human traffic)
• ensure that the client has adequate personal space
• do not argue or agree with unusual beliefs, simply listen and validate how the client is feeling
• arrange transfer to an emergency department if psychosis is severe.

32.3 Withdrawal

Clients withdrawing from methamphetamine may experience a variety of symptoms, including:
• dysphoria
• lethargy
• poor concentration
• feeling angry or upset
• long but disturbed sleep, insomnia, tiredness
• drug cravings
• hunger
• anxiety
• depression
• irritability or restlessness.

Acute symptoms of withdrawal tend to peak within 1–2 days of abstinence, while some symptoms (e.g. sleep and mood difficulties) can last for a period of months (Dyer & Cruikshank, 2005). The duration and severity of withdrawal symptoms may be influenced by:
• age (older and more dependent users may experience more severe withdrawal)
• general health
• mode of administration
• quantity and quality of methamphetamine consumed prior to cessation
• polydrug use.

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

To date there are no clear evidence-based pharmacological strategies for managing amphetamine withdrawal (Lingford-Hughes et al., 2012). There is clinical agreement, however, that psychosocial support should be provided in a safe, non-threatening environment, and that medication such as benzodiazepines, antidepressants or antipsychotics should be prescribed on an individual basis for symptomatic relief when indicated (Jenner & Saunders 2004).
32. Methamphetamine

32.4 Harm reduction

Given the high rates of relapse among clients, as well as the varying goals that clients bring to treatment, attention should be paid to harm reduction strategies when delivering treatment. In conjunction with the harms associated with injecting (see Chapter 16 Harm reduction), people who regularly use methamphetamine are also at risk of experiencing the following harms:

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

Counsellors may need to employ motivational interviewing strategies to facilitate the process of ‘negotiating’ less risky using practices that are acceptable to the client (see Chapters 7 and 16 Motivational interviewing and Harm reduction).

32.5 Cognitive impairment

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

Counsellors can assess the client’s level of cognitive functioning by conducting a thorough clinical assessment and enquiring about the client’s perception of their cognitive functioning. For example, ask the client whether they have had difficulty remembering things or paying attention. The client’s presentation in session, such as excessive distractibility, difficulty concentrating and suppressing irrelevant information, may also indicate cognitive impairments. It is important to note, however, that clinician- and client-reported cognitive performance may not be a reliable insight into the client’s actual cognitive functioning (Moritz et al., 2004).

If a counsellor is concerned about the client’s cognitive functioning, the client should be referred to a neuropsychologist, or an appropriately trained psychologist, for a comprehensive assessment.

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

- attention and concentration
- visual and verbal memory
- information processing
- problem-solving
- decision-making
32. Methamphetamine

- response inhibition
- sequencing
- emotional processing.

Often the presentation of current and former methamphetamine users is characterised by the manifestations of such deficits in cognitive functioning. Typically the clinical presentation of these clients is characterised by:
- excessive distractibility
- difficulty concentrating
- difficulty sustaining attention
- difficulty suppressing irrelevant task information.

Numerous cognitive functions are required to derive benefit from many of the counselling strategies. Clients who have deficits in attention, memory, verbal skills, problem-solving or abstract reasoning are less likely to experience positive treatment outcomes unless their cognitive functioning is considered. Counsellors also need to be aware that cognitive deficits can impact upon client engagement behaviours, such as regular attendance and completing homework tasks, rather than automatically assuming these behaviours are the consequence of ambivalence about counselling, low motivation to change, or drug use.

Thus when engaging methamphetamine users in treatment, counsellors need to be able to tailor the treatment to cognitive deficits the client displays by integrating strategies to target areas of cognitive difficulty with traditional components of treatment (e.g. therapeutic alliance, assessment, motivational interview, problem-solving, goal-setting, harm reduction, relapse prevention and management). The strategies that can be used are pragmatic, such as reminding clients of appointments and encouraging them to write down important things from the counselling session. See Chapter 39 Cognitive impairment for more detailed recommendations for working with clients with cognitive impairments.

32.6 Stepped care treatment

Cognitive behavioural treatment has been found to produce the greatest improvements in the treatment of amphetamine dependence. A stepped care approach has been recommended as the most effective psychosocial treatment for managing the treatment of amphetamine users (Baker & Dawe, 2005; Kay-Lambkin, 2009). This approach involves determining the intensity and range of treatment approaches on the basis of client presentation in terms of co-occurring psychiatric disorder (e.g. psychosis, anxiety, depression) and other psychosocial needs. Step 1 involves assessment, self-help materials and scheduled monitoring; Step 2, for those who did not respond to step 1, is two sessions of CBT; Step 3, for clients who do not respond to previous steps, or who have clinically significant depression, is four sessions of CBT; and more intensive interventions for clients who do not respond to these interventions, or are experiencing psychosis or suicidity.

The advantages of this graded approach to treatment are that it:
- allows for flexibility in intervention and matches treatments to the client’s needs
- accommodates differences between individuals with co-occurring problems in terms of type and severity of use and readiness to change
- optimises use of resources such as practitioner time.

Because of the flexibility required for stepped care, it has been difficult to conduct controlled clinical trials on the efficacy of this approach. However, the approach is considered promising in providing a treatment approach tailored to the complex needs of methamphetamine users (Kay-Lambkin et al., 2010).
32. Methamphetamine

### Methamphetamine – tip sheet

When a client presents as intoxicated, counsellors should aim to establish a non-stimulating environment, support and reassurance, and prevent the client from harming themself or others.

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

Both prolonged and occasional methamphetamine use are associated with psychosis. Clients with problematic methamphetamine use should be screened for symptoms of psychosis. The Psychosis Screener (Appendix 9) may be used to guide the assessment. Counsellors should refer for a full psychiatric assessment if significant symptoms appear to be present.

If a client presents with acute psychosis, consider the following:
- ensure that the room is well lit
- maintain a non-stimulating environment (e.g. reduce noise and human traffic)
- ensure that the client has adequate personal space
- do not argue or agree with unusual beliefs, simply listen and validate how the client is feeling
- arrange transfer to an emergency department if psychosis is severe.

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

Widespread deficits in cognitive functioning can be a consequence of heavy, prolonged methamphetamine use, which has implications for the content, process and outcome of treatment. Clients experiencing manifestations of cognitive impairment will often present with:
- excessive distractibility
- difficulty concentrating
- difficulty sustaining attention
- difficulty suppressing irrelevant task information.

If a counsellor is concerned about the client’s level of cognitive functioning, they should arrange a formal assessment by referring the client to a neuropsychologist or appropriately trained psychologist. Intervention strategies and delivery of counselling should be tailored accordingly (see Chapter 39 Cognitive impairment). It is recommended that standard cognitive behavioural strategies for AOD counselling form the basis of the approach and be adapted as appropriate.

Methamphetamine users tend to suffer from more intense and long-lasting psychological disturbances compared to users of most other drugs. Patience is required when working with this client group and counsellor and client should tackle the issues using a stepped care approach.

Information for clients coming off methamphetamine is in Appendix 22.
Volatile substance use (VSU) refers to the deliberate inhalation of substances that produce a vapour or gas at room temperature, for their intoxicating effects. VSU is also commonly referred to as sniffing, inhalant use, solvent use or chroming.

Volatile substances which are used for the purposes of intoxication include solvents such as petrol, paint, glue, toluene; aerosols such as spray paints, deodorant, hairspray, fly spray and vegetable oil cooking sprays; gases such as nitrous oxide and butane; and nitrites such as amyl nitrite and butyl nitrite.

Volatile substances are a central nervous system depressant causing effects similar to alcohol but faster acting. Short-term effects may include: euphoria, loss of inhibition, drowsiness/sedation, nausea, headaches, agitation, confusion and hallucinations.

Long-term use of volatile substances can cause damage to the brain and other organs such as the heart, lungs, liver and kidneys. While some damage is reversible if the person stops using, long-term chronic use can cause permanent damage.

Volatile substances are mainly used by adolescents (many are aged 12–16 years), and is often experimental or opportunistic in nature. VSU tends to be episodic, cyclical and highly localised in nature. The majority of young people, particularly in urban settings, tend to experiment once or twice and generally do not continue to use.

However, significant harm can occur from a single occasion of use, including injury from accidents, antisocial behaviours, long-term physical and psychological health issues and even sudden death.


### 33.1 Interventions for VSU\(^5\)

Harm reduction education on VSU should be tailored to the target group, which may include users of inhaled volatile substances, those at risk, and their families and peers.

Education for users of inhaled volatile substances, those at risk, and their families and peers, should provide information about:
- health effects of volatile substances and strategies for reducing harm
- basic first aid for an intoxicated person (e.g. assessing danger to the person and others, letting the person rest in a quiet safe place with fresh air, making sure the person can breathe, when to call emergency services)
- how to monitor an intoxicated person during and after recovery (e.g. managing symptoms, what to look for, making sure the person eats and drinks, when to call emergency services)
- what to do if there is danger (e.g. contact people in community responsible for safety, such as police and other authorised people)
- information about services that can help the person recover (e.g. counselling services, residential rehabilitation facilities, youth and activity programs).

Education for people who use inhaled volatile substances and those considered to be a significant risk of VSU should include:
- information about short-term and long-term harmful effects of VSU
- strategies for quitting or at least reducing use
- basic first aid and care for an intoxicated person
- information about reducing harm due to VSU.

33. Volatile substance use

Key messages to reduce harm due to VSU should include:
Never use volatile substances:
• in an enclosed space
• when you are alone
• with a bag over your head so that air can’t get in
• if you have drunk alcohol or used any other drugs
• before you exercise
• when you are smoking or near a lit cigarette or fire.

Do not spray a substance directly into your mouth.

If someone is sniffing, huffing, bagging or chroming:
• make sure there is fresh air in the place, open windows and doors
• never fall asleep (or let someone else fall asleep) with a bag over their face
• don’t chase them or try to hold them if they are struggling – this could be dangerous for their heart
• keep other people away from them if they are acting aggressively
• get help if there is danger to the person or other people – call the police, someone responsible for safety in your community, or an older person who will know what to do.

If you are looking after someone who has been sniffing, huffing, bagging or chroming:
• If you can smell fumes (e.g. from the person or their clothing), let fresh air into the room and keep them away from flames (e.g. lighters, fires).
• Make sure someone watches the person for at least six hours to ensure they are recovering.
• Call an ambulance or contact local emergency medical services if the person:
  • is getting more anxious or agitated
  • is acting or talking strangely
  • has collapsed or ‘blackened out’ and you cannot wake them
  • the person is losing consciousness or their thinking is becoming less clear. (You may have to gently wake the person to check.)
  • has turned an unhealthy-looking colour in their face, fingertips or lips (looks pale, blue or darker than normal), or has cold or sweaty fingers. (Any of these signs could mean their blood is not flowing properly and they are not getting enough oxygen.)
  • has a seizure (convulsion, fit).

Shock tactics, such as telling young people that they could die while using a volatile substance, may not be an effective way to help them quit and, for some people, the threat of death may actually increase the excitement of VSU.

Australian researchers have reported that young people were more likely to be worried about their VSU if they were warned that it may damage their coordination and their ability to play sport.

Therefore it may be more effective to focus VSU education on the harmful short-term consequences of continuing to use and the positive benefits of quitting, such as ability to think more clearly and better coordination during physical activity.
33. Volatile substance use

Volatile substance use – tip sheet

Volatile substance use refers to the deliberate inhalation of substances that produce a vapour or gas at room temperature, for their intoxicating effects. VSU is also commonly referred to as sniffing, inhalant use, solvent use or chroming.

Volatile substances are a central nervous system depressant.

Long-term use of volatile substances can cause damage to the brain and other organs such as the heart, lungs, liver and kidneys. While some damage is reversible if the person stops using, long-term chronic use can cause permanent damage.

Single occasion use can also cause significant harm, including injury from accidents, antisocial behaviours, long-term physical and psychological health issues and even sudden death.

Harm reduction education on VSU should be tailored to the target group, which may include users of inhaled volatile substances, those at risk, and their families and peers.

Education for users of inhaled volatile substances, those at risk, and their families and peers, should provide information about:

- health effects of volatile substances and strategies for reducing harm
- basic first aid for an intoxicated person (e.g. assessing danger to the person and others, letting the person rest in a quiet safe place with fresh air, making sure the person can breathe, when to call emergency services)
- how to monitor an intoxicated person during and after recovery (e.g. managing symptoms, what to look for, making sure the person eats and drinks, when to call emergency services)
- what to do if there is danger (e.g. contact people in community responsible for safety, such as police and other authorised people)
- information about services that can help the person recover (e.g. counselling services, residential rehabilitation facilities, youth and activity programs).

Education for people who use inhaled volatile substances and those considered to be a significant risk of VSU should include:

- information about short-term and long-term harmful effects of VSU
- strategies for quitting or at least reducing use
- basic first aid and care for an intoxicated person
- information about reducing harm due to VSU.

Focus VSU education on the harmful short-term consequences of continuing to use and the positive benefits of quitting, such as ability to think more clearly and better coordination during physical activity.
Co-occurring severe mental illness

Mental health disorders, ranging from mild depression or anxiety through to severe mental illness (e.g. bipolar disorder, psychotic disorders, severe major depression and severe borderline personality disorder) are very common in clients in AOD treatment. As Minkoff and Cline (2003) note, ‘dual diagnosis is the expectation, not the exception’ for the AOD treatment sector. For example, Australian research on clients in drug and alcohol residential settings indicated over 70% had a co-occurring mental illness (Mortlock et al., 2011).

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 often complicated and it is often difficult to clearly establish the causal connection between AOD problems 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.

Because of the high prevalence of co-existing disorders, it is crucial to screen for mental health disorders as part of a comprehensive assessment. Counsellors should also attempt to identify severe mental illness (i.e. bipolar disorder, psychotic disorders and severe borderline personality disorder) that may require psychiatric and specialist intervention. Psychosocial interventions are effective for people with co-occurring severe mental illness and substance use disorders, however these interventions must be coordinated, multidisciplinary and provide long-term follow up (Horsfall et al., 2009). Guidelines for working with clients with severe mental illness in an AOD context are outlined below.

Engagement

The network of helping professionals

Often by the time clients with severe mental health issues come into contact with the AOD field they will have had extensive experience, 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 11 Case management).

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 et al., 2008). This may be due to a collaborative recognition of areas of concern and insight into how relevant and viable the therapy plan is. 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 problems on their lives and on their experiences of supporting the client also acknowledges the efforts that the family members have made and supports them in their own right.

Exploring client strengths and looking for exceptions

Exploring client strengths is important for both engagement and assessment purposes and can be applied to both individual clients and relatives. Exceptions are those past experiences in a client’s life when the problem might have been expected to occur but somehow did not.

Discovering times when the client has experienced a reduction or disappearance of psychiatric symptoms or substance use introduces the notion of the presence of change and helps to minimise a belief that situations are permanently stable and difficult. Successful engagement acknowledges those aspects of an individual’s life that can become obscured by mental illness and substance use.
34. Co-occurring severe mental illness

**Client’s ways of coping**

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

**Assessment**

*Considering the interplay between stressors, psychiatric symptoms and drug use*

The assessment principles outlined earlier in this guide (Chapter 4 Assessment) apply to the assessment of a client with a co-occurring severe mental illness. Counsellors should be aware, however, 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 for both the client and counsellor. Similarly, exploring the influence of psychiatric medication on the level of drug use and vice versa and exploring the influence of AOD use on mental health symptoms is worthy of attention. The clarification that emerges from this line of inquiry can contribute to a comprehensive treatment plan and setting appropriate goals.

**Adopting a holistic approach**

Clients with both AOD and severe mental health problems often experience many other difficulties such as relationship problems, legal and financial difficulties, unstable accommodation and poor self-care. These difficulties in turn can impact on feelings of self-worth and contribute to the perpetuation of AOD use and mental health problems. Asking the client to rank the more pressing problems can help to distinguish the context and impact of each problem in the client’s life and can form part of a collaborative assessment and intervention process.

**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 towards identifying alternative solutions.

**Understanding the family’s experience first**

An assessment of the family context should primarily concern itself with understanding the family’s experience of living with the co-existing AOD and severe mental health problem. Traditionally, most professional responses to families have been guided by interventions that aim to change the family. These stem from theoretical constructs that view family relationships as implicated in the causes and maintenance of the problem.

As a consequence, families have experienced many service providers as blaming and not sensitive to their diverse needs and situations. The importance of adopting a more family-inclusive model of working that places importance on counsellors and agencies having a collaborative mindset with respect to families is paramount (see Chapter 42 Significant others). This approach involves looking at current and previous solutions, evaluating their success and exploring different possibilities 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 with families.
35. Co-occurring depression

Co-occurring severe mental illness – tip sheet

- Co-occurring mental illness 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.
- Involve families and caregivers early on. Be proactive in introducing family involvement with your client. The terms of confidentiality can be negotiated between family and client.
- During assessment explore the relationship between the client’s AOD use, mental illness, current medication regime and stressors. If a mental illness is suspected, but not yet diagnosed, discuss with the client and liaise with mental health professionals if appropriate.
- Explore what has been tried, what has worked.
- Be practical – help with practical difficulties such as housing, finances, food, legal difficulties and self-care.
- Link clients into services and day centres that offer practical help and activities to give clients something meaningful to do during the day.
- Explore stress reduction methods – there is a strong link between stress and relapse in mental illness. Giving up AOD use can increase stress levels so make sure you explore ways that the client can reduce stress.
- Psychiatric intervention should be sought for clients with severe co-existing mental health disorders.
- Liaise with appropriately trained medical and allied health personnel and mental health service providers.
Co-occurring depression

Depression is characterised by a range of symptoms including:
- low mood
- loss of pleasure or interest in activities
- lethargy
- social withdrawal
- poor concentration
- appetite or sleep disturbances
- irritability or agitation
- feelings of guilt and worthlessness
- suicidal ideation.

Depressive disorders frequently co-occur with AOD disorders (Mills et al., 2009). For many clients symptoms of depression may precede the onset of AOD difficulties and indicate an underlying disorder. AOD use can also cause depression when it did not previously exist, or exacerbate pre-existing depression. It is also common for clients to experience symptoms of depression during withdrawal and early periods of abstinence from substance use. Although these symptoms tend to resolve in the first few weeks after abstinence, in some cases they can persist, which is often an indication that depression is the primary disorder and needs to be targeted during treatment. Counsellors who are not trained to work with severely depressed clients are encouraged to engage with supervisors for assistance with containing and managing a client’s symptoms or to refer to specialist clinicians.

Counsellors should try to target symptoms of depression during treatment in order to avoid the risk of poor outcomes. This applies regardless of whether these symptoms are related to the drug use or due to an underlying depressive disorder that preceded the drug use. This is because the symptoms of depression (e.g. lethargy, social withdrawal, low mood) can potentially interfere with the components of traditional AOD treatments, such as the acquisition of new coping behaviours, attendance at self-help meetings and being self-motivated to complete homework tasks. In addition, negative mood is often a trigger for relapse. Therefore, integrating the treatment of depressive symptoms into treatment plans is an integral component of relapse prevention for AOD clients with depressive symptoms. Clients should also be informed that early abstinence is often associated with increased levels of depression and that unless there are pre-existing problems with depression, the symptoms should gradually decrease over a few weeks.

35.1 Recommended treatment approach

Cognitive behaviour therapy (CBT) has been identified as an effective way of treating co-occurring AOD and depressive disorders (Watkins et al., 2011). CBT strategies commonly used to treat symptoms of depression include:
- goal-setting
- problem-solving
- cognitive restructuring
- pleasure and mastery events scheduling
- mindfulness training to reduce relapse to depression.

These strategies should be integrated with other counselling interventions.

Goal-setting

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

It is important that the goals are specific, achievable, short-term, measurable, described in positive terms and negotiated (see Chapter 9 Goals of intervention).

Cognitive restructuring

Cognitive restructuring rests on the notion that our behaviours and feelings are a result of our automatic thoughts (those thoughts that happen so quickly that we are unaware of them happening), which in turn are related to our core beliefs (deeply held beliefs about ourselves, others and the world). Cognitive restructuring involves identifying and challenging negative thoughts and beliefs. For example, the belief that ‘I am totally useless because I use drugs’ may result in feelings of sadness, guilt and worthlessness, and cause negative behaviours (e.g. social withdrawal). Depression, relapse, anxiety or other life problems are linked to core beliefs, which can be observed through feelings, actions and automatic thoughts. Automatic thoughts are commonly based on incorrect beliefs which can be challenged by using cognitive restructuring exercises (see Chapter 18 Cognitive restructuring).

The ‘Don’t think’ exercise helps clients to understand that thoughts are important, cannot be simply pushed out of mind and have a major impact on how we feel and what we do. We are often unaware that we are thinking, let alone what we are thinking. We can’t stop thinking even if we want to. Explain to your client that you are going to get them to do an exercise where you are going to give them one minute and in that time, you want them to stop thinking. After a minute ask the client if they managed to stop thinking. We are willing to bet that they spent that minute thinking about not thinking.

Next give the client an example to demonstrate that how we think influences how we feel about a situation. Deliberately ambiguous situations, such as waving to a friend who doesn’t wave back, can illustrate this. An example might be:

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

Sally says to herself: ‘Sarah is doing so well; she has got a job and a great relationship. I wish my life was more like hers, I can never hold down a job or a relationship, I am such a failure.’ Sally feels really sad and finds herself dreading catching up with Sarah. Sally then starts to feel guilty and she does not want to see Sarah.

Jane says to herself: ‘Wow, Sarah has come so far since we first met; maybe it really is possible for people to sort themselves out and get their life back on track.’ Jane feels hopeful and finds herself looking forward to catching up with Sarah.

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

Counsellors can also use the ABCDE Model (see Chapter 18 Cognitive restructuring) to teach clients how to first catch their automatic thoughts and then examine them to see how rational they are. For example, in the case of Sally:

A Antecedent – phone call from Sarah
B Beliefs – ‘I am a failure.’
C Consequences – feeling sad, guilty
D Disputation – ‘I might not have a job but I have cut down my drinking by half.’
E Alternative explanation – ‘Just because I don’t have a job doesn’t mean I am a failure. I have succeeded in other things.’

Another important step that counsellors should reinforce with clients:

F Forging ahead – Once you have resolved the issue move on. Don’t continue to keep going back over the situation time and time again. You can’t change yesterday, only tomorrow.
Pleasure and mastery events scheduling

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

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

To start with, some very depressed clients might be encouraged to think of one activity they can do for achievement each day (e.g. wash x number of dishes each day, water the pot plants) and one they can do each day that is even slightly pleasurable (e.g. watch a program on TV that they get some pleasure from, pat the dog). They should write these down on a list to work on each day. Each week more activities can be added. There are also lists of activities available for clients to choose from. The Centre for Clinical Interventions (CCI website\(^1\)) includes one in their ‘Back from the Bluez’ workbook for clients.

Clients may also need to be reminded of the fact that they deserve to feel good and that in many cases feelings of motivation generally only arise once we are active, rather than 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, which can break the cycle of their low mood, lack of energy and feelings of guilt.

Problem-solving

Clients with depression often believe they are not capable of solving problems. Teaching them a structured way of solving problems can be useful for demonstrating to them the skills they already have. Problem-solving can also be used to facilitate other treatment strategies, such as working out how to overcome obstacles to engaging in pleasure/mastery activities.

There are five steps in problem-solving.

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

(See Chapter 8 *Problem-solving* for more details.)

Clients with cognitive impairment may find problem-solving difficult, as may severely depressed clients as depression can temporarily affect cognitive functioning. These clients may require a lot of practice and simple, easy-to-follow information. For suggestions on techniques to use with cognitively impaired clients, refer to Chapter 39 *Cognitive impairment*.

Mindfulness

There is empirical support for the use of mindfulness training to help reduce relapse to depression (for review see Chiesa & Serretti, 2011). Mindfulness Based Cognitive Therapy (MBCT) has been shown to reduce relapse to depression by over 40% (Ma & Teasdale, 2004). In addition, there is evidence to suggest that mindfulness training can benefit comorbid depression and AOD disorders (Brewer et al., 2010). It is recommended that mindfulness strategies should form part of the therapy plan for clients with co-occurring depression. Mindfulness strategies may be most beneficial as part of a relapse prevention plan, following therapeutic gains from the abovementioned CBT strategies (see Chapter 21 *Mindfulness*).
35. Co-occurring depression

Mindfulness therapy approaches can be helpful for clients with AOD issues and co-occurring depression in order to decrease avoidance, tolerate unpleasant withdrawal and painful emotions, and unlearn maladaptive thoughts and behaviours (Brewer et al., 2010).

These CBT strategies should be integrated with other components of treatment, such as motivational interviewing, relapse prevention and management and pharmacotherapy. The CCI website also provides information and resources for the treatment of depression using CBT, which are designed for use by both professionals and clients.

Clients may also benefit from antidepressant medication. However, it is recommended that the prescription of antidepressants occur concurrently with the provision of therapy targeting specific depressive symptoms and AOD difficulties, as this has been shown to improve treatment outcome (Nunes & Levin, 2004).

Counsellors also need to be aware of the increased risk of suicide among clients with co-occurring AOD difficulties and depression. Careful assessment and periodic monitoring of the client’s suicidal ideation and risk of suicide completion is recommended. Counsellors are referred to Chapter 5 Suicide assessment and management for further information on this.

Depression – tip sheet

Many clients will present with co-occurring AOD difficulties and depression.

It can be difficult to tease apart the relationship between a client’s substance use and symptoms of depression.

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

Because negative mood is often a trigger for relapse, treating depressive symptoms is also an integral component of relapse prevention.

Cognitive behaviour therapy has been identified as one of the most effective ways of treating co-occurring depression and substance use difficulties.

The following CBT strategies can be used to target symptoms of depression:

- goal-setting
- cognitive restructuring
- pleasure and mastery events scheduling
- problem-solving
- mindfulness training – formal or informal – to reduce relapse to depression.

These specific CBT strategies should be integrated with other components of treatment such as motivational interviewing, relapse prevention and management and pharmacotherapy.

If antidepressant medication is prescribed, this should occur concurrently with the provision of counselling strategies targeting specific depressive symptoms and AOD difficulties, as this improves treatment outcome.

Careful assessment and periodic monitoring of clients’ levels of suicidal ideation and risk of suicide completion is recommended.
Co-occurring anxiety

Many AOD clients have difficulties with anxiety. Anxiety related problems can manifest in a variety of different psychological disorders including PTSD, generalised anxiety disorder (GAD), panic disorder, social phobia and obsessive compulsive disorder (OCD).

Clients with an AOD disorder are five times more likely than the general population to develop an anxiety disorder and vice versa (Barlow, 2004). Thus, there is a strong relationship between the experience of anxiety and AOD difficulties. There is evidence to suggest that the relationship between anxiety disorders and substance use is often reciprocal (Baillie et al., 2010), however the nature of the relationship for each client can be difficult to identify. Many clients report that symptoms of anxiety preceded problematic AOD use and/or that they began to use AOD as a means of coping with their anxiety. However, anxiety symptoms can also develop as a consequence of AOD use. A thorough assessment is necessary to specify the relationship between comorbid disorders and to provide a formulation and rationale for treatment. For example, if the comorbid disorders have a reciprocal relationship, then an integrated treatment should aim to address anxiety, AOD use, and the processes that maintain the relationship (Baillie et al., 2010).

It is common to suffer from symptoms of anxiety (e.g. muscle tension, increased heart rate, nausea, sweating, breathlessness, dizziness, depersonalisation, restlessness) during the withdrawal period and the first few weeks of abstinence. Similarly, people may experience symptoms of anxiety while intoxicated. Clients should be informed of the association between AOD use and anxiety and reassured that if there is no underlying anxiety disorder the anxiety symptoms should gradually decrease with abstinence. If anxiety symptoms persist when the client is not intoxicated or following an extended period of abstinence, counsellors should investigate the presence of a primary anxiety disorder. If counsellors are not trained to work with primary anxiety disorders they should refer to specialist clinicians, such as clinical or counselling psychologists, or liaise closely with a supervisor for help with containing and managing the client’s symptoms. Given the high prevalence of comorbid disorders in AOD clients, all counsellors should have training in the management of clients with co-occurring AOD and mental health conditions.

If anxiety symptoms serve to maintain the AOD use and are not targeted through treatment, then poorer outcomes, including increased risk of relapse, are likely. Thus counsellors should endeavour to develop a comprehensive formulation of the interaction between the comorbid disorders and integrate strategies that target anxiety symptoms into their treatment plans.

36.1 Recommended treatment approach

Cognitive behavioural approaches are effective for the treatment of co-occurring anxiety and AOD disorders. CBT strategies commonly used to treat symptoms of anxiety include:

- goal-setting
- relaxation and grounding
- cognitive restructuring
- problem-solving
- mindfulness.

These strategies should be integrated with other counselling interventions.

Goal-setting

As well as goals related to AOD use, clients should be assisted to set goals related to managing anxiety. For example, they could set a goal of keeping track on a week-by-week basis of their progress in therapy. An example is a goal of monitoring their use of relaxation techniques and how they feel as a result. This not only provides information regarding the utility of particular strategies but also allows clients to experience success, which can be an effective way of targeting feelings of helplessness.

It is important that the goals are specific, achievable, short-term, measurable, described in positive terms and negotiated (see Chapter 9 Goals of intervention).
36. Co-occurring anxiety

These specific CBT strategies should be integrated with other components of treatment such as motivational interviewing, relapse prevention and management, and pharmacotherapy. The CCI website also provides information and resources for the treatment of particular anxiety disorders (social anxiety, GAD, panic disorder) using CBT. These resources are designed for use by both professionals and clients and are relevant to the treatment of general symptoms of anxiety.

Relaxation

There are many relaxation strategies that clients can use. It is worth asking the client what strategies they already use to relax as for some clients paradoxical strategies, such as listening to loud music or engaging in strenuous physical exercise, are more effective than slow and gentle approaches.

Three common methods of relaxation that can assist with managing a variety of anxiety-based symptoms are described in detail in Chapter 19 Relaxation strategies. The first of these strategies is controlled breathing, which involves focusing on breathing very slowly and deeply. This strategy not only directly reduces tension but can also help clients to manage distress by focusing them away from the distress. The second relaxation strategy is progressive muscle relaxation, which involves tensing and relaxing specific muscle groups. Because this exercise provides clients with a concrete focus it can also facilitate distress reduction as well as increased relaxation. The final relaxation technique is the use of visual imagery to create an imaginary sanctuary or safe place.

Introduce these strategies by noting that no one approach suits everyone and that if a particular strategy has untoward effects such as increasing their anxiety they should not persist with it. These strategies should be introduced in session so clients can try them out and give you feedback.

Grounding

Grounding strategies are useful tools that can be used by clients to manage acutely distressing symptoms of anxiety such as flashbacks, intrusive memories, panic, fear and dissociation. These strategies, categorised as mental, physical or soothing, help clients to focus their attention onto the outside world rather than inward on traumatic memories or feelings of distress/anxiety (see Chapter 20 Grounding for more detail).

Cognitive restructuring

Cognitive restructuring rests on the notion that our behaviours and feelings are a result of our automatic thoughts (those thoughts that happen so quickly that we are unaware of them happening), which in turn are related to our core beliefs (deeply held beliefs about ourselves, others and the world). It is a strategy that forms the basis of CBT and involves identifying and challenging negative thoughts and beliefs that result in feelings of anxiety and also result in negative behaviours (e.g. social avoidance). Anxiety, relapse, feeling depressed or other life problems are the result of core beliefs that can be observed through feelings, actions and automatic thoughts. Automatic thoughts are commonly based on incorrect beliefs, which can be challenged by using cognitive restructuring exercises (see Chapter 18 Cognitive restructuring).

The ‘Don’t think’ exercise helps clients to understand that thoughts are important and cannot be simply pushed out of mind, and have a major impact on how we feel and what we do. We are often unaware that we are thinking, let alone what we are thinking. We can’t stop thinking even if we want to. Explain to your client that you are going to get them to do an exercise where you are going to give them one minute and in that time, you want them to stop thinking. After a minute ask the client if they managed to stop thinking. We are willing to bet that they spent that minute thinking about not thinking.

Next give the client an example to demonstrate that how we think influences how we feel about a situation. Deliberately ambiguous situations, such as waving to a friend who doesn’t wave back, can illustrate this. An example might be:

Situation: Being on the train and the person sitting opposite you smiles at you before getting off.
36. Co-occurring anxiety

Peter says to himself: ‘Why was that person laughing at me? He must have thought my clothes make me look like a loser. How embarrassing. I am a loser and everyone can tell.’ Peter then starts to feel very anxious and worried that everyone on the train will think he is a loser.

John says to himself: ‘I wonder why that person smiled at me? Maybe he had mistaken me for someone he knows.’ John feels neutral.

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

Counsellors can also use the ABCDE Model (see Chapter 18 Cognitive restructuring) to teach clients how to first catch their automatic thoughts and then examine them to see how rational they are. For example in the case of Peter:

A Antecedent – smile on train
B Beliefs – ‘Everyone is laughing at me and thinking I’m a loser’
C Consequences – feeling anxious
D Disputation – ‘Maybe the person who smiled at me was someone I used to work with, or had mistaken me for someone else.’
E Alternative explanation – ‘Just because someone smiled at me doesn’t mean they are laughing at me.’

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

Problem-solving

Teaching clients a structured way of solving problems is related to more positive treatment outcomes. Problem-solving can also be used to facilitate other treatment strategies (e.g. working out how to overcome obstacles to practising relaxation techniques).

There are five steps in problem-solving.

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

(See Chapter 8 Problem-solving for more details.)

Clients with cognitive impairment may find problem-solving difficult and require a lot of practice and simple, easy-to-follow information. For suggestions on techniques to use with cognitively impaired clients, refer to Chapter 39 Cognitive impairment.

Mindfulness

There is empirical support for the use of mindfulness training for clients with anxiety disorders (e.g. Evans et al., 2008). Mindfulness research suggest that this approach can reduce recurrence of anxiety symptoms among clients with anxiety disorders (Chiesa & Serretti, 2011). It is therefore recommended that mindfulness strategies are incorporated as part of the counselling plan for clients with co-occurring anxiety (see Chapter 21 Mindfulness).
36. Co-occurring anxiety

PTSD and AOD
Due to the very high rates of PTSD among AOD populations, and the fact that the symptoms of this disorder can worsen following the cessation of substance use, counsellors are encouraged to be aware of how to respond appropriately to clients who present with symptoms of PTSD. For further information refer to Chapter 20 *Grounding* and Chapter 37 *Co-occurring trauma issues*.

### Anxiety – tip sheet

Many clients who experience difficulties with alcohol or other drug use will concurrently experience difficulties with anxiety.

Although there is a strong relationship between the experience of anxiety and AOD difficulties, the nature of this relationship, which is often reciprocal, can be difficult to tease apart.

A comprehensive formulation and treatment plan should address the interaction between co-occurring anxiety and AOD use and include strategies to target anxiety symptoms.

CBT is an effective way of treating co-occurring anxiety and AOD disorders.

The following CBT strategies can be used to target symptoms of anxiety:

- goal-setting
- relaxation and grounding
- cognitive restructuring
- problem-solving
- mindfulness – formal and informal practices.

These specific CBT strategies should be integrated with other components of treatment such as motivational interviewing, relapse prevention and management, and pharmacotherapy.

Due to high rates of PTSD among AOD clients, counsellors should be familiar with how to respond appropriately to clients who suffer from PTSD and are referred to Chapter 20 *Grounding* and Chapter 37 *Co-occurring trauma issues*. 
The majority of clients in AOD treatment report past experiences of trauma, often chronic trauma starting in childhood. A history of trauma is associated with more severe clinical presentations and worse treatment outcomes in AOD clients (Pirard et al., 2005).

Clients often report managing their trauma-related symptoms with AOD use (Hien et al., 2010). Therefore ceasing using does not resolve trauma-related symptoms (Najavits, 2002) and can in some cases make them worse unless clients have other ways to manage them. Some forms of AOD use can also exacerbate trauma symptoms in the longer term, as it can interfere with clients learning other ways to manage them. AOD use may also make clients more vulnerable to further trauma such as family violence and sexual assault.

The research suggests that integrated treatments, which aim to address co-occurring trauma and AOD issues, are associated with better treatment outcomes (Pirard et al., 2005). Consequently, it is essential to assess for a history of trauma among clients presenting for AOD treatment and to formulate a treatment plan accordingly.

The experience of trauma can result in a range of symptoms. Many people experience short-term (lasting less than a month) symptoms of ‘acute stress disorder’ (ASD) when exposed to a traumatic event, such as actual or threatened death, serious injury or sexual violation. Symptoms include dissociative phenomena, persistent re-experiencing of the trauma in various sensory modalities, efforts to avoid reminders of the event, and symptoms of anxiety and increased arousal (American Psychiatric Association (APA), 2013). For a proportion of people, symptoms persist and are termed posttraumatic stress disorder (PTSD). Approximately half of individuals who develop PTSD initially present with ASD (APA, 2013).

### 37.1 Posttraumatic stress disorder (PTSD)

The Diagnostic and Statistical Manual of Mental Disorders (DSM-5, APA, 2013) describes PTSD as involving “exposure to actual or threatened death, serious injury, or sexual violence” and classifies PTSD symptoms, as a result of this exposure, into four groups.

1. Presence of intrusive symptoms, including recurrent, involuntary and intrusive distressing memories of the traumatic event, recurrent distressing dreams and dissociative reactions such as flashbacks, intense psychological distress and marked physiological reactions.
2. Persistent avoidance of stimuli associated with the traumatic event, including memories, thoughts, feelings and external reminders such as people, places, objects, situations.
3. Negative alterations in cognitions and mood associated with the trauma, including inability to remember an important aspect of the trauma (typically due to dissociative amnesia), persistent and exaggerated negative beliefs or expectations, distorted cognitions, negative emotional state, diminished interests, feelings of detachment and persistent inability to experience positive emotions.
4. Marked alterations in arousal and reactivity which result in irritable behaviour, angry outbursts, reckless or self-destructive behaviour, hypervigilance and sleep disturbance.

The clinical presentation of PTSD varies from individual to individual. These symptoms operate in a cycle, whereby intrusive memories of the trauma, accompanied by re-experiencing and hyperarousal symptoms, are followed by suppression of memories and avoidance of reminders, usually accompanied by emotional numbing.

### 37.2 Complex PTSD

The experience of chronic trauma (type 2, or ‘complex’ trauma), particularly when it begins in childhood, can result in a range of symptoms that extend well beyond those of PTSD. Chronic childhood trauma disrupts early attachment experiences and the development of affect regulation. Attachment disruption causes difficulties in later relationships and clients with complex trauma issues often want and seek closeness but then fear it and push people, including counsellors, away. They also tend to present with very high levels of distress and a complex array of problems including somatic (physical), cognitive, affective, behavioural and interpersonal issues (Herman, 1992).

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17 This chapter is adapted from Marsh et al. (2012) Chapter 3 ‘Trauma, posttraumatic syndromes and AOD use’ and Chapter 11 ‘Responding to trauma: safety and containment’.
37. Co-occurring trauma issues

These more complex presentations are the norm rather than the exception in AOD treatment populations, and this extended spectrum of symptomatology has been termed complex PTSD, complicated PTSD, and disorders of extreme stress not otherwise specified (DESNSO) (Herman 1992; Roth et al., 1997). These complex presentations are not covered in the DSM-5. Symptoms of complex PTSD include the following (Courtois, 2008; Herman, 1992; Streek-Fischer & van der Kolk, 2000).

1. **Difficulties controlling affect and impulses**, which refers to difficulties tolerating and reducing distressing emotions without resorting to tension reduction activities such as self-harm, compulsive stealing, AOD use, bingeing and purging, impulsive aggression, chronic suicidal ideation, or other deliberate avoidance strategies. Clients tend to have rapid mood swings, short but intense depressive episodes lasting a few hours, preoccupation with suicide, difficulties expressing or controlling anger, extreme response to mild events or comments, difficulty self-soothing, and dissociative responses.

2. **Problems in attention and consciousness**, such as impaired ability to focus on relevant stimuli, transient amnesia or hypermnesia (abnormally strong memory) for traumatic events, dissociative responses, and transient posttraumatic psychotic reactions. Clients who are dissociative can appear ‘spacey’, have trouble talking or understanding what is said to them, have a feeling or image without being able to link it to any other aspects of a memory, report ‘lost time’ when they were not aware of what they were doing, or receive feedback that they have done things that they don’t remember doing. They might also say that they feel like an observer rather than a participant in a situation, as if they are in a fog or on autopilot, like a different person at different times, or that they feel ‘unreal’ or that their environment feels unreal. They might have trouble remembering recent events and appointments and have gaps in their life story. Transient posttraumatic psychotic reactions can include trauma congruent hallucinations or delusions, cognitive slippage (including items unrelated to the topic of conversation which become related through tangential connections), and loosened associations (such as speaking in a very roundabout fashion that includes extraneous elements and often changes of topic).

3. **Problems or instability of self-perception**, which includes low self-esteem, hating oneself, feeling permanently damaged, feeling bad or dirty, helplessness, hopelessness, shame, excessive guilt, or feeling completely different from others. In session clients might voice concerns about these issues and resist the clinician challenging their negative self-beliefs on the grounds that they just know they are different from others and so logic that applies to other people does not apply to them. They have difficulty distinguishing between feelings and facts, for example believing that if they feel bad, this means that they are bad. They may have a childlike sense of responsibility, blaming themselves for the abuse or having trouble taking responsibility for their own actions in the present.

4. **Problems relating to others**, which include distrust and suspiciousness, feeling constantly threatened, interpersonal difficulties in relation to affect-laden situations and negotiation of power dynamics, failures in self-protection (do not pick up early warning signs of danger, feel unable to act to protect themselves), isolation, withdrawal, inability to feel intimate, revictimisation or victimising others, fear of abandonment, and excessive fears around danger. These difficulties make it hard for clients to develop social support systems. Clients might be hyper-alert for negative evaluation by the counsellor, be overly controlling during the session, be overly clingy and dependent, or ask the counsellor overly personal questions. Sex is another area of difficulty within relationships that arise often for people who have been sexually abused. They might experience pain or difficulty when having sex, or have fears and concerns around sex, often because it triggers trauma memories and reliving experiences.

5. **Alterations in systems of meaning**, which manifests as despair that anyone will ever be able to understand or help them or that they will ever recover from their suffering, and in beliefs that the world is a dangerous place and that others, including the clinician, will eventually hurt, betray or abandon them. Clients might believe life has no meaning and they often have trouble making choices and acting to make changes in their lives.

6. **Somatic (physical) complaints and medical problems**, which include somatisation (preoccupation with physical complaints), psychogenic pain (pain for which no medical cause can be found), and conversion reactions such as paralysis or blindness with no medical cause. Pain and gastrointestinal, sexual, and neurological (e.g. headaches) symptoms which cannot be explained medically are commonly reported. There can also be medically-based problems resulting from the trauma. For example, many survivors of sexual abuse experience real medical issues as a result of the abuse in the form of pelvic or gastrointestinal problems.
37. Co-occurring trauma issues

7. Alterations in perception of the perpetrator, which include adopting the distorted belief system of the perpetrator, idealisation or justification of the perpetrator and the abuse, and preoccupation with hurting the perpetrator.

The similarities between symptoms of complex PTSD and symptoms of borderline personality disorder (BPD) have led to the suggestion that when BPD is associated with childhood trauma, as it is in the majority of cases (Linehan, 1993b), it may be better conceptualised as complex PTSD (Herman, 1992; McLean & Gallop, 2003). This removes the pejorative associations of BPD (e.g. difficult, untreatable, manipulative) and provides an understanding of why the symptoms have developed.

Ongoing AOD use or withdrawals can cause some of the symptoms described above. Counsellors should therefore check whether clients experience the symptoms when they are not influenced by or withdrawing from alcohol or other drugs.

37.3 Recommended treatment approach

Once a therapeutic alliance has been developed, clients can be asked whether they have experienced trauma and whether it still affects them. This should be done in a sensitive manner after the first session or two. Clients should be told that they do not need to discuss these issues in any detail as doing so can re-traumatise them. Also be aware that feelings of shame associated with sexual abuse can be particularly intense for male clients due to involuntary signs of arousal. See ‘A note on trauma’ in Chapter 4 Assessment for more detail about raising the issue of trauma.

A phased model is considered the treatment of choice for work with traumatised clients. The notion of safety is central to phased models, which propose an initial focus on increasing stability and safety, before moving on, if the client can tolerate it and desires it, to direct processing of the trauma (Towers, 2008). Herman (1992) was the first to propose a phase-oriented model. She identified three phases: safety, remembrance and mourning, and integration.

- Safety includes enhancing psychological, physical and environmental safety.
- Remembrance and mourning includes exposure to and processing of traumatic memories and the development of a narrative around the trauma.
- Integration is signalled by the client indicating that they want to focus on life beyond the trauma as they work towards developing a meaningful future.

Treatment was never intended to be linear, but the model provides a guide as to the primary focus at different points during treatment. For counsellors working with AOD clients a rehabilitation model of treatment is recommended that does not include the remembrance and mourning phase, as described below.

37.3.1 Rehabilitation model of trauma treatment

A client’s response to trauma is influenced by the type of trauma, the severity of the trauma and their pre-trauma developmental capacities. A client’s response to trauma also influences the appropriate counselling approach in terms of managing the therapeutic relationship and focusing on the trauma. The diagram over the page from Vivekananda (2002) summarises these issues and the explanation below should be read in conjunction with the diagram.

- Type of trauma – interpersonal deliberate harm is more traumatising than impersonal trauma such as natural disasters.
- Severity of trauma – the impact of a one-off incident of impersonal trauma is less severe than multiple incidents of interpersonal trauma, particularly when the trauma is perpetrated by caregivers (attachment trauma).
- Developmental capacities – the earlier the trauma occurs, particularly when it is prolonged attachment trauma, the more it interferes with the child’s development in multiple areas including the ability to manage stress, self-soothe and manage emotions and impulses, form relationships, trust, develop a stable sense of self and depend on themselves.
37. Co-occurring trauma issues

A Framework for Responding to Trauma (Vivekananda, 2002)

TYPE OF TRAUMATIC EVENTS

Single Traumatic Event          Multiple Traumatic Events

Acute or impersonal trauma      Interpersonal trauma      Chronic interpersonal trauma      Early, prolonged, and repeated attachment trauma

SEVERITY OF TRAUMA

Acute or impersonal trauma      Interpersonal trauma      Chronic interpersonal trauma      Early, prolonged, and repeated attachment trauma

DEVELOPMENTAL CAPACITIES

Well-developed capacities: secure attachments, coping skills, cognitive, language and problem solving skills and resources. High resilience factors
Disruption of later developmental tasks (adolescent/adult): moderate levels of resilience
Significant disruption of early developmental tasks

POST-TRAUMA RESPONSES

Acute stress disorder, Acute PTSD
Chronic PTSD
Chronic PTSD with comorbid conditions (depression, substance abuse, dissociative disorders, personality disorders)

THERAPEUTIC RELATIONSHIP

Easily established – basic trust exists
Helping client to reconnect with previously known resources that have been lost through the process of overwhelming trauma
Building basic relationship resources and capacities not previously existing; trust and ego-supportive work and relationship repair skills essential; transference, boundary and traumatic re-enactment issues will be highly potent

FOCUS ON TRAUMA

Trauma-focused interventions; after initial engagement and development of safety clients will usually move to directly address and uncover traumatic events (exposure-based interventions and reintegration of traumatic material)
Stage-oriented model: longer period of establishing safety; developing affect regulation and distress tolerance skills; address here-and-now problems; stabilisation of symptoms prior to addressing traumatic material
Rehabilitation model: psycho-educational approach for managing PTSD as a chronic condition; life-time self-care and self-management strategies; compensation strategies; developmental repair; relatively structured, directed, reality oriented focus on coping with current life stressors; address traumatic material largely indirectly – little or no uncovering of trauma

37. Co-occurring trauma issues

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 need for less (or no direct) focus on the trauma with more traumatised clients is due to their lack of skills to manage the intense distress that arises with a focus on the trauma. Although focusing directly on the trauma in the form of exposure treatment (exposure to traumatic memories and making sense of the trauma in a safe therapeutic environment) is considered the treatment of choice for resolving PTSD, it is generally contraindicated for people who have experienced chronic childhood trauma and for people with AOD disorders (Foa et al., 1999). This is because clients who experienced chronic childhood trauma tend to manage the intense distress that arises from exposure to traumatic memories in risky ways such as drug use, self-harm, aggression, or suicide attempts. Clients with AOD issues often manage by relapsing to drug use or dropping out of treatment (Marsh, 2008). Having said that, some traumatised AOD clients might attain sufficient stability and coping skills in counselling to be able to tolerate exposure work. If so, counsellors should ensure the client is referred to an appropriately trained clinician to engage in this work as it can be difficult and re-traumatising for clients if not done very carefully.

Safety and containment should be considered in a number of areas including environmental, behavioural, physiological and therapeutic. Central aspects are:

1. Establishing a safe and supportive therapeutic relationship.
2. Helping clients to build coping resources and the ability to care for themselves while decreasing AOD use (and other potentially damaging behaviours).
3. Case management to link clients with resources and services to help with their multiple needs, including practical needs such as stable and safe accommodation.

In the following we consider points one and two. Point three, case management, was discussed in Chapter 11 Case management.

Establishing a safe and supportive therapeutic relationship

The need for increased focus on building a safe and supportive therapeutic relationship with more traumatised clients is due to the need to help them to either reconnect with lost relationship resources and capacities, or to build basic relationship resources and capacities that have never previously existed if they experienced prolonged early attachment trauma (Vivekananda, 2002).

Clients who experienced chronic trauma within their family of origin (abuse, criticism, neglect) have unmet developmental needs that are triggered when they get close to anyone, including the counsellor, and which cause them immense anxiety. To deal with this anxiety, and in an effort to either get these needs met or protect themselves from the painful feelings associated with not having their needs met, clients can engage in a variety of challenging interactions in their close relationships. In counselling, for example, they might demand that the counsellor rescues them, they might idealise the counsellor as the only person who can help, or they might oscillate between neediness (demanding that the counsellor answers frequent phone calls, threatening self-harm or suicide, or not wanting to leave at the end of the session) and rejection (not speaking in session, not turning up for counselling, or ’sacking’ the counsellor). They also tend to easily interpret neutral and even positive behaviour and comments on the part of others, including the counsellor, in a negative manner, because they expect to receive the same hurtful responses they received as children from their parents or caregivers and are alert for any signs of maltreatment.

These disruptions to the therapeutic relationship can provoke strong reactions from counsellors, from intense sympathy and sorrow to anger and resentment. These reactions are normal, but can further disrupt the therapeutic relationship if counsellors do not respond in therapeutic ways. These sorts of countertransference reactions should be discussed regularly in supervision so that counsellors can consider how to interpret and manage them.

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18 Countertransference is generally currently defined as all of the feelings a clinician has towards a client, which can be related to the client’s behaviour but also the clinician’s own issues (Kahn, 2001).
37. Co-occurring trauma issues

Essentially, counsellors need to respond to clients in new healing ways, rather than the old hurtful ways that they expect based on previous experience. This is not always easy as many client behaviours ‘pull’ strongly for particular responses, which are often not therapeutic. For example, a client who idealises a counsellor as the only one who can help ‘pulls’ for a rescuing response from the counsellor, and many counsellors want to help and easily fall into doing too much for a client rather than supporting them to develop skills themselves. A client who refuses to talk in therapy and acts in a rejecting manner to a counsellor ‘pulls’ for a rejecting and angry response from a counsellor, which just reinforces the client’s belief that people will hurt or reject them. In both these examples, the trick is for the counsellor to find a way to comment empathically on what they see occurring in the relationship, normalise the client’s behaviour in the context of their past traumatic experiences, and help the client to understand why they feel and behave that way.

Because traumatised clients have difficulties trusting relationships, it is very important that counsellors:

- ask clients how they are feeling about counselling and things you as a counsellor say and do
- empathise with and normalise clients’ concerns and fears
- clarify misunderstandings
- are ready to apologise and repair the relationship when you make therapeutic errors.

Counsellors also need to be aware that the constant physiological hyperarousal experienced by traumatised clients means they have little tolerance for emotional intensity. Counselling therefore needs to be very supportive and counsellors should be transparent about what they are doing and why.

**Building coping and self-care resources and reducing potentially damaging coping strategies**

Clients with AOD and trauma issues often have difficulties with coping and self-care across a number of different areas and tend to use potentially damaging ways of coping, such as drug use and self-harm. AOD use can further interfere with the development of coping skills because it provides a ‘quick fix’, which means there is less of an immediate need to use other strategies. It can also reduce awareness and hence the ability to maintain environmental safety. Self-harm such as cutting or burning can cause permanent scarring and damage, and if severe enough, can inadvertently cause death.

**AOD use**

Counsellors should explore with clients how they see their trauma symptoms and distress interacting with their drug use, and provide them with some information about trauma and PTSD/complex PTSD and the frequent self-medication function that drug use plays. This not only helps clients to be less critical of themselves, but also provides a rationale for developing other ways to manage trauma symptoms, relationships and life challenges.

As clients attempt to quit or reduce their drug use, they will need to use other strategies to cope with how they feel. AOD interventions outlined in other chapters, such as motivational interviewing, relapse prevention, harm reduction, and addiction pharmacotherapies are all relevant.

**Suicide and self-harm**

Suicide assessment and prevention, and working with chronically suicidal clients’ are addressed in Chapter 5 *Suicide assessment and management*.

Self-harming behaviours such as cutting and burning without intent to die can be approached in a similar way to AOD use: 19

- Explore their function and how the client uses self-harm to regulate their distress.
- Motivational interviewing to examine the good and less good things about engaging in self-harm.
- Relapse prevention, which includes examining triggers for self-harm, identifying alternative ways to cope with those triggers, and helping clients to develop alternative coping and emotion regulation strategies generally.
- Harm reduction, whereby if clients do engage in self-harm, they are encouraged to identify self-harming behaviours that cause the least damage.

19 Marsh et al. (2012) have a chapter on suicide and self-harm that provides more detail about these issues.
37. Co-occurring trauma issues

**Alternative coping strategies**

Alternative coping strategies can be many and varied, depending upon the issue that the client is working on. A number of them are included in chapters in this guide and several other good resources for coping strategies for use with traumatised clients are Cloitre et al. (2006), Marsh et al. (2012), Najavits (2002). Examples are:

- grounding (to detach from emotional pain and bring clients who are dissociating back in touch with reality)
- emotion regulation: identifying, naming and learning to tolerate emotions
- controlled breathing
- mindfulness strategies
- progressive muscle relaxation
- problem-solving
- identifying and challenging problematic beliefs about self and others
- assertion and effective communication
- anger management.

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.

37.3.2 Developing a life beyond the trauma (integration)

As clients reduce their AOD use and become more able to manage their emotions, trauma symptoms, and interpersonal relationships, many of them make significant changes in their lives. They make new friends, and start to look at developing aspects of their lives beyond the trauma and the AOD use, such as study or work. This is the equivalent of Herman’s (1992) ‘integration’ component of treatment.

### Co-occurring trauma issues – tip sheet

The majority of clients in AOD treatment report past experiences of trauma, often chronic trauma starting in childhood. AOD use is often a way in which clients try to manage their trauma-related symptoms.

The experience of trauma can result in a range of symptoms.

The DSM-5 describes PTSD as involving “exposure to actual or threatened death, serious injury, or sexual violence” and classifies PTSD symptoms, as a result of this exposure, into four groups.

1. Presence of intrusive symptoms, recurrent distressing dreams and dissociative reactions such as flashbacks, intense psychological distress and marked physiological reactions.
2. Persistent avoidance of stimuli associated with the traumatic event, including memories, thoughts, feelings and external reminders such as people, places, objects, situations.
3. Negative alterations in cognitions and mood associated with the trauma.
4. Marked alterations in arousal and reactivity.

Complex PTSD from chronic trauma, particularly early attachment trauma, entails a wider range of symptoms:

- difficulties controlling affect and impulses
- problems in attention and consciousness
- problems or instability of self-perception
- problems relating to others
- alterations in systems of meaning
- somatic (physical) complaints and medical problems
- alterations in perception of the perpetrator
37. Co-occurring trauma issues

Co-occurring trauma issues – tip sheet

Complex PTSD is the norm rather than the exception in AOD populations and these clients tend to be highly distressed and present with a complex array of problems.

Trauma issues and AOD problems cannot be treated as discrete entities but need to be treated together.

For AOD clients with trauma issues, counsellors should adopt a rehabilitation approach in which clients are assisted to contain and manage symptoms and enhance safety, with no direct focus on the trauma. This is because focusing on the trauma can be re-traumatising and can result in relapse if the client does not have the skills to manage the emotions that arise. Should a client become ready for trauma-focused work, they should be referred to someone specialised in this work.

Key aspects of a rehabilitation approach are:

- ensuring a safe and supportive therapeutic relationship
- helping clients to build coping resources and the ability to care for themselves while decreasing AOD use (and other potentially damaging behaviours)
- case management to link clients with resources and services to help with their multiple needs, including practical needs such as stable and safe accommodation.

Raise the issue of sexual abuse and other trauma with sensitivity once a therapeutic alliance has been formed and ensure you tell the client that it is not be necessary to provide details of the trauma for you to understand the impact.

Normalise client reactions to the trauma.

Because traumatised clients often have difficulties trusting relationships, it is very important that counsellors:

- ask clients how they are feeling about counselling and things you as a counsellor say and do
- empathise with and normalise clients’ concerns and fears
- clarify misunderstandings
- are ready to apologise and repair the relationship when you make therapeutic errors.

Counsellors also need to be aware that the constant physiological hyperarousal experienced by traumatised clients means they have little tolerance for emotional intensity. Counselling therefore needs to be very supportive and counsellors should be transparent about what they are doing and why.
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 from the effects of AOD. 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 alcohol and other drugs as a way of coping with grief or loss issues; other clients may continue to use alcohol and other drugs 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.

38.1 Bereavement

From the outset it is important for counsellors to 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. 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 (2009).

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 vacillating between a range of 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 a long period of time. This shouldn’t be taken as a sign of the client having failed to resolve their feelings and counsellors should endeavour to normalise this process for the client.

Physical

Bereaved people commonly experience a number of 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. Mimicking a reaction whereby 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 drug-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.
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Counsellors should normalise the client’s experience of cognitive changes and empathise that certain thoughts can trigger intense, but normal, feelings. It may be useful for the counsellor to be 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 ignore 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.

38.2 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). Therefore it is recommended that counsellors adopt a client-focused approach and explore grief issues if the client expresses concern in this regard. If it is apparent that the client is experiencing prolonged, traumatic or complicated grief then liaise closely with a supervisor and consider referral to specialist clinicians who have experience with complicated grief reactions.

Worden (2009) conceptualises the normal process of mourning as consisting of four tasks to be achieved in order to adapt to the loss:
1. To accept the reality of the loss.
2. To process the pain of grief.
3. To adjust to a world without the deceased.
4. To 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. It is noted, however, that 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 is drawn from Worden (2009) to 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.
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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 while 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 while also integrating their ‘changed relationship’ into their daily lives.

38.3 Useful techniques
The following techniques, adapted from Worden (2009), 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 to 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 impact on 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 18 Cognitive restructuring). 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.
38. Grief and loss

38.4 General points when working with grief

While the following points are specific to grieving or bereaved people, they are appropriate to bear in mind when working with other grief and loss issues. Grief is universal, with common underlying themes across different sources.

- Grief is normal, natural and painful and cannot be avoided.
- No two people will experience grief in the same way though there may be common elements. Thus it is important to normalise a client’s experience of grief reactions, particularly if the client perceives that these reactions indicate they are going mad (a common thought experienced by bereaved people).
- Bereaved people often appear distracted and preoccupied.
- Give people permission to grieve.
- Grief takes time to resolve and people may need to retell the story of their loss many times over. There are no time lines for grief. People do not ‘get over’ grief but learn to live with it.
- Facilitate clients talking about their feelings regarding a deceased person, not just the positive ones but also the negative ones. Unless both positive and negative feelings are processed, some clients will not adequately process the grief.
- Previous losses will affect the current situation. An individual’s reaction may seem inappropriate to the current loss as it may be influenced by previously unresolved loss issues that may need to be talked about as well.
- Give the client your undivided attention. Actively listen, and communicate empathy and unconditional positive regard.
- Try to avoid giving someone only a time-limited commitment. Working through issues of grief is often long term.
- If you need to give information to someone who is bereaved, always give both verbal and written instructions. When someone is grieving it is often difficult for them to concentrate.
- Use the name of the deceased and use the word ‘death’ to increase acceptance of the reality of the loss. The use of euphemisms will not help soften the pain.
- People often need practical help as well as emotional support.
- Encourage clients to find an avenue to help them express their grief. Such avenues include:
  - talking
  - writing (a letter, poem, stream of consciousness)
  - artistic expression (drawing, sculpting, painting)
  - physical expression (running, rowing, hitting a punching bag wearing gloves, walking, going to the gym)
  - emotional expression (screaming, crying, yelling).
- Encourage the client to find somewhere that they feel comfortable and safe before they try any of the above strategies, as well as trying to develop strategies of their own.
- Encourage clients to find a ritual in order to help them to move on. Counsellors should use clinical judgement as to the appropriateness of this intervention and ensure that the client is ‘ready’ to move on.
- Encourage clients to seek social support. This may be in the way of friends, family, Alcoholics Anonymous/ Narcotics Anonymous and bereavement support groups.
- 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.
38. Grief and loss

- Consider the well-being of the whole family – partner, siblings and other generations.
- A consistent finding is that recent bereavement is a risk factor for suicide (Foster, 2011). If suicidal ideation is indicated monitor the client’s level of suicide risk. Suicidal risk may be elevated two to three days after the funeral and also eight to twelve weeks after death, when most social supports tend to withdraw. See Chapter 5 *Suicide assessment and management*.
- Monitor the client’s levels of depression. Should clinical depression develop and continue for a significant period of time after the loss with no indications of relief or improvement, specific interventions designed to alleviate the depression may be appropriate. (See Chapter 35 *Co-occurring depression*).
- Drug use tends to be actively condoned during the grieving process. People are often prescribed sleeping pills or antidepressants, or encouraged to have a drink. For those already struggling with AOD issues, it may be useful to book them into a residential service during this time which will allow access to more social support, professional support and monitoring by staff.
- There is a lack of conclusive evidence that bereaved parents are more likely to divorce (Schwab, 1998), however 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 can not 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.

When working closely with grieving individuals, counsellors should have the support and guidance of a clinical supervisor experienced in the area. Assistance can also be provided by various funeral organisers or grief recovery centres, many of which can be found by searching the web.

### 38.5 Client death

It is normal for counsellors to be saddened and experience a sense of loss and grief following the death of a client. A short period of time off work and consultation and support from their supervisor and colleagues is encouraged. If counsellors wish to attend the funeral, they should be encouraged to do so but are reminded to maintain confidentiality. Counsellors should not attend the funeral if they believe it will upset family members.

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.
38. Grief and loss

<table>
<thead>
<tr>
<th>Grief and loss – tip sheet</th>
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<tbody>
<tr>
<td>• Grief can arise from a number of different sources, not just from the death of someone close.</td>
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<tr>
<td>• Grief is a normal, natural and painful process.</td>
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<tr>
<td>• No two people will experience grief in the same way. Normalise clients’ varied emotional, physical, cognitive and behavioural reactions to grief.</td>
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<tr>
<td>• Adopt a client-centred approach and focus on grief issues if the client expresses concern in this regard. Avoid time-limited counselling if possible as working through issues of grief is often long term.</td>
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<tr>
<td>• The first year including the first Christmas, birthday or any anniversary is particularly painful. However, there are no time lines for grief.</td>
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<td>• Don’t judge others by your standards.</td>
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<td>• Previous losses will affect the current situation.</td>
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<td>• The story relating to the loss may need to be told several times.</td>
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<td>• Facilitate the client talking about both their positive and negative feelings about a deceased person as not doing so can result in unresolved grief.</td>
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<td>• Be open and client-centred. Allow the client the freedom to talk about the loss, or about other issues, as they wish.</td>
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<td>• If information is to be provided to the bereaved, always give both verbal and written instruction.</td>
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<td>• Encourage parents grieving over the loss of a child to seek support or professional help together.</td>
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Cognitive impairment is a term used to describe damage to or alterations in cognitive (i.e. thinking) functions as a result of either direct damage to or other conditions affecting the central nervous system (CNS). Cognitive impairment can arise from head injury, psychiatric illness (such as depression or schizophrenia), medical conditions and AOD use. Cognitive impairment can be present at birth or acquired at any stage across the lifespan. Clients with problematic AOD use are at a higher risk of acquiring cognitive impairments due to the neurobiological effects of the drug and associated harms, such as head injuries resulting from accidents and/or violence.

There is now extensive evidence to suggest that cognitive impairments are prevalent among AOD clients, with the severity of impairments dependent on the nature and extent of the drugs used. Cognitive functions, including memory, learning, attention and executive functioning, are often impaired in AOD clients; yet these abilities can directly affect how these clients respond to treatment interventions. Clients need to be able to attend to discussions, learn, retain and implement new strategies, monitor their thoughts and behaviour, and control their impulse to use the drug of concern (Carroll et al., 2011). Not being able to do these things may mean that the treatment the client ends up receiving is sub-optimal, because their ability to cognitively engage in treatment is detrimentally affected by their substance use.

Because of this, it is imperative that counsellors enquire about and screen for cognitive difficulties that clients experience, arrange for a referral to a neuropsychologist if necessary, and adapt treatment approaches accordingly. The following provides a review of the cognitive impairments often associated with AOD use and highlights ways that counselling can be adapted to suit the client’s cognitive functioning.

### 39.1 Alcohol and cognitive impairment

The link between alcohol and cognitive impairment has been well documented. The majority of clients with alcohol use disorders experience mild to moderate deficits in learning and memory, visuo/spatial abilities and executive functions (Manning & Betteridge, 2011). The severity of impairments in brain structure and function due to alcohol is dependent on the frequency and severity of use. Importantly, while alcohol is associated with widespread cognitive impairments, there is evidence that following 12 months of strict abstinence and healthy living, solid recoveries can be seen (Stavro et al., 2012). However in extreme cases, chronic drinkers may develop Wernicke–Korsakoff syndrome, which consists of an inability to form new memories, and an inability to plan activities and comprehend abstract information. These clients also have neurological damage affecting their eye movements and gait.

### 39.2 Illicit drug use and cognitive impairment

Illicit drug use is also associated with cognitive impairments: deficits in memory and executive functioning have been identified among users of psychostimulants, opioids, and cannabis (Manning & Betteridge, 2011). Clients who use psychostimulants, such as ecstasy, methamphetamine and cocaine, often have impaired cognitive functions:

- Ecstasy is associated with impairments in attention, verbal and non-verbal learning and memory, motor skills, and executive functions (Kalechstein et al., 2007).
- Long-term methamphetamine use may result in deficits in memory, executive functions, processing speed, as well as motor, verbal, and visuospatial skills (Scott et al., 2007).
- Long-term cocaine use is associated with deficits in learning and memory, executive functions, processing speed, and pronounced impairments in attention (Jovanovski et al., 2005). Recent research has shown that even recreational cocaine use is associated with impaired attention (Soar et al., 2012).

Opioids such as heroin can also lead to cognitive impairment, such as deficits in executive functioning, including the ability to switch attention and inhibit behaviours (Gruber et al., 2007).

The short-term effects of cannabis include impaired attention and concentration, decision-making and risk-taking, and working memory (Crean et al., 2011). There is some evidence that many of these acute impairments resolve with abstinence. However, impaired decision-making and risk-taking are recognised as long-term cognitive consequences of cannabis use (Crean et al., 2011).
39. Cognitive impairment

39.3 Volatile substance use and cognitive impairment

Volatile substance use (VSU) can have a devastating impact on neurocognitive functioning and is associated with significant risks of acquired brain injury. Volatile substances such as petrol, paint and glue are absorbed into the bloodstream and CNS and cause brain dysfunction leading to impaired attention, memory, visual and spatial abilities, and executive and motor functions (Dingwall & Cairney, 2011). Heavy VSU can lead to severe brain dysfunction or ‘VSU-induced encephalopathies’ characterised by abnormal eye movements, impaired coordination and involuntary movements (Dingwall & Cairney, 2011). Despite these pronounced consequences, clients presenting with VSU can begin to recover cognitive functions within weeks of abstinence and memory and executive functions can recover within two years of abstinence (Dingwall et al., 2011). (For further information see Chapter 33 Volatile substance use.)

39.4 Assessment of cognitive impairment

Cognitive impairments can impede a client’s ability to benefit from AOD treatment approaches that require intact cognitive functioning. Even mild cognitive impairment can have a negative effect on treatment outcome (Aharonovich et al., 2005, 2008). Therefore the assessment and recognition of cognitive impairment needs to be considered early in treatment.

As part of assessing mental state, counsellors should make observations regarding any indications of poor cognitive functioning, such as difficulty concentrating and comments from clients about poor memory or difficulties organising their lives. Counsellors can assess the client’s level of cognitive functioning by conducting a thorough clinical assessment and enquiring about the client’s perception of their cognitive functioning. For example, ask the client whether they have any difficulty remembering things or paying attention and explore this further by eliciting relevant examples. The client’s presentation in session, such as excessive distractability, or difficulty concentrating and suppressing irrelevant information, may also indicate cognitive impairment. Importantly, however, clinician- and client-reported cognitive performance may not be a reliable insight into the client’s actual cognitive functioning (Moritz et al., 2004) because cognitive impairments are not always obvious upon presentation. In addition, the client’s presentation in session may be related to the effects of the drug-using lifestyle, such as a lack of sleep.

Another important source of information regarding a client’s functioning is the reports from their spouse, family member or friend. If appropriate, it is important for those working with AOD clients to ask those who know the client well if they have noticed any change in the client’s thinking over time. It is not uncommon for clients to deny or under-report the extent of their difficulties and how they are impacting on their daily lives. Asking similar questions of those close to the client can elicit valuable information in this regard.

If cognitive impairment is suspected and of concern, it is recommended that a referral is made to a neuropsychologist who can conduct a formal assessment. A diagnosis of cognitive impairment should only be made by a neuropsychologist who is endorsed to practise in the area of neuropsychology.

One of the difficulties with referring clients for assessment only when impaired cognitive functioning is obvious is that mild cognitive functioning difficulties, which are often not readily apparent, can still have a significant negative impact on treatment (Aharonovich et al., 2008). For example, a client with impaired executive functioning (which is involved in making plans and carrying them out) might repeatedly agree to reduce drinking and complete homework tasks but fail to do so due to impaired organisational skills. Behaviour such as this may be interpreted by counsellors as low motivation to change. However the client might be very motivated to reduce but need some extra help to break tasks down, sequence them and problem-solve difficulties that might arise to enable them to put their agreements into action. It is always important for counsellors to ascertain whether it is a motivational or cognitive impairment issue when homework tasks are not completed. With subtle cognitive impairments, it may only be as counselling progresses that the counsellor starts to notice difficulties the client is having that may be due to impaired cognitive functioning.
39. Cognitive impairment

An appropriate way for counsellors to quickly screen for the presence of cognitive deficits is through the use of the MOCA (Montreal Cognitive Assessment). This brief instrument is freely available on the internet. It takes about 5–10 minutes of the clinician’s time and provides a quick indication if a client may have impairments in their thinking abilities. Please note, that this is only a screen intended to inform clinical judgement. Also, obtaining a high score on the MOCA does not mean that the client does not have cognitive difficulties – their difficulties may be more subtle than this screening measure can detect.

39.5 Managing cognitive impairment

Where cognitive deficits are suspected or clearly present counsellors should tailor their intervention strategies to the client’s abilities, or the efficacy of the interventions is likely to be limited. When working with clients where cognitive impairment is suspected, a number of strategies can enhance the effectiveness of standard AOD cognitive behavioural interventions. Ideally particular strategies will be incorporated into treatment in response to cognitive difficulties in particular areas. However, unless a neuropsychological assessment has been completed and recommendations for specific treatment adaptations made, it is difficult for counsellors to be clear about the exact nature of cognitive deficits that the client is experiencing.

Therefore, although the strategies below are targeted to particular cognitive difficulties, counsellors may choose to include them to a degree in treatment with all AOD clients unless it becomes apparent that the client does not wish them to be included or is managing well without them. A ‘first-line’ approach to managing possible cognitive impairment is to integrate cognitive rehabilitation strategies, including repetition, writing things down, and cues to recall important information, into counselling (Crean et al., 2011).

Clients with AOD problems often report that they have difficulty ‘remembering to remember’ that causes difficulties in their daily lives. Remembering to do things, and at the intended time, is referred to as ‘prospective memory’, research has shown that AOD clients have deficits in this particular ability (Weinborn et al., 2011). To help clients to manage this difficulty, counsellors can ask clients at the start of counselling how well they remember appointments. If they say that they have difficulties, explore why this is and whether reminders are necessary. When discussing issues it can also be helpful to ask clients if they want to write down any particularly important points or between-session tasks. Adapting counselling using the strategies listed below (adapted from Manning & Betteridge, 2011) can be helpful when working with clients with suspected cognitive impairment, whether due to recent AOD use, long-term impairment from AOD use, or other factors.

Attention problems

- Provide clear structure for sessions (you can even involve the client in establishing this structure).
- Have shorter, more frequent sessions (i.e., instead of seeing a client for 60 minutes see them for 2 x 25 minute sessions with a 10-minute break in the middle).
- Avoid ‘overloading’, by limiting content of each session.
- Supplement content of sessions with written handouts of important information.
- Reduce pace of sessions.
- Provide breaks if necessary.
- Maintain focus on relevant issues to optimise attention.
- Have sessions in a quiet room, free from distractions and interruptions.
39. Cognitive impairment

Learning and memory problems
- Present information that has to be remembered using both verbal and visual methods (e.g. you can draw a genogram with a client when discussing their family situation, or summarise sessions in writing perhaps including diagrams20).
- Use repetition and summaries of key ideas.
- Offer the opportunity for the client to speak about what they recall from prior sessions.
- Encourage the use of prompts and aids to improve recall (e.g. write things down, use memory aids, develop routines).
- Remind client of appointments (use a diary, calendar, mobile phone alarms, offer appointment letters).
- Keep appointments at regular times (e.g. every Monday at 10 am).
- Review important issues from previous session at the beginning of the next one to accommodate poor memory continuity across sessions.
- Limit the amount of content covered each session.

Executive functioning (mental flexibility, planning, organisational skills, impulsivity, problem-solving)
- Encourage daily planning and developing routines.
- Divide goals into smaller, manageable tasks.
- Verbalise and practise how to manage high-risk situations.
- Particularly for impulsive clients, encourage self-monitoring and the use of cue cards with prompts of strategies to use.

Cognitive impairment – tip sheet
- Cognitive impairment is a term used to describe damage to or alterations in cognitive (i.e. thinking) functions as a result of damage to the central nervous system (CNS).
- The majority of clients with alcohol and other drug disorders have cognitive deficits. In many cases these acquired deficits are associated directly with their substance use, or may be secondary to their use, such as a head injury sustained from falling over while intoxicated.
- Volatile substance use (VSU) is associated with significant risks of acquired brain injury. Volatile substances cause brain dysfunction leading to impaired attention, memory, visual and spatial abilities, executive and motor functions.
- Solid recoveries of cognitive function from AOD use can be achieved with abstinence and healthy living. However the time frame for this is usually around 12 months – it does not happen after a week (or month) of abstinence!
- Depending on the degree or severity of suspected cognitive impairment, counsellors may wish to refer clients to a neuropsychologist, or clinical psychologist endorsed to practise in neuropsychology, for further assessment. The purpose of such a referral should be clear to both client and counsellor.
- Unless counselling is adapted to suit the client’s needs, cognitive impairments can have a negative impact on treatment outcome.
- Interventions should be adapted to the client’s level of cognitive functioning.
- A ‘first line’ approach is to integrate cognitive rehabilitation strategies (repetition, writing things down, cues to recall important information) into counselling. In addition, the general counselling approach can be adapted by providing structure, reducing the pace, and avoiding ‘overloading’ clients with information.

20 ‘Mind maps’ can be useful – information about them can be found on the internet.
Coerced clients

Clients can be coerced or mandated into AOD treatment from a variety of sources. They can include those who are mandated to attend AOD treatment by the judicial system, their place of employment, or child protection services; adolescents referred by parents or schools; and people who are seeking treatment under pressure from partners. Although coerced clients can be difficult to work with, treatment does not need to be voluntary to be effective (National Institute on Drug Abuse, 2009).

Issues of confidentiality, conflict of interest, working with resistance and the appropriateness of harm reduction interventions are particularly important when working with coerced clients. A related issue concerns clarifying the question, ‘Who is the client?’

Although confidentiality is never absolute, it is further complicated when working with coerced clients. For example, difficulties can arise about how much information to provide when a report is required upon the conclusion of counselling and a client on a court order has continued to use. To date there has been no systematic development of guidelines regarding confidentiality in such situations, although agencies may have developed their own guidelines and procedures to follow in these instances (see Chapter 50 Confidentiality).

Confidentiality should be negotiated and clarified between all interested parties at the outset of any therapeutic enterprise. Counsellors should ensure that they are aware of the type of information that they may be required to give to a third party, and open communication regarding the boundaries of confidentiality needs to occur with all parties. Counsellors need to be honest with clients and not promise levels of confidentiality that cannot be met. It is important to follow the policies and procedures of agencies in this regard. The client’s understanding of the release of information should be documented in writing with a release of information form. Asking the client to complete this form can help to facilitate a discussion about the limits of confidentiality when third parties are involved.

Young people brought to treatment by their parents are often ‘coerced’ in the sense that they may not want to be there. Parents of minors considered not sufficiently mature to give informed consent are legally entitled to information about their child’s treatment. However, if the young person is considered to have the maturity to provide informed consent, then their wishes for confidentiality must be respected unless other legal constraints and obligations apply. This assessment is usually made around the age of 14 or 15. In all cases, it is essential that the limits of confidentiality are explained clearly to the young person and the parents or guardians at the commencement of treatment. In most situations it is helpful to have parents involved in treating young people and this should be managed and discussed in advance with the young person. For further information on working with young people, see Chapters 42 and 43 on Significant others and Young people.

To reduce the possibility of conflict of interest between referring bodies and professional integrity, it is recommended that agency staff engage in ongoing discussions about the purpose and boundaries of counselling, and that counsellors discuss these issues in supervision. These discussions necessarily need to take into account the competing needs of different parties, such as the drug user, the victim of a drug-related offence, the general public, the client’s family and the justice system. Issues such as relapse management may need to be carefully considered in the context of inter-agency protocol as well as on a case-by-case basis.

Working with coerced clients often involves working with resistance. The initial encounter with coerced clients is essentially a conflict situation requiring mediation and negotiation skills. There are six steps to allow adoption of the role of negotiator or conflict manager (Barber, 1991):

• Clear the air.
• Identify legitimate client interests.
• Identify non-negotiable aspects of intervention.
• Identify negotiable aspects of intervention.
• Negotiate the case plan.
• Agree on criteria for progress.
40. Coerced clients

As with working with voluntary clients, working with involuntary clients should focus on building a therapeutic alliance. Avoid probing questions as a coerced client may perceive this as intrusive and therefore become defensive (Brodsky, 2011). Counsellors should ‘roll’ with resistance and acknowledge it with the client, instead of working against it: reluctance to be in treatment and to divulge information should be discussed with the client and not confronted or viewed as something ‘bad’. Motivational interviewing is a useful technique for working with resistance. For example, the counsellor can ask the client to consider the good and less good things about coming to counselling. Through use of these techniques, opportunities for change to occur may arise even when a client is coerced to attend treatment sessions.

Harm reduction also requires careful consideration. For some clients, the primary harm relating to drug use may be the re-imposition of a prison sentence. Depending upon the court ordered requirements, even low levels of illicit substance use may be associated with serious harm to the client. Likewise, when drug use is seriously affecting the ability to care for children or is associated with violence or other criminal behaviour, clinicians need to weigh up the harms of the drug-using client against the harms to ‘indirect’ clients. If appropriate, however, the process of negotiating less risky using practices may potentially strengthen the therapeutic relationship with the client (Marsh & Dale, 2006).

<table>
<thead>
<tr>
<th>Coerced clients – tip sheet</th>
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<tbody>
<tr>
<td>• Clients can be coerced into AOD treatment for many reasons.</td>
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<tr>
<td>• Treatment is effective for coerced clients.</td>
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<tr>
<td>• Confidentiality should be negotiated between all interested parties at the outset of treatment.</td>
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<td>• Reporting requirements from the mandated agency need to be clarified.</td>
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<tr>
<td>• Documentation to release information should be completed.</td>
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<tr>
<td>• As a general guide, parents of children under the age of 16 can have access to information. Discuss the type of information to be disclosed to parents openly with both the client and the parents.</td>
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<tr>
<td>• Be aware of conflicts of interest between what the counsellor may perceive to be best for the client and what the referral body requires.</td>
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<tr>
<td>• Focus on building a therapeutic alliance and avoid probing questions that may be perceived as intrusive or judgemental.</td>
</tr>
<tr>
<td>• Resistance is common among coerced clients. Adopt the role of negotiator or conflict manager. Follow the six steps:</td>
</tr>
<tr>
<td>1. Clear the air.</td>
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<tr>
<td>2. Identify legitimate client interests.</td>
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<td>3. Identify non-negotiable aspects of intervention.</td>
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<td>4. Identify negotiable aspects of intervention.</td>
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<td>5. Negotiate the case plan.</td>
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<tr>
<td>6. Agree on criteria for progress.</td>
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<tr>
<td>• Learn to ‘roll’ with resistance. Accept, acknowledge and discuss the resistance with your client. Motivational interviewing is a useful technique for working with resistance.</td>
</tr>
<tr>
<td>• Where appropriate, consider harm reduction strategies and attempt to negotiate less risky using strategies. Harm reduction options should be clarified with the statutory agency.</td>
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Much has been written about the link between crime and alcohol and other drug issues and it has long been accepted that the prison population has one of the highest rates of drug use. Consequently, it is becoming increasingly common for AOD treatment services to be involved with the prison system. Incarceration can provide a prime opportunity for intervention that otherwise would not be possible. Incarcerated clients can be difficult to work with, especially as the counsellor may be required to work in a system that is not conducive to therapeutic change.

Confidentiality is an important issue when working with this client group (see Chapter 40 Coerced clients). Counsellors need to be clear about the type of information that they should disclose and to whom. It is essential that the limits of confidentiality are explained to clients prior to treatment. Due to the restrictions associated with working in a prison, 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.

Harm reduction is critically important when working with incarcerated clients. Western Australian data indicates a high incidence of unprotected sex, sharing of injecting equipment, and consequently the transmission of blood-borne viruses, among prisoners in both metropolitan and regional prisons (Watkins et al., 2011). There is also evidence to suggest that former inmates are at a higher risk of drug overdose, especially in the immediate period following their release from prison (Binswanger et al., 2012). Counsellors should advise former inmates of the higher risk of drug overdose because of reduced tolerance, among other things.

Clients and counsellors need to work together on a plan of harm reduction strategies that the client is willing to implement. Protective factors for clients after their release from prison include engagement in a structured drug treatment program, use of community resources including self-help groups, and availability of social supports (Binswanger et al., 2012). A treatment plan for an incarcerated client should include a focus on the gradual transition back into the community, enhancing protective factors, and helping the client to manage environmental stressors and triggers. It is important to consider whether a residential setting would benefit a client to make the transition back into the community.

Counsellors need to be aware of the debriefing and liaison process when incarcerated clients express suicidal ideation or are self-harming. Counsellors have a duty of care to inform the centre psychologist and obtain increased support for the client.

Counsellors need to have a clear understanding of the policies and procedures relevant to working in prisons, as well as an overall knowledge of the general running of the prison. Relevant issues include the levels of command, to whom they should report, and the type of information that they should disclose and to whom.

### Incarcerated clients – tip sheet

- Be clear regarding to whom you need to report the client’s activities. Make sure you communicate this to incarcerated clients prior to the onset of counselling.
- Be clear as to the limits of confidentiality and the nature of activities that will be reported to the relevant authorities. Again, clearly communicate this to the client prior to the onset of counselling.
- Harm reduction should be a focus of any intervention.
- Acknowledge resistance and negotiate the relationship accordingly.
- If a client is self-harming and/or suicidal you have a duty of care to inform the centre psychologist.
- Have a clear understanding of prison policies and procedures, such as the levels of command, who you need to report to, the type of information you need to disclose and to whom, as well as having an overall knowledge of the general running of the prison.
Significant others

It is widely accepted that alcohol and other drug use causes stress to family members and friends of people with AOD use problems and that significant others may require support in their own right. It is also apparent that significant others can be instrumental in facilitating treatment engagement for the person with AOD problems and that their involvement may improve the treatment outcome (Orford et al., 2005). Even simple interventions with significant others, such as the provision of self-help materials, can lead to significant improvements in terms of 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 problems.
- To explore general life problems and stressors.
- To assess the quality of the relationship between the person with AOD use problems 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. Different 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.21

### 42.1 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 problems in a family have a similar effect to major trauma in the sense that trauma puts extreme pressure on clients and family members and on their relationships with each other.
- Blame, guilt, grief, shame and frustration are natural companions of the trauma of AOD and mental health problems and other major family difficulties in our culture.
- Families have needs in their own right and have a right to have their needs acknowledged.
- By and large, families and AOD clients have a personal and social intention mainly directed to personal and social survival rather than malevolence. That is, people usually do the best they can given their situation, history and personal style.
- Approaching families in a generous way, empathising with their hardship and acknowledging their strengths, will tend to facilitate a therapeutic alliance.
- The distinction between intention (which is usually good) and effect of action is important in understanding why clients and families, at times, inadvertently act in unhelpful ways.
- Establishing a trusting relationship with families puts counsellors in a better position to assist families to overcome crises and problems. This often means time efficiencies in the long-term.
- On occasions when family members behave in destructive ways, an appreciation of the family situation can help counsellors address this destructiveness more effectively.
- It is important to understand the family inclusive principles and assumptions in order to be able to make a professional commitment to them.

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21 See www.bouverie.org.au
42. Significant others

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

42.2 Working with significant others as clients in their own right

Excessive AOD use is a cause of stress to families, partners and friends of problem AOD users. 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 not uncommon for this client group to independently seek counselling to help them better cope with their family member or friend’s drug use. Heightened levels of anxiety and depression are common in these clients and they often report feeling helpless and isolated. It is therefore important that they be provided with appropriate support. Goals and treatment plans for counselling should be negotiated. If the AOD user is in treatment with one counsellor, it is often appropriate that support for families and friends be provided by a different counsellor. This helps clinicians to avoid conflicts of interest and breaches of confidentiality. An exception to this is when the whole family is considered to be the client as in a treatment that has family therapy as a base, such as the Multidimensional Family Therapy (MDFT; see Liddle et al., 2001) approach (described in Chapter 43 Young people).

Counsellors can assist the significant other to review their role as it relates to the AOD user as well as to examine general life problems and develop ways to better cope with the problem drug 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 client with their presenting issue(s) is an important component in building a good therapeutic relationship. Once established, other options can be explored and different strategies introduced to the client. Finally, working with this group can offer an opportunity to provide accurate AOD information, which directly helps the client and indirectly may assist the AOD user through dissemination of the information via the family or friends.

A useful heuristic to recall in working with significant others is ‘stress coping health’ and the following five steps (Copello et al., 2005):

1. Give the family member or partner the opportunity to talk.
2. Provide relevant information.
3. Explore how the family or partner responds to the person’s substance use.
4. Explore and enhance social support.
5. Discuss the possibilities of onward referral for further specialist help.

These components aim to reduce the level of strain, both physical and psychological, experienced by the family or partner and enhance their coping mechanisms. 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 problem and to respond empathically to their concerns. Provide significant others with information, explore their current coping skills, and help them to develop support (Copello, 2011). It may also be necessary to discuss the possibilities of onward referral for further specialist help.
42. Significant others

42.3 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:

1. To change AOD-related interactional patterns and develop interactions that support change in AOD using behaviour.
2. To help the family confront and resolve relationship conflicts without the client resorting to AOD use.
3. To help mend rifts in relationships that have been aggravated as a result of the AOD use.
4. To help the family or couple develop shared activities that are rewarding and do not involve AOD use.

Counsellors should be careful to avoid blame and should not refer to either the AOD user or the significant other as the problem.

Practice that is family-centred does not require specialist family therapy training and can result in family members receiving the support they need in their own right and can also be beneficial to treatment outcomes for the drug user. However, if counsellors wish to engage in family therapy, specific skills and specialist training are required.

42.4 Confidentiality

It is not uncommon for family members, partners or friends to contact the counsellor working with the AOD user regarding the progress of the client. To acknowledge the presence of someone in treatment is a breach of confidentiality without prior consent being obtained from the client. Information regarding progress should only be provided with the agreement of the client and the information provided should be in general terms. The exception to this is that parents of minors considered not sufficiently mature to give informed consent are legally entitled to information about their child’s treatment. However, if the young person is considered to have the maturity to provide informed consent, then their wishes for confidentiality must be respected. This assessment is usually made around the age of 14 or 15. (See Chapter 43 Young people).

Responding to family members, partners or friends who call for information when the client has not given consent is therefore quite tricky. It is important to express empathy regarding the request, but make it clear that you are unable to provide information without consent from a client. 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.

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 to clarify with your client what issues they are happy to have talked about with significant others and what they want to remain confidential.

42.5 Some issues specific to parents

As drug use among young people has become more prevalent and complex, and significantly more young people are living at home for longer periods, parents are at the front line struggling to cope with all the associated difficulties. Many of the clinical presentations exhibited by parents result from the stress experienced when a child is using drugs. Parents often report feeling shock and disbelief, isolation, anger, fear, guilt and shame when they become aware of their child’s AOD problems (PDIS, 2006). Grief is also common, not just from the death of a child but also from things not working out as planned and ‘lost dreams’ for their child.
42. Significant others

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 (PDIS, 2006). High levels of stress and anxiety and low levels of self-efficacy may hamper a parent’s 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.

A number of useful resources are available for parents to provide information and guidance. For example, the Parent Drug Information Service (PDIS) ‘Information and Support Pack for Parents and Families’ is freely available at www.dao.health.wa.gov.au

Information and strategies to explore with parents include the following:

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

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

**Significant others – tip sheet**

There are two levels of working with significant others:

- working with parents, partners, families and friends as clients in their own right
- 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 substance user to seek assistance.
- Provide significant others with accurate AOD information, help them to explore the impact of the drug user’s behaviour on their own health and well-being, explore their coping skills, and help them to enhance available social support.
42. Significant others

**Significant others – tip sheet**

*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 drug user than individual treatment.
- Never invite family and friends to participate in treatment with you as the counsellor without the express consent of your client.

Counselling should include:

- helping the family member or partner reduce their level of stress and anxiety
- helping develop interactions that encourage self-responsibility and promote positive change in the AOD-using behaviour
- assisting the family or partner to deal with conflict in relationships
- helping the family member or partner to develop coping strategies to minimise the negative impact of AOD use on themselves and enhance their quality of life.

*Confidentiality*

- Family members, partners or friends may contact you regarding progress of a client. Client confidentiality needs to be respected.
- Any information should only be provided to family members with the written agreement of the client and the information provided should be in general terms.
- If the client wants information given to significant others, it can be useful for this to occur in a session with the client present so they know what is discussed.
- Provide alcohol and other drug information and basic support at a minimum.

*Issues specific to parents*

- Parent levels of anxiety, depression and grief should be acknowledged prior to providing advice and working on strategies to better manage the situation with their AOD-using child.
- Concentrate initially on lessening 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
- strengthen parenting role and the parent’s confidence
- communication skills
- conflict resolution skills
- negotiating guidelines/boundaries
- issues of attachment and commitment
- responding versus reacting.
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 the adolescent’s development, and tailor their approach accordingly.

### 43.1 Developmental issues and tasks

Developmental issues and developmental tasks that characterise adolescents and young people can include (adapted from 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 a number of different developmental stages, these issues will not all apply to each 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.

### 43.2 Risk and protective factors

Adolescent drug use occurs in the context of a range of risk and protective factors that need to be targeted in a multidimensional way in treatment. Risk factors can be grouped into individual, family, peer, school, neighbourhood/community and societal influences (Hawkins et al., 1992). Risk factors at the individual level include early behavioural problems, difficulties at school, associations with drug-using peers, and an 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.

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 and also to cope with emotional distress. Or a teenager with a reactive temperament may influence family relationships and management.
43. Young people

For example if the adolescent reacts with intense anger when parents attempt to put boundaries in place, the parents might become chronically frustrated with the adolescent, be less consistent in boundaries to maintain family peace, resulting in less parental monitoring and control over the adolescent and allowing the adolescent more freedom to become involved with drug-using peers.

Protective factors occur in the same domains as risk factors. Protective factors involve connections to prosocial pursuits and relationships inside and outside the family. A good relationship with parents is particularly important as a buffer against the development of problems and the emotional support provided by such a relationship can also reverse the course of negative peer influences once problems have begun to develop (Steinberg et al., 1994).

43.3 Treatment approach

A number of principles should guide treatment with adolescents.

*Take a multidimensional approach*

Many young people entering alcohol and other drug treatment experience a number of difficulties including family, psychological, accommodation, legal, education and training, social and recreational issues. It is important to address these with young people and where appropriate link them to additional services, and to work with other services involved with the young person (see Chapter 11 *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 drug treatment, particularly with young people, is widely researched and recommended. Parents or caregivers, if appropriately resourced, can have a positive impact on the young person’s behaviour, including their substance use (Liddle, 2004). Note that 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. It is recommended that AOD treatment agencies ensure they have trained family therapists on staff and offer family therapy training to as many staff members as possible as this therapeutic approach is likely to be necessary for more complex family situations.

*Avoid scare tactics*

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 their behaviour (Towers & Carmichael, 2009).

*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 (Towers & Carmichael, 2009).

*Provide options and freedom of choice*

Young people need to be able to express their own opinions and sense of self, and to have 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).
43. Young people

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 16 Harm reduction).

Provide practical coping strategies

Motivational interviewing, problem-solving, relapse prevention, social skills training, anger management and cognitive restructuring can all be helpful. These strategies entail the young person considering their own feelings and opinions and provide 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. It is best to clarify what a young person is referring to and to use language and terminology that the counsellor is comfortable using (Towers & Carmichael, 2009). Counsellors should also be aware of the language they use and avoid using sophisticated words that their clients may not understand.

Respond to psychological comorbidity

Mental health issues are common among young people presenting for AOD treatment. These can include mood disorders, conduct disorder, anxiety disorders, dissociative disorders, attention deficit hyperactivity disorder, schizophrenia and eating disorders. Late adolescence is the most common time for a psychotic disorder (e.g. schizophrenia, bipolar disorder) to initially present and it can be difficult to distinguish between symptoms of a psychiatric disorder and symptoms of a drug-induced psychosis. Young people with co-existing mental health issues have less positive outcomes from traditional AOD treatment approaches than those without mental health issues and are also more likely to experience relapse following treatment for their AOD use (Brown & Ramo, 2006). 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.

43.4 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.

In making a judgement about a young person’s maturity, their intelligence, ability to think logically and abstractly, ability to think through situations and consider their implications should be considered. Most young people would be considered to be ‘mature minors’ by the age of around 14 or 15. In this case there is no obligation to provide information to the parents unless other legal and reporting constraints operate. In most circumstances, however, it is helpful to have parents involved in treating young people and this should be discussed with the young person at the outset of treatment and their consent for parental involvement sought.
43. Young people

When working with young people who are unable to give voluntary informed consent, clinicians must protect the minor’s best interests and consider their responsibilities to inform the parents or guardian. Parents or guardians have a right to information about the treatment of such a young person, as their legal responsibility for the young person’s interests takes precedence over the wishes of the young person. 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 an involuntary client due to a court diversion program or school drug policy. It is important to explain to involuntary young people what information will be provided to the referral source. In addition, some young people may be coerced into therapy by their parents. Working with coerced young people requires a different therapeutic approach (see Chapter 40 Coerced clients).

43.5 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. 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 1 January 2009 to the Department for Child Protection. Although it is not mandatory for other professions to report child sexual abuse, agencies have their own policies around these issues. When reporting is not mandatory, the clinician will often have an ethical responsibility to intervene and report to the authorities.

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. For example, a young person might be living with the abuser (for example their father or an older man) and be reliant on him for accommodation and money, and therefore reluctant to move away. A young person in a sexual relationship with an older man might perceive the relationship to be an equal one, and believe they and the man are in love with each other. A young person might also be living at home and being abused by an older brother who they love, and see the abuse as an expression of his love for them.

In these situations, when the clinician raises the issues of reporting the abuse, the worst outcome is that the client feels betrayed and withdraws from counselling. It is often possible, however, even when the client does not want the abuse reported, to work with the client to negotiate that this needs to occur and enlist their active involvement in reporting it, and thus maintain the therapeutic relationship.

There will also be situations involving a small age difference between the client and an older man, or other forms of abuse, where in the absence of mandatory reporting, and in the interests of maintaining a therapeutic relationship, clinicians are uncertain whether to report the abuse or not.

Clinicians should always seek the advice and support from supervisors and specialised colleagues (such as social workers) regarding risk assessments and whether to report abuse to the authorities. (See Chapter 44 Child protection issues.)

22 This section adapted from Marsh et al. (2012). pp.248-9.
43. Young people

**Young people – tip sheet**

Intervention with young drug users should be based on an understanding of the developmental processes that characterise adolescence, along with a thorough assessment of the risk and protective factors which provide the context for the AOD use and related problems for the adolescent.

Involving families in drug 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 run. Counsellors do not need to be trained in family therapy to offer family inclusive counselling, but agencies should ensure they have some 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 using 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 symptomatology and referral for psychiatric assessment as necessary.

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 issues the young person presents with (e.g., where there is 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.
Although problematic AOD use does not necessarily result in poor parenting, it is often a contributing factor, with children of parents with AOD problems at a greater risk of developing emotional, behavioural or social problems. Although AOD use is commonly implicated in child abuse and neglect, it is rarely the only factor. Usually there is a picture in ‘at risk’ families of multiple risk factors including domestic violence, mental health problems, parents who experienced abuse or neglect as children, financial problems and/or housing problems (Dawe et al., 2007).

As a result, when working with AOD-using parents, counsellors must be equipped to:
- accurately assess and manage the potential risk of harm to a child in the client’s care
- work in a multisystemic manner with the parents to address other areas of difficulty that impact on their parenting capacities.

### 44.1 Definitions of abuse and neglect

It is useful for counsellors to have knowledge of what constitutes abuse and neglect. The following definitions are adapted from the Department of Health (2009) guidelines.

- **Physical abuse** occurs when a child has experienced severe and/or enduring mistreatment through behaviours such as beating, shaking, suffocation, excessive discipline or 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. This includes exposure to sexual acts or pornography.
- **Emotional or psychological abuse** refers to enduring and inappropriate mistreatment of a child through an abusive style of parenting which is often characterized 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.

### 44.2 Assessment and management of child safety

Issues of child safety should be raised gently in the context of a supportive therapeutic relationship. During the initial assessment counsellors should establish whether the client currently has children in their care, or with whom they have access visits. If a client states that they do not have consistent contact with children it is still necessary to assess child safety and pursue the client’s motivation to improve their relationships with their children. If a level of suspicion exists as a result of the assessment interview, structured assessment instruments can be used to explore child safety in more detail. A number of assessment instruments have been designed to assess child safety among parents with AOD use issues. These instruments should be used in conjunction with 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. The Signs of Safety 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 assessment helps to map the harm, danger, complicating factors, strengths, existing and required safety of children. The framework contains four domains for inquiry:

1. What are we worried about? (e.g. past harm, future danger, complicating factors)
2. What’s working well? (existing strengths and safety)

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23 Signs of Safety resources, including a DVD with case examples, are available at www.signsofsafety.net.
44. Child protection issues

3. What needs to happen? (future safety)

4. 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.)

The Risk Assessment Checklist for Parental Drug Use\textsuperscript{24} is an instrument that can be used to assist with assessing parenting and child safety in the context of parental drug use. This is an Australian instrument designed to assist clinicians and clients to identify the impact of AOD use on parenting and to track improvement. It covers a number of 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, though it has not been evaluated for reliability and validity.

The Department of Health (2009) guidelines indicate that children are at an increased risk of abuse and neglect if the primary caregiver has a history of abuse or neglect in childhood, diagnosed mental illness, AOD problems, a history of criminal activities, and domestic violence within the past 12 months.

Additional parental risk factors to take into consideration include (Department of Health, 2009):

• history of abuse towards another child
• prior involvement with child protection services
• post-natal depression
• significant intellectual impairment
• disadvantaged background
• under 21 years of age
• poverty and/or a transient lifestyle
• minimal social support
• poor parent–child attachment
• engages in punitive parenting and/or unrealistic expectations of the child
• family isolation.

Note that the presence of some of these risk factors indicates that a thorough assessment of child safety should be conducted.

The following information on management of risk is adapted from the Metro Community Drug Services and Drug and Alcohol Youth Services – Integrated Service Policy, Child Protection (July 2010).

Immediate risk is indicated by:

• evidence of physical abuse and/or sexual abuse has been disclosed or evidenced
• child prostitution has been disclosed or evidenced
• threats or behaviours towards the child indicate a probable intent to harm the child
• the child has been left unsupervised or with irresponsible/unsafe adults
• the parent’s ability to ensure the safety of a child is grossly impaired by their current level of intoxication or acute mental health condition
• the parent’s behaviour is chaotic with escalating levels of unsafe substance use
• homelessness.

Note that increased risk is also indicated if the child is younger than 5 years of age (Department of Health, 2009).

44. Child protection issues

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 social worker and/or a referral to an appropriate child protection service has been made.
• Consult with a child protection authority duty officer prior to a referral being made.
• Record all relevant information and referral details in the client’s file.

Possible risk is indicated by:

• the client’s child is not engaged with any other services or other responsible adults who can monitor their safety (e.g. are not at childcare centre, school or being cared for by other family members)
• 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
• current family or domestic violence
• defensiveness when talking about relationships with family members
• the child is residing with unknown other males or females.

Note that increased risk is also indicated if the child is younger than 5 years of age.

Managing possible risk:

• Raise concerns with parent/s and advise them of counsellor’s duty of care.
• Document concerns.
• Consult with social worker or medical consultant.
• Encourage client to voluntarily engage with an appropriate child protection or parenting service to access support and services.
• Continue to monitor the situation and if no improvement is noted or the situation escalates follow immediate risk management strategies.

Counsellors should always seek the advice and support from supervisors and specialised colleagues (e.g. social workers) regarding risk assessments and treatment plans. Counsellors can also consult anonymously with the Department for Child Protection regarding child protection and safety issues.

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 1 January 2009 to the Department for Child Protection. Although it is not mandatory in Western Australia for other professions to report child sexual abuse, agencies have their own policies around these issues. When reporting is not mandatory, the clinician will often have an ethical responsibility to intervene and report to the authorities. Clinicians should ensure that they are familiar with their legal and agency responsibilities.
44. Child protection issues

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**Child protection issues – tip sheet**

It is important to be aware of what constitutes abuse (physical, sexual and psychological) and neglect. Problematic AOD use does not necessarily result in poor parenting, but is often a contributing factor, with children of AOD-using parents at greater risk of developing 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 with whom they have access visits. 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 illness
- history of criminal activities and/or 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.

Counsellors should assess the potential risk of harm to a child when working with AOD-using parents. This can be done by exploring information from the following areas:

- child’s functioning
- 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. Child protection agencies can provide confidential consultation.

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.
Intervention with AOD-using parents involves balancing child protection with interventions to improve parents’ lives. It involves multisystemic interventions to enhance the protection and care for children and improve the parents’ 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.

Multisystemic 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 et al., 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.

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 Circle of Security website 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 do family home visiting to assist with parenting.

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 duty of care.

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25 For more detail regarding parenting interventions, particularly with clients with AOD and trauma issues, see Marsh et al. (2012) Chapter 21 ‘Parenting – Parenting Assistance’.


27 www.triplep.net

28 www.circleofsecurity.net
45. Parenting interventions

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 about having their children taken away. These feelings often prevent parents with AOD issues from accessing treatment services, which is likely to increase the level of risk to the children. Those parents who do enter treatment tend to be extremely defensive about issues surrounding childcare, making it difficult to assess accurately the level of risk to the child. This highlights 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.

Counsellors often experience the management and treatment of AOD-using parents as difficult and frustrating. They are therefore encouraged to monitor their own countertransference reactions to avoid ruptures in the therapeutic relationship.

When attempting to conduct an accurate risk assessment and design an appropriate treatment plan, counsellors may encounter difficulties due to restrictions, such as their inability to see the children in the home environment. This may be compounded by the fact that many substance-using parents may not be able, or willing, to present an accurate picture of the impact of their use and the consequences it has on children in their care. Therefore, counsellors should encourage the client to involve the children at some point in the counselling process, by asking to see them e.g. ‘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 should also consider involving non-using significant others to establish the child’s situation. It may be necessary, particularly when there are young children, to refer the family to a service that has the capacity for home visits and intensive support. Referrals to more intensive services may also enable the complex issues often faced by families with substance using difficulties to be dealt with more effectively.

In addition to seeing children to assess how well they are being cared for, it is also important to consider the perspective of children living with parents who have AOD problems as this is often neglected. Dawe (2007) reviewed this limited research which indicates that children generally know about parental drug use earlier than the parents are aware of, 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 drugs. Dawe (2007) concluded that children need to be provided with the opportunity to talk about their experiences and helped to understand their parents’ drug use in an age-appropriate manner.

29 In WA see the Western Australian Network of Alcohol and other Drug Agencies (WANADA) – www.wanada.org.au – for a directory of relevant services, such as ‘Attach’ (www.unitingcarewest.org.au) and ‘Saranna – Women’s Residential Program’ (www.cyrenianhouse.com).
45. Parenting interventions

**Parenting interventions – tip sheet**

Working effectively with AOD-using parents involves balancing child protection with interventions to improve parents’ lives. Counsellors should aim to:

- enhance the protection and care for children by accurately assessing and managing the potential risk of harm to a child in their client’s care
- improve the quality of life for parents by working in a multisystemic manner to address other areas of difficulty that impact on the parent’s capacities.

In conjunction with the parent’s substance use interventions a range of other issues often need to be addressed. Co-occurring issues can include: parenting skills, drug-related problems, family discord, co-occurring psychological disorders, support systems, safety of the familial environment, housing, education, employment and support systems and reducing barriers to treatment.

Interventions can aim to build family resources, reduce barriers to accessing help, and/or improve parenting skills.

Counsellors should ask to see children so they can ascertain for themselves the level of care they are receiving.

Children in AOD-using families should be provided with opportunities to talk about and understand their experiences with their AOD-using parents.
Gender issues

The social model of health highlights the need to consider social, environmental, economic, and psychological factors that influence physical and mental health outcomes (NSW Department of Heath, 2002). The social context of AOD use issues must be taken into account in order to work effectively with clients. It is important to consider gender issues and to recognise that the sociocultural and psychological context of harmful drug use is different for men and women.

It is also necessary to have knowledge of the difference between men and women in terms of the physiological impact of alcohol and other drugs. Counsellors should be aware of the physiological differences between men and women which alter the effects and specific risks associated with drug use. Women are more vulnerable to experiencing negative medical consequences of substance use and dependence (Greenfield et al., 2007). For example, women drinkers develop liver cirrhosis more quickly than men, may suffer reproductive and sexual dysfunctions and are more likely to die from medical conditions related to alcohol use. Hence, it is important that counsellors be well informed as to the specific gender risks associated with AOD use.

46.1 Working with women

AOD use issues are more prevalent in men; however women with AOD use disorders are less likely than men to enter into treatment (Greenfield et al., 2007). This may be due to social, economic, psychological and practical barriers to entering treatment. A social barrier to entering treatment includes the societal view that it is more unacceptable for women to have AOD problems, especially when the drug is of an illegal nature (Thomas, 1997). As a result, women in AOD treatment may be more likely to suffer greater levels of shame, stigmatisation and powerlessness and these issues need to be acknowledged and addressed during the course of treatment.

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 problems, such as mood disorders, personality disorders, and eating disorders (Marsh et al., 2012). Additionally, women with AOD use issues are more likely than men to experience negative social and psychological consequences of AOD use (Greenfield et al., 2007). Histories of sexual abuse and assault are also more common in women with AOD problems and many women presenting for treatment also report having experienced higher levels of domestic violence than the general population both as children and adults.

Because of the high rates of trauma, usually perpetrated by men, experienced by female clients presenting for AOD treatment, it is imperative for treatment settings to be capable of providing an environment in which women feel safe. It is therefore important to offer women the option of a female counsellor, to offer information and/or referral regarding women-only AOD services when appropriate, and for residential treatment services to provide separate bedroom and bathroom facilities for women. ‘Women only’ groups are preferable for some women with AOD use issues, particularly women who are pregnant or primary caregivers (Greenfield et al., 2007). Ideally, women should be offered this option if attending group therapy. There is also some evidence suggesting that women do better than men in self-help groups and that social support is essential to positive treatment outcomes (Grella et al., 2005; Timko et al., 2002). Therefore, where appropriate, treatment programs should link women to self-help and/or social support groups and expand their support networks. Above all, treatment with female clients is likely to be most successful if treatments are designed to be gender-sensitive and address co-occurring issues and barriers to treatment that are specific to women. Counsellors should endeavour to reduce barriers and address the client’s broad range of needs. In addition to a focus on AOD use issues and co-occurring mental health problems, this may include facilitating access to childcare facilities and arranging relevant referrals to services for health, family, economic and employment problems.
46. Gender issues

46.2 Working with men

Men also 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 (Marsh et al., 2004). When working with male clients, facilitate engagement with services for health, family, economic, legal, and employment support, as necessary.

Due to the strong association between drug use (especially drinking) and violence among men, counsellors should explore with the client the consequences of anger and violence (including family violence). Specific skills training involving anger management strategies should be included where appropriate (see Chapter 22 and 23 Anger management and Assertiveness training). Men with anger and violence issues should also be referred to groups that deal with these issues when they are available.

Physical, emotional and sexual abuse is also highly prevalent among male clients seeking AOD treatment. As with women, this creates feelings of shame, guilt and powerlessness, which are often compounded by the feelings associated with AOD dependency. Counsellors need to be aware of these issues when working with men and consider referral to an appropriate service if necessary.

It is also important to consider the high rates of completed suicide among men as opposed to women. Men are much more likely to choose lethal means for suicide attempts and are therefore much more likely to be successful. Counsellors should always assess suicidal ideation. For more information, counsellors are referred to Chapters 4 and 5 Assessment and Suicide assessment and management in this guide.

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**Gender issues – tip sheet**

- Treatment should consider the social, cultural, and psychological context of AOD use, which is different for men and women.

**Working with women**
- Female clients should have the option of a female counsellor.
- Where possible, women should have the option of women-only groups.
- Consider linking female clients into additional support services and groups as they tend to respond very well to engagement in support groups.
- Pay attention to the full range of co-occurring issues that a woman may be facing: physical and emotional health, justice, childcare and welfare.

**Working with men**
- Facilitate engagement with services to address co-occurring health, family, economic, employment and legal problems.
- Be sensitive in your assessment and handling of issues of past sexual or other abuse. Men tend to suffer even greater levels of shame from past abuse than women.
- Where appropriate, encourage male clients to examine the consequences of anger, violence or domestic violence.
- Where appropriate include the development of anger management strategies and alternative coping strategies to AOD use. Refer to groups addressing anger management issues when appropriate.
- Be aware of the high rates of lethality of suicide attempts in men when conducting suicide assessments and always assess for suicidal ideation.
This chapter provides brief information on and strategies for responding to alcohol and other drugs during pregnancy. While concern is often focused on the impact of illicit drugs during pregnancy, alcohol presents a significant risk to the developing fetus due to the potential for life-long impairment caused by in-utero alcohol exposure combined with the ready acceptance and availability of alcohol in Australia. Therefore the discussion on alcohol and pregnancy is more detailed than other drugs in this chapter.

In the 2010 National Drug Strategy Household Survey around 48% of women reported drinking alcohol while pregnant (Australian Institute of Health and Welfare, 2011a) and less than 5% of women surveyed used illicit drugs during pregnancy or while breastfeeding (Australian Institute of Health and Welfare, 2011b).

There are a range of reasons why women use AOD during pregnancy including dependence, being unaware of the impact and not being aware they are pregnant. There can be enormous stigma associated with AOD use and pregnancy along with a range of barriers to accessing antenatal services for these women (Roberts & Pies, 2011). Women may experience significant guilt over their drug use, as well as concerns regarding the health of their child.

AOD use during pregnancy ‘can result in obstetric complications, miscarriage, or significant problems for the fetus’ (Center for Substance Abuse Treatment, 2009, p. 48). Determining the specific impacts of drugs on the developing fetus can be complicated by the use of more than one drug (Chen & Maier, 2011), and the fact that AOD use during pregnancy often occurs alongside other factors such as poverty, stress, mental ill-health and family and domestic violence (Poole & Urquhart, 2010).

Research on the impact of maternal illicit-drug use on the fetus is limited by relatively small sample sizes, difficulty controlling for other variables and ethical concerns. Therefore, the impact of AOD on the developing fetus is an area that requires further research.

The impact of tobacco use during pregnancy is widely known and will not be discussed in this chapter.

### 47.1 Alcohol and pregnancy

Alcohol is a teratogen, meaning that it can cause birth defects. When alcohol enters the mother’s blood stream, it crosses over the placenta into the fetus’ blood stream. The fetus’ blood alcohol concentration (BAC) quickly rises to the same BAC as the mother. Additionally, amniotic fluid acts as a reservoir for alcohol, resulting in prolonged exposure to alcohol compared to the rate at which alcohol is metabolised by the mother (Vaux & Chambers, 2010). Compared to other drugs of dependence, alcohol has a greater neurobehavioural impact on the fetus (Stratton, Howe, & Battaglia, 1996). These impacts may be increased by a combination of drugs being used through pregnancy, for example, alcohol and cigarettes.

According to O’Leary (2002) the toxic effects of alcohol may impact on conception as well as affecting the quality of the egg and sperm prior to conception.

Alcohol may cause death (miscarriage), deformities, growth deficiencies, and functional deficits to the developing fetus (Streissguth, et al., 1997). The effects of alcohol on the development of the fetus such as central nervous system dysfunction as well as intellectual and behavioural problems are life-long (O’Leary, 2002), and are related to a range of secondary disabilities including unemployment, dependent living and mental health problems (Streissguth et al., 1997).

Not all children born to mothers who consumed alcohol during pregnancy will be born with Fetal Alcohol Spectrum Disorder (FASD). A range of factors in addition to maternal alcohol consumption may influence the development of FASD, some of which are nutrition, maternal stress, genetic vulnerabilities and maternal age (May & Gossage, 2011).

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30 This chapter was written by Judi Stone, Drug and Alcohol Office, Western Australia
47. Alcohol, other drugs and pregnancy

47.1.1 What is FASD?

FASD is not a diagnostic term, rather it is an umbrella term used to describe a range of diagnoses which are caused by maternal alcohol consumption during pregnancy. These can include damage to the brain, major organs, facial structure and central nervous system. FASD is the main cause of ‘preventable non-genetic intellectual handicap in developed countries’ (Russell, 2002, p.16). Diagnosis of a FASD is a complex process and requires a range of specially trained health professionals.

Four diagnoses currently are located under the FASD umbrella:

**Fetal Alcohol Syndrome (FAS)** is the most visible condition. The four broad clinical features which constitute a FAS diagnosis include:

- Confirmed alcohol exposure in pregnancy
- Growth restriction – pre or post nataally
- Central nervous system abnormalities
- Characteristic face which includes;
  - short palpebral fissures (small eye slits);
  - indistinct philtrum (the groove under the nose)
  - thin upper lip

Current literature suggests that FAS is seen in patients whose mothers have a history of chronic, daily, heavy alcohol use (5 or more standard drinks a day) or frequent, heavy, intermittent use (5 to 6 drinks per occasion (Pyett et al., 2007). Currently there is no international or national consensus on the diagnostic criteria for FAS (Pyett et al., 2007).

**Partial Fetal Alcohol Syndrome (pFAS)** refers to a syndrome which presents with confirmed maternal alcohol consumption, evidence of central nervous system abnormalities (structural, neurological and/or functional impairment), along with behavioural and/or cognitive problems and some of the facial features present in FAS (Samson et al., 1997).

**Alcohol Related Neurodevelopmental Disorder (ARND)** refers to a range of central nervous system neurodevelopmental abnormalities caused by alcohol consumption during pregnancy, including any one of the following: decreased head size at birth; structural brain abnormalities such as microcephaly; abnormal neurological signs such as impaired fine motor skills; neurosensory hearing loss, poor tandem gait and poor hand–eye coordination (Alcohol and Pregnancy Project, 2009). Additionally, ARND-affected children present with ‘evidence of a complex pattern of behaviour or cognitive abnormalities that are inconsistent with the child’s developmental level and cannot be explained by familial background or environment alone’ (Alcohol and Pregnancy Project, 2009, p.10). This may include significant impairment in the performance of complex tasks such as problem-solving, planning, judgement, and abstraction as well as higher-level receptive and expressive language deficits; and disordered behaviour, for example, difficulties in interpersonal interactions (Alcohol and Pregnancy Project, 2009).

**Alcohol Related Birth Defects (ARBD)** confirmed alcohol exposure in pregnancy and birth defects including: cardiac, skeletal, auditory, ocular and renal (Alcohol and Pregnancy and Fetal Alcohol Spectrum Disorder, 2009).


Current evidence suggests that frequent high-level intake of more than 5 standard drinks a day during pregnancy is associated with an increased risk of FASD (Elliott, Payne, Morris, Haan, & Bower, 2008).

(For more information see http://alcoholpregnancy.childhealthresearch.org.au.)
47. Alcohol, other drugs and pregnancy

47.2 Prevention of FASD

At least two Australian studies highlight the role of health professionals in preventing FASD. Western Australian research has shown that 97% of health professionals thought that women should be informed about the consequences of consuming alcohol in pregnancy (Payne et al., 2005). A national survey of women of childbearing age reported that 91% of Australian women think that health professionals should advise pregnant women to give up drinking alcohol (Peadon et al., 2008). This research supports the important role that AOD counsellors play in the prevention of FASD, not only with women who are pregnant and using alcohol, but also with all women of childbearing age.

47.2.1 Prevention of FASD in pregnant women who are drinking

If a client is pregnant and drinking alcohol, the following approach is recommended:

- A non-judgemental, holistic, woman-centred approach that is able to respond to the context of a woman’s substance use is best practice (Leslie & Roberts, 2004; Poole, 2008).
- Alcohol consumption often occurs in the first few weeks of pregnancy when the woman is unaware she is pregnant (Colvin et al., 2007), therefore caution must be taken not to cause undue concern in women who may have used alcohol prior to becoming aware of their pregnancy (National Health and Medical Research Council, 2009).
- Advise the client of the risks of alcohol use during pregnancy, that it can harm the fetus and the breastfeeding baby. Importantly the level of alcohol which causes damage to the developing fetus is unknown and therefore the current National Health and Medical Research Council (NHMRC) guidelines (2009) recommend that no alcohol is the safest option during pregnancy, planning a pregnancy or breastfeeding (Guideline 4.A).
- An assessment of the client’s alcohol use including quantity and frequency is important in establishing the level of risk to the developing fetus and to assess whether the client is dependent. Different patterns of alcohol use during pregnancy will have different impacts on the developing fetus at different times (Alcohol and Pregnancy Project, 2009; O’Leary, 2002).
- Interventions to address AOD use ‘should be embedded within the context of broader efforts toward improving health and wellbeing. Strategies that include family members are more likely to improve outcomes’ (Pyett et al., 2007, p.18).
- Develop an understanding of the contributing factors to her alcohol use.
- Assess risk and protective factors such as social situation, stressors, nutrition, other drug use, support networks etc.
- Provide support to stop or reduce her alcohol use through assessing her stage of change and utilising motivational interviewing.
- Adopt a harm-reduction approach; if the client is unable to stop drinking alcohol, cutting down her alcohol use at any stage of pregnancy will be beneficial to her and her baby.
- Encourage the client to link in with antenatal care and actively assist her to do so.
- Some women may state that they have had one or more pregnancies previously where they have consumed alcohol and there have been no apparent birth defects. It is important to advise the woman that each pregnancy is different and reiterate that any reduction or cessation in her alcohol use will be beneficial. If she uses alcohol at a high-risk level, particularly frequently consuming more than 5 standard drinks in one sitting, linking her into a service that specialises in the prenatal care of women with alcohol and other drug use problems is strongly recommended.

47.2.2 Prevention of FASD in all female clients of childbearing age

- Provide information about the risks and harms of alcohol use during pregnancy to all women of childbearing age (NSW Health & SA Health, 2006).
47. Alcohol, other drugs and pregnancy

- Ask about contraception and pregnancy planning and provide information, advice and referral. While some women stop drinking alcohol once they learn they are pregnant, up to half of Western Australian women’s pregnancies are unplanned (Colvin et al., 2007), therefore women may drink alcohol before they are aware of their pregnancy. To prevent this, women need to use effective contraception and to stop drinking alcohol when they are trying to become pregnant. Refer to an appropriate sexual health service or doctor for contraception and pregnancy planning advice. Sexual health and safer-sex may also be addressed at this time.

- Screen all female clients of childbearing age for alcohol consumption, irrespective of their presenting problem. In AOD treatment agencies most assessment procedures include asking clients about their alcohol use as standard practice. Screening can also be undertaken with a standardised alcohol screening test such as the World Health Organization’s Alcohol Use Disorders Test (AUDIT or AUDIT–C) which is freely available online. Screening tools should be culturally sensitive.

47.2.3 Access to treatment
Pregnant women identified as consuming risky levels of alcohol (as defined in the NHMRC 2009 Australian guidelines to reduce health risks from drinking alcohol) should have priority access to alcohol treatment services, including comprehensive assessment and detoxification, but also including therapeutic options such as brief intervention, cognitive behavioural therapy and group sessions (National clinical guidelines for the management of drug use during pregnancy, birth and the early developmental years of the newborn, NSW Health & SA Health, 2006, Guideline 3.1.4).

The need for detoxification is an indication for inpatient admission and treatment. Pregnant women who require alcohol detoxification should be admitted into a supportive health care environment and provided with continuity of care, including ongoing counselling. Women who are withdrawing from alcohol should be supported with medication and nutritional and vitamin supplements and should have access to appropriate maternal and fetal monitoring. The therapeutic environment should be sensitive to gender and cultural issues that influence the acceptability of treatment (NSW Health & SA Health, 2006).

47.2.4 Aboriginal and Torres Strait Islander women
Clinical interventions with Aboriginal and Torres Strait Islander pregnant women should be guided by the six common principles identified by the Ministerial Council on Drug Strategy (2006) for addressing substance use by Aboriginal and Torres Strait Islander peoples. These are:

- The use of alcohol, tobacco and other drugs must be addressed as part of a comprehensive, holistic approach to health that includes physical, spiritual, cultural, emotional and social wellbeing, community development and capacity building.
- Local planning is required to develop responses to needs and priorities set by local Aboriginal and Torres Strait Islander communities.
- Culturally valid strategies that are effective for Aboriginal and Torres Strait Islander peoples must be developed, implemented and evaluated.
- Aboriginal and Torres Strait Islander peoples must be centrally involved in planning and implementing strategies to address use of alcohol, tobacco and other drugs in their communities.
- Aboriginal and Torres Strait Islander communities should have control over their health, drug and alcohol and related services.
- Resources to address use of alcohol, tobacco and other drugs must be available at the level needed to reduce disproportionate levels of drug-related harm among Aboriginal and Torres Strait Islander peoples.

Comprehensive information on alcohol treatment for Aboriginal and Torres Strait Islander people can be obtained from the National Indigenous Drug and Alcohol Council’s (2007) Alcohol Treatment Guidelines for Indigenous Australians (http://www.alcohol.gov.au/internet/alcohol/publishing.nsf/Content/AGI02).
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47.2.5 Continuity of care
A multidisciplinary approach to providing care will assist with optimal pregnancy, birth and parenting outcomes for the woman and her family. Collaboration between agencies and continuity of care are important for the ongoing care of the woman well into the post-natal period. A case-management approach should be adopted to facilitate this.

47.2.6 Child protection
Although drug and alcohol use alone may not be an indicator for a child protection report or notification, child protection is a consideration in all AOD interventions for pregnant women. See Chapter 44 Child protection issues.

47.2.7 Pharmacotherapies
Currently there are no alcohol pharmacotherapy treatments that are designated as safe for use during pregnancy (Burns, Kingsbury & Tudehope, 2006).

47.3 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), AOD counsellors have an important role to play in the prevention or reduction of maternal and fetal harm.

Some of the known impacts of commonly used drugs are described below, however, the lack of available research demonstrating long-term impacts of various drugs should not be mistaken for an absence of harm. The safest choice is not to use drugs during pregnancy. The impacts of AOD on the developing fetus are further complicated by polydrug use, environmental and systemic factors.

47.3.1 Methamphetamine/amphetamine-type stimulants
Infants born to mothers who used methamphetamine or other amphetamine-type stimulants have been shown to be small for gestational age, may be lethargic shortly after birth (Nguyen et al., 2010) and are at risk of experiencing withdrawal symptoms (Broussard et al., 2011), however the long-term impact of stimulants requires further study as research has produced contradictory results (Shah et al., 2012).

47.3.2 Cannabis
There are limited numbers of studies which show the long-term impact of cannabis on the developing fetus. To date research indicates that cannabis does not appear to cause major fetal growth or physical abnormalities (Minnes, Lang & Singer, 2011). Cannabis may have long-term effects on emotional, cognitive and behavioural development, particularly attention, impulsivity, and problem-solving (Fried, 2011).

47.3.3 Opioids
There is no evidence that maternal opioid use results in congenital malformations, but a decrease in birth weight, length and head circumference has been observed (Minnes et al., 2011) with the exception of codeine use in the first trimester, which has been linked to heart defects and possibly other defects, however these require more research (Broussard et al., 2011). There is a lack of scientifically rigorous studies with sufficient participant numbers and further research is required to gain a better understanding of the full effect of maternal opioid use on the developing fetus. As stated by Singer and Minnes (2011), ‘evidence of CNS damage in humans prenatally exposed to opiates is mounting, although the effects appear to be specific rather than a more global or overall deficit as seen with other teratogens’ (p.143).
47. Alcohol, other drugs and pregnancy

Sudden abstinence from opioids following maternal dependence can cause withdrawal symptoms (Fetal or Neonatal Abstinence Syndrome). Maintenance therapy with opioid pharmacotherapies for opioid-dependent mothers has been shown to reduce fetal stress caused by the intense intoxication followed by withdrawal which is associated with illicit opioid use. Additionally maintenance on opioid pharmacotherapies can reduce cravings to use illicit opioids and may therefore reduce some of the risks associated with drug-using behaviour such as injecting (Singer & Minnes, 2011).

47.3.4 Volatile substances

Volatile substance use during pregnancy can result in premature birth, miscarriage, developmental disorders and physical malformations in the developing fetus. Toluene, which is found in many volatile substances, is consistently associated with infant birth defects (Lubman, Yucel, & Lawrence, 2008) that can resemble Fetal Alcohol Syndrome (FAS) including facial abnormalities, delayed growth, behavioural and neurological problems as well as other physical abnormalities (Bowen, 2011). The impact of volatile substances on the developing fetus depends upon the timing, pattern and dose of toluene consumed during pregnancy as well as other drug use, maternal nutrition and other factors (Bowen & Hannigan, 2006). As with FAS, diagnosis is complex.

Some cases of fetal withdrawal have been documented (Bowen, 2011).


47.3.5 General principles for responding to drug use and pregnancy

• AOD workers can assist to prevent maternal AOD use through raising the issue of adequate contraception and providing accurate information regarding the effects of AOD on the developing fetus to all female clients of childbearing age in a sensitive manner.

• 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.

• Good antenatal care from early in the pregnancy is important for the health of the woman and the developing fetus. However, a number of barriers to accessing antenatal care may exist for these women and support and assistance may be required to engage the client in antenatal care.

• Interventions should be culturally secure and family inclusive.

• The impact of AOD on the developing fetus is often compounded by other drug use, poverty, violence, poor mental health and other stressors. Supporting the woman to manage these stressors can assist to maximise maternal health.

• Harm reduction strategies such as safer sex and sterile injecting are important considerations for reducing the risk of exposing the fetus to blood-borne viruses such as hepatitis C and HIV.

• Sensitively providing accurate information on the impact of drug use on the developing fetus and relevant harm-reduction strategies can create opportunities for the woman to reduce or cease their drug use.

• Comprehensive care which addresses the medical, psychological and practical needs of the mother has been shown to increase positive outcomes.

• A collaborative inter-agency approach should be adopted for women who are dependent.

• Women who have difficulty stopping their drug use after receiving appropriate information about the potential harms should be linked in with a specialist service where available.\footnote{In the Perth Metropolitan area – Women and Newborn Drug and Alcohol Service (WANDAS) Telephone: (08) 9340 2222}
47. Alcohol, other drugs and pregnancy

Alcohol, other drugs and pregnancy – tip sheet

Alcohol is a teratogen, meaning that it can cause birth defects. The National Health and Medical Research Council’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 (Guideline 4.A.).

**Fetal Alcohol Spectrum Disorder (FASD)** is an umbrella term used to describe a range of birth defects which are caused by maternal alcohol consumption during pregnancy. These can include damage to the brain, major organs, facial structure and central nervous system.

**Fetal Alcohol Syndrome (FAS)** is characterised by the following:
- Confirmed alcohol exposure in pregnancy
- Growth restriction
- Central nervous system abnormalities
- Characteristic facial features which include
  - short palpebral fissures (small eye slits)
  - indistinct philtrum (the groove under the nose)
  - thin upper lip

Children born with FAS also have growth deficiencies and central nervous system abnormalities (Peadon, et al., 2007).

**Partial Fetal Alcohol Syndrome (pFAS)** refers to a syndrome which presents with confirmed maternal alcohol consumption, evidence of central nervous system abnormalities (structural, neurological and/or functional impairment), along with behavioural and/or cognitive problems and some of the facial features present in FAS (Samson et al., 1997).

**Alcohol Related Neurodevelopmental Disorder (ARND)** refers to a range of central nervous system neurodevelopmental abnormalities and ‘evidence of a complex pattern of behaviour or cognitive abnormalities that are inconsistent with the child’s developmental level and cannot be explained by familial background or environment alone’ (Alcohol and Pregnancy Project, 2009, p.10).

**Alcohol Related Birth Defects (ARBD)** confirmed alcohol exposure in pregnancy and birth defects including: cardiac, skeletal, auditory, ocular and renal (Alcohol and Pregnancy and Fetal Alcohol Spectrum Disorder, 2009).

AOD counsellors have an important role to play in the prevention of FASD not only with women who are pregnant and using alcohol, but also with all women of childbearing age. Pregnant women identified as consuming risky levels of alcohol should have priority access to alcohol treatment services.

The need for detoxification is an indication for inpatient admission and treatment.

Interventions should be culturally appropriate.

Although drug and alcohol use alone may not be an indicator for a child protection report or notification, child protection is a consideration in all AOD interventions for pregnant women.

Currently there are no alcohol pharmacotherapy treatments that are designated as safe for use during pregnancy (Burns et al., 2006).
47. Alcohol, other drugs and pregnancy

Alcohol, other drugs and pregnancy – tip sheet

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), AOD counsellors have an important role to play in the prevention or reduction of maternal and fetal harm.

• Lack of available research demonstrating long-term impacts of various drugs should not be mistaken for an absence of harm.
• The safest choice is not to use drugs during pregnancy.
• The impacts of AOD on the developing fetus are complicated by polydrug use, environmental and systemic factors.

Methamphetamine/amphetamine-type stimulants

• Infants have been shown to be small for gestational age, may be lethargic shortly after birth and are at risk of experiencing withdrawal symptoms.
• Long-term impact of stimulants requires further study as research has produced contradictory results.

Cannabis

• Limited studies which show the long-term impact of cannabis on the developing fetus.
• Research to date indicates that cannabis does not appear to cause major fetal growth or physical abnormalities.
• Cannabis may have long-term effects on emotional, cognitive and behavioural development, particularly attention, impulsivity, and problem-solving.

Opioids

• There is no evidence that maternal opioid use results in congenital malformations.
• Further research is required to gain a better understanding of the full effect of maternal opioid use on the developing fetus.
• Evidence of CNS damage in humans prenatally exposed to opioids is mounting, although the effects appear to be specific rather than a more global or overall deficit.
• Sudden abstinence from opioids following maternal dependence can cause withdrawal symptoms (Fetal or Neonatal Abstinence Syndrome).
• Maintenance on opioid pharmacotherapies for opioid-dependent mothers has been shown to reduce fetal stress and reduce cravings to use illicit opioids.

Volatile substances

• Volatile substance use during pregnancy can result in premature birth, miscarriage, developmental disorders and physical malformations in the developing fetus.
• Toluene is consistently associated with infant birth defects that can resemble FAS including facial abnormalities, delayed growth, behavioural and neurological problems as well as other physical abnormalities.
• The impact of volatile substances on the developing fetus depends upon the timing, pattern and dose of toluene consumed as well as other drug use, maternal nutrition and other factors.
47. Alcohol, other drugs and pregnancy

Alcohol, other drugs and pregnancy – tip sheet

**General principles for responding to drug use and pregnancy**

- Provide accurate information on contraceptives.
- Provide information on the effects of AOD on the developing fetus to all female clients of childbearing age in a sensitive and non-judgemental way.
- Good antenatal care from early in the pregnancy is important for the health of the woman and the developing fetus.
- Support and assistance may be required to engage the client in antenatal care.
- Interventions should be culturally secure and family inclusive.
- The impact of AOD on the developing fetus is often compounded by other drug use, poverty, violence, poor mental health and other stressors. Support the woman to manage these stressors.
- Harm reduction strategies such as safer sex and sterile injecting are important for reducing the risk of exposing the fetus to blood-borne viruses such as hepatitis C and HIV.
- Comprehensive care which addresses the medical, psychological and practical needs of the mother has been shown to increase positive outcomes.
- A collaborative inter-agency approach should be adopted for women who are dependent.
- If difficulties arise in stopping drug use, women should be linked in with a specialist service.
Culturally and linguistically diverse (CALD) people are those whose first language is one other than English or their family background is from a non-English speaking country. CALD clients are thought to be under-represented in AOD treatment due to a number of barriers in accessing suitable services. AOD counsellors and services should work from the principle that ‘collaboration between AOD treatment agencies and ethnospecific services’ are likely to lead to the best treatment outcomes for CALD clients (Drug and Alcohol Multicultural Education Centre (DAMEC), 2007).

48.1 Barriers to accessing AOD treatment
Some of the barriers to CALD clients and their families accessing AOD treatment, adapted from DAMEC (2007; 2010), include:
- shame and guilt
- fear of stigmatisation/judgement about accessing AOD treatment
- cultural differences between the client and clinician
- confusion and lack of education or exposure to public health campaigns
- different expectations of treatment and difficulty clarifying these due to language barriers
- lack of awareness that AOD treatment services exist
- lack of awareness about what AOD treatment services are available
- lack of awareness about how to get referred to an AOD treatment service
- confusion about AOD dependence
- language difficulties which make participation in AOD treatment programs difficult
- when clients are referred to a more culturally appropriate service (ethnospecific or bilingual such as a migrant resource centre), clinicians often do not have sufficient AOD knowledge
- wanting to seek treatment outside their own community because of the shame and stigma of being known in their own community, yet fearing to seek help outside their community for fear of being judged.

48.2 Improving AOD treatment accessibility
Improving AOD treatment accessibility for CALD clients requires the building of relationships, at both agency and clinician levels, between AOD services and multicultural and ethnospecific welfare agencies (DAMEC, 2010). Memorandums of Understanding (MOUs) can also be developed to formalise these relationships. There are also a number of arrangements that clinicians and agencies can facilitate to improve accessibility, as adapted from DAMEC (2007; 2010).
- Implement policies that promote collaboration between AOD workers and ethnospecific agencies and migrant resource centres.
- Promote local AOD services to the main CALD groups in the local area, as well as to their relevant welfare agencies, community and religious organisations.
- Promote local AOD services to local migrant and multicultural centres.
- Present written AOD information in relevant languages for the local area.
- Consult with local CALD groups to identify their AOD treatment and information concerns and needs.
- If a client is referred to a specific or bilingual service that does not specialise in AOD problems, the AOD service should provide support to the person working with the client.
- If an agency has a considerable number of clients of a particular ethnicity seeking AOD treatment, consider employing a bilingual worker who is trained or can be trained in AOD issues. Develop recruitment procedures to encourage relevant bilingual applicants.
- Manage expectations: explain that the client can request an interpreter, and what is available in terms of treatment.
- Use an interpreter service when necessary and acceptable to the client.
- Have an AOD worker conduct the initial assessment, with the aid of an interpreter if necessary, and ensure a treatment plan is developed. Having an AOD worker conduct the initial assessment is necessary as their expertise will be needed for developing an appropriate treatment plan.
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48.3 Improving the AOD treatment experience

Basic approach
There are several basic but important things that clinicians should bear in mind when working with CALD clients.

• Ask the client how you should address them, and address them appropriately and pronounce their name correctly.
• Explore the client’s expectations of treatment and clarify what is realistic.
• Be mindful that many CALD clients experience acute embarrassment around issues that Australians might not find difficult, and be aware of cultural taboos.
• Be clear, concrete and specific in what you say.

Understand AOD use within the cultural base
Houseman (2003) notes the importance when working with CALD clients of understanding their AOD use in the context of their cultural base. She argues that gaining knowledge of their cultural base provides a context for understanding how they might be interpreting and feeling about their experiences with substance use and in AOD treatment and helps the counsellor avoid making assumptions that may be wrong. Houseman suggests this involves gathering information about three aspects of clients’ lives:

• Context of the migration: why they left their country of origin, how they got to Australia, their legal status, whether they have residency and whether they have had any trauma experiences in the context of their country of origin or migrating to Australia.
• Subgroup membership: ethnicity, gender, sexual orientation, area in which they live, refugees or immigrants and religious affiliation.
• Degree of acculturation: traditional if the client adheres completely to beliefs, values and behaviours of their country of origin; bicultural if they have a mix of new and old beliefs, values and behaviours; acculturated if the client has modified their old beliefs, values and behaviours in an attempt to adjust to new ones; and assimilated if they have completely given up their old beliefs, values and behaviours and adopted those of the new country.

Offer practical help with stressors
CALD clients experience many stressors which make life difficult for them. Clinicians and services should be aware of these stressors and where possible, provide practical assistance or refer to someone who can provide this assistance. The following list of common stressors for CALD clients is adapted from Brewer (2009).

• The stressful nature of arriving and settling in Australia, including uncertainty around immigration or refugee status, which results in depression and fear.
• Language difficulties resulting in problems accessing appropriate health care, support services and employment.
• For women in particular, domestic violence, including verbal, emotional, physical and financial abuse by husbands and in-laws, and threats of divorce and deportation. Because of cultural differences, some women do not recognise behaviour considered abusive in Australia as such.
• Legal issues around domestic violence, separation and divorce and child custody, which can be made very difficult to negotiate by language difficulties.
• Social isolation and lack of support networks, which is often very different from the social connectedness they experienced in their country of origin.
• The need for cultural sensitivity around customs, beliefs, particular areas of sensitivity and shame, notions of time and appointment keeping, perceptions of the importance of education, notions of illness and feelings about accessing services.
• Trauma: many CALD clients not only come from war-torn countries, but can also be traumatised by experiences of domestic violence.
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- Children and child protection issues, difficult for anybody, can be even more frightening for CALD clients due to their lack of familiarity with the processes in Australia and language difficulties.
- Loss of qualifications and careers as a result of leaving their country of origin.
- Discrimination and racism.
- Limited transportation, making it difficult for clients to access services and social support. Language difficulties can also make finding transport services, even when they exist, difficult.
- Lack of familiarity with available services.
- Mental health issues can leave CALD women vulnerable to exploitation, in some instances, by husbands and in-laws.
- Western explanations of mental health issues can be poorly understood, depending on the client’s cultural background and education.
- Mental health issues such as depression in a family member often need to be explained to the whole family unit, not just the person with the mental health issue.
- Access to appropriate childcare services can also be difficult for CALD women.

Clinicians should endeavour to find ways to help with stressors such as those listed above when they devise a treatment plan. Many of these issues can be barriers to continuing in AOD treatment, and the stress they create can also perpetuate AOD problems. Therefore, unless clinicians can be of practical help with many of these issues, they will be unsuccessful in addressing the AOD use. In addition, helping clients to place their AOD problems in the context of such experiences can help to reduce shame and increase self-compassion.

Use family inclusive practice

Be aware that clients from CALD backgrounds may place a much higher value on extended family than non-CALD clients if they come from a collectivist rather than individualist perspective. Individualism refers to the tendency of people in some cultures to value individual identity, rights and achievements over those of the group and for people to be expected to look after themselves and their immediate family. Collectivism refers to the tendency of people in other cultures to value group identity and concerns over individual concerns and for people to be integrated into strong, cohesive groups, which provide them with protection in exchange for unwavering loyalty (Hofstede, 1991).

When working with CALD clients who come from a collectivist perspective, counsellors need to be particularly oriented towards family inclusive practice (see Chapter 42 Significant others) and when appropriate build a sensitive collaboration with families. Essentially family inclusive practice involves working in an open, respectful and collaborative fashion with families if the primary client indicates they would like them to be involved. If the client does not want them to be involved directly this may involve helping family members to access support and counselling of their own.

Be aware of issues around using interpreters

Mills et al. (2009) describe practical considerations relevant to arranging an interpreter for a CALD client:
- Ask ahead of time whether a client wants an interpreter. Note that even clients who have basic English proficiency might benefit from the help of an interpreter to describe feelings and issues.
- Allow at least twice the usual time for a session as counselling activities tend to take longer when an interpreter is used.
- Ask whether the client would prefer a male or female interpreter.
- Be aware when securing interpreter services that dialects can differ and ensure the dialect is correct.

Note that the use of interpreters can be problematic. First, confidentiality issues need to be addressed carefully with the interpreter as well as the client. Some clients may be reluctant to disclose personal information in front of an interpreter who is not a trained counsellor. Second, feedback from CALD workers suggests that some CALD clients may be reluctant to use an interpreter in case the interpreter comes from their own community and in case the interpreter is known to them, which can heighten shame. Third, languages often do not translate directly into English and vice versa, which means that some of the meaning of what is said by both client and counsellor may be lost when using an interpreter.
48. Culturally and linguistically diverse people

Whenever an interpreter is used, counsellors should be conscious of using very clear and unambiguous language so as to avoid misunderstanding.

Raise issues with the interpreter if you have concerns that they are becoming more involved in the ‘counselling’ process rather than interpreting.

It is also useful to check with clients whether there is a problem with using interpreters from different ethnic groups even though they speak the same language.

**Be aware of cultural views of psychological symptoms**

Different cultures can have very different understandings of psychological symptoms and what constitutes mental illness. Clinicians should try to understand the cultural meaning of the client’s problems, and also be aware that signs and symptoms of psychological disorders can differ with culture. For example, someone who is psychotic in Australia might talk of being controlled by aliens, whereas in Fiji a person might talk of black magic (Mills et al., 2009).

**Culturally and linguistically diverse people – tip sheet**

Improving AOD treatment accessibility for CALD clients requires building relationships, at both agency and clinician levels, between AOD services and multicultural and ethnospecific welfare agencies.

Be aware of potential difficulties for CALD clients seeking AOD treatment:

- different expectations of treatment and difficulty clarifying these due to language barriers
- lack of familiarity with what AOD treatment services are available
- confusion about AOD dependence
- language difficulties which make participation in AOD treatment programs difficult
- insufficient AOD knowledge among counsellors at more culturally appropriate services
- feelings of shame and fear of stigmatisation.

To make treatment more accessible and effective:

- Manage expectations: explain that the client can request an interpreter, explain what is available in terms of treatment.
- Have an AOD worker conduct the initial assessment (with the aid of an interpreter if necessary) as they have the expertise to develop an appropriate treatment plan.
- If the client is then referred to a specific or bilingual service that does not specialise in AOD problems, the AOD service should provide support to the person working with the client.
- If an agency has a considerable number of clients of a particular ethnicity seeking AOD treatment, consider employing a bilingual worker who is trained or can be trained in AOD issues.
- Implement policies that promote collaboration between AOD workers and ethnospecific agencies and migrant resource centres.

Understand the cultural base of the client’s AOD use in the context of their migration, subgroup membership and degree of acculturation.

Be aware of potential problems when thinking of using an interpreter, such as client concerns about confidentiality, the interpreter coming from their own community or being known to them and difficulty translating some languages accurately.

Be aware of the potential need to include family members in treatment, particularly if the client comes from a collectivist perspective and wants family involvement.

Raise issues with the interpreter if there are concerns that they are becoming involved in the ‘counselling’ process rather than interpreting.

Provide CALD clients with practical help to manage stressors as these often perpetuate the AOD use.
Aboriginal people or Indigenous Australians experience AOD problems, particularly related to alcohol, at a disproportionate rate to non-Indigenous Australians. Problematic AOD use among Aboriginal people is associated with a range of health problems, such as high rates of alcohol-related death and hospital admissions, as well as social problems, such as family violence, child abuse and neglect, unemployment, and high levels of imprisonment (Wilson et al., 2010). There is a clear need to provide effective AOD treatment for Indigenous Australians in a culturally appropriate manner, however mainstream models of practice in the AOD field have overwhelmingly been developed within western systems of knowledge and may ignore an Aboriginal ‘world view’. Application of these models to working with Aboriginal people can be detrimental and lead to Aboriginal people disengaging from seeking support and treatment. This is especially the case if the treatment approach directly undermines Aboriginal cultural ways of working and results in Aboriginal people feeling disempowered as their cultural beliefs/values and family systems are ignored, misunderstood or disrespected. In the past there have also been efforts to impose approaches from Indigenous people in other countries on Aboriginal Australians. This approach is often embedded in western disease ideology, which is very different to an Aboriginal concept of holistic health and well-being, and can weaken Australian Aboriginal culture and lead to devastating outcomes.

49.1 Culturally secure ways of working

The Indigenous Australian community is diverse and there is no ‘one size fits all’ treatment for problematic AOD use among Indigenous people (Australian Government Department of Health and Ageing, 2007). However AOD evidence-based approaches have been adapted so that they are holistic and culturally secure. These new models, framed from within an Aboriginal cultural context and developed by Aboriginal people, are considered to be culturally secure in that they respect the legitimate rights, values and expectations of Aboriginal people and acknowledge the diversity within and between Aboriginal communities living in remote, regional and metropolitan areas. These models also:

- incorporate an Aboriginal holistic concept of health and well-being
- are grounded in an Aboriginal understanding of the historical factors, including traditional life, the impact of colonisation and the ongoing effects
- aim to strengthen Aboriginal family systems of care, control and responsibility
- address culturally secure approaches to harm reduction
- work from within empowerment principles.

An example of a culturally secure approach to addressing AOD problems is Strong spirit strong mind (Casey & Keen, 2010), which includes information about how to work with the client, family or community in culturally secure ways. In essence, Strong spirit strong mind emphasises the importance of strengthening the inner spirit to enhance good decision-making and support behavioural change at an individual and collective level, within the family and community. It also outlines how working with the inner spirit can be applied in a therapeutic context and provides a framework for understanding the structure of traditional Aboriginal life, the implications of colonisation and the introduction of alcohol and other drugs, and the continuing impact of oppression upon the lives of Aboriginal clients, their families and their communities. The resource outlines the negative impact of problematic AOD use on seven important areas of life for Indigenous people: culture and country, Aboriginal law, health, family and community, money and work, legal, and grief and loss. It is important when working with Aboriginal clients that non-Aboriginal workers have an understanding of how AOD use impacts on these areas of the client’s life and consider the underlying issues that often present with AOD use problems.

33 There are regional and community differences in preferences for the word ‘Aboriginal’ or ‘Indigenous Australian’. It is important to ask an Indigenous client which word is preferred to describe their cultural heritage and community (Australian Government Department of Health and Ageing, 2007).
49. Aboriginal people

Casey and Keen (2010) also developed a guide entitled ‘Strong spirit strong mind. Making sense and supporting change: a guide for our people’ which is a useful resource to work through with Aboriginal clients. The resource provides culturally appropriate handouts about AOD use and dependence, harm reduction, stages of change at an individual and community level, relapse prevention and goal-setting.

Mainstream models can also be helpful when working with Aboriginal people. Social learning theory (SLT) acknowledges that drug use is learned and that people learn to use drugs from the environment in which they live. This approach complements traditional Aboriginal ways of learning as Aboriginal people have always learnt from their elders, other family and community members on a day-to-day basis through observing, listening, and trying it out. Since colonisation Aboriginal people have been exposed to hazardous and harmful patterns of AOD use by the broader Australian society. In the present day, in keeping with traditional ways of learning, Aboriginal people are strongly influenced by observing hazardous and harmful patterns of AOD use from their own people, with tragic consequences for their health and well-being.

The social model of health highlights the need to consider social, environmental, and economic determinants of health and AOD use. It is important to recognise that the sociocultural context of harmful AOD use is different for Indigenous Australians. The majority of Indigenous Australians experience poor environmental, social, and economic conditions, which are linked to higher rates of AOD and health problems (Wilson et al., 2010). Multiple factors influence AOD use among Aboriginal people and the complexity of interrelated physical, social, emotional, economic and environmental inequalities that contribute to and exacerbate AOD use among Aboriginal people, means that a range of culturally secure principles need to be incorporated into responses. The implications for agencies and AOD workers are:

- Opportunities for partnerships and collaboration with Aboriginal services and individuals should be pursued to increase culturally respectful practice.
- Opportunities should be taken, within AOD agencies and other sectors, to build capacity for responding effectively to AOD problems in Aboriginal people and communities to improve cultural competence.
- Agencies should employ skilled Aboriginal people and provide them with training and resources to increase their effectiveness in contributing to the Aboriginal AOD area.
- Prior to working with Aboriginal clients non-Aboriginal workers should participate in cultural awareness training.
- If non-Aboriginal counsellors are working with Aboriginal clients they should seek ongoing cultural supervision from healthcare providers with competence in working with Aboriginal people.
- Aboriginal clients should be offered referral to or additional support from Aboriginal-specific AOD services where possible and desired by the clients.
- Counsellors should be aware of the importance of family systems to Indigenous Australians and recognise that the concept of family in Aboriginal culture includes immediate and extended family and relatives. With the permission of the client, include family members in the counselling as much as possible.
- A flexible approach is needed when working with Aboriginal clients, as family, community and cultural obligations will often take precedence over appointments.
- Counsellors should be aware of the high levels of grief and loss that are a constant factor in the lives of many Aboriginal people, their families and communities.
- Counsellors should be aware of the impact of intensely distressing levels of shame that many Aboriginal clients experience, which can become exacerbated when dealing with a non-Aboriginal counsellor/worker.
- Cognitive behavioural approaches work well with Aboriginal people provided they are used in culturally secure ways.

Aboriginal people – tip sheet

Use culturally secure ways of working with Aboriginal people, their families and communities.

Culturally secure ways of working respect the legitimate rights, values and expectations of Aboriginal people and acknowledge the diversity within and between Aboriginal communities living in remote, regional and metropolitan areas.

Culturally secure models of working:
• incorporate an Aboriginal holistic concept of health and well-being
• are grounded in an Aboriginal understanding of the historical factors, including traditional life, the impact of colonisation and the ongoing effects
• aim to strengthen Aboriginal family systems of care, control and responsibility
• address culturally secure approaches to harm reduction
• work from within empowerment principles.

Social Learning Theory (SLT) should also be used to understand Aboriginal AOD use as it acknowledges that drug use is learned. This approach complements traditional Aboriginal ways of learning as Aboriginal people have always learnt from their elders, other family and community members on a day-to-day basis.

The complexity of the factors contributing to AOD problems by Aboriginal people means that culturally secure responses need to occur at all levels of government, agencies, and the community, and partnerships and collaboration between Aboriginal and non-Aboriginal agencies and individuals are essential.

Implications for ways of working with Aboriginal clients include the following considerations:
• Opportunities for partnerships and collaboration with Aboriginal services and individuals should be pursued.
• Opportunities should be taken, within AOD agencies and other sectors, to build capacity for responding effectively to AOD problems in Aboriginal people and communities.
• Agencies should employ skilled Aboriginal people and provide them with training and resources to increase their effectiveness in contributing to the Aboriginal AOD area.
• Prior to working with Aboriginal clients non-Aboriginal workers should participate in cultural awareness training.
• Non-Aboriginal counsellors working with Aboriginal clients should seek ongoing cultural supervision from healthcare providers with competence in working with Aboriginal people.
• Aboriginal clients should be offered referral to or additional support from Aboriginal specific AOD services where possible.
• Counsellors should be aware that the concept of family in Aboriginal culture includes immediate and extended family and relatives and, with the permission of the client, include family members in the counselling as much as possible.
• A flexible approach is needed when working with Aboriginal clients, as family, community and cultural obligations will often take precedence over appointments.
• Counsellors should be aware of the high levels of grief and loss that are a constant factor in the lives of many Aboriginal people, their families and communities.
• Counsellors should be aware of the impact of intensely distressing levels of shame that many Aboriginal clients experience, which can become exacerbated when dealing with a non-Aboriginal counsellor/worker.
• Cognitive behavioural approaches should be integrated into work with Aboriginal clients as they work well provided they are used in culturally secure ways.
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’ as in 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:

- disclosing information about clients during the course of supervision or case management
- if the client threatens to harm him or herself or someone else
- if a child is currently ‘at risk’ of abuse or neglect
- if the counsellor or case notes are subpoenaed to court.

Counsellors should be honest regarding the limits of confidentiality prior to any therapeutic engagement. 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 problems and progress will be shared with other treating team members.

Counsellors should be aware of confidentiality in communications with related professionals. Written informed consent should be obtained from the client in all instances prior to the sharing of information, unless sharing the information is deemed necessary to prevent immediate risk to the client or another person. Counsellors should carefully consider the possible lack of confidentiality particularly when faxing, posting or emailing client information.

Confidentiality is limited for coerced clients where reporting client progress to a third party is required. These limits need to be carefully explained to clients at the onset of therapy (see Chapter 40 Coerced clients).

Finally, counsellors should be aware that under the Commonwealth Freedom of Information Act 1982 and the WA Freedom of Information Act 1992 clients can apply to have access to their own case notes and assessment information. When working with children 16 years and under, parents can legally apply for case information unless the young person is deemed to have the maturity to give informed consent (they are deemed to be a ‘mature minor’ – see Chapter 43 Young people).

**Confidentiality – tip sheet**

There is no such thing as ‘absolute confidentiality’ in counselling relationships. Counselling relationships are ‘confidential’ but not ‘privileged’ as in 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:

- disclosing information about clients during the course of supervision and case management
- if the client threatens to self-harm or harm someone else
- if there is a child involved who is currently ‘at risk’ of abuse
- if the counsellor or case notes are subpoenaed to court.

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

State the limits of confidentiality prior to any therapeutic engagement.

Written informed consent should be obtained from clients prior to an agency (or counsellor) sharing any client-related information with associated professionals or otherwise.

When sharing information about clients, counsellors should consider the possible lack of confidentiality when posting, faxing and emailing information.

Agencies need to be aware that under the Commonwealth and State Freedom of Information acts clients can apply to have access to their own case notes and assessment information.
Clinical supervision

Well managed supervision improves the quality of client service and provides staff with an opportunity to improve their professional skills and build confidence in working from an integrated treatment approach with AOD clients (Graham, 2004). The central aims of clinical supervision include:

- improved clinical practice
- enhanced supervisee capacity to meet professional, ethical and best-practice standards
- provide support and encouragement to supervisees
- attainment of standards of the employing organisation (NCETA, 2005).

Evidence-based practice requires staff to integrate knowledge from the research and professional field, as well as their own experiences, into their clinical practice. This process requires:

- a range of learning opportunities both on the job and off-site to update skills and knowledge
- effective and supportive supervision to build a climate of continuous learning and support
- organisational structures that allow for reflective practice to integrate acquired knowledge and skills into the workplace
- the ability to use both successes and mistakes as learning opportunities.

There are various ways in which learning and development occurs via work. These include supervision, opportunistic learning, intentional on-the-job learning, use of job aids, attending training events and action learning. The focus of this chapter is on how clinical supervision can facilitate learning and professional development. Agencies have policies and procedures in place in terms of supervision requirements that need to be adhered to.

Clinical supervision is an important aspect of any treatment service as it assists in the maintenance and improvement of counsellors’ standards of practice. It involves exploration of the way that the supervisee works with clients. It is regular, systematic and carries with it a responsibility to ensure quality of practice. Clinical supervision should occur regularly for all staff. For supervision to be most effective, both supervisor and supervisee should be familiar with common supervisory practices. Role boundaries and goals should be established at the commencement of supervision and reviewed over time.

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.

Carroll (2010) (p.1) 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 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?
51. Clinical supervision

The focus of clinical supervision is the learning of the supervisee which occurs via the supervisor facilitating the reflection of the supervisee on his or her practice. A useful framework that can be used to guide supervision is the ‘After Action Review’ (AAR; 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?
• So what have I learned from evaluating what happened?
• What will I do differently next session as a result of this learning from past sessions?

The function of a clinical supervisor is to facilitate growth and development of the supervisee as a counsellor. A supervisor needs to be able to act as a mentor, even to quite experienced counsellors. A supervisor should promote team problem-solving while also making clear that counsellors have primary responsibility for their clients’ care. The supervision style should include a balance of support, feedback, problem-solving and instruction. Proctor (1988) describes the main functions of supervision in counselling as ‘normative’, ‘formative’, and ‘restorative’.

• The normative function refers to issues of professional standards, such as case management.
• The formative function refers to the development of the supervisee’s knowledge and clinical skills.
• The restorative process of supervision refers to the supportive function through the encouragement of debriefing and emotional processing.

Supervision is about enhancing the standards of practice. It involves the supervisor having sufficient trust in supervisees to allow them to make their own mistakes, while at the same time being able to guide and develop their practice.

51.1 What makes effective supervision?

Effective supervision consists of a clearly developed contract stating the purpose of supervision and expectations of the supervisor and supervisee. It should be developed via negotiation and mutual agreement. It should:

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

Once the structure for supervision has been set, other elements of effective supervision include the following (adapted from Helfgott, 2009b):

• a balance of support, feedback, problem-solving and instruction
• clear, open communication
• active listening and attending skills
• providing supervisees with an adequate mix of support, empathy and respect
• proactive agenda setting
• having clear professional boundaries
• providing clear and specific goals and expectations with appropriate timing
• being able to give and receive constructive and corrective feedback
• having knowledge and skills of the alcohol and other drug area and the process of supervision
• engaging in both teaching and conceptualising behaviours where appropriate
• stimulating supervisee self-reflection and self-examination
• being respectful of the supervisee’s current levels of practice while also extending the supervisee’s work beyond their current capabilities.
51. Clinical supervision

Understanding the dynamics of parallel process, also known as the mirroring process, is an important part of the supervisory relationship. This occurs when the supervisee reproduces in the supervisor some of the feelings that the client promotes in the supervisee. For example, a client trivialising drug use in counselling and then the supervisee trivialising the issue in supervision.

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).

The supervisor should tailor the level of supervision to the supervisee’s current level of practice.

Michael Carroll, in his writings and workshops on supervision, draws on Hawkins and Shohert’s (1989) model of supervision to suggest that supervisors and supervisees should focus on different areas as appropriate:

1. Reflection on the content of the counselling session.
2. Exploration of the strategies and interventions used by the counsellor.
3. Exploration of the counselling process and relationship.
4. Focus on the counsellor’s countertransference.
5. Focus on the here and now process as a mirror or parallel of the there and then process – i.e. the process issues occurring in supervision that reflect the process issues that occurred during counselling.
6. Focus on the supervisor’s countertransference.

As counsellors increase their levels of confidence, the style of supervision should move away from an analysis of the techniques used and content of the counselling sessions and more towards examining issues of process in both the counselling and supervision sessions. Readers are referred to Milne (2009), or Bernard and Goodyear (2009) for a more detailed discussion on supervision.

51.2 Obligations of the supervisee

Supervisees share half of the responsibility in terms of the effectiveness of clinical supervision. The responsibilities of the supervisee are to:

- help draw up a contract for supervision
- be clear in their expectations of supervision
- be clear and open in their communication with the supervisor
- be conscious of, and clearly communicate, changing supervision needs
- be honest in all interactions with the supervisor and ensure that the supervisor gets an accurate picture of counselling sessions, as well as issues of countertransference
- be honest about the process of supervision, and if needs are not being met, voice this
- be open to constructive feedback
- do any homework tasks as set by the supervisor.

51.3 Group supervision

Group supervision offers a number of advantages over individual supervision, including the development of a supportive team atmosphere, a greater pool of resources and skills, and exposure to an increased number of client cases. However, 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). There are also individual differences in the perceived benefits of group supervision (Mastoras & Andrews, 2011). Therefore it is recommended that counsellors should also have access to regular individual clinical supervision.
51. Clinical supervision

51.4 Reviewing recordings and case notes in supervision

It is useful for counsellors to record some counselling sessions. By either viewing (optimal) or listening to audio recordings of counselling sessions counsellors can practise a form of self-supervision by keeping track of their own progress and process and highlighting issues they may have missed the first time around.

Recordings of sessions are also an integral component of effective supervision as they provide the supervisor with an inside view into the counselling process. In the absence of recordings, the supervisor is totally dependent on the self-reporting of the supervisee. Self-reporting is likely to suffer from bias and is limited by the awareness and knowledge of supervisees. It is helpful for supervisors to have access to an insider’s view.

Obtain written permission from the client to record sessions and play these to your supervisor. Make sure you describe the purposes of recording sessions to your client and clearly explain that they have every right to refuse if they are not comfortable with the idea. A consent form should be signed by the client.

The supervisor should also periodically review case notes and reports. If the counsellor receives outside supervision (away from the grounds of the agency) counsellors should photocopy the case notes and blank out any identifying information. Never remove confidential information from your agency with identifying details on it.

Clinical supervision – tip sheet

The aim of clinical supervision is to enhance the supervisee’s ability to meet professional, personal and agency objectives and standards and to facilitate growth and development of the supervisee as a counsellor. It involves exploring in detail the way that the supervisee works with clients. It is regular, systematic and carries with it a responsibility to ensure quality of practice.

Supervision is not therapy.

Agencies should have policies and procedures about supervision and counsellors should abide by these.

Clinical supervision has three functions.

• Normative: the managing or administrative function.
• Formative: the educative or teaching function.
• Restorative: the supportive or enabling function.

Supervision should facilitate the worker’s ability to:

• become aware of and able to recognise more complex client issues
• become aware of their own reactions and responses to clients
• become aware of transference and countertransference issues
• understand the dynamics of how they and the client interact
• examine possible interventions and their consequences
• explore alternative ways of working.

A supervisor guides and encourages the supervisee to develop their own hypotheses and directions for working with particular clients.

Supervision should involve the development of a contract stating the purpose of supervision and the expectations of the supervisee and supervisor. It should:

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

The quality of the supervision relationship is essential for effective supervision. Factors that have been identified as important in this regard include:

- collaboration between the therapist and supervisor on interventions, goals and strategies that could be used with particular clients
- mutual understanding of the supervision process
- rapport (level of comfort, openess, honesty, and respect).

Other elements of good supervision include:

- a balance of support, feedback, problem-solving and instruction.
- clear open communication
- active listening and attending skills
- provision of an adequate mix of support, empathy and respect
- proactive agenda setting
- provision of clear and specific goals and expectations with appropriate timing
- having clear professional boundaries
- being able to give and receive constructive feedback
- stimulating supervisee self-reflection and self-examination
- having knowledge and skills of the alcohol and other drug area and the process of supervision
- the engagement of both teaching and conceptualising behaviours where appropriate
- understanding the dynamics of parallel process.

The supervisor should be more experienced than the supervisee.

The supervisor should recognise the supervisee’s current level of practice and tailor the level of supervision accordingly.

The supervisor should have access to recorded sessions (with the client’s written permission) to review with the supervisee.

On occasion, the supervisor should review case notes and client reports while always ensuring that confidentiality is protected.

The supervisee shares the responsibility in terms of the effectiveness of supervision. Specific responsibilities include the following:

- help draw up a contract for supervision
- be clear in your expectations of supervision
- be clear and open in your communication with your supervisor
- be conscious of, and clearly communicate, changing supervision needs
- be honest about the process of therapy with clients and ensure that your supervisor gets an accurate picture of counselling sessions, as well as issues of countertransference
- be honest about the process of supervision and tell your supervisor if your needs are not being met
- be open to constructive feedback
- do any homework tasks as set by your supervisor.
Stress
A manageable level of stress in the workplace is normal and can be motivating. There are a number of different sources of stress in the workplace, the most common of which is the stress associated with workload and time pressures. Other sources of stress include concerns about whether you are making a difference and have the necessary competencies to do your job effectively, and whether you are valued in the workplace and adequately remunerated. Issues such as distressing outcomes for clients, conflict in the workplace, unsympathetic 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.

Burnout
Burnout is a term used to describe the experience of long-term strain and exhaustion as a result of chronic work stressors (Maslach et al., 2001). 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 et al., 2001):

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

There are three recognised dimensions to the experience of burnout (Maslach et al., 2001):

- 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 predominance of 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 in the counselling profession, as counsellors 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 counsellors given the high rates of relapse among clients with AOD problems.

Burnout is associated with job dissatisfaction and workers who experience burnout are more likely to be absent from work or resign. Burnout is also associated with negative stress-related physical health outcomes. Burnout is a particularly important issue in the counselling profession as it seriously affects the counsellor’s ability to continue to deliver a quality service. Counsellors 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 and support from co-workers and clinical supervision is critical in this regard. If you are concerned about the level of work-related stress that you are experiencing, or if you start to feel cynical, detached or ineffective at work, raise this issue with a supervisor and make arrangements for support. Agencies and workers generally have access to free employee assistance programs which workers can access should they experience work-related burnout, or other issues which may 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. Active coping strategies include the following:

- Physical self-care: eating well, sleeping well, exercise, allocating time for relaxation and leisure activities.
52. Stress and burnout

- Emotional self-care: ensuring opportunities to talk and debrief.
- Professional self-care: by maintaining adequate support, clinical supervision, professional development, time-management, and addressing any concerns about work demands, unfairness or inequity.

A recent finding suggests that engagement in the workplace and appreciation of the value of the work can reduce the risk of burnout, particularly among AOD counsellors (Vilardaga et al., 2011). It is important for AOD counsellors 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 a number of different sources of stress in the workplace. The most common source of stress is associated with workload and time pressures. Other sources of stress include the following:

- concerns about whether you are making a difference
- concerns about whether you are doing your job effectively
- concerns about whether you are valued and adequately remunerated
- distressing outcomes for clients
- conflict in the workplace
- unsympathetic 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. There are three components of burnout:

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

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

Workplace risk factors that have been associated with burnout include:

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

If you are concerned about your risk of burnout, 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, doing exercise, relaxation and leisure activities.
- Emotional self-care: ensure opportunities to talk and debrief.
- Professional self-care: maintain adequate support, clinical supervision, professional development, time-management, and address concerns about work demands, unfairness or inequity.
Working with clients with AOD issues often involves working with trauma issues. This can be a challenging and emotional experience that can have a significant impact on clinicians. When this impact includes a negative transformation in the clinician where the clinician starts to experience some symptoms of traumatisation, we refer to ‘vicarious traumatisation’ (VT).

53.1 What is vicarious trauma?

Vicarious trauma can be defined as follows:

‘Vicarious trauma (VT) is 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)

It is thought that clinicians develop VT because they engage emphatically with the client but do not adequately process their own empathic responses (Pearlman & Caringi, 2009). VT reactions are not just linked to hearing about horrific traumatic experiences. They are also influenced by the sorts of difficult interpersonal process issues and therapeutic interactions that can occur when counselling traumatised clients.

A negative and unsupportive social, cultural and political context towards trauma survivors compounds the issue of VT. VT does not reflect the level of competence of the worker, it is an effect of working with survivors of trauma (Pearlman & Saakvitne, 1995, p.31).

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

- Difficulty:
  - managing emotions aroused in response to a client’s trauma stories
  - managing feelings
  - feeling stable and consistent
  - making decisions.

- Somatic problems.

- 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, anxiety.

- Loss of meaning and hope.

- Difficulty with boundary management.

53.2 The physiological basis of VT

VT has a physiological basis in that our autonomic nervous system reacts in sympathy with that of our clients. In VT, the clinician vicariously experiences the client’s trauma in his or her nervous system, in a way that is similar to vicariously experiencing excitement when the main character in a movie we are watching wins a race or when we watch someone on a roller coaster ride on television (Rothschild & Rand, 2006). These autonomic nervous system reactions form an aspect of empathy and are very useful for clinicians. Behaviours that increase the extent to which our nervous system responds in sympathy with a client include copying or ‘mirroring’ the client’s facial expression, breathing pattern, body posture, and movements; sitting close to the client; and experiencing auditory and visual imagery associated with the things the client discloses. When our nervous system reactions occur unconsciously and extensively they can contribute to VT.

This chapter is adapted from Marsh et al. (2012) Chapter 26 ‘Vicarious trauma’.
53.3 Other factors that contribute to the development of VT

The literature identifies a number of interacting factors as contributing to the development of VT. These include work-related, helper-related and sociocultural factors. The summary of these factors below is based on Pearlman and Caringi (2009).

53.3.1 Work-related factors

The sorts of experiences disclosed by clients

More relentless and horrific experiences are more likely to result in VT.

Therapeutic relationship dynamics

Traumatised clients tend to have difficulty regulating affect, may have poor distress tolerance and lack self-worth and the ability to trust. They may be unable to identify and verbalise their emotional states and therefore may act out, engaging in behaviours such as self-harm, suicide attempts, aggression, being seductive towards the clinician, or withdrawal. Rather than remembering the trauma in words and images, traumatised people often recall their experiences through behaviours and responses that repeat the past. This may result in the client engaging in trauma re-enactment which may result in them casting others, including the clinician, into the role of perpetrator, bystander and victim in their interactions with them. They can become involved in repeated abusive relationships, be dissociative, and use drugs in destructive ways. The impact of these client behaviours on clinicians can be huge: they can feel, for example, very responsible for their clients, frightened for the safety of their clients, love for their clients, confused, helpless, hopeless, useless, abandoned, frustrated, lost, deskilled or trapped.

Confidentiality demands and debriefing opportunities

When there is little opportunity to debrief and process reactions to a client and the client’s trauma experiences in a safe and supportive manner, clinicians can be left with unprocessed reactions which make VT more likely.

Amount of trauma work and exposure

The more trauma work and exposure to traumatic client material a clinician has, the more likely VT is to develop.

53.3.2 Helper-related factors

Support system

Clinicians with few social and professional supports are more likely to develop VT.

Trauma history

Clinicians with trauma in their own histories are not necessarily more likely to develop VT. It does appear, however, that if clinicians with a trauma history seek healing through their work with traumatised clients instead of through their own personal and professional development, then the likelihood of VT increases. This is because their own trauma history becomes triggered by the client work and the clinician becomes less able to help the client.

Level of training and experience

VT is less likely with increasing knowledge and understanding of trauma and the implications it has for how clients operate within and outside the therapeutic relationship.
53. Vicarious trauma

.Helper avoidance
Persistent avoidance of a client’s pain, so-called ‘type I’ clinician countertransference, can contribute to VT. This is because avoidance does not protect against the impact of trauma stories or therapeutic relationship difficulties. Instead, it makes clinicians less able to process their reactions of pain, sorrow, frustration, anger and resentment, which can then continue to build over time across therapeutic relationships.

.Helper attachment style
Clinicians with an insecure attachment style, who tend to have problems with self-worth and relationships, a number of negative cognitive schemas, and difficulty managing emotions, are more likely to develop VT.

53.3.3 Sociocultural factors
Sociocultural factors that contribute to VT include a lack of support from agencies and, for practitioners working in the private system, private and government health funds for support and counselling for clients with complex trauma histories. Agencies and health funds tend to allocate limited resources to the treatment of any particular client, and there is often pressure on clinicians to finish treatment well before the client is ready to do this.

53.4 Preventing and responding to VT
Strategies to prevent and respond to VT include strategies to reduce physiological responses to clients, general personal and professional self-care strategies, and agency strategies.

53.4.1 Strategies to reduce physiological responses to clients
The following discussion of reducing physiological responses to clients is based on Rothschild and Rand (2006).

.Reducing unconscious mirroring
Mirroring forms part of the basis for empathy – being able to understand and acknowledge what other people feel. When used consciously, mirroring can help clinicians gain a deeper understanding of how a client is feeling. Some clinicians tend to unconsciously mirror their clients closely and extensively, which is thought to contribute to the development of VT. Rothschild and Rand (2006) make several suggestions for reducing unconscious mirroring of clients:

• Use mindfulness during sessions to become aware of what client expressions, breathing, or body posture you are mirroring and how you are feeling. See Chapter 21 in this guide entitled Mindfulness. Watching videotaped client sessions can also help with this.
• Occasionally in session consciously change an aspect of your expression, breathing, or body posture to ‘unmirror’, and notice whether you feel any different or if your client notices. Rothschild and Rand (2006) note that most clients will not notice, though some may prefer more mirroring, and some may be relieved when you mirror them less because it enables them to stay more in touch with themselves.

.Reducing physiological arousal
Because our autonomic nervous system can react in sympathy with those of our clients, we can be at risk of becoming hyperaroused when we work with chronically traumatised clients who are in a constant state of hyperarousal. Hyperarousal, or the fight and flight response, is signalled by rapid heart rate and respiration, and skin becoming cool, moist, and pale. Becoming aware of our bodily reactions and taking action to slow down our hyperarousal responses has been found to be associated with less likelihood of developing VT (Forester, 2001, cited in Rothschild & Rand, 2006).

36 Note: ‘type II’ clinician countertransference responses are over-involvement, enmeshment and rescuing responses (Wilson, Lindy & Raphael, 1994).
53. Vicarious trauma

Rothschild and Rand (2006) recommend checking your level of arousal several times during a session and using a grounding technique, or ‘sensory anchor’, to reduce arousal when it becomes uncomfortably high. A sensory anchor can be a pleasant and relaxing image with associated sounds, smells, feelings, and sensations, a particular sound, or even a body movement that makes you feel calmer. Clinicians can use these sensory anchors after a session, or during a session, by briefly recalling the calming image or sound, or making subtle body movements when they feel themselves becoming too hyperaroused.

Firm physical boundaries
Rothschild and Rand (2006) suggest that awareness of physical boundaries can help clinicians stay calm. Physical boundaries can include how far you sit from clients (this can vary from client to client and from time to time with the same client depending upon how you and the client are feeling), clothing that makes you feel calm or perhaps protected on days when you feel emotionally vulnerable, and tensing up muscles over particular areas of the body that feel vulnerable.

Controlling imagery
Controlling auditory or visual imagery that arises from distressing or traumatic things clients have disclosed is also important. Rothschild and Rand (2006) suggest imagining that you have the controls to an audio player or television and manipulating the images. You might imagine playing with controls for the audio player to change the sound quality to high or low voices or cartoon voices, to speed up or slow down what is said, or to muffle the sounds in the image. For visual images, you might imagine playing with the controls to change the colours in the image, make it black and white, put snow or lines across it, or make it smaller. Manipulating the images like this can provide clinicians with a sense of control over them.

53.4.2 General personal and professional self-care strategies

- Build a satisfying social support system.
- Ensure a healthy balance between your professional and personal life – avoid long hours, take a lunch break, take regular holidays.
- Maintain good self-care and a healthy lifestyle: get enough sleep, eat well, exercise regularly, socialise regularly, have fun, rest, relax.
- Develop some sort of ‘spiritual’ life that can be self-nourishing and provide a sense of meaning. This can include a range of activities from participation in prayer and organised religion through to being involved in the community, being useful to others, or involvement in nourishing relationships with others or nature.
- Acknowledge an awareness of the impact of VT when it occurs.
- Ensure you receive regular supervision.
- Debrief with colleagues and your coordinator or supervisor.
- Attend staff meetings so you feel that you are part of a team.
- Set clear boundaries and limits with clients.
- Set clear boundaries and limits with yourself by allowing for breaks between clients and not over-booking clients.
- Give yourself permission to slow down.
- Maintain a manageable caseload and, where possible, have a mix of clients with different levels of complexity.
- Develop a clear theoretical base to make sense of and guide the use of your own reactions to clients.

---

37 These strategies are drawn from Pearlman and Caringi (2009), Pearlman and Saakvitne (1995), and the King Edward Memorial Hospital and Princess Margaret Hospital’s ‘Psychological Medicine Clinical Care Unit policy on vicarious trauma’ (May 2008).
53. Vicarious trauma

- Maintain awareness of your personal experience while sitting with clients, as well as the therapeutic boundaries of the situation.
- Acknowledge personal and professional limitations, and that counselling, although important and powerful, is limited in what it can achieve.
- Focus on the process of what needs to be done to help the client rather than the outcome in terms of the client’s ability to change. Change is very slow for traumatised clients with AOD problems, and it is important to focus on noticing and reinforcing desired behaviours and attitudes rather than what has not been achieved.
- Write progress notes immediately after a session as this can help to process your reactions.

53.4.3 Agency strategies

- Ensure ongoing clinical supervision opportunities are available to all clinicians.
- Ensure that clinicians have opportunities to attend professional development days.
- Ensure that clinicians who work with traumatised clients are given information and training on vicarious trauma.
- Encourage debriefing when dealing with complex or distressing situations.
- Encourage and support the use of external counselling services when necessary.
- Encourage an open, non-judgemental and supportive work environment in which staff feel comfortable to discuss VT.
- Encourage a culture of sharing of information and provide opportunities for this to occur, for example via team meetings and clinical review meetings.
- Facilitate team building opportunities such as strategic planning days.
- Ensure that staff take lunch breaks.
- Ensure a fair and equitable distribution of workload.
- Ensure that new clinicians are given a thorough orientation and have help available as they learn the job.
- Ensure relevant information about the agency is disseminated to all staff.
- Ensure that there are organisational policies and procedures around how to respond to VT.

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38 These strategies are drawn from Pearlman and Caringi (2009), Pearlman and Saakvitne (1995), and the King Edward and Princess Margaret Hospitals’ "Psychological Medicine Clinical Care Unit policy on vicarious trauma" (May 2008).
## Vicarious trauma – tip sheet

**Vicarious trauma**

When the impact of working with traumatised clients includes a negative transformation in the clinician in which the clinician starts to experience some symptoms of traumatisation themselves, we refer to ‘vicarious traumatisation’ (VT). VT is part of the normal range of reactions to working with trauma survivors.

It is thought that clinicians develop VT because they engage empathically with the client but their own empathic responses are not adequately processed.

Our autonomic nervous system can react in sympathy with that of our clients. These autonomic nervous system reactions form an aspect of empathy and are very useful for clinicians. When they occur unconsciously and extensively, however, they can contribute to VT.

### Strategies to reduce physiological responses to clients

Rothschild and Rand (2006) suggest using mindfulness to be aware of:

- unconscious mirroring of clients’ facial expressions, breathing patterns, facial and body postures and movements, so that, if taking on too much of what the client is feeling, steps can be taken to ‘unmirror’
- symptoms of hyperarousal (rapid heart rate and breathing, cold and sweaty skin), in order to use calming anchors to reduce arousal if necessary
- physical boundaries (seating position, clothing, muscle tension around vulnerable parts of your body), so that they can be adjusted if they are causing stress
- auditory and visual imagery that you experience as a result of client disclosures, so that imaginary controls can be used to manipulate these images if they stay with you.

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

- Build a satisfying social support system.
- Ensure a healthy balance between professional and personal life.
- Maintain good self-care and a healthy lifestyle.
- Develop some sort of ‘spiritual’ life.
- Acknowledge an awareness of the impact of VT on the self when it occurs.
- Ensure that you receive regular supervision and debriefing.
- Attend staff meetings to feel part of a team.
- Set clear boundaries and limits with clients.
- Give yourself permission to slow down if you need it.
- Maintain a manageable caseload with a mix of complexity.
- Develop a clear theoretical base to understand and use countertransference reactions.
- Maintain awareness of personal reactions with clients, as well as therapeutic boundaries.
- Acknowledge personal and professional limitations.
- Focus on what needs to be done rather than on how far there is to go with a client.
- Write progress notes immediately after a session to help to process reactions.

### Agency strategies that can help to minimise VT

Agencies need to be aware of the difficult nature of working with clients with AOD and trauma issues, and implement strategies to support staff in their work so as to minimise VT. Supporting clinicians to feel part of a team; to receive supervision, debriefing and professional development; and ensuring manageable caseloads are all important.
Contributing to the prevention of AOD problems is the responsibility of clinical AOD workers as well as many other health and mainstream professions and sectors. Preventing AOD problems from occurring in the first instance will reduce the requirement for treatment as well as reduce the social and financial costs attributable to alcohol and other drug use. Research shows that for each dollar invested in prevention, savings of up to $10 in treatment for AOD problems can be seen (e.g. Miller & Hendrie, 2009). The expertise AOD clinicians possess puts them in a legitimate position within their community to comment on the harms associated with AOD use and influence change at a higher level.

### 54.1 What is prevention?

Many different definitions of prevention exist. In general, prevention can be defined as strategies that prevent or stop a disease or injury from occurring in the first place. There are three levels of prevention:

<table>
<thead>
<tr>
<th>Generic definition</th>
<th>AOD specific definition</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary prevention</strong>: Primary prevention strategies aim to maintain and/or enhance the well-being of the general population. Within primary prevention there are three categories:</td>
<td>Primary prevention involves strategies that aim to prevent the uptake of AOD use, or delay the age at which use begins (WHO, 2002).</td>
<td>Early childhood interventions including home visiting to strengthen protective factors and decrease risk factors in young children.</td>
</tr>
<tr>
<td>• Universal or general prevention is defined as those interventions that are targeted at the general public or a whole population group. In this level no specific risk factors have been identified, rather the aim is to prevent specific health problems for everyone (Auseinet, 2007; WHO, 2002).</td>
<td></td>
<td>Programs to improve academic outcomes for school-aged children and other evidence-based alcohol and other drug school education programs (e.g. ‘School Drug Education and Road Awareness’ in Western Australia).</td>
</tr>
<tr>
<td>• Selective or at-risk prevention targets individuals or subgroups of the population who are at increased level of risk.</td>
<td></td>
<td>Alcohol taxation or minimum floor pricing.</td>
</tr>
<tr>
<td>• Indicated or high-risk prevention targets high-risk people (WHO, 2002).</td>
<td></td>
<td>Blood alcohol content (BAC) limits for driving.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social marketing campaigns (e.g. Drug Aware, Alcohol. Think Again – Western Australia).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Liquor licensing initiatives.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Reducing outlet density (i.e. reducing number of outlets selling alcohol).</td>
</tr>
</tbody>
</table>

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39 This chapter was written by Sara Rouwenhorst, Drug and Alcohol Office, Perth, Western Australia.
54. Prevention

<table>
<thead>
<tr>
<th>Generic definition</th>
<th>AOD specific definition</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Secondary prevention:</strong> Secondary prevention seeks to lower the number of cases of a disorder or illness in the population (this is known as prevalence) through early detection (screening) and treatment (WHO, 2004).</td>
<td>Secondary prevention refers to strategies and interventions that aim to prevent AOD use becoming a problem among people already using as well as limit the degree or duration of individual or social damage caused, and which assist people who use AOD who may wish to stop using (WHO, 2002).</td>
<td>Brief interventions. Diversion programs.</td>
</tr>
</tbody>
</table>

AOD counsellors can make a significant impact on preventing AOD problems by increasing their knowledge and skills regarding prevention.

54.2 Prevention paradox

Research shows most alcohol-related harm is caused by the majority who occasionally binge drink, rather than by a minority who regularly drink at harmful levels. The prevention paradox refers to the fact that in order to see the largest amount of difference across the population it is therefore more effective to concentrate prevention programs on the broader population rather than the minority of consistently high-risk drinkers (Kreitman, 1986).

54.3 What works?

There are a number of effective AOD prevention strategies, identified through an extensive review of the literature, which have the greatest potential to make the most significant impact on reducing harm from AOD use across the population:

- increasing alcohol taxation, including introducing differential tax on forms of alcohol that are particularly subject to problematic use
- partial or complete bans on advertising and promotion of alcohol
- measures to reduce drink driving, including reducing legal BAC level and increasing random breath testing
- brief interventions in primary care to reduce hazardous alcohol consumption

(Commonwealth of Australia, 2009).
54. Prevention

An example of a highly effective community action program (Holder et al., 1997) is the Community Trials Project (CTP). The project utilised an effective evidence-based multi-strategic approach to reduce the harm from alcohol in six local communities. Strategies included:

- mobilising communities (develop coalitions, increase public awareness and support for reducing alcohol-related harm)
- introducing responsible beverage service (to reduce intoxication in licensed premises)
- reducing drink driving (through police activity to increase the perceived and real risk of being caught)
- reducing underage drinking (and associated trauma)
- reducing community access to alcohol.

There are many other prevention strategies that have been shown to be effective in reducing AOD problems. As Holder (2001) points out, the most effective strategies are those that seek to alter the system that produces alcohol problems, however, strategies that are the most effective are often the least popular.

54.4 Social determinants of health

Counsellors are already aware that there are a number of factors that impact an individual's health and wellbeing. The social determinants of health are the circumstances in which an individual is born, grows up, works and lives. Education, employment, housing, wealth/poverty, transport, race/ethnicity, safety/security, discrimination/equity, working conditions, social connectedness and social cohesion, clean drinking water, sanitation and other environmental factors all impact health. Social determinants are influenced by higher-level forces such as economics, social policies and politics and are often not in the control of individual clinicians. However, the role for clinicians in advocating for change to these factors is legitimate and necessary.

54.5 Risk and protective factors

Risk and protective factors should also be kept in mind when thinking about prevention. Presence of a risk factor may increase the likelihood that a person partakes in risky AOD use. Presence of protective factors can potentially help protect a person or group from AOD-related problems. Factors cannot be viewed on their own and factors tend to interact at the individual and group level. Risk factors include, but are not limited to:

- early age factors such as inherited vulnerability (for males), maternal smoking and alcohol use, extreme social disadvantage, family breakdown and child abuse and neglect
- school age factors such as early school failure, child conduct disorder, aggression and favourable parental attitudes to drug use
- adolescent factors such as low involvement in activities with adults, perceived and actual level of community drug use, availability of drugs, parent–adolescent conflict, parental AOD problems, poor family management, school failure, deviant peer associations, delinquency and favourable attitudes towards drugs.

Protective factors include:

- early age factors such as being born outside Australia, having an easy temperament, social and emotional competence and a shy and cautious temperament
- adolescent factors such as family attachment, parental harmony and religious involvement (Loxley et al., 2004).
54. Prevention

54.6 Key populations
A number of groups are at higher risk of developing AOD problems and have been identified as requiring priority:

- children and young people
- Aboriginal and Torres Strait Islander people
- people with co-occurring mental health and AOD problems
- people in rural and remote areas
- families including AOD-using parents
- offenders

(Loxley et al., 2004).

54.7 What you can do
There are a number of things AOD counsellors can do to contribute to the prevention of AOD problems in their communities and across the state. It is important to concentrate on the things that work; therefore activity should be based on evidence.

- Strengthen community action through joining and actively participating in local coalitions and steering groups (e.g. Local Drug Action groups). These groups coordinate a range of prevention projects locally and can influence activity at a national and state-wide level. Use these groups to bring together community members and stakeholders to influence policy.
- Promote the messages from state mass media campaigns such as Drug Aware and Alcohol. Think Again (e.g. familiarise yourself with the messages, display information leaflets/posters, refer people to website).
- Comment and contribute to consideration of local liquor licensing applications in your community (liquor licences lead to the opening of new licensed bars/clubs/pubs/shops).
- Refer people to QUIT line, Alcohol and Drug Information Service, Parent Drug Information Service, positive parenting and family intervention programs or other support services.
- Implement evidence-based family and parenting support programs in local AOD treatment services.
- Promote healthy public policy such as brief interventions in primary care and in your own service.
- Promote the development of healthy workplace AOD policies.
- Become familiar with other policies such as smoke-free areas and responsible service of alcohol and promote these locally.
- Raise awareness in the wider community of the harms associated with alcohol use. (Use the media to raise awareness and stimulate local discussion.)
- Monitor alcohol advertising in your local area and speak out when it is not appropriate (e.g. aimed at young people or using sex to sell).
- Encourage local events to be drug and alcohol free, or offer alternatives to alcohol (e.g. mocktails).
- Teach your local community about standard drinks and where they are located on containers.

(Queensland Government, 2009)


Prevention goes beyond health education. Changing knowledge alone does not result in behaviour change. Health education is one aspect of a comprehensive approach to prevention and needs to be supported by strong community action.
54. Prevention

An increasingly popular and effective approach to social change, such as preventing harm associated with alcohol and other drugs, is social marketing. Social marketing involves utilising marketing strategies, tools and techniques to achieve a socially desirable goal. Social marketing approaches provide an approach to planning and implementing a comprehensive prevention program through conducting in-depth market research with the target population to understand their motivations, barriers and costs of adopting a desired behaviour, formulating a plan including a series of potential interventions, testing ideas with the target group, implementing, evaluating and sustaining the program. In-depth information on how to design a social marketing project is beyond the scope of this chapter, however if you wish to know more about this approach to prevention you may wish to read Donovan and Henley (2003) or investigate local training programs.

<table>
<thead>
<tr>
<th>Prevention – tip sheet</th>
</tr>
</thead>
<tbody>
<tr>
<td>AOD counsellors can contribute to the prevention of AOD harms in their local community by doing the following:</td>
</tr>
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<td>• Strengthen community action through joining and actively participating in local coalitions and steering groups (e.g. Local Drug Action groups).</td>
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</tbody>
</table>

Heath education alone does not prevent AOD harms. Prevention requires a coordinated multi-strategic approach which can be driven by local communities, including AOD counsellors.
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 a number of key areas of client functioning from the beginning to the end of treatment and at one and three months following treatment (where possible). The assessment of client satisfaction is also a core performance indicator.

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

- AOD issues – use and associated problems
- co-occurring mental health issues
- general well-being
- 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 described in Chapter 4 Assessment. Deady (2009) also provides a review of other assessment tools. Many agencies use simple rating scales in which clients and counsellors can rate progress in each area on a scale from one (much worse than at the start of counselling) to five (much better than at the start of counselling).

Treatment engagement and completion can be assessed by examining attendance of scheduled appointments and drop out. 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.

Performance indicators of agency functioning are also important. Agency performance indicators should reflect those at which expectations are directed for ensuring high quality service standards. 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


References


References


References


References


References


References


References


References


References


References


Princess Margaret Hospital (2008). *Psychological Medicine Clinical Care Unit policy on vicarious trauma*. Perth, WA: Princess Margaret Hospital, Government of Western Australia.


References


References


References


References


References


Appendices

Appendix 1: Assessment of suicide risk

Adapted from Metropolitan Community Drug Services and Drug and Alcohol Youth Services – Integrated Service Policy, Suicide risk assessment. Revised October 2010.

Suicide risk assessment

Name .................................................................................................................. Date of Birth ................................................

Date of assessment:

1. Current suicidal ideation (intensity, frequency, duration, plans, intent, plans in anticipation of death)

2. Access to means (weapons, medication, etc.)

3. Current presentation (mood state, hopelessness, agitation, intoxication, etc.)

4. Current psycho-social stressors (loss, disappointment, homelessness, legal, relationship, etc.)

5. Previous history of suicidal behaviour (includes self-harm, risk-taking behaviour, assess impulsivity of attempts, usual level of suicidal risk, have they sought help in the past)

6. Have significant others attempted suicide?

7. History of impulsivity (behaviours and triggers for impulsive behaviour)

8. Hopelessness (future plans, motivation for treatment)

9. Mental health diagnoses (note diagnoses, practitioner and service where diagnosis made, date of diagnosis)

10. Recent psychiatric admission
Appendices

11. Physical health

..............................................................................................................................................................................................

12. Protective factors (family, friends, other services, religious/moral beliefs)

..............................................................................................................................................................................................

13. Previous compliance with treatment plans and current capacity to comply with risk assessment plan

................................................................................................................................................................................................

Assessment of risk (See ‘Suicide risk levels and response’)

| Risk level: Non-existent | Mild | Moderate | Severe | Extreme |

Comments (include short-term and long-term risks)

................................................................................................................................................................................................

Risk assessment plan
With whom discussed (e.g. supervisor, colleague, manager), and what action to be taken? Include plans to address the triggers for suicidal thoughts and impulsive behaviours.

**Clinician**

................................................................................................................................................................................................

**Client**

................................................................................................................................................................................................

Who else is involved in the client’s safety plan? (family member, friend, other agency)

................................................................................................................................................................................................

What is their role?

................................................................................................................................................................................................

Date for review by Team: ....................................................

**Clinician** (print) ............................................................ Signature .................................................................

Note: complete ‘Suicide prevention plan – for clients’ over page and give copy to client and keep one on file.
Appendices

Suicide prevention plan – for clients

Strategies (what you will do, who can help and how):

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Client (print) ........................................................Signature ..........................................................................

Clinician (print) ....................................................Signature .........................................................................
## Appendices

### Suicide risk levels and response

<table>
<thead>
<tr>
<th>Suicide risk assessment outcome</th>
<th>To be included in management plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-existent</td>
<td>Monitor the client as required, checking at regular intervals for change in circumstance, mood or mental state.</td>
</tr>
<tr>
<td>No identifiable suicidal ideation.</td>
<td>Discuss appropriate strategies with the client to manage suicidal thoughts and address triggers. Provide the client with various helpline numbers. During office hours encourage the client to call you if their thoughts increase in intensity. Advise client about presenting to the emergency department if their risk increases. Offer regular contact with the client. Inform other professionals on the team who are involved in the client’s care about their risk and plan how each team member will support the client. Continue to monitor risk until risk is non-existent. Complete ‘Risk assessment plan’.</td>
</tr>
<tr>
<td>Mild</td>
<td>Involve other team members who are involved in the client’s care in the assessment of the risk and plan how each team member will support the client. Request client’s permission to contact their supports and inform them of the situation and involve them in the safety plan. Discuss appropriate strategies with the client to manage suicidal thoughts and address triggers. Provide the client with various helpline numbers. During office hours encourage the client to call you if their thoughts increase in intensity. Advise client about presenting to the emergency department if their risk increases. Ensure weekly contact with the client and arrange regular check-in calls. Continue to monitor the risk until risk is non-existent. Consider referral for immediate assessment by doctor if available/appropriate. Present client at next clinical review meeting. Complete ‘Risk assessment plan’.</td>
</tr>
<tr>
<td>Suicidal ideation of limited frequency, intensity and duration. No identifiable plans, no intent (i.e. subjective or objective), mild dysphoria/low mood, mild mental health symptoms, good self-control (i.e. subjective or objective), few risk factors and identifiable protective factors. Accepting help and hope for the future.</td>
<td></td>
</tr>
<tr>
<td>Moderate</td>
<td></td>
</tr>
<tr>
<td>Frequent suicidal ideation of limited intensity and duration, some specific plans, no intent (i.e. subjective or objective), limited dysphoria/low mood, moderate mental health symptoms, some risk factors present, identifiable protective factors. Ambivalent about receiving help. Pessimistic about the future.</td>
<td></td>
</tr>
<tr>
<td>To be included in management plan</td>
<td></td>
</tr>
</tbody>
</table>
### Suicide risk assessment outcome

<table>
<thead>
<tr>
<th>Severe</th>
<th>To be included in management plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequent, intense and enduring suicidal ideation. Specific plans, method is available/accessible, some limited preparatory behaviour, evidence of impaired control (i.e. subjective and/or objective), severe dysphoria/low mood, severe mental health symptoms, multiple risk factors present, few (if any) protective factors. Refuses help or unable to follow strategies on risk assessment plan, helplessness and hopelessness about the future.</td>
<td>Refer client to doctor for assessment and referral immediately if possible. Clients may be referred to a mental health service on forms and require transportation by ambulance with police assistance. If assessment is conducted via telephone, contact the police and arrange a welfare check. Inform your local mental health emergency response team. Clearly document all interventions and actions taken. Inform significant others as per client’s request. Consider informing significant others against the client’s will.</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Extreme</th>
<th>Interventions as for ‘severe’ suicide risk.</th>
</tr>
</thead>
<tbody>
<tr>
<td>In addition to meeting criteria for severe rating there is clear subjective and objective intent. No protective factors.</td>
<td></td>
</tr>
</tbody>
</table>

Inform significant others as per client’s request. Consider informing significant others against the client’s will.
Appendices

Appendix 2: Mental State Examination (MSE)


Mental State Examination (MSE) form

(Adapted from Mills et al., 2009, p.152–153)

- 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, homocidality, depressed/anxious thoughts?
Appendices

- Perception. Hallucinations? Depersonalisation? Derealisation?


- Insight and judgement. Awareness? Decision-making?
Appendices

Mental State Examination (MSE): Guidelines for describing mental state
(Adapted from Mills et al., 2009, p.38–39)

**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/pinion 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?
Appendices

Appendix 3: Clinical Institute Withdrawal Assessment for Alcohol Scale


**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 sought immediately.

Clinical Institute Withdrawal Assessment for Alcohol (CIWA-Ar) Scale

Client ............................................................ Date ........................................... Time  .........................

**NAUSEA AND VOMITING** — Ask ‘Do you feel sick to your stomach? Have you vomited?’ Observation.

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>no nausea and no vomiting</td>
</tr>
<tr>
<td>1</td>
<td>mild nausea with no vomiting</td>
</tr>
</tbody>
</table>
| 2     | \[-------------
| 3     | intermittent nausea with dry heaves |
| 5     | \[-------------
| 6     | \[-------------
| 7     | constant nausea, frequent dry heaves and vomiting |

**TREMOR** — Arms extended and fingers spread apart. Observation.

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>no tremor</td>
</tr>
<tr>
<td>1</td>
<td>not visible, but can be felt fingertip to fingertip</td>
</tr>
</tbody>
</table>
| 2     | \[-------------
| 3     | \[-------------
| 4     | moderate, with patient’s arms extended |
| 5     | \[-------------
| 6     | \[-------------
| 7     | severe, even with arms not extended |

**PAROXYSMAL SWEATS** — Observation.

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>no sweat visible</td>
</tr>
<tr>
<td>1</td>
<td>barely perceptible sweating, palms moist</td>
</tr>
</tbody>
</table>
| 2     | \[-------------
| 3     | \[-------------
| 4     | beads of sweat obvious on forehead |
| 5     | \[-------------
| 6     | \[-------------
| 7     | drenching sweats |
Appendices

ANXIETY — Ask ‘Do you feel nervous?’ Observation.
0  no anxiety, at ease
1  mildly anxious
2
3
4  moderately anxious, or guarded, so anxiety is inferred
5
6
7  equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

AGITATION — Observation.
0  normal activity
1  somewhat more than normal activity
2
3
4  moderately fidgety and restless
5
6
7  paces back and forth during most of the interview, or constantly thrashes about

TACTILE DISTURBANCES — Ask ‘Have you any itching, pins and needles sensations, burning sensations, numbness or do you feel bugs crawling on or under your skin?’ Observation.
0  none
1  very mild itching, pins and needles, burning or numbness
2  mild itching, pins and needles, burning or numbness
3  moderate itching, pins and needles, burning or numbness
4  moderately severe hallucinations
5  severe hallucinations
6  extremely severe hallucinations
7  continuous hallucinations

AUDITORY DISTURBANCES — Ask ‘Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?’ Observation.
0  not present
1  very mild harshness or ability to frighten
2  mild harshness or ability to frighten
3  moderate harshness or ability to frighten
4  moderately severe hallucinations
5  severe hallucinations
Appendices

6 extremely severe hallucinations
7 continuous hallucinations

VISUAL DISTURBANCES — Ask ‘Does the light appear to be too bright? Is its colour different? Does it hurt your eyes? Are you seeing anything that is disturbing to you? Are you seeing things you know are not there?’ Observation.
0 not present
1 very mild sensitivity
2 mild sensitivity
3 moderate sensitivity
4 moderately severe hallucinations
5 severe hallucinations
6 extremely severe hallucinations
7 continuous hallucinations

HEADACHE, FULLNESS IN HEAD — Ask ‘Does your head feel different? Does it feel as if there is a band around your head?’ Do not rate for dizziness or lightheadedness. Otherwise, rate severity.
0 not present
1 very mild
2 mild
3 moderate
4 moderately severe
5 severe
6 very severe
7 extremely severe

ORIENTATION AND CLOUDING OF SENSORIUM — Ask ‘What day is this? Where are you? Who am I?’
0 oriented and can do serial additions
1 cannot do serial additions or is uncertain about date
2 disoriented for date by no more than 2 calendar days
3 disoriented for date by more than 2 calendar days
4 disoriented for place and/or person

Total CIWA-Ar score: ......................
Rater’s initials: .................
Maximum possible score: 67
Appendices

**Appendix 4: Opiate Withdrawal Scales**

Objective Opiate Withdrawal Scale OOWS: Range 0–13
Subjective Opiate Withdrawal Scale SOWS: Range 0–64.

**Objective Opiate Withdrawal Scale (OOWS)**
Name........................................................................................................Date.................. Time..................

Observe the client during a

**5 minute observation period**
Then indicate a score for each of the opioid withdrawal signs listed below (items 1–13). Add the scores for each item to obtain the total score.

<table>
<thead>
<tr>
<th>Sign</th>
<th>Measures</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Yawning</td>
<td>0 = no yawns 1 = ≥ 1 yawn</td>
<td></td>
</tr>
<tr>
<td>2 Rhinorrhoea (runny nose)</td>
<td>0 = &lt; 3 sniffs 1 = ≥ 3 sniffs</td>
<td></td>
</tr>
<tr>
<td>3 Piloerection (goose bumps –</td>
<td>0 = absent 1 = present</td>
<td></td>
</tr>
<tr>
<td>observe arm)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 Perspiration</td>
<td>0 = absent 1 = present</td>
<td></td>
</tr>
<tr>
<td>5 Lacrimation (runny eyes)</td>
<td>0 = absent 1 = present</td>
<td></td>
</tr>
<tr>
<td>6 Tremor (hands)</td>
<td>0 = absent 1 = present</td>
<td></td>
</tr>
<tr>
<td>7 Mydriasis (large pupils)</td>
<td>0 = absent 1 = ≥ 3 mm</td>
<td></td>
</tr>
<tr>
<td>8 Hot and cold flushes</td>
<td>0 = absent 1 = shivering/huddling for warmth</td>
<td></td>
</tr>
<tr>
<td>9 Restlessness</td>
<td>0 = absent 1 = frequent shifts of position</td>
<td></td>
</tr>
<tr>
<td>10 Vomiting</td>
<td>0 = absent 1 = present</td>
<td></td>
</tr>
<tr>
<td>11 Muscle twitches</td>
<td>0 = absent 1 = present</td>
<td></td>
</tr>
<tr>
<td>12 Abdominal cramps</td>
<td>0 = absent 1 = Holding stomach</td>
<td></td>
</tr>
<tr>
<td>13 Anxiety</td>
<td>0 = absent 1 = mild–severe</td>
<td></td>
</tr>
</tbody>
</table>

**TOTAL SCORE**

Range 0–13
Appendices

Subjective Opiate Withdrawal Scale (SOWS)

Name........................................................................................................ Date.......................... Time..........................

<table>
<thead>
<tr>
<th>Symptom</th>
<th>not at all</th>
<th>a little</th>
<th>moderately</th>
<th>quite a bit</th>
<th>extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel anxious</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>2. I feel like yawning</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>3. I am perspiring</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4. My eyes are teary</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5. My nose is running</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>6. I have goosebumps</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>7. I am shaking</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>8. I have hot flushes</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>9. I have cold flushes</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>10. My bones and muscles ache</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>11. I feel restless</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>12. I feel nauseous</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>13. I feel like vomiting</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>14. My muscles twitch</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>15. I have stomach cramps</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>16. I feel like using now</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
</tr>
</tbody>
</table>

Range 0–64
Appendices

Appendix 5: Benzodiazepine Withdrawal Assessment Scale


Benzodiazepine Withdrawal Assessment Scale

These questions refer to how the person is feeling right now, at the present moment.

<table>
<thead>
<tr>
<th></th>
<th>Anxiety</th>
<th></th>
<th>Headache</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No anxiety – at ease</td>
<td>0</td>
<td>No headache</td>
</tr>
<tr>
<td>1</td>
<td>Mild</td>
<td>1</td>
<td>Mild</td>
</tr>
<tr>
<td>4</td>
<td>Moderately anxious or guarded so anxiety is inferred</td>
<td>4</td>
<td>Moderate</td>
</tr>
<tr>
<td>7</td>
<td>Equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions</td>
<td>7</td>
<td>Severe</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Restlessness/agitation</th>
<th></th>
<th>concentration?</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Normal activity</td>
<td>0</td>
<td>No difficulty concentrating</td>
</tr>
<tr>
<td>1</td>
<td>Somewhat more than normal activity</td>
<td>1</td>
<td>Mild</td>
</tr>
<tr>
<td>4</td>
<td>Moderately fidgety or restless</td>
<td>4</td>
<td>Moderate</td>
</tr>
<tr>
<td>7</td>
<td>Unable to sit or stand still</td>
<td>7</td>
<td>Severe</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Palpitations</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>No palpitations</td>
<td>0</td>
<td>No loss of appetite</td>
</tr>
<tr>
<td>1</td>
<td>Mild palpitations</td>
<td>1</td>
<td>Slight loss</td>
</tr>
<tr>
<td>4</td>
<td>Moderate awareness of heartbeat</td>
<td>4</td>
<td>Moderate loss</td>
</tr>
<tr>
<td>7</td>
<td>Aware of heart racing constantly</td>
<td>7</td>
<td>Complete loss of appetite, unable to eat at all</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>Sleep</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>Sufficient sleep</td>
<td>0</td>
<td>No loss of appetite</td>
</tr>
<tr>
<td>1</td>
<td>Some sleep</td>
<td>1</td>
<td>Slight loss</td>
</tr>
<tr>
<td>4</td>
<td>Moderately/restless sleep</td>
<td>4</td>
<td>Moderate loss</td>
</tr>
<tr>
<td>7</td>
<td>No sleep</td>
<td>7</td>
<td>Complete loss of appetite, unable to eat at all</td>
</tr>
</tbody>
</table>

(0800 observations only—not to be included in total score)

Ask ‘How did you sleep last night?’
### Appendix 6: Amphetamine Cessation Symptom Assessment Scale


**Amphetamine Cessation Symptom Assessment (ACSA) SCALE**

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

<table>
<thead>
<tr>
<th>Questions refer to past 24 hours only. Please circle one response to each question</th>
<th>Not at all</th>
<th>A little</th>
<th>Moderately</th>
<th>Quite a lot</th>
<th>Extremely</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Have you had difficulty concentrating? (e.g. on reading, conversation, tasks, or making plans)</td>
<td>Not at all</td>
<td>A little</td>
<td>Moderately</td>
<td>Quite a lot</td>
<td>Extremely</td>
</tr>
<tr>
<td>2 Have you been sleeping (or wanting to sleep) a lot?</td>
<td>Not at all</td>
<td>A little</td>
<td>Moderately</td>
<td>Quite a lot</td>
<td>Extremely</td>
</tr>
<tr>
<td>3 Have you been tense?</td>
<td>Not at all</td>
<td>A little</td>
<td>Moderately</td>
<td>Quite a lot</td>
<td>Extremely</td>
</tr>
<tr>
<td>4 Have you had vivid, unpleasant dreams?</td>
<td>Not at all</td>
<td>A little</td>
<td>Moderately</td>
<td>Quite a lot</td>
<td>Extremely</td>
</tr>
<tr>
<td>5 Have you felt irritable?</td>
<td>Not at all</td>
<td>A little</td>
<td>Moderately</td>
<td>Quite a lot</td>
<td>Extremely</td>
</tr>
<tr>
<td>6 Have you been tired?</td>
<td>Not at all</td>
<td>A little</td>
<td>Moderately</td>
<td>Quite a lot</td>
<td>Extremely</td>
</tr>
<tr>
<td>7 Have you been agitated?</td>
<td>Not at all</td>
<td>A little</td>
<td>Moderately</td>
<td>Quite a lot</td>
<td>Extremely</td>
</tr>
<tr>
<td>8 Have you felt that life is not worth living?</td>
<td>Not at all</td>
<td>A little</td>
<td>Moderately</td>
<td>Quite a lot</td>
<td>Extremely</td>
</tr>
<tr>
<td>9 How active have you been compared to your usual level of activity?</td>
<td>Usual level of activity</td>
<td>A little less active</td>
<td>Moderately less active</td>
<td>Quite a lot less active</td>
<td>No activities at all</td>
</tr>
<tr>
<td>10 Have you felt anxious?</td>
<td>Not at all</td>
<td>A little</td>
<td>Moderately</td>
<td>Quite a lot</td>
<td>Extremely</td>
</tr>
<tr>
<td>11 Have you lost interest in things or no longer take pleasure in them?</td>
<td>Not at all</td>
<td>A little</td>
<td>Moderately</td>
<td>Quite a lot</td>
<td>Extremely</td>
</tr>
<tr>
<td>12 Have you found it difficult to trust other people?</td>
<td>Not at all</td>
<td>A little</td>
<td>Moderately</td>
<td>Quite a lot</td>
<td>Extremely</td>
</tr>
<tr>
<td>13 Have you felt sad?</td>
<td>Not at all</td>
<td>A little</td>
<td>Moderately</td>
<td>Quite a lot</td>
<td>Extremely</td>
</tr>
<tr>
<td>14 Have you felt as if your movements were slow?</td>
<td>Not at all</td>
<td>A little</td>
<td>Moderately</td>
<td>Quite a lot</td>
<td>Extremely</td>
</tr>
<tr>
<td>15 In the past 24 hours, how much of the time have you been craving for amphetamines?</td>
<td>None of the time</td>
<td>A little of the time</td>
<td>Moderate amount of the time</td>
<td>Quite a lot of the time</td>
<td>All of the time</td>
</tr>
<tr>
<td>16 How strong has your craving for amphetamines been?</td>
<td>No craving</td>
<td>A little</td>
<td>Moderately</td>
<td>Quite a lot</td>
<td>Extremely</td>
</tr>
</tbody>
</table>

Scale range 0–64
Appendices

Appendix 7: Cannabis Withdrawal Assessment Scale


Scale accessed via doi:10.1371/journal.pone.0044864.t001.

Cannabis Withdrawal Scale

Instructions: This version of the 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.

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).


Scale and instructions downloaded using doi: 10.1371/journal.pone.0044864.t001.

<table>
<thead>
<tr>
<th>Item</th>
<th>Statement</th>
<th>Not at all</th>
<th>Moderately</th>
<th>Extremely</th>
<th>Negative Impact on daily activity (0–10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>The only thing I could think about was smoking some cannabis</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>2</td>
<td>I had a headache</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>3</td>
<td>I had no appetite</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>4</td>
<td>I felt nauseous (like vomiting)</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>I felt nervous</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>6</td>
<td>I had some angry outbursts</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>7</td>
<td>I had mood swings</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>8</td>
<td>I felt depressed</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>9</td>
<td>I was easily irritated</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>10</td>
<td>I had been imagining being stoned</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>
Appendices

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Not at all</th>
<th>Moderately</th>
<th>Extremely</th>
<th>Negative Impact on daily activity (0–10)</th>
</tr>
</thead>
<tbody>
<tr>
<td>11</td>
<td>I felt restless</td>
<td>0 1 2 3</td>
<td>4 5 6</td>
<td>7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>I woke up early</td>
<td>0 1 2 3</td>
<td>4 5 6</td>
<td>7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>I had a stomach ache</td>
<td>0 1 2 3</td>
<td>4 5 6</td>
<td>7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>I had nightmares and/or strange dreams</td>
<td>0 1 2 3</td>
<td>4 5 6</td>
<td>7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>Life seemed like an uphill struggle</td>
<td>0 1 2 3</td>
<td>4 5 6</td>
<td>7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>16</td>
<td>I woke up sweating at night</td>
<td>0 1 2 3</td>
<td>4 5 6</td>
<td>7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>17</td>
<td>I had trouble getting to sleep at night</td>
<td>0 1 2 3</td>
<td>4 5 6</td>
<td>7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>18</td>
<td>I felt physically tense</td>
<td>0 1 2 3</td>
<td>4 5 6</td>
<td>7 8 9 10</td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>I had hot flushes</td>
<td>0 1 2 3</td>
<td>4 5 6</td>
<td>7 8 9 10</td>
<td></td>
</tr>
</tbody>
</table>
Appendices

Appendix 8: Depression, Anxiety and Stress Scale (DASS)


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.
Appendices

<table>
<thead>
<tr>
<th>DASS</th>
<th>Name:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please read each statement and circle a number 0, 1, 2 or 3 which</td>
<td></td>
<td></td>
</tr>
<tr>
<td>indicates how much the statement applied to you over the past week.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>There are no right or wrong answers. Do not spend too much time on</td>
<td></td>
<td></td>
</tr>
<tr>
<td>any statement.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>The rating scale is as follows:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0 Did not apply to me at all</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 Applied to me to some degree, or some of the time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 Applied to me to a considerable degree, or a good part of time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 Applied to me very much, or most of the time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 I found myself getting upset by quite trivial things</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>2 I was aware of dryness of my mouth</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>3 I couldn’t seem to experience any positive feeling at all</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>4 I experienced breathing difficulty (e.g. excessively rapid</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>breathing, breathlessness in the absence of physical exertion)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 I just couldn’t seem to get going</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>6 I tended to over-react to situations</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>7 I had a feeling of shakiness (e.g. legs going to give way)</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>8 I found it difficult to relax</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>9 I found myself in situations that made me so anxious I was most</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>relieved when they ended</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 I felt that I had nothing to look forward to</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>11 I found myself getting upset rather easily</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>12 I felt that I was using a lot of nervous energy</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>13 I felt sad and depressed</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>14 I found myself getting impatient when I was delayed in any way</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>(e.g. lifts, traffic lights, being kept waiting)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>15 I had a feeling of faintness</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>16 I felt that I had lost interest in just about everything</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>17 I felt I wasn’t worth much as a person</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>18 I felt that I was rather touchy</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>19 I perspired noticeably (e.g. hands sweaty) in the absence of</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>high temperatures or physical exertion</td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 I felt scared without any good reason</td>
<td>0 1 2 3</td>
<td></td>
</tr>
<tr>
<td>21 I felt that life wasn’t worthwhile</td>
<td>0 1 2 3</td>
<td></td>
</tr>
</tbody>
</table>
**Reminder of rating scale:**

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

<table>
<thead>
<tr>
<th></th>
<th>Description</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>I found it hard to wind down</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>23</td>
<td>I had difficulty in swallowing</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>24</td>
<td>I couldn’t seem to get any enjoyment out of the things I did</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>25</td>
<td>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)</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>26</td>
<td>I felt down-hearted and blue</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>27</td>
<td>I found that I was very irritable</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>28</td>
<td>I felt I was close to panic</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>29</td>
<td>I found it hard to calm down after something upset me</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>30</td>
<td>I feared that I would be ‘thrown’ by some trivial but unfamiliar task</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>31</td>
<td>I was unable to become enthusiastic about anything</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>32</td>
<td>I found it difficult to tolerate interruptions to what I was doing</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>33</td>
<td>I was in a state of nervous tension</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>34</td>
<td>I felt I was pretty worthless</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>35</td>
<td>I was intolerant of anything that kept me from getting on with what I was doing</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>36</td>
<td>I felt terrified</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>37</td>
<td>I could see nothing in the future to be hopeful about</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>38</td>
<td>I felt that life was meaningless</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>39</td>
<td>I found myself getting agitated</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>40</td>
<td>I was worried about situations in which I might panic and make a fool of myself</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>41</td>
<td>I experienced trembling (e.g. in the hands)</td>
<td>0 1 2 3</td>
</tr>
<tr>
<td>42</td>
<td>I found it difficult to work up the initiative to do things</td>
<td>0 1 2 3</td>
</tr>
</tbody>
</table>
**Appendices**

<table>
<thead>
<tr>
<th>DASS Scoring Template</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
</tr>
<tr>
<td></td>
</tr>
</tbody>
</table>

Apply template to both sides of sheet and sum scores for each scale: D=depression, A=anxiety, S=stress.
Appendices

Appendix 9: Psychosis Screener


A cut-off score of >3 has been found to be indicative of psychosis.

Psychosis Screener

1. In the past 12 months, have you felt that your thoughts were being directly interfered with or controlled by another person?

....................................................................................................................................................................
....................................................................................................................................................................

1a. Did it come about in a way that many people would find hard to believe, for instance, through telepathy?

....................................................................................................................................................................
....................................................................................................................................................................

2. In the past 12 months, have you had a feeling that people were too interested in you?

....................................................................................................................................................................
....................................................................................................................................................................

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?

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3. Do you have any special powers that most people lack?

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....................................................................................................................................................................

3a. Do you belong to a group of people who also have these special powers?

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....................................................................................................................................................................

4. Has a doctor ever told you that you may have schizophrenia?

....................................................................................................................................................................
....................................................................................................................................................................
Appendices

Appendix 10: Problem-solving practice sheet

What exactly is the problem?
Stand back from the problem and imagine that you are advising a friend. Write it down:

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Brainstorm solutions
Make a list of all possible solutions, even silly ones.

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Look at your list of brainstormed solutions and cross out any that immediately appear silly or impossible. With the remaining list imagine the possible short- and long-term consequences of each option. Which strategies are possible? Write down your three favourite solutions:
1. ........................................................................................................................................................................
........................................................................................................................................................................
2. ........................................................................................................................................................................
........................................................................................................................................................................
3. .......................................................................................................................................................................
...........................................................................................................................................................................

Implementation/set short-term goals (See Appendix 11)
What do you need to do in order to implement the solution? Rehearse the strategy and consider whether it worked, or could be employed.
Appendices

Appendix 11: Goal-setting worksheet

I am going to....................................................................................................................................................
..........................................................................................................................................................................
..........................................................................................................................................................................
..........................................................................................................................................................................
..........................................................................................................................................................................

The most important reasons I want to achieve this goal are ...........................................................................
..........................................................................................................................................................................
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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) ...................................
..........................................................................................................................................................................
..........................................................................................................................................................................
..........................................................................................................................................................................
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I will start achieving this goal by .......................................................................................................................
..........................................................................................................................................................................
..........................................................................................................................................................................
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I will know when I have achieved this goal because ........................................................................................
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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-framed – worked within a specific time frame
Appendices

Appendix 12: 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.

..........................................................................................................................................................................
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*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.

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*Thoughts*
Your thoughts are those things that you say to yourself that make you want to use. For example:

‘I am nothing but a no-good “junkie”. I’ll never be able to give up.’

‘It’s just one taste. One taste won’t hurt, I deserve just one more taste.’

Jot down your high-risk thoughts.

..........................................................................................................................................................................
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..........................................................................................................................................................................
Appendices

**People**
This includes anyone who, when you are around them, influence you to use. It could include your parents, mates, parole officer etc. For example:
- hanging around with your using mates
- hanging around with people who stress you out.
Jot down your high-risk people.

**Places**
For example:
- places where you used to use
- places where other people are using
- suburbs where your old dealers live
- places where you used to score.
Jot down your high-risk places.

**My reasons for changing my substance use**
Appendices

Appendix 13: Common thinking errors\(^{40}\)

**All or none thinking**  
Interpreting one set-back as meaning total failure.  
‘If I fail one test, I am a total failure.’

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

**Overgeneralisation**  
Expecting that just because something has happened once it always will.  
‘I tried to give up once before but relapsed. I will never be able to give up.’

**Catastrophising**  
Exaggerating the impact of events – imagining the worst case scenario.  
‘I am never going to find somewhere to live. I am homeless and am going to starve to death.’

**Mistaking feelings for facts**  
Often people get confused between feelings and facts.  
‘I feel like a failure, so therefore I am a failure.’

**‘Should’ statements**  
Living in the world of the shoulds, oughts and musts.  
‘I must give up heroin.’

**Personalising**  
Often people blame themselves for any unpleasant event and take too much responsibility for others’ feelings and behaviours.  
‘It’s all my fault, I must have done something wrong.’

**Discounting positive experiences**  
People often discount positive things that happen.  
‘I stayed clean because I didn’t run into any of my using mates.’

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Appendices

Appendix 14: 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 practise controlled breathing. Follow the instructions below.
1. Rate your level of anxiety on a scale from one 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.

Practise 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.
Appendices

**Appendix 15: 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 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 ten slowly), before releasing and feeling the tension drain out of your body (for 15 seconds).
3. Clench your fists and tighten your biceps by drawing your forearms up towards your shoulders. 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.

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Appendices

Appendix 16: 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?
Appendices

Appendix 17: 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 name.
Jump up and down.
Change your posture to a more upright one.
Stretch.
As you breathe say ‘in’, ‘out’ as you inhale and exhale; or on the exhale say ‘calm’ or ‘easy’ or ‘safe’.

Examples of soothing grounding:
Rub nice smelling hand cream slowly into hands and arms and notice the feel and smell.
Say encouraging statements to yourself such as ‘You’re okay, you’ll get through this’.
Think of favourites of any kind of object (e.g. cars) or 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.

Appendices

Appendix 18: 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 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 ... 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 ...
Appendices

Appendix 19: Mindfulness of emotions

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.

43 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.
Appendices

**Appendix 20: Mindfulness of thoughts: cognitive defusion**

The term ‘cognitive defusion’ is used 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.

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’.

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Appendices

Appendix 21: Bill of Rights

Everybody has the right to:
- Make mistakes.
- Change their mind.
- Offer no reasons or excuses for their behaviour.
- Make their own decisions.
- Not to have to work out solutions for other people’s problems.
- Criticise in a constructive and helpful manner.
- Say ‘no’ without feeling guilty.
- Tell someone that they do not understand their position or else ‘do not care’.
- Not have to depend on others for approval.
- Express feelings and opinions.
- Be listened to by others.
- Disagree with others.
- Have different needs, wants, and wishes from other people.
Appendices

Appendix 22: Coming off methamphetamine

- Ensure your environment is safe and low stress.
- Surround yourself with supportive, non-irritating, non-authoritarian people who can provide reassurance without being overly intrusive.
- Find strategies that will help you:
  - cope with mood swings
  - cope with strange thoughts
  - cope with cravings
  - improve sleep.
- Eat healthy food.
- Do some exercise daily.
- Use relaxation techniques.
- Structure your days.
- Concentrate only on the immediate future.
- Identify high-risk situations.
- Break goals up into small parts.
- Don’t start working through distressing past incidents until you are feeling more robust and stable.