

Evidence Based Practice Indicators for Alcohol and Other Drug Interventions: Literature Review

2nd edition

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List of abbreviations and acronyms

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

Foreword

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

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

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

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

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

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

The ***Literature review for evidence based practice indicators for alcohol and other drug interventions*** forms the basis of the best practice indicators and the counsellor guide.

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

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Basic Elements of Treatment

1. General counselling approach

Counselling is a joint endeavour between the counsellor and client involving the development of a therapeutic relationship with treatment plans and goals negotiated and agreed upon, by both parties. A sound therapeutic relationship provides an avenue to communicate respect, understanding, warmth, acceptance, commitment to change and a corrective interpersonal experience (Teyber 2006).

In the general psychotherapy literature there is plenty of evidence that counselling works, but a distinct lack of evidence that particular theoretical approaches to counselling are better than others, the most common conclusion being equivalence between therapies (e.g. Andrews 2001; Lambert & Bergin 1994; McNeilly & Howard 1991). Research specific to AOD treatment also indicates that counselling approaches from different ideological perspectives achieve similar outcomes (Farrell 2001; Hall 2001; National Institute of Drug Addiction 2001). At the same time there is some limited evidence that particular types of treatments suit some clients with some problems better than others (see *Treatment Matching*).

What is clear in both the general psychotherapy and addiction literature, is the importance of the therapeutic alliance to treatment outcome. Specifically, 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 (Andrews 2001; Farrell 2001; Hall 2001; Martin et al 2000; Meier et al 2005).

In addition to the therapeutic relationship, a growing body of research has found a number of counsellor qualities to be associated with successful intervention. The qualities associated with improved outcomes include the ability to develop a therapeutic alliance, the extent to which the counsellor remains true to the techniques of their therapeutic philosophy, and the extent to which the counsellor is judged to be well adjusted, skilled and interested in helping their clients (Luborsky et al 1985). 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 outcomes (McLellan et al 1998).

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

Recognising the importance of therapeutic relationship also raises the issue that therapeutic relationships end. As with working with other painful client themes, issues and emotions that arise for clients in ending need to be responded to with empathy, and often with exploration of their similarities and differences to past experiences. Essentially, as outlined in Teyber (1997), the key principles of ending are:

- letting clients know about the ending well in advance;
- inviting clients to express and explore both positive and negative feelings about ending and about the counsellor, and responding nondefensively to those feelings by reacting with empathy and acceptance; and
- exploring with clients the meaning that the end has for them and for the counsellor.

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 handing the client to another counsellor, spreading out the final sessions is usually not appropriate.

In addition to a good therapeutic relationship, for alcohol and other drug (AOD) use to change for most, a variety of other specific interventions are usually required. Specifically, counsellors should operate from an 'evidence-based' approach which assumes that the basis for the treatment approach adopted with a particular client should be based on an integration of:

- best existing research evidence;
- clinical wisdom and expertise; and
- 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 or addiction pharmacotherapies or admission to a therapeutic community. 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 literature review.

Finally, professional development is an important aspect of general counselling. Continuous reflective practice, supervisory support and other professional development methods will be associated with better outcomes.

General counselling approach – best practice

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

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

General counselling should include the following.

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

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

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

2. Program content

Program content refers to the types of intervention contained within both individual and group programs. The goals of many treatment programs focus on the cessation of drug use. There is, however, a hierarchy of possible goals incorporating various aspects of clients' lives and they may, or may not, incorporate abstinence. Mattick & Hall (1993) argue that harm reduction, for example, can be incorporated into even the most rigid abstinence based programs.

Specific interventions based on a cognitive behavioural orientation have been found to be of particular benefit when working with AOD clients. Specific intervention techniques include: motivational interviewing; goal setting; exploration of the links between thoughts, feelings and behaviours; exploration of and skills for coping with high risk situations; problem solving; relapse prevention and management; interpersonal skills training and relaxation training (Allsop 1990; Baker et al 1996; 2005; 2006; Billings & Moos, 1983; Jarvis et al 1995; Mattick & Hall, 1993; Saunders et al 1996). All of these interventions have been associated with more successful treatment outcomes and lower relapse rates. However, these interventions need to be implemented in a manner that respects the treatment matching literature and needs of special populations.

While research generally recommends cognitive behavioural therapy (CBT) approaches as the primary mode of intervention for AOD treatment, counsellors should not be restricted to this orientation, particularly when working with clients who have complex issues. Cognitive behavioural approaches

have been more researched than most other orientations, but as outlined in Chapter 1, **General Counselling Approach**, research shows that counselling approaches from different ideological perspectives achieve similar outcomes (Farrell 2001; Hall 2001; National Institute of Drug Addiction 2001). Some literature also suggests more process oriented psychotherapy (see Teyber 2006) as a more effective approach for enduring change (Woody et al 1983, 1987), and this approach can be integrated with CBT.

The literature suggests non residential and residential treatment services should have a program that includes individual and group therapy, stress management, social, occupational and assertiveness skills training, relapse prevention and management, and exploration of harm reduction strategies (Heather et al 1989; Mattick & Hall 1993).

There is a growing body of evidence indicating the need for treatment programs to focus on social support and where appropriate, link clients to additional services. McLellan et al (1998) found that enhanced treatment programs linking drug dependent clients into other social services (for example, medical screening, housing assistance, parenting classes and employment services) were significantly more effective than traditional services alone. Clients treated in enhanced programs showed significantly less substance use, fewer physical and mental health problems and better social functioning. This finding is consistent with other research investigating the impact of additional medical, psychiatric and social services to traditional alcohol and other drug treatment, (Chen et al 2006; Gerstein & Harwood 1990; Volpicelli et al 2000).

There is evidence to support the use of family therapy when working with alcohol and other drug clients (Copello et al 2005; Miller & Hester 1986; Stanton et al 1982). Family-based interventions have been found to have a positive impact on the engagement and retention of clients as well as the therapeutic outcomes (Copello et al 2005). Family therapy should only be undertaken when the client has sufficient contact with their family of origin and/or is willing to allow them to become involved in treatment (De Civita et al 2000; Mattick et al 1998). Family therapy should only be undertaken by experienced personnel with specialist training in family therapy.

Program content – best practice

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

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

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

Program content should:

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

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

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

3. Assessment

Assessment should culminate in a summary of the facts and a formulation of clear treatment goals and plans, which are discussed with and acceptable to the client. Assessment can include two components: the assessment interview and the collection of information using standardised questionnaires and assessment tools.

The assessment interview involves the client and counsellor working together to obtain a shared understanding of the nature of the client's difficulties and the client's past and present life story. Groth-Marnat (2003) notes that the assessment interview is probably the single most important means of data collection and that without it, standardised assessment is rendered meaningless. Standardised assessment involves the collection of information via instruments such as questionnaires that have been shown to validly and reliably measure what they purport to measure. The literature acknowledges

the importance of both types of assessment when working with clients who have AOD issues (Davis, 2005; Kleber 1994; McPhail & Wiest 1995; Moore 1998; Winters & Zenilman 1995; Winters 1999).

3.1 The assessment interview

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

- presentation including appearance and behaviour, mental state (see Counsellor Guide for Mental State Examination guide);
- presenting issues;
- drug use history and related harms;
- motivational interviewing - to assess and enhance readiness to change;
- risks including suicidal ideation, self-harm, thought of harming others, experiencing harm from others, safety of children in the client's care;
- previous treatment for drug use, psychological issues or serious illnesses;
- current situation, including accommodation, work/study, support networks;
- background and personal history (family composition and history, childhood experiences, adolescent experiences, experiences of school, occupational history, sexual and marital adjustment, legal issues, financial and housing information and risk taking behaviours);
- how clients view themselves;
- strengths and weaknesses;
- cognitive functioning if cognitive impairment suspected; and
- summary or formulation which consists of a summary of the presenting problems their development and maintenance.

3.2 Standardised assessment

Standardised assessment involves using standardised tools as a means of gathering data (Kauffman & Woody 1995; Moore 1998; Winters 1999; Winters & Zenilman 1995). Standardised assessment should complement the assessment interview by providing support for tentative hypotheses and highlighting important issues that may not have been uncovered previously. It provides an objective view of the client's difficulties and current life situation. Perhaps most importantly, standardised assessment 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 (Gossop 2003; Groth-Marnat 2003). In addition, common measurement of agreed outcomes has the potential to enhance our knowledge of what works for whom (Mattick & Hall 1993; Moore 1998; Winters 1999). Ideally standardised assessment should be completed upon entry into and exit from a treatment program, as well as at post treatment follow up (Mattick and Hall 1993; Winters 1999).

The use of standardised assessment requires training as the tools can be inappropriately used or misinterpreted, over relied on at the expense of integrating findings from the assessment interview, or result in mislabelling clients or inappropriate feedback of results to the clients (Groth-Marnat 2003).

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

For AOD treatment evaluation purposes, there is general agreement about a number of key domains for standardised assessment (Commonwealth Services and Health Training Australia 1997; Darke et al 1992; Gowing et al 2002; Lawrinson et al 2005; Marsden et al 1998). These domains include:

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

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

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

- The BTOM has been adopted in New South Wales for routine AOD treatment outcome monitoring. It takes on average 21 minutes to complete. It assesses level of dependence, quantity and frequency of substance use, blood borne virus risk exposure, psychological functioning, social functioning and client satisfaction. This instrument does not ask about illegal activity other than arrests for offences allegedly committed in the last 3 months. The BTOM includes modules specific to counselling, detoxification, rehabilitation and methadone treatment.
- The OTI is another Australian scale which takes on average 20-30 to complete. It assesses quantity and frequency of substance use, blood borne virus risk exposure, physical health, psychological functioning, social functioning, and illegal activity. Depending upon the circumstances, clients may be unwilling to provide counsellors with the level of detail that is asked about, and it may be unwise for counsellors to have overly detailed information on a client's criminal behaviour in case notes are subpoenaed.
- The MAP is a British scale developed primarily for research purposes which takes about 12 minutes to complete. It addresses quantity and frequency of substance use, blood borne virus risk exposure, physical health, psychological functioning, social functioning, and illegal activities engaged in during the last month. As for the OTI, clients may not feel safe disclosing the level of information requested about illegal activity.

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

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

Screening instruments to alert the clinician to possible psychological difficulties such as psychosis, depression, anxiety, dissociation or posttraumatic stress disorder (PTSD) can also be useful. An instrument with demonstrated reliability and validity for briefly screening for anxiety and depression symptoms is the *Depression, Anxiety, Stress scale (DASS)* (Lovibond & Lovibond 1995). The *Psychosis Screener* (Jablensky et al 2000), which was developed to screen for psychosis in the general population, rather than just in the presence of psychosis, can be useful as a screen for psychotic

symptoms. This instrument, rather than one designed for use with clearly psychotic people, is recommended because often psychotic symptomatology in users of drugs such as amphetamines may not be obvious unless specifically asked about. The instrument is in the process of being evaluated for reliability and validity (see Degenhardt et al 2005). Note that none of the instruments mentioned above is diagnostic. Other instruments to assess particular issues are readily available via searching the web, though some of these may have questionable reliability and validity.

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

Use of standardised assessment measures is often not appropriate for 'one off' sessions or brief intervention and is not usually appropriate when the client is not using AOD (eg clients attending treatment because of a family member's AOD use).

In addition, some clients demonstrate extremely high levels of distress upon entry into a treatment program and results of some standardised assessments, particularly those that take some time to complete, conducted at this time may be misleading. In such situations it can be better to introduce standardised assessment in the second or third session, or to ask the client to complete it over a number of sessions to minimise fatigue. The appropriate introduction of standardised assessment will also mediate how the client feels about completing the questionnaires (Groth-Marnat 2003). The introduction should include:

- providing the client with a rationale for assessment;
- providing the client with an explanation of the purpose of each instrument;
- explaining that it is a standard procedure for all clients in the agency;
- explaining that standardised assessment can be useful because it provides an objective measurement of how successful the client is in achieving his/her goals; and
- providing appropriate feedback of the results of assessment.

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

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

Hillbrant (1998) also suggests that when collecting post treatment follow-up information, it can be better to use an independent evaluator because (a) the rapport developed between clients and agency staff can hinder the collection of accurate information and (b) agency staff may not be available to contact ex-clients at times convenient to them such as evenings and weekends. Another difficulty of collecting follow-up information is keeping track of clients once they leave treatment. Seeking the client's permission to contact a friend or family member to help locate the client 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 agencies to administer too many assessment instruments in addition to the general intake questions and interview. However, it can be very useful to have objective demonstration of client progress, and to have similar measures used across agencies for research and comparison purposes. In addition, it can be useful to objectively assess particular client issues that might arise such as symptoms of depression, anxiety, posttraumatic stress disorder or withdrawal from particular substances.

For treatment evaluation purposes, it is therefore recommended that an instrument like the BTOM, OTI or MAP be used universally and that additional standardised assessment instruments be administered as appropriate. In addition, a client satisfaction scale such as the 8 item CSQ-8 (Appendix 3 in the Counsellor Guide) which takes 5 minutes to complete should be routinely administered on treatment exit (unless the BTOM is used as this contains a clients satisfaction scale).

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

Realistically, with stretched resources and numerous demands on clinician time, the use of standardised instruments will often not occur. Something clinicians and clients often find easier is the use of simple rating scales to reflect the severity of key issues such as drug use, crime, depression etc. These ratings can be compared from start to finish of treatment to gain an idea of change.

Note: see then Counsellor Guide for copies of various assessment instruments

3.3 Feedback

Following completion of assessment procedures, it is important to interpret the results in relation to information collected from the clinical interview. Results and clinical impressions should then be fed back to clients. Feedback should include an exploration of the client's strengths, and then weaknesses, without using labels and in terms appropriate for the client. For example, give the client information in the context of what it means in terms of treatment, use terms that the client can understand and avoid telling a client about suspected psychological diagnoses unless you are qualified to make such diagnoses and it would be in the client's best interests to be told. Assessment results should be fed back to the client in an honest but encouraging and hopeful manner with the aim of providing the client with an enhanced understanding of their difficulties and to provide hope for the future by discussing a treatment plan linked to these addressing these difficulties (Marsh & Dale 2006). Indeed, when done effectively, the process of feeding back to clients their assessment results has been found to contribute to positive therapeutic outcomes, by enabling clients to gain greater insight into their difficulties (Armstrong 2005).

Assessment – best practice

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

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

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

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

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

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

Assessment interview

The assessment interview should cover:

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

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

Standardised Assessment

Standardised assessment:

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

Assessment – best practice (cont.)

Key areas for standardised assessment include:

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

Client engagement and treatment completion should also be recorded.

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

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

Feedback

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

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

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

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

4. Treatment matching

Eliany & Rush (1992) argue that the fundamental purpose of assessment should be to match the individual client to the appropriate treatment intervention, thereby maximising treatment effectiveness. Matching is based on the interaction between the client type (characteristics) and treatment type. Research into treatment matching examines the effects of treatment modality (group or individual psychotherapy), treatment duration or setting (residential or non residential), counsellor (peer or professional) and treatment goal (moderation or abstinence) (Eliany & Rush 1992; Institute of Medicine 1990; Marsh & Dale 2006; Project MATCH Research Group 1998).

Eliany & Rush (1992) outline four factors they consider being important to treatment matching. More recent research has confirmed the importance of these four factors.

4.1 Problem severity

Research has consistently found links between the degree of involvement in a drinking or drug using social network and the treatment intensity required (Beattie et al 1992; Beattie & Longabaugh 1997; Denning 2000; Havassy et al 1991; Project MATCH Research Group 1998). Individuals enmeshed in a social network supportive of continued drinking or drug use require more intensive treatment. Research also demonstrates that clients with differing levels of problem severity tend to benefit from interventions offering differing degrees of structure, with those clients presenting with severe difficulties more likely to benefit from intensive, highly structured treatment programs (Chen et al 2006; Timko & Sempel 2004).

The Project MATCH Research Group (1998) argue that more intensive treatment may take the form of residential treatment or non residential treatment that includes access to group therapy or 12 Step groups (Alcoholics Anonymous (AA), Narcotics Anonymous (NA)). Longabaugh et al (1998) compared 12 Step and Motivational Enhancement Therapy and found that for those clients whose networks were supportive of drinking, 12 Step programs produced significantly better outcomes at three year follow up. As a result, they concluded that AA should be considered irrespective of the form of individual therapy. Those clients with strong social networks supportive of changing drug use or drinking are likely to experience better outcomes with non residential individual therapy.

For alcohol dependent clients, the research also demonstrates that controlled drinking goals are usually indicated for those individuals with a lower severity of dependence, and who believe that controlled drinking is possible (Adams & Sellman 2001). Conversely, abstinence is recommended for those individuals with a prolonged and extensive history of drinking, a high degree of dependence, and for those who believe that abstinence is the only option (Heather 1989; Rosenberg & Melville 2005; Sobell & Sobell 1987). There is some evidence that recommends a period of abstinence prior to the introduction of a controlled drinking regime.

4.2 Cognitive factors

Research indicates that cognitive functioning can impact significantly on treatment effectiveness. Clients with some degree of cognitive damage are likely to benefit from intensive, highly structured residential treatment (Moore 1998). When working with clients who have cognitive damage, generic research indicates the need for highly structured behaviourally based intervention strategies (Barlow & Durand 1995). Therefore core cognitive behavioural approaches to treating AOD problems should be adapted to be more behavioural. For example, some adaptations for poor memory might be to limit the amount covered each session, repeat important things, have clients write things down and keep notes and flashcards with them. Therapy should include a strong life skills component addressing issues of finance, accommodation, domestic duties and involvement in a non substance using community. Typically, cognitive deficits related to chronic use of alcohol and methamphetamine are of primary concern when considering the impact of cognitive factors on treatment process and outcome. When working with this population, choice of treatment strategies should include consideration of the following areas of cognitive functioning in which deficits are commonly observed:

Alcohol:

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

Methamphetamine:

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

- emotional processing.

For a more detailed discussion of the implications of cognitive deficits for the process and outcome of counselling please refer to the *Cognitive Impairment* chapter in this literature review and the counsellor guide.

4.3 Life problems

Eliany and Rush (1992) maintain that specific problems in various aspects of the client's daily living may indicate the need to match clients to specific components of broad based treatment. For example, anxious clients are likely to benefit from additional relaxation training and coping skills training. Furthermore, the Project MATCH Research Group (1998) found that the level of anger was a key factor in treatment matching. Clients experiencing high levels of anger experienced better outcomes from motivation enhancement types of treatment than cognitive behavioural coping skills treatment.

4.4 Client motivation and choice

Researchers maintain the importance of client choice in treatment type to treatment efficacy (Denning 2000; Ward et al 1998b). Eliany & Rush (1992) argue that it is important that clients make informed choices from a range of plausible treatment alternatives. Indeed, research suggests that a variety of benefits ensue from the active participation of clients in the making of decisions about treatment, including increased satisfaction and decreased symptom burden (Adams & Drake 2006).

Client motivation and choice is also relevant to the use of addiction pharmacotherapies (see *Pharmacotherapies for dependence*). Research indicates that methadone maintenance and buprenorphine (Subutex, Suboxone) which have opiate effects are effective treatment options for long term users with severe opiate dependence. Naltrexone maintenance treatment is likely to be successful for clients who place great importance on being drug free and who have a social network supportive of abstinence (Farren 1997).

Prochaska and DiClemente's (1992) transtheoretical model of behaviour change, commonly referred to as the *Stages of change model*, is also relevant to matching specific counselling strategies in terms of client motivation. The model was originally developed through an examination of the stages and process of self-change in smokers. The stages of change model suggests that people attempting to change behaviour move through a number of stages of change: precontemplation (not interested in change), contemplation (seeing the need for change but not yet ready), preparation (putting plans in place for a change attempt), action (implementing change), and maintenance (maintaining change). In their review of 20 years research on the model, Prochaska and Norcross (2001) concluded that tailoring the counselling relationship and clinical interventions to stage of change can significantly enhance outcome. Recommended interventions for clients at each stage include:

- For precontemplators, provide harm reduction information and where possible negotiate safer methods of using.
- For contemplators, motivational interviewing to assist with evaluation of behaviour and increase motivation to change
- For preparers, motivational interviewing to confirm the decision to change, goal setting, planning, identifying triggers for relapse and problem solving.
- For actioners, focus on relapse prevention and management, reinforce the positive changes that have made, assist clients find alternative rewards, problem solve difficulties, encourage clients to start thinking about longer term goals and general life style issues such as study, work and leisure activities.
- For maintainers, continue to reinforce the positive changes that have been made and encourage clients to begin working towards their longer-term lifestyle goals.

4.5 Other client characteristics

Other client characteristics that should be considered include age, gender, level of education, culture, social situation and non-using social support.

Treatment matching – best practice

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

- severity of dependence;
- cognitive functioning⁷
- life problems;
- client motivation and choice;
- gender, age and cultural issues; and
- support networks.

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

- Clients with a higher degree of dependence should be encouraged to engage in more intensive programs that help to develop a social network not supportive of drinking or drug using.
- Clients with higher levels of alcohol dependence are likely to do better with treatment focused on abstinence rather than controlled drinking.
- Residential treatment programs are more strongly indicated for clients with a lack of stable housing or primary relationships, and those clients with a support network supportive of continued using.
- If a client has a support base encouraging continued drinking or drug using, it is recommended that they consider attending at least three sessions of AA/NA in order to assess its appropriateness.
- Clients with high levels of anger respond better to motivational enhancement treatment.
- Core cognitive behavioural AOD treatment approaches should be adapted to be more behavioural to take account of particular cognitive deficits.
- Methadone maintenance and buprenorphine (Subutex², Suboxone³) treatments have been found to be effective for long term users with severe opiate dependence.
- Naltrexone maintenance treatment has been found to be effective for clients highly motivated for abstinence and for those who have networks supportive of ceasing use.
- Counselling interventions should be appropriate to the client's stage of change.

² SUBUTEX® Reckitt Benckiser.

³ SUBOXONE® Reckitt Benckiser.

5. Treatment plans

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

Detailed treatment plans as the basis for intervention with clients are particularly relevant given the complex and multidimensional nature of the problems many clients tend to present with (Gossop 2003), and research indicates they enhance treatment effectiveness (Mattick et al 1998). Clearly developed treatment protocols and well kept case notes have been found to be associated with better therapeutic outcomes (McLellan et al 1988). Regularly reviewed treatment plans, with the client participation in their development and evaluation have been found to produce favourable results in the areas of client satisfaction and treatment success (National Treatment Agency for Substance Misuse UK 2006).

Treatment plans should be jointly negotiated between the counsellor and client and structured around meeting the client's articulated goals and needs (Gossop 2003). Individual program plans should contain:

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

The components of individual program plans should be in accordance with factors considered to be important for treatment success (eg Annis 1990; Eliany & Rush 1992; Helfgott 1997a; Moore 1998; Winters 1999). Important components include practical skill acquisition, addressing psychological difficulties when necessary, building client strengths, addressing support needs and evaluating the outcome.

If evaluation of a client's progress indicates the need for the renegotiation of the treatment plan, it is recommended that this process be done explicitly and together with the client to ensure the client and counsellor continue to be pursuing the same agenda (Gossop 2003).

Treatment plans – best practice

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

Treatment plans should be:

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

Treatment plans should contain:

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

6. Goals of intervention

Goal directed therapy has a long history in therapeutic intervention and is particularly important in terms of outcomes. Jarvis et al (1995) state that goals act as concrete signposts to guide counselling and measure progress over time and Allsop (1997a) maintains that goal setting is important to allow clients to experience success, thus countering the learned helplessness that is common to many drug users. According to Marsh and Dale (2006) goal setting is an integral component of counselling as it ensures that the process remains client focused and directed, irrespective of the counsellor's own theoretical orientation.

Goals of intervention need to be clear, negotiated, geared towards the client's stage of change, specific and observable, broken down into their smallest components and achievable in the short term (Allsop 1997a; Gossop 2003; Heather 2006; Mattick & Hall 1993). Gossop also recommends that goals be stated in positive terms to ensure the client is clear about what they are working towards. Research indicates that clients are more likely to achieve treatment outcomes when those outcomes are consistent with their personal goals (Lozano et al 2006). The literature also suggests that while goals should always be client directed, counsellors should use their expertise and knowledge to guide clients in the formulation of their goals (Adamson & Sellman 2001; Heather 2006; Jarvis et al 1995).

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; and

- how they will know when they have achieved the goal.

The goals of many treatment programs focus on the cessation of drug use. There are, however, other possible goals incorporating various aspects of clients' lives that may, or may not, incorporate abstinence. Mattick & Hall (1993) argue that harm reduction goals can be incorporated into even the most rigid abstinence based programs. Rosenberg & Melville (2005) note that decisions regarding the inclusion of controlled AOD use goals into treatment should depend on the severity of the client's substance use and must take into account the client's own outcome goals. Some research has shown that clients with more severe problems tend to present more frequently with abstinence-based goals compared to those clients with less severe problems who are more likely to present with goals related to moderate use (Adamson & Sellman 2001; Lozano et al 2006).

For alcohol dependent clients, the research regarding goals of controlled drinking versus abstinence demonstrates that controlled drinking goals are usually indicated for those individuals with a lower severity of dependence, and who believe that controlled drinking is possible (Adamson & Sellman 2001). Conversely, abstinence is recommended for those individuals with a prolonged and extensive history of drinking, a high degree of dependence, and for those who believe that abstinence is the only option (Heather 1989; Rosenberg & Melville 2005; Sobell & Sobell 1987). There is some evidence indicating the advisability of a period of abstinence prior to the introduction of a controlled drinking regime.

The National Competency Standards (Commonwealth Services and Health Training Australia 1997) suggest that intervention goals can also include improved physical health, improved psychological health, reduction in criminal behaviour, and improved social adjustment and functioning – all of which are reflected in the Best Practice Indicators.

Goals of intervention – best practice

Goals should be negotiated and:

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

Goals should include:

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

7. Harm reduction

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

Mattick and Hall (1993) argue that harm reduction can be incorporated into even the most rigid abstinence based programs. Harm reduction strategies aim to reduce problems associated with continuing alcohol and/or other drugs, such as:

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

Given the high risk of death following opiate overdose, the following risks have been identified as associated with both fatal and non-fatal overdose (Davidson, 1999) and are useful targets for harm reduction discussion with clients:

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

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

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

Harm from drug use can be conceptualised as occurring in several spheres of life. Roisen (1983) has named these Liver, Lover, Livelihood, and Legal. Using this “4L” framework, the main harms associated with drug use can be conceptualised as follows.

- *Liver* - health problems (eg liver damage, Hepatitis C, overdose, physical harm from car accidents, fights etc).
- *Lover* - social and relationship problems (eg domestic violence, family breakdowns, loss of friends etc).
- *Livelihood* - financial and occupational harm (eg job loss, debt, lack of interest in leisure or study activities etc).
- *Law* - legal problems (eg being arrested for drunk and disorderly conduct, or dealing etc).

Research notes the existence of barriers that prevent safer using strategies (eg the ‘using’ ritual) (Dear 1995; Even 1998; Loxley 1998). The literature recommends using an approach that 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 (Dear 1995; Even 1998; Little et al 1998; Little & Even 1998). Often, counsellors will need to ‘negotiate’ with clients when deciding upon which harm reduction strategies to implement, as in many cases clients may not be willing to implement those strategies which are considered ‘best’ by the counsellor (Marsh & Dale, 2006). It is recommended that counsellors use motivational interviewing to explore the factors constraining clients’ implementation of harm reduction strategies, as well as to reduce any possible ambivalence around safer using (Marsh & Dale).

Harm reduction – best practice

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

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

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

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

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

8. Case management

Case management is a process that coordinates the acquisition and delivery of services to meet individual client needs. It facilitates a holistic approach to client care. Case managers are not expected to provide all the necessary services themselves, but instead to refer to and facilitate engagement with appropriate agencies. Substance users generally present with a myriad of additional issues that need to be addressed during the course of treatment, including general health, living issues, psychological or co-existing psychiatric disorders, employment, education and skills training, legal issues and family

difficulties. The aims of a case management approach are to increase the likelihood that clients receive specialist assistance where needed, and to facilitate client retention and contact with treatment providers, both of which are strongly associated with better treatment outcomes for both AOD using and not using clients (Mejta et al 1997).

While there are a number of different models, Siegal (1998) suggests a number of broad principles of case management, including that it:

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

Case management can include a huge range of elements. Core elements that are almost always present are assessment of the health and social service needs, planning and coordination of these services, monitoring to ensure the client is receiving the services, and client advocacy (Mejta et al 1997, Noel, 2006). Other elements of case management that may or may not be present include relapse prevention, counselling on other life issues, outreach, and taking clients to appointments.

Research into the effectiveness of case management with clients with AOD issues indicates that case management seems to keep clients engaged in treatment, stabilise clients and lead to better treatment outcomes (eg Lanehart et al 1996, McLellan et al 1999; Siegal 1998; Vaughn-Sarrazin et al 2000), improve access to service providers (McLellan et al 1999; Shadi et al 2003) and provides continuity of care (McLellan et al 2005; Willenbring et al 1991).

An essential component of case management is clear and open communication between the relevant professionals involved. This communication should involve clarification of the requirements and boundaries of each specialist, clear establishment of the boundaries of confidentiality and what will be communicated to and by the case manager (or team), and knowledge of other professionals involved and the nature of their involvement in the case. Siegal (1998) suggests a formalised, written record (or contract) of expectations and boundaries of service provision can be useful for both primary and combined case management.

Other important ingredients for good case management include:

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

There is a wide range of case management models available. In Australia, the most common forms of case management are primary and combined (or shared care).

8.1 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). An example would be a corrections officer obtaining services for a client, with the other professionals responsible for reporting feedback to the corrections officer.

8.2 Combined case management

Combined case management (shared care) involves several professionals (often interagency) who work collaboratively as a team to provide multiple services for clients on a case by case basis (Siegal 1998). 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 client need is shared, although accountability for the provision of each service remains with the relevant agency/individual. Frequent communication between the agencies is essential. According to Gossop (2003) a shared care approach to treatment often also enables for the integration of medical care to be incorporated into the client's drug or alcohol treatment program, which is particularly useful when pharmacotherapy is an integral component of the treatment plan.

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

Case management – best practice

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

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

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

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

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

Effective primary and combined case management involves the following:

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

9. Information and advisory services

Although there is no formal research concerning information and advisory services, the provision of information is a central component of many services. Therefore, it is important that counsellors are knowledgeable regarding current information related to the alcohol and other drug field, and have up to date materials suitable for a wide range of clients (eg parents, youth, partners, health and harm reduction information, quitting information; information regarding services statewide).

Information and advisory services – best practice

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

10. Follow up

The importance follow up to improved outcomes for the client has been acknowledged in the literature. Despite the difficulties of following up clients, mainly due to the transient nature of this population, the practice of follow up has great utility as it can provide useful information regarding treatment efficacy, effective components of treatment and relapse rates. In turn, this information can be used to shape future treatments in order to ensure that the alcohol and other drug field is following evidence based treatment procedures (Heather 1995).

Importantly, follow up can also provide the opportunity for brief intervention to diminish the build up of crises that often result in clients re-seeking treatment. Follow up provides clients with a sense of care and commitment on behalf of the service provider and may result in the client being more likely to re-engage in treatment should the need arise.

The importance of, and format for, follow up should be explained to clients prior to the cessation of treatment. Clients should be given the option to participate in follow up. It can be useful to seek permission from the client to contact a friend or family member in the event that contacting the client proves difficult. It should be considered a significant (not additional) component of the treatment program, with the next follow up session being scheduled while the client is still engaged in treatment. Reminder phone calls also help to keep track of clients as well as increasing the chance of clients attending follow up.

Ideally, all clients should be engaged in follow up within one to three months at the conclusion of treatment. It is recommended that follow up sessions primarily consist of rapport re-establishment, discussions of drug use and current issues facing the client, and the completion of the standardised assessment instruments that were used on entry into the program. Follow up procedures can be offered via an individual or group format. Group follow up procedures may be more cost and time effective and provide clients with a support network. In instances where face to face contact is not possible, telephone or written contact is sufficient.

Follow up – best practice

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

- Despite the difficulties of following up many drug using clients, follow up be conducted.
- Follow up should be arranged within one to three months at the conclusion of treatment.
- Preference should be given to face to face (individual or group) or telephone contact, however, even written contact has benefit.
- The importance of, and format for, follow up procedures should be explained to clients prior to discharge. Clients should be given the option to participate in follow up.
- The follow up session should be scheduled prior to the client leaving the program.
- Clients should be followed up (where possible) regardless of whether they have relapsed.
- Follow up procedures should offer continued support, referral to another service, referral to self help groups or re-engagement in the program where appropriate.

11. Brief intervention

Brief intervention refers to short interventions, usually one to five sessions. Brief interventions can be conducted in general health care settings as well as AOD-specific settings.

Brief interventions often include the provision of self help materials and may extend to a brief assessment, providing advice or information (in a one off session), assessment and feedback of the client's readiness to change (motivational interview), problem solving, goal setting, relapse prevention, harm reduction and follow up (Heather 1995). Additional components of brief interventions can include building social support networks, cognitive restructuring, assertiveness skills, communication skills, self-efficacy training, lifestyle modification, coping strategies for withdrawal symptoms; relaxation techniques and controlled use strategies (Baker et al 2001, 2005; Copeland et al 2001; Dennis et al 2004; Lang et al 2000; Martinet al 2005).

Research indicates that brief interventions can be useful for clients who are experiencing few problems related to their substance use, have low levels of dependence, or who are not wishing to substantially reduce their drug use (Gossop 2003; Heather 1995; Stephens et al 2004). Brief interventions have been found to be a particularly useful means of accessing populations of clients who are resistant to the idea of treatment (Bernstein et al 2005; Peterson et al 2006). Several randomised controlled trials have demonstrated that brief intervention is beneficial in treating cannabis dependence (Copeland et al 1999, 2001; Dennis et al 2004; The Marijuana Treatment Project Research Group, 2004). Recent research also suggests that brief interventions can effectively treat benzodiazepine, cocaine, heroin and amphetamine dependence (Baker et al 2001, 2005; Bernstein et al 2005; Heather et al 2004). Some evidence suggests that brief interventions can also be useful for prompting clients (even those with more severe levels of dependence) to access more structured and intensive treatment (Tait et al 2004).

Brief interventions are not considered suitable for more complex clients with additional psychological and psychiatric issues, clients with severe dependence, clients with poor literacy skills, or clients with

difficulties related to cognitive impairment. In these instances, more in depth intervention is recommended (Baker et al 2001; Heather 1995).

There is also a growing body of evidence implicating the utility of brief interventions as a means to communicate and implement harm reduction strategies (Baker et al 1996; Jarvis et al 1995; Sanchez-Craig 1990; Stein et al 2002; Tait et al 2004).

While brief intervention can result in significant gains at minimum cost, generalist workers conducting brief interventions will not replace the need for specialist alcohol and other drug treatment (Heather 1995; Mattick & Hall 1993; Roche & Freeman 2003).

Brief intervention – best practice

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

Brief intervention is recommended for clients with:

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

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

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

Multiple sessions could include:

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

12. Withdrawal management

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

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

- providing information about what to expect to clients and support people as this can help to allay some of their fears and concerns (Allen et al., 2005);
- helping clients develop a plan to cope with the withdrawal;
- ensuring appropriate support;
- organising access to medication as needed by linking the client with doctor or a home-based withdrawal service – there are some very effective medications available for some drugs; and

- helping them to plan follow-up support and treatment.

Various booklets are available that provide clients with information about what to expect, and tips for managing the process. It is useful to provide written information so clients can go over the information themselves as they often do not absorb it all on hearing it once. Examples of useful written information include a range of small booklets produced by Turning Point Alcohol and Drug Centre in Victoria for clients to assist them with withdrawal from alcohol, amphetamine, heroin and methadone, and a booklet on quitting cannabis produced by the National Drug and Alcohol Research Centre in NSW.

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

- the drugs being used;
- the severity of dependence and hence the degree to which neuroadaptation must be reversed
- co-existing medical, psychological or psychiatric issues;
- psychosocial factors such physical environment, support, expectations, motivation and fears;
- the client's reasons for withdrawing; and
- the client's motivation for abstinence.

(Allen et al 2005; Mattick & Hall 1993; Saunders et al 2002)

Specialist inpatient withdrawal is most appropriate when:

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

(Saunders et al., 2002; Wesson 1995)

Outpatient withdrawal is most appropriate when:

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

(Saunders et al., 2002; Wesson 1995)

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

Several other issues of note:

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

- Inpatient withdrawal management should never be insisted upon. For example some women may feel unsafe in an inpatient environment (Swift & Copeland, 1998), particularly if they have a history of sexual abuse. In such instances premature discharge can occur.
- Pregnant women should always be referred to a specialist drug and alcohol services and linked with obstetric services, and withdrawal management should usually occur as an inpatient as some withdrawal symptoms can place the pregnancy at risk.

12.1 Alcohol

The cessation of alcohol use can be dangerous and potentially life threatening without medication in clients with significant physical dependence. Symptoms of alcohol withdrawal may include increased body temperature, nausea, vomiting, tremors, tachycardia (rapid heart beat), sweating, hypertension, anxiety/irritability, depression, agitation, and insomnia (Cohagan et al 2005; Saunders et al 2002). In the most severe cases of alcohol withdrawal (complicated withdrawal), clients can develop life threatening symptoms including grand mal tonic-clonic fits, and delirium tremens (DTs). Delirium tremens involve severe hyperactivity, severe tremor and agitation, clouding of consciousness, disorientation and hallucinations. A medical practitioner should therefore always be involved in treatment of a client with significant alcohol dependence. Most withdrawals settle over 5 days or so, though anxiety, depression and sleep problems can last longer.

Various medications, including benzodiazepines, are effective in assisting with alcohol withdrawal symptoms, including seizures. Whether benzodiazepines are better than various alternatives, however, is unclear, as to date the research has used different interventions and assessment of outcome (Ntasi et al 2005).

12.2 Benzodiazepines

The sudden cessation of benzodiazepines (both short and long acting), can be dangerous and potentially life threatening in clients with significant physical dependence. Symptoms of benzodiazepine withdrawal can include aches and pains, muscle twitching, muscle spasms, muscle stiffness, tremor, headaches, visual disturbance, dizziness, nausea/vomiting/diarrhoea, agitation, irritability, anxiety, panic attacks, depression, insomnia and visual disturbances (Saunders et al 2002). In the most severe cases of benzodiazepine withdrawal (complicated withdrawal), clients can develop life threatening symptoms including grand mal tonic-clonic fits, delirium, clouding of consciousness, paranoid ideations/delusions, visual and auditory hallucinations, and suicidal thoughts. Although many acute withdrawal symptoms will settle within 2-3 weeks, many withdrawal symptoms, particularly anxiety, depression and sleep problems, can last much longer.

The correlation between benzodiazepine dose and duration of use to the incidence and severity of benzodiazepine withdrawal remains to be quantified (Copeland 1998). Withdrawal from benzodiazepines should always be undertaken under medical supervision due to the risk of serious and potentially life threatening withdrawal symptoms.

Withdrawal from dependence on benzodiazepines usually entails switching the client from short to long acting benzodiazepines (usually diazepam), and then gradually reducing the dose. Due to the risk of clients suffering serious withdrawal symptoms Gossop (2003) recommends that withdrawal for these clients occur in an in-patient setting. However a slow out-patient withdrawal regime under medical supervision is usually quite safe.

12.3 Opiates

Withdrawal from opiates will result in a number of symptoms including flu like signs and anxiety. Specifically symptoms include dilated pupils, lacrimation (runny eyes), yawning, hot and cold flushes, perspiration, rhinorrhoea (runny nose), piloerection (goose flesh, abdominal and muscle cramps,

diarrhoea, backache, nausea/vomiting restlessness, anxiety, irritability, depression and insomnia (Cohagan et al 2005; Saunders et al 2002). These symptoms are not life threatening but are very uncomfortable. Withdrawals last longer for some opiates than others. Most symptoms will settle over 5 days for heroin, over 21 days for methadone, and over a longer period for buprenorphine. Anxiety, depression and sleep problems, however, can last much longer. Withdrawals tend to be more severe for heroin than for the longer acting methadone and buprenorphine.

The management of withdrawal symptoms may be medicated or non medicated, though the withdrawal is generally considerably more comfortable if medicated. Opiate agonist pharmacotherapies (methadone and buprenorphine) and clonidine hydrochloride⁴ are effective in relieving withdrawal symptoms and can be used on an inpatient or outpatient basis (Mattick & Hall 1993). The effects and pattern of symptoms observed with opiate pharmacotherapies as opposed to clonidine hydrochloride are different, with unpleasant side-effects more likely with clonidine, but a longer withdrawal period with opiate agonist pharmacotherapies. Clonidine markedly reduces blood pressure, and is not suited to some clients as it drops their blood pressure to dangerously low levels. Therefore blood pressure needs to be monitored when clonidine is used to aid opiate withdrawal.

Clients on opiate agonist pharmacotherapies as maintenance treatment should not be encouraged to withdraw from the treatment if it is against their wishes or the advice of the prescribing doctor (Ward et al 1998d). Ward et al (1998d) recommend that in the case of dual dependence on benzodiazepines and opiates that clients should not be encouraged to withdraw from both benzodiazepines and at the same time but withdraw from benzodiazepines first.

Research on the relative effectiveness of inpatient and outpatient withdrawal programs for opiate users found that those clients undergoing inpatient withdrawal were significantly more likely to complete withdrawal than the outpatient group (Gossop et al 1986, 2000). However, whether this is due more to the location of the services, or the intensity of the services in the program is unclear (Mattick & Hall 1993).

Abrupt withdrawal from opiates is not recommended during pregnancy, with methadone maintenance treatment recommended in this instance.

12.4 Amphetamines

During the initial “crash” period (usually 1-2 days) clients may experience exhaustion, excessive sleep, restlessness, paranoia, irritability, anxiety, depression, hallucinations and delusions, and decreased appetite. The withdrawal phase which follows includes depression, anxiety, irritability and anger outbursts, lethargy, increased appetite and strong cravings to use (Cohagan et al 2005; Saunders et al 2002). Many symptoms of withdrawal can last up to months, but acute symptoms tend to peak within 1-2 days of abstinence (Dyer & Cruickshank 2005).

To date there are no clear evidence based psychological or pharmacological strategies for managing amphetamine withdrawal (Proudfoot & Teesson 2000, Srisurapanont et al 2007). There is clinical agreement, however, that psychosocial support should be provided in a safe, non-threatening environment, and that medication should be prescribed on an individual basis for symptomatic relief when indicated (Jenner & Saunders 2004).

For amphetamine dependent clients with high levels of functioning home withdrawal is often appropriate (e.g. Hando et al 1997). However many clients with severe methamphetamine dependence suffer such severe withdrawals and cravings that an inpatient withdrawal is necessary.

⁴ CATAPRES® Boehringer Ingelheim.

12.5 Cannabis

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

To date there are no medications approved specifically for treating cannabis dependence and withdrawal though research is underway (Hart, 2005), though medication for symptomatic relief can at times be useful. Inpatient withdrawal treatment is rarely appropriate for cannabis dependence.

12.6 Scales for assessing withdrawals

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

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

12.7 For more detailed information

For more detailed information on assisting clients with withdrawal, see Saunders et al. (2002)

Clinical protocols for detoxification: General practise and community settings:

<http://www.health.qld.gov.au/atods/documents/24905a.pdf>

<http://www.health.qld.gov.au/atods/documents/24905b.pdf>

Withdrawal management – best practice

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

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

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

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

Specialist inpatient withdrawal is most appropriate when:

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

Outpatient withdrawal is most appropriate when:

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

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

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

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

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

Non using significant others should be engaged as supports.

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

13. Therapeutic communities

A wide range of treatment options should be available for those wishing to change their substance use, as different treatments suit different people at different stages of their drug using careers (Gowing et al 2002). To date, treatment options have primarily consisted of minimal interventions, inpatient and outpatient withdrawal management, pharmacotherapies, outpatient counselling and therapeutic communities (TCs).

Gowing et al (2002) reviewed the literature on outcomes from TCs and concluded that it was difficult to draw clear conclusions about the effectiveness of TCs compared to other treatments due to bias and confounding factors in the research. However they did conclude that multiple follow-up studies provide evidence that TC treatment is associated with reduced drug use and criminality even two years post treatment, significantly improved psychological and physical health, and trends to increased involvement in work, education and training.

Although TCs vary, several key features are characteristic of them all (Gowing et al 2002, p. 17):

- “Residents participate in the management and operation of the community.
- The community, through self-help and mutual support, is the principal means for promoting behavioural change.
- There is a focus on social, psychological and behavioural dimensions of substance use, with the use of the community to heal individuals emotionally, and support the development of behaviours, attitudes and values of healthy living”.

Although there is limited evidence regarding which clients are suited to TCs, the research that does exist is consistent. There is evidence to suggest that residential treatment is appropriate for alcohol dependence where the client is a chronic drinker with a long history of drinking and a high level of dependence, suffers cognitive damage as a result of alcohol abuse, is homeless or needs an alternative environment for respite (Eliany & Rush 1992; Project MATCH Research Group 1998). TC treatment is also indicated for alcohol dependent clients whose social networks are supportive of continued drinking (Project MATCH Research Group 1998).

In terms of the suitability of TCs for clients using other drugs (and alcohol in many cases), Melnick et al (2001) identified four decision points:

1. Outpatient treatment is recommended for low risk drug use. High risk drug using clients enter the next decision point.
2. Outpatient treatment is recommended for clients who have one or more years of abstinence in the last 4, or who have been using for less than four years. Clients who do not meet this criterion move to the next point.
3. Residential treatment is recommended if social factors do not support abstinence (drug-use in living environment, peer involvement with drugs, criminal behaviour) and are considered high-risk. Other clients move to the final decision point.
4. Residential treatment is recommended for clients who have few skills for earning a living (did not complete high school or technical training, do not have sufficient work skills and experience to earn a living). Others are referred to outpatient treatment.

This matching process was found in their research on 725 adult clients entering 9 TCs in the USA to improve 12 month retention and treatment completion. They also found independent effects for external motivation from legal pressure, and internal motivation as assessed by motivation-readiness scales. The study was limited by a small sample of mismatched clients but results were nevertheless strongly suggestive that matching improved outcomes.

There is also evidence that modifications made to TCs to suit particular subgroups of clients can improve retention and performance on outcome measures. For example De Leon et al. (2000) found

that a low intensity program resulted in better retention and outcome than a moderate intensity program for homeless clients with mental health disorders. Fals-Stewart & Schafer (1992) found improved outcomes for AOD clients with obsessive-compulsive disorder (OCD) when they received specific OCD treatment. Gowing et al (2002) note that adapting TCs to address cultural issues is also likely to be important. They recommend that TCs should explore ways of modifying their programs to suit different individual clients, and assess the impact of these modifications. Their suggestions for modifications include altering the intensity of the program, including additional elements for specific client needs (such as family involvement, parenting training, treatment for psychological disorders, culture-specific variations), introducing introductory programs to prepare clients, increasing the coordination of aftercare services, varying the timing of the various TC elements, and conducting research to explore the effectiveness of methadone withdrawal within the context of a TC program.

There is also evidence that residential TC programs are more effective when a broad range of treatments and interventions are involved, including access to medical care, both individual and group counselling, as well as life skills training, training or employment options and recreation options (Gerstein & Harwood 1990; Moore 1998; Timko et al 2000). Anecdotal evidence suggests that many clients desire additional activities to maintain high levels of motivation and interest. Maintaining such levels of motivation and interest is likely to increase clients' levels of engagement and satisfaction, which has been demonstrated to contribute to more positive treatment outcomes (Hser et al 2004). The duration of treatment has also consistently been identified as contributing to the efficacy of treatment outcomes, with longer durations associated with better outcomes (at least 3 months and as long as a year) (Broekaert, 2006; Gossop, 2003; Hser et al 2004; Moos et al 1999; Zhang et al 2003).

Once clients have stabilised on the program, they should be encouraged to begin to seek out employment, training, volunteer, or leisure activities of interest to them. It is important that clients be encouraged to explore options of interest that fill in time, help restore faith in the future and consequently, minimise relapse rates. It is envisaged that this will also encourage re-integration into a non using life style, and therefore increase the quality of clients' post treatment lifestyle, a significant indicator of the maintenance of abstinence (Gossop 2003).

Therapeutic communities – best practice

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

TC treatment should be considered for clients who:

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

Therapeutic community programs should be broad based and include:

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

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

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

14. 12-Step self help groups

Evidence exists to support the utility of having a wide spectrum of treatment approaches, including self help groups. The most common self help groups are AA and NA.

Research into the efficacy of 12 Step groups has been bedevilled by methodological difficulties including variations in terms of whether the 12 step treatment is stand alone or in the context of a treatment program. Most research is cross sectional and correlational with retrospective assessment of variables undertaken at a single point in time, there are variations in whether outcome is measured by attendance only or by level of involvement in the program itself, some participants are coerced, and power is often low (see Kelly 2003).

However, recently conducted sound research in the form of controlled trials and longitudinal studies in which causal links are examined indicate that involvement in self help groups such AA and NA is helpful and leads to better treatment outcomes (most of this research is focused on AA, with some limited examination of NA). Indeed evidence suggests that twelve-step treatment programs can be just

as effective as cognitive-behavioural treatment programs (Crits-Christoph et al 1999, Finney et al 2001, cited in Gossop 2003; Moos et al 1999; Project MATCH Research Group, 1997, 1998).

The relapse literature also identifies the utility of linking individuals to self help groups. A key feature distinguishing those individuals who relapse from those who maintain change is their quality of lifestyle post change including housing, employment and relationships (Allsop 1997b; Billings & Moos 1983). Billings and Moos (1983) argue that perhaps one of the most significant predictors of relapse is a lack of non drug using social support. Provision of non drug using social support is probably the most powerful aspect of 12 Step groups (Gossop, 2003). Indeed, the treatment matching literature indicates that for those individuals with social networks supportive of continued drinking or drug use, access to 12 Step groups can be an integral component of successful treatment as a mechanism for providing alternative sources of social support, leisure and modelling of prosocial, non-drug-related behaviours (Longabaugh et al 1998; Project MATCH Research Group 1998, Gossop 2003).

The literature suggests that perhaps the most successful use of a 12 Step group is as continuing after care treatment as it provides essential social support and is readily accessible in most communities (Bradley 1988; Gossop 2003; Kirby 2004). Self-help programs are also increasingly considered in terms of their ability to complement other forms of treatment (Fiorentine & Hillhouse 2000; Gossop 2003; Humphreys et al 2004; Moos et al 1999). It is suggested that 12 Step groups be recommended to anyone who is open to their philosophy, has a high level of dependence on alcohol or drugs, and has few non AOD using social supports (Eliany & Rush 1992; Ouimette et al 2001).

Although drop out rates from 12 Step groups are high (Kelly 2003), the likelihood of clients actively engaging in the group are increased if counsellors facilitate referral to appropriate groups (Humphreys et al 2004). Clients should be made aware of the services offered by NA, and those who are interested are encouraged to attend for at least three meetings (Mattick & Hall 1993). Counsellors should know where and how to refer clients to NA.

Kelly (2003) reviewed evidence regarding who 12 Step groups suit or do not suit. He concluded that they equally suit religious and non-religious people, and men and women, that the extent to which young people benefit was largely unstudied, that people with psychosis attend and benefit less than others, that people with depression become less socially involved, and that people with PTSD benefit as much as people with an AOD disorder alone.

12 Step self help groups – best practice

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

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

15. Sobering up centres (SUCs)

Sobering up centres (SUCs) were established in Western Australia in response to the *Detention of Drunken Persons Act 1989*, which decriminalised public drunkenness in Western Australia. Establishment of SUCs is also consistent with recommendations in the *Royal Commission into Aboriginal Deaths in Custody – Final Report* (1991). There are currently 12 sobering up centres operating in metropolitan and regional WA. SUCs also operate in other states.

A SUC is defined as a safe place where an intoxicated person may receive care and respite until the effects of the substances consumed has dissipated. As such, the primary purpose of a SUC is to provide a safe, care oriented environment in which persons found drunk in public may sober up, thereby reducing the risk of harm to themselves or others and diverting them from police lock ups (WA Drug Abuse Strategy Office 1998; Brady et al 2006).

For a SUC to operate effectively it needs the support of local police, community patrols and health and welfare services. In order to achieve this, the establishment of a SUC should follow a community development process, whereby all local key stakeholders are consulted and included. According to Brady et al (2006), the centres tend to have wide spread support from the communities which they serve.

At minimum, SUCs should offer clients a shower, clean bed and laundering of clothes (worn by the person at admission). Clients need to be observed regularly to ensure that they are sobering up safely. The centres do not provide medical intervention. Therefore in the event of physical complications during the sobering up process, the person should be sent to the nearest hospital. Withdrawal from alcohol and benzodiazepines can be particularly dangerous, and staff need to be able to recognise symptoms of a severe withdrawal syndrome in order to access medical services if required. The staff of SUCs should have training in first aid and be able to recognise medical conditions requiring hospital referral. They also need to be well trained in managing intoxicated people, critical incidents, and in procedures associated with observation.

SUCs may be the first point of contact for many potential AOD clients. Therefore, it is important that they are able to provide clients with a link to further treatment and other health and welfare services when there is the opportunity to do so. They also provide the opportunity for brief intervention strategies to be implemented (Brady et al 2006).

Data collected by the Drug and Alcohol Office (2007) indicate that admissions to SUCs in WA increased 13-fold since their establishment in 1991 and 2005, the number of intoxicated people detained in police lock-ups declined between 1992 and 2005 by 84% (Drug and Alcohol Office, 2007), and the SUCs have resulted in a number of positive outcomes (Drug and Alcohol Office, 2007):

- reduced police time and resources managing intoxicated people in lock ups;
- reduced court time and resources;
- reduced domestic violence and other alcohol-related problems; and
- reduced hospital burden because of fewer alcohol related illnesses and accidents requiring hospitalisation.

The Drug and Alcohol Office (2007) also notes that communities in which there is a SUC tend, over a period of time, to develop additional services to address alcohol related problems such as outreach programs, community patrols, homeless support programs, alcohol and other drug education programs and initiatives to restrict alcohol availability.

Sobering up centres – best practice

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

Sobering up centres should:

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

The following is recommended for staff of sobering up centres:

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

16. Pharmacotherapies for dependence

There are a number of pharmacotherapies for opiate and alcohol dependence. Pharmacotherapies should not be seen as stand alone treatments but are optimally used in conjunction with counselling (Mattick & Hall 1993). Counsellors need a basic understanding of pharmacotherapies as they may find themselves working with increasing numbers of clients who are prescribed these medications.

16.1 Pharmacotherapies for opioid dependence

Pharmacotherapies for opioid dependence generally fall into two categories:

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

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

Methadone

Methadone is a synthetic opioid that was developed in 1941 in Germany for the relief of pain. It has been used as a treatment for opiate dependence for nearly 40 years and is the most common addiction

pharmacotherapy used in Australia. Methadone in the form of methadone syrup⁵ or methadone liquid⁶ is approved by the Therapeutic Goods Administration (TGA) as a maintenance and withdrawal treatment for opiate dependence. It is a schedule 8 drug.

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

Evidence is consistent from controlled trials and program evaluations that methadone maintenance treatment results in reduced heroin use, crime, deaths from overdose, and blood borne virus risk behaviours (Foy 2007; Gossop et al 2000; Gowing et al 2004; Teesson et al 2006). Improvements in physical and psychological health and improved social and occupational functioning are also demonstrated with methadone maintenance (Bell et al 1995; Chitwood et al 1995; Foy 2007; Gunne & Gronbladh 1981; Gronbladh & Gunne 1989; Hubbard et al 1984, 1989; Ward et al 1992). In addition, methadone substitution treatment has been found to be more effective than drug free treatment, withdrawal management alone, and placebo in retaining opiate dependent clients in treatment and reducing heroin use (Mattick et al 2003a).

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

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

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

The client generally initiates withdrawal from treatment and the rate of reduction in methadone is dependent on the client’s ability to tolerate withdrawal symptoms. Follow up counselling after completion of treatment with methadone is associated with improved outcomes (Gill & Evans 1996).

Research indicates that methadone is safe in pregnancy, and methadone maintenance is the recommended treatment of choice for opioid dependent pregnant women (Ward et al 1998e). It should be noted that 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 (Ward et al 1998e), so withdrawal, if undertaken, should be slow. Methadone dose is usually increased during pregnancy. When working with pregnant opioid dependent clients, counsellors should consult with the relevant medical personnel to help ensure the client is linked with obstetric services, and preferably those specialising in pregnancy and AOD use.

Buprenorphine (Subutex⁷, Suboxone⁸)

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

⁵ METHADONE SYRUP® Glaxo Wellcome.

⁶ BIODONE FORTE® National Sales Solutions

respiratory depression and overdose is less common with buprenorphine. 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.

Buprenorphine in the form of Temgesic⁹, an injection, has been used in many countries since the 1980s for the treatment of pain. More recently, two sublingual tablet forms of buprenorphine have been approved by the TGA for treatment of opioid dependence: Subutex was approved in 2000 and Suboxone was approved in 2005. Suboxone is a combination of buprenorphine and naloxone. Naloxone is an opioid antagonist that when absorbed into the blood stream precipitates withdrawals in opioid dependent people. It is not well absorbed when swallowed, but is active when injected. The rationale for including naloxone in Suboxone is to discourage clients injecting.

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

Buprenorphine appears to be as effective as methadone in terms of reductions in illicit opioid use and improvements in psychosocial functioning, but may be associated with lower retention in treatment (Foy 2007; Mattick et al 2003b).

Buprenorphine is not currently approved for use in pregnancy. However some pregnant women continue buprenorphine knowing its effects have not been properly researched. Pregnant women taking buprenorphine should be on Subutex as it does not contain the added drug naloxone. Research in France (Lacroix et al 2004) and the USA (Johnson et al 2003) indicates that babies born to mothers on buprenorphine experience a milder neonatal abstinence syndrome than babies born to mothers on methadone.

Naltrexone¹⁰

Naltrexone is an opioid antagonist that displaces opioids from the receptors in the brain and has no opioid effect. When taken by opiate dependent people, naltrexone will precipitate opioid withdrawals, and when opioids are taken in the presence of naltrexone they have no euphoric effect (Foy 2007). Naltrexone is long acting and has minimal side effects for most people, though it can cause liver damage and is contraindicated for use for people with acute hepatitis or liver failure. The most common side effects are headaches and nausea which are experienced by about 10% of clients.

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

Naltrexone was first used for the treatment of opioid dependence in the USA in the 1970s. Research evidence on naltrexone, however, remains limited. Tucker et al (2004) notes evidence that naltrexone can reduce cravings to use opioids during treatment, and is associated with improvements in psychosocial functioning, but has limited acceptability, uptake and retention in treatment. Retention in treatment is much lower for oral naltrexone than for methadone or buprenorphine. Higher retention and completion rates are found for clients who are highly motivated to cease using and remain abstinent, such as physicians, business executives, parolees (Farren 1997; Washton et al 1984), and clients who are detoxified and stable (Foy 2007).

⁷ SUBUTEX® Reckitt Benckiser.

⁸ SUBOXONE® Reckitt Benckiser.

⁹ TEMGESIC INJECTION® Reckitt Benckiser.

¹⁰ REVIA® Orphan Australia. (Approved at the 200th meeting of the Australian Drug Evaluation Committee 3-4 December 1998.)

Lerner et al (1992 cited in Tucker & Ritter 1997) identified a number of pre-treatment variables related to increased retention in naltrexone treatment including better scores on measures of education level, employment status, completion of military service, number of police records and marital status with. 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. Farren (1997) notes that naltrexone treatment may be more effective with a wider range of people when it is accompanied by ancillary services. A number of adjunctive therapies have been used successfully with naltrexone, including supportive therapy (individual, group and family) and cognitive behavioural therapies (Tucker & Ritter 1997).

A problem associated with oral naltrexone is the increased risk of fatal overdose should the tablets be ceased and heroin used due to markedly reduced tolerance (Foy 2007; DiGusto et al 2004; Tucker et al 2004). It is therefore important that only clients highly motivated for abstinence are encouraged to enter naltrexone programs, and that clients are made aware of the increased risk of overdose in the event of a lapse.

In summary, the available evidence indicates that oral naltrexone is a viable treatment alternative for highly motivated people with good social supports and incentives to remain abstinent.

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

16.2 Pharmacotherapies for alcohol dependence

Naltrexone

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

Naltrexone appears to be safe and moderately effective in the treatment of alcohol dependence, though not all clients respond to the treatment (Buonopane & Petrakis 2005; Srisuranpanont & Jarusuraisin 2005). It appears to reduce craving to drink and amount drunk per drinking episode (Mason 2003), has little effect on returning to drinking per se, but does appear to reduce the rate at which clients return to heavy drinking particularly when combined with CBT focussed on stopping the progression of drinking (Anton et al 2005). O'Malley (1998) demonstrated that naltrexone treatment is most effective when used as an adjunct to psychosocial treatments including cognitive behavioural coping skills treatment and supportive therapy. A recent study has demonstrated that clients can be trained to take it in high-risk situations and that this could slightly more effective than daily use (Hernandez-Avila 2006).

Acamprosate

Acamprosate¹¹ has been approved by the TGA and is indicated as a therapy to maintain abstinence in alcohol dependent patients, to be combined with counselling. It is PBS listed for this purpose. It is taken 3 times a day. The only common side effect is mild transient diarrhoea.

Acamprosate has been demonstrated in clinical trials to be an effective treatment in reducing alcohol intake, prolonging the duration of abstinence and reducing alcohol craving (Buonopane & Petrakis 2005; Garbutt et al 1999; Mason 2003). It is considered to be more effective when combined with counselling (Foy 2007). Treatment outcomes where abstinence is an original goal remain positive if treatment continues for one year or longer (Mason 2003).

Recent research has found acamprosate to be less effective than either naltrexone (Rubio et al 2001) or disulfiram (de Sousa & de Sousa 2005) so its role is being questioned (Foy 2007). Acamprosate and

¹¹ CAMPRAL® Alphapharm.

naltrexone treatments can be used in combination, and although some research has found the combination more effective than either drug alone, recent research has questioned whether acamprosate adds anything to naltrexone alone (see Foy 2007).

Disulfiram (Antabuse)

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

Disulfiram (Antabuse)¹² is approved by the TGA but is not listed on the PBS. It is indicated as a deterrent to alcohol consumption and as an aid in the overall management of selected alcohol dependent people.

While there is substantial literature on the use of disulfiram to treat alcohol dependence, the number of controlled clinical trials is limited (For 2007). Garbutt et al (1999:1323) reviewed eleven controlled clinical trials of disulfiram and found they provided “moderate evidence of reduced drinking frequency but no evidence of enhanced abstinence”. There is also some evidence to suggest that supervised disulfiram is more effective than unsupervised disulfiram (Brewer 1996).

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

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

¹² ANTABUSE® Orphan Australia.

Pharmacotherapies for opioid dependence – best practice

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

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

Methadone

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

Indications that methadone treatment might be suitable include the client:

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

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

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

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

Buprenorphine

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

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

Indications that buprenorphine treatment might be suitable include the client:

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

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

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

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

Pharmacotherapies for opioid dependence – best practice (cont.)

Naltrexone

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

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

Naltrexone is appropriate for clients who:

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

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

Pharmacotherapies for alcohol dependence – best practice

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

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

Naltrexone

Naltrexone is an effective treatment for alcohol dependence.

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

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

Acamprosate

Acamprosate appears to reduce cravings, decrease drinking and reduce relapse.

Acamprosate may be less effective than naltrexone.

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

Pharmacotherapies for alcohol dependence – best practice (cont.)

Disulfiram (Antabuse)

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

Disulfiram:

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

17. Methamphetamine

Due to the growing prevalence of methamphetamine use in Western Australia (see Australian Institute of Health and Welfare 2005), counsellors may need to consider the following issues that are of particular concern among this population of clients.

17.1 Managing intoxication

If a client presents with methamphetamine intoxication counsellors may be faced with the challenge of managing potentially violent and aggressive behaviour and/or the display of mental disturbances (Queensland Health 2004). In these instances it is recommended that counsellors aim to:

- provide a non-stimulating environment;
- approach the client slowly but with confidence;
- give reassurance and support;
- avoid arguing; and
- prevent the client from harming self or others.

It is recommended that counsellors adhere to the following guidelines if a client presents as particularly hostile or agitated:

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

(See *Managing intoxicated clients* in the counsellors guide for more detail.)

17.2 Psychotic symptoms

Amphetamine-induced psychosis is common with prolonged heavy methamphetamine use (Drug and Alcohol Office 2006; Queensland Health 2004). Common symptoms of psychosis include paranoia, hallucinations (particularly auditory), delusions and misperceptions. Sub-clinical psychotic symptoms are also common in regular users, in particular hostility, suspiciousness, paranoia and disordered thought processes (Baker & Dawe 2005; Vincent et al 1998). Repeated amphetamine-related psychotic episodes seem to result in a process of reverse tolerance or sensitisation, making it more likely that further psychotic episodes will be experienced in relation to lower doses of amphetamine, and even in relation to non-specific stressors (Baker & Dawe 2005). Psychotic symptoms associated with methamphetamine use tend to be much longer lasting than with the less potent amphetamine, often requiring antipsychotic medication (Fujii 2002).

It is recommended that these clients be screened for psychotic disturbances. If results from psychosis screening tools indicate the presence of psychosis, it is recommended that clients be referred for a full psychiatric assessment. A psychosis screening tool, *The Psychosis Screener* (Jablensky et al 2000) is included in Appendix 10 in the Counsellor's Guide.

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

17.3 Methamphetamine withdrawal

Less is understood about the process of withdrawing from methamphetamine than depressant substances (Queensland Health, 2004). During the initial "crash" period (usually 1-2 days) clients may experience exhaustion, excessive sleep, restlessness, paranoia, irritability, anxiety, depression, hallucinations and delusions, and decreased appetite. The withdrawal phase which follows typically includes:

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

According to Dyer and Cruickshank (2005) 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. The duration and severity of withdrawal symptoms may be influenced by:

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

To date there are no clear evidence based psychological or pharmacological strategies for managing amphetamine withdrawal (Proudfoot & Teesson 2000, Srisurapanont et al 2007). 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, Queensland Health 2004). Methamphetamine withdrawal does not usually need to occur in an inpatient setting, however, the client's medical, psychiatric and social functioning needs to be considered when making this decision (Baker & Lee, 2003). If the client has a long history of methamphetamine use they should be monitored for the presence of symptoms of psychosis and a thorough mental health assessment should be conducted.

17.4 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, 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);
- unsafe sex;
- overheating and dehydration;
- sleep deprivation;
- marked weight loss;
- poor nutrition;
- loss of insight;
- depression;
- anxiety;
- impaired cognition and motor performance;
- memory and concentration difficulties;
- agitation;
- accidents; and
- overdose/toxicity.

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

17.5 Cognitive impairment

As a consequence of growing rates of heavy methamphetamine use, increasing numbers of clients are also presenting with amphetamine-related cognitive impairments which hold significant implications for the content, process and outcome of counselling. The literature recommends that counsellors should endeavour to assess a client's level of cognitive functioning and tailor their intervention strategies and delivery of counselling accordingly (Aharonovich et al 2003; Nordahl et al 2003; Simon et al 2000).

Therapeutic implications

Research and anecdotal evidence demonstrates that current and former users of methamphetamine tend to present clinically as easily distracted, finding it difficult to concentrate or sustain attention and have difficulty suppressing irrelevant task information (Nordahl et al 2003; Ornstein et al 2000; Salo et al 2002). Importantly, research indicates that clients presenting with acute symptoms of distractibility and inattention are often less likely to remain in treatment, and those who do appear to have poorer outcomes and higher relapse rates (Aharonovich et al 2003; Dyer & Cruickshank, 2005). Indeed, level of cognitive functioning has been demonstrated to mediate the effectiveness of CBT treatment, as the treatment strategies require particular levels of comprehension which may depend on a client's ability to focus as well as hold and sustain attention (Aharonovich et al). According to Technier et al (2003), of a range of cognitive abilities, attention has the strongest relationship to the attainment of treatment objectives. It is hypothesised that without the ability to sustain attention clients experience difficulties

with memory and learning and thus respond poorly to the traditional treatment strategies (Aharonovich et al 2003; Technier et al 2003). Clients suffering from psychotic symptoms are also less likely to remain engaged in treatment (Dyer & Cruickshank). Simon et al. (2000) describe the deficits experienced by people with long-term patterns of methamphetamine use as extending to impairment in abstract thinking, which is the ability to combine information in new ways and to make inferences from new combinations of information.

Generally the cognitive deficits observed in long-term users of methamphetamine relate to all areas of cognitive functioning including memory (verbal and visual), information processing (slow processing speed, slow to grasp and understand) and executive functioning (impaired ability to manipulate information, problem solving and sequencing difficulties, inhibitory control, decision making problems) (Meredith et al 2005). Some evidence also suggests that the structural and functional changes which occur in areas of the brain following long-term consumption of methamphetamine are associated with impairment in the regulation of emotions (Meredith et al 2005). It is also becoming apparent that the recovery of cognitive functioning following abstinence may be limited.

Given the impact of the deficits in cognitive functioning experienced by chronic amphetamine users on the outcomes of treatment, it is imperative for counsellors to be cognisant of the deficits that clients may present with and to be armed with strategies for tailoring the counselling to the needs of this particular client type. As Teichner et al (2002) highlight, in order to benefit from many of the strategies commonly used in the treatment of drug and alcohol difficulties, numerous cognitive functions are required (eg attention, memory, verbal skills, problem solving and abstract reasoning). Those clients who experience deficits in any of these areas of cognitive functioning are thus likely to experience poorer treatment outcomes if their level of cognitive functioning is not taken into consideration when engaging in treatment planning. Aharonovich et al (2003) recommend that when working with clients who display attention/concentration difficulties, counsellors consider shortening the length of sessions and facilitate frequent rehearsals and feedback of the content. These authors also note that it is important for counsellors to consider the impact of cognitive deficits upon client engagement behaviours (eg irregular attendance, non-compliance with homework completion) rather than automatically assuming these behaviours are the consequence of more typically salient explanations (eg resistance, ambivalence to change etc.).

17.6 Treatment

Baker et al (2004) argue on the basis of reviews of research into psychosocial interventions with amphetamine users that cognitive behavioural treatment is useful. In their research, Baker et al (2004) compared a control group with a group receiving two sessions of CBT and a group receiving 4 sessions of CBT. Topics covered in the CBT sessions were motivational interview, coping with cravings, controlling thoughts about amphetamine use and pleasurable activities, and amphetamine refusal skills and preparation for high risk situation. They found that abstinence significantly improved with 2 or more treatment sessions, and depression levels improved with more sessions. As a result they recommended a stepped care approach whereby intensity and range of treatment approaches is determined by client presentation in terms of co-occurring psychiatric disorder (psychosis, anxiety, depression) and other needs. They recommend that Step 1 is assessment plus self help materials and scheduled monitoring; Step 2, for those who did not respond to step 1, is two sessions of CBT; Step 3, for clients who do not respond to previous steps, or who have clinically significant depression is 4 sessions of CBT; and more intensive interventions for clients do not respond to these interventions, or are experiencing psychosis or suicidality.

Lee et al (2007) identify the advantages of this graded approach to treatment as:

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

Given the difficulties methamphetamine users with cognitive impairment are likely to have with successfully participating in treatment, it is recommended that cognitive behavioural addiction treatment interventions are tailored to take into account potential cognitive impairment. For a detailed description of recommended strategies to be incorporated into treatment when working with clients who have neuropsychological deficits refer to *Methamphetamine* and *Cognitive Impairment* chapters in the counsellor guide.

Methamphetamine – best practice

When working with clients using methamphetamine the following is recommended.

- As intoxicated and withdrawing amphetamine users can present with potentially violent and aggressive behaviour counsellors should be trained in how to respond to challenging behaviour.
- Given that psychotic symptoms are more likely to be present and persistent in clients with long-term methamphetamine use, it is recommended that these clients be screened for psychotic disturbances
- Methamphetamine withdrawal can be inpatient or outpatient, depending on the client's medical, psychiatric and social functioning. It does not necessarily entail medication, but may involve medication with benzodiazepines, antidepressants or antipsychotics.
- Given the high rates of relapse among clients, as well as the varying goals that clients bring to treatment, attention should be paid to harm reduction strategies when delivering treatment.
- Heavy, prolonged methamphetamine use is associated with cognitive deficits which hold significant implications for the content, process and outcome of counselling. Counsellors should endeavour to have a client's level of cognitive functioning assessed and tailor their intervention strategies and delivery of counselling accordingly. It is recommended that standard cognitive behavioural strategies for AOD counselling form the basis of the approach, and be adapted as appropriate.

18. Clients with complex issues

It is well recognised that the majority of clients presenting to AOD treatment agencies have a number of issues. Such issues may include impending legal action from illegal activity, having a child placed in care due to parental alcohol and/or other drug abuse, lack of accommodation and psychological disorders (eg anxiety, depression or personality disorders) or more severe co-existing psychiatric disorders requiring psychiatric intervention (eg psychotic disorders) (see *Clients with Co-existing Psychological Disorders*).

Overseas research estimates of the presentation rates for clients with complex issues in AOD treatment range from 40-90% (Khantzian & Treece 1985; Hendriks 1990). Similar rates are expected in Australia (Ward et al 1998a). As with all clients, a holistic approach is recommended when working with clients with complex issues. Particular attention should be paid to the personal and social issues and the impact they may be having on the client's substance abuse problem. Counsellors should liaise with appropriate services where required. This may include social welfare agencies, medical, psychological and psychiatric practitioners (see *Case management*). Counsellors should also link clients to additional support services.

Consideration of both the severity and mix of specific related issues will determine the need to refer to or consult with other service.

Clients with complex issues – best practice

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

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

19. Co-occurring mental health issues

Drug dependence commonly co-occurs with other mental health issues, with up to three quarters of AOD clients estimated to have co-occurring psychological disorders (see Dawe 2007 for a review of the evidence). A broad range of diagnoses are associated with substance dependence including anxiety disorders (including PTSD), mood disorders (depression or bipolar disorder), amnesic disorders (memory disturbance) and psychotic disorders (schizophrenia and delusional disorder) and personality disorders (eg American Psychiatric Association 2000; Dawe 2007; Najavits et al 1997; Swift et al 1996; Verheul 2001; Verheul et al 2000).

It is often difficult to establish the causal connection between AOD disorders and psychological disorders. More importantly, counsellors should distinguish at assessment between those people with substance abuse issues who have co-existing psychological disorders (eg anxiety disorders) and those with more severe disorders (eg manic depression, bipolar and psychotic disorders) which may require psychiatric intervention. However, due to the fact that long or short term drug or alcohol use, as well as withdrawal, can cause clients to experience symptoms of psychological disorders, the diagnosis of psychological disorders among the substance using population is often complicated (Baker & Dawe, 2005; Marsh & Dale, 2006).

For those clients who are not easily differentiated, effective cooperation between AOD treatment agencies and mental health services is essential to ensure the client receives treatment that can best manage their condition. It is strongly recommended that AOD services liaise with appropriately trained medical and allied health personnel, and that the AOD agencies strengthen their links with local mental health service providers.

Co-occurring mental health issues – best practice

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

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

20. Depression

Research indicates that depression is more prevalent among drug users in treatment than in the general population, with rates of depression among treatment populations varying from 24% (current major depressive disorder), to 54% (lifetime depressive disorder), with up to 60% of clients believed to present with some symptoms of depression at intake (Gossop 2003).

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

AOD use tends to have a reciprocal relationship with the experience of depression. This means that although for many clients the experience of symptoms of depression may precede the onset of their difficulties with alcohol or other drugs, AOD use can also cause or exacerbate 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 a long term focus during treatment. Thus it can be difficult to tease apart the relationship between a client's substance use and symptoms of depression. Counsellors who are not trained to work with depression are encouraged to refer to specialist clinicians (eg clinical psychologist) or engage with supervisors for assistance with containing and managing a client's symptoms.

Generally it is essential that counsellors endeavour to target symptoms of depression during treatment to avoid the risk of poor outcomes (McKay 2005). Indeed, the symptoms of depression (eg lethargy, social withdrawal, low affect) can potentially interfere with the components of traditional AOD treatments such as acquisition of new coping behaviors, attendance at self-help meetings, or being self-motivated to complete homework tasks (Burns et al 2005; McKay 2005). It is also suggested that treating depressive symptoms is an integral component of treatment due to the possible reductions in the risk of relapse, given evidence which indicates that depressed mood is a common trigger for relapse (Brown et al 1997).

Cognitive behavioural therapy has been identified as one of the most effective ways of treating co-occurring depression and substance use difficulties (Brown et al 1997). Typically, components of CBT

(cognitive restructuring, pleasure and mastery activity scheduling, goal setting, problem solving) are incorporated with AOD treatment such as motivational interviewing, relapse prevention and management and pharmacotherapy.

The Centre for Clinical Interventions (CCI) website (www.cci.health.wa.gov.au) also provides information and resources for the treatment of depression using CBT, as well as client handouts. These resources are designed for use by both professionals and clients.

Antidepressant medication has also been found to be effective in the treatment of depression among AOD clients (Nunes & Levin 2004). 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).

It is important to be cognisant of the increased risk of suicide among clients who suffer from both AOD difficulties and depression. Careful assessment and periodic monitoring of clients' levels of suicidal ideation and risk of suicide completion is recommended (Gossop 2003). Refer to *Suicide Assessment and Management* in the counsellor guide for further information.

Depression – best practice

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

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

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

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

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

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

It is recommended that the prescription of antidepressants occur concurrently with the provision of therapy targeting specific depressive symptoms and AOD difficulties.

Careful assessment and periodic monitoring of clients' levels of suicidal ideation and risk of suicide completion is recommended.

21. Anxiety

Research demonstrates that many clients who experience difficulties with alcohol or other drug use will concurrently be experiencing difficulties with anxiety (Barlow 2002). For example, lifetime rates of anxiety disorders have been reported in up to 66% of clients with AOD difficulties (Burns et al 2005). Anxiety-related problems can manifest in a variety of different psychological disorders, the

most common of which (among AOD populations) are post-traumatic stress disorder (PTSD), generalised anxiety disorder (GAD), panic disorder, social phobia and obsessive-compulsive disorder (OCD) (Marsh & Dale 2006).

Research indicates that clients with an AOD disorder are five times more likely than the general population to develop an anxiety disorder, and visa versa (Barlow 2002). Thus, there is a strong relationship between the experience of anxiety and AOD difficulties but the nature of this relationship can be difficult to tease apart. Many clients report that their symptoms of anxiety preceded their substance use, and/or that they began to use substances as a means of coping with their anxiety (Barlow). However, anxiety symptoms can also develop as consequence of drug or alcohol use.

Suffering from symptoms of anxiety (eg muscle tension, increased heart rate, nausea, sweating, breathlessness, dizziness, depersonalisation, worrying) is common during the withdrawal period and the first few weeks of abstinence (Marsh & Dale 2006). Similarly, people may experience symptoms of anxiety while intoxicated (Gossop 2003). However, if these symptoms persist whilst not intoxicated or following an extended period of abstinence, counsellors should investigate the presence of a primary anxiety disorder. If counsellors are not trained to work with anxiety disorders they should refer to special clinicians such as clinical psychologists or liaise closely with a supervisor for help with containing and managing the client's symptoms.

Targeted treatment of anxiety symptoms is related to more positive treatment outcomes and reduced risk of relapse (Barlow 2002). Research suggests that cognitive behavioural therapy is an effective way of treating co-occurring anxiety and AOD disorders (Baillie & Rapee 2003; Baker & Dawe 2005; Burns et al 2005). CBT strategies commonly used to treat symptoms of anxiety include relaxation training, cognitive restructuring, grounding, problem solving and goal setting.

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

There are very high rates of PTSD among AOD populations (Jacobsen et al 2001). The symptoms of this disorder can worsen following the cessation of substance use (Marsh & Dale, 2006), thus counsellors are referred to *Sexual Abuse and Other Traumas* and *Grounding* in the counsellor guide for information on how to appropriately respond to clients who present with symptoms of PTSD.

Anxiety – best practice

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

Targeted treatment of anxiety symptoms is related to more positive treatment outcomes and reduced risk of relapse.

Research suggests that cognitive behavioural therapy is an effective way of treating co-occurring anxiety and AOD disorders.

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

- relaxation training;
- cognitive restructuring;
- grounding;
- goal setting; and
- problem solving.

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

Due to high rates of PTSD among AOD clients counsellors should be familiar with how to respond to AOD clients who suffer from PTSD.

22. Sexual abuse and other trauma

Research consistently finds a significant relationship between childhood sexual abuse (CSA) and substance dependence (Jarvis et al 1998). This relationship is reflected in studies finding rates of CSA to be between 37-74% of women in AOD treatment programs that estimate the rates (Covington 1986; Rohsenow et al 1988; Swift et al 1996; Simpson & Miller 2002). Sexual abuse in men presenting to AOD treatment is also not uncommon. In their review of the literature Simpson and Miller (2002) reported that an average of 16.3% of adult males seeking substance abuse treatment report a history of childhood sexual abuse.

In addition to sexual abuse, clients presenting for treatment report greater levels of family and domestic violence, both in their family of origin and currently, than the general population. For example, Brems et al (2004) found that 20% of men and 50% of women in a sample of clients in an inpatient withdrawal service in the US disclosed a history of childhood physical or sexual abuse. Another US survey of a sample of clients in an inpatient withdrawal service found that 81% of women and 69% of men reported physical and /or sexual abuse, and 75% of them first experienced it as children (Liebschutz et al 2002). In Australia, Swift et al (1996) found that 37% of a sample of women in AOD treatment reported child sexual abuse, 21% child physical abuse, 35% sexual assault as an adult, and 38% physical assault as an adult.

22.1 Relationship between sexual abuse or other trauma and AOD disorders

The relationship between CSA or other trauma and AOD disorders is mediated by the development of PTSD symptoms. That is, trauma exposure per se does not lead to increased AOD use. Rather, increased AOD use is only likely if PTSD symptoms develop from exposure to the trauma (McFarlane 1998; Simpson & Miller 2002). There is a high prevalence of Post Traumatic Stress Disorder (PTSD) in survivors of sexual abuse (McFarlane & Yehuda 1996). One study showed that up to 50% of rape

victims in the community develop PTSD (McFarlane & Yehuda 1996). Estimated lifetime PTSD rates in AOD treatment populations range between 25-62%, with higher rates found in inpatient settings (Jacobsen et al 2001; Mills et al 2003).

The literature indicates symptoms of PTSD play a causal role in the development of AOD disorders, with AOD being used to self-mediate PTSD symptoms (Marsh in press). PTSD symptoms fall into three groups: intrusive reminders of the trauma, attempts to avoid reminders of the trauma, and physiological hyperarousal (American Psychiatric Association 2000). Evidence supporting AOD as self medication for PTSD symptoms includes research showing that AOD use usually follows or develops concurrently with PTSD symptoms (Bremner et al 1996; Jacobsen et al 2001), that clients report that some drugs, particularly depressants such as opiates and alcohol, ameliorate their PTSD symptoms of arousal and re-experiencing, at least in the short term (Bremner et al 1996; Marsh et al 2004), that clients expect variations in PTSD symptoms to be more influential on their drug use than vice versa (Brown et al 1998), and that reduced PTSD symptomatology is associated with greater amelioration of AOD use than the reverse (Back et al 2006).

It has also been hypothesised that the drug of choice by women with CSA could be relevant to treatment. For example, the regular use of sedative drugs by women with CSA is consistent with the notion of self medication against psychological 'pain' (Jacobson et al 2001; Simpson 2003; Simpson & Miller 2002). Similarly, it has been hypothesised that a preference for stimulant drugs by CSA survivors may be an active step to assist in the self protective vigilance (Harrison et al 1989). Counsellors need to have an understanding of the functional relationship between PTSD and substance use, and use this understanding as a basis for treatment.

It is commonly found that clients with co-occurring AOD disorders and PTSD have more complicated clinical profiles and poorer treatment outcomes than people with only one disorder (Brown et al 1996; Najavits 2002; Ouimette et al 1998). This, along with the self-medication function of drug use for PTSD symptoms, has led to the conclusion that rather than treating each disorder separately, treatment of PTSD and AOD disorders should be integrated (Najavits 2002). Indeed Herman (1992) and Van Der Kolk (1996) argue that divided treatment is unlikely to be successful, with the result sometimes being an exacerbation, not amelioration, of client distress. Substance use often serves to decrease many of the symptoms of PTSD, so when substance use is decreased, the severity of PTSD symptoms may increase. Therefore, client coping strategies need to increase as substance use decreases. For opioid using clients, opioid substitution treatments (methadone, buprenorphine) can be very helpful in continuing to provide the drug effect that helps contain PTSD symptoms allowing clients to reduce their other AOD use more quickly. Psychiatric medications, particularly some antidepressants, can also be useful. Due to the difficulties often encountered when treating clients suffering from PTSD and substance-related problems (Jacobsen et al 2001), it is recommended that counsellors consult extensively with skilled practitioners during the course of treatment, and consider referral of such clients to appropriate services or personnel. Marsh and Dale (2006) also recommend counsellors seek close supervision when working with clients who have PTSD.

22.2 Treatment model and approach

The treatment model recommended in the literature for conceptualising clinical work with clients with sexual abuse issues and PTSD, or PTSD from any trauma, is a phased model. The model draws particularly on the work of Briere (2002), Herman (1992) and van der Kolk (2001). Phase 1 focuses on establishing safety and building client resources. Phase 2 focuses on the trauma. Many clients, particularly those who experienced multiples traumas and have AOD problems, are unable to tolerate work that focuses on the trauma, and their treatment would just focus on phase 1 activities. For clients with AOD problems, AOD treatment strategies are included in phase 1 work.

Phase 1, establishing safety, focuses on establishing a therapeutic relationship, validating and normalising the experiences of the client, and building client resources, while reducing unsafe behaviours (eg drug use and related risky behaviours, suicide attempts, self harm) and circumstances

(eg living on the streets, staying in an abusive relationship). Client resources targeted in treatment can include affect regulation and distress tolerance skills, skills to manage trauma symptoms and dissociation (grounding), general coping skills and social support, developing healthy relationships. Psychoeducation about PTSD, exploration of the link between PTSD symptoms and a client's AOD use, and AOD treatment should also be integrated into this phase of treatment. Establishing safety for many clients is the longest and most difficult stage of recovery. This stage is also where AOD counsellors can provide clients with much assistance.

Phase 2 focuses on the trauma. Referred to as “remembrance and mourning” by Herman (1992) it, involves remembering and making sense of the trauma that was experienced. It involves exposure to memories of the trauma and the feelings associated with it and reprocessing of the traumatic material. Although exposure treatment is considered the treatment of choice for PTSD from a single traumatic event, it is often contraindicated for people with PTSD from chronic childhood trauma and for people with AOD disorders (Foa et al 1999). Exposure treatments involve re-experiencing intense negative affect, which people with PTSD from chronic childhood trauma tend to manage in risky ways such as drug use, self harm, aggression, or suicide attempts, and which people with AOD disorders often manage by relapsing to drug use or dropping out of treatment (Marsh in press). It is therefore not appropriate for many AOD clients with sexual abuse unless they have managed to attain sufficient stability during the safety stage of treatment. This phase of treatment should only be undertaken by clinicians trained to do this work, and only with clients who are able to tolerate it.

Herman (1992) and Van Der Kolk (1996) have written extensively on the treatment of sexual abuse and stress the importance of long, slowly paced therapy guided by the client and the continual establishment of safety.

A very useful resource for clinicians working with AOD clients who have experienced sexual abuse or other trauma is a 25-topic cognitive behavioural manualised treatment for co-occurring PTSD and AOD disorder called ‘Seeking Safety’ (Najavits 2002). The approach integrates AOD and PTSD treatment and focuses on phase 1 safety strategies to assist with affect regulation, containing and managing PTSD symptoms, managing interpersonal situations, and AOD relapse prevention. It does not include exposure, and is therefore suited for use by a broader range of counsellors than the treatments that include exposure. Although to date not well evaluated, initial work indicates that the program is helpful for reducing PTSD symptoms and AOD use (Hien et al. 2004; Najavits et al 1998; Zlotnick et al 2003).

It is important that clinicians are aware of the considerable rates of sexual abuse, other trauma and PTSD in AOD treatment populations while conducting an initial client assessment. Once a therapeutic alliance has been developed between the clinician and the client, then clients can be asked whether they have experienced sexual abuse or other trauma, and whether it still affects them. This should be done in a sensitive manner during assessment. It is important that clients are advised that they do not need to discuss these issues if they don't feel ready. It is also important that counsellors do not question clients in too much depth about these experiences unless or until the clients have developed the skills to manage the intense negative affect likely to arise when talking about them.

Marsh and Dale (2006) also highlight the need for counsellors to be aware of the difficulties that may arise when attempting to gain the trust of clients who have a history of childhood sexual or physical abuse. When working with such clients it is recommended that counsellors be realistic in their expectations of both themselves and the client, and tailor treatment to take into account the client's emotional and cognitive capacity to engage in the tasks of therapy (Marsh & Dale 2006). Treatment for clients with AOD issues and sexual abuse is usually of necessity long term, and can require referral to clinicians trained in working with PTSD. At the same time, counsellors not trained in this area can still often provide valuable assistance to clients in terms of increasing their safety and stability.

Sexual abuse and other trauma – best practice

PTSD is common among survivors of sexual abuse and other trauma.

AOD problems are associated with the development of PTSD symptoms with AOD use usually providing a self-medication function.

PTSD and AOD problems can not be treated as discrete entities but need to be treated together.

When working with people who have been traumatised counsellors should consider the following.

- The need to assess and raise the issue of sexual abuse and other trauma with sensitivity once a therapeutic alliance has been formed.
- It may not be necessary to elicit extensive details of the trauma to understand the impact on the client.
- The importance of reassuring and normalising client reactions to the trauma.
- The importance of establishing, and continually re-establishing if need be, therapeutic and practical safety with the client.
- The importance of building client resources and coping strategies.
- Brief intervention is not indicated when working with clients who have trauma issues.
- Use Najavits (2002) “Seeking Safety” as a guide to assist traumatised clients with safety and stability
- Exposure treatments are not recommended for clients with PTSD from prolonged abuse or AOD disorders unless sufficient stability and coping skills are developed
- Referral to appropriate clinicians or services may be required.

23. Cognitive impairment

Long term heavy use of some commonly used drugs, in particular alcohol and methamphetamine, is linked to cognitive impairment. For example, an estimated of 30-80% of dependent drinkers and 40% of dependent methamphetamine users demonstrate at least mild to moderate impairment on neuropsychological tests (Carey et al 2006; Grohman & Fals-Stewart 2004; Rourke & Loberg 1996; Simon et al., 2000). Recently detoxified chronic dependent drinkers tend to present with unimpaired verbal skills and general intellectual functioning, but deficits in novel problem solving, learning and memory, visuospatial skills, and complex perceptual motor integration (Rourke & Loberg 1996). Long term dependent users of methamphetamine tend to present with deficits in all areas of cognitive functioning including memory (verbal and visual), information processing (slow processing speed, slow to grasp and understand) and executive functioning (impaired ability to manipulate information, problem solving and sequencing difficulties, inhibitory control, decision making problems) (Meredith et al 2005).

While extreme cognitive impairment is relatively easy to observe, more subtle difficulties that impact on treatment are more difficult to assess. Depending on the degree of severity of suspected cognitive

damage, counsellors may wish to refer clients to a clinical or neuropsychologist for further assessment. A diagnosis of cognitive impairment should only be made by a neurologist, neuropsychologist or clinical psychologist with experience in neuropsychology.

Higher levels of neurocognitive impairment are associated with poorer treatment outcomes such as treatment dropout, early discharge from treatment due to misconduct, and poorer positive treatment participation (Fals-Stewart & Schafer 1992; McKellar et al 2006; Teichner et al 2002). Level of cognitive functioning has also been demonstrated to mediate the effectiveness of CBT treatment, as the treatment strategies require particular levels of comprehension which may depend on a client's ability to focus as well as hold and sustain attention (Aharonovich et al 2003). That cognitive deficits are associated with poorer treatment outcomes is not surprising given that AOD treatment include learning and practicing new coping techniques, examining and changing problematic thoughts and behaviours, and compliance with treatment activities (eg keeping appointments, taking medication as prescribed, completing counselling homework). As noted by Teichner et al (2002) in order to benefit from many of the strategies commonly used in the treatment of AOD difficulties, numerous cognitive functions are required (e. attention, memory, verbal skills, problem solving and abstract reasoning).

The literature recommends that counsellors should endeavour to assess a client's level of cognitive functioning and tailor their intervention strategies and delivery of counselling accordingly (Aharonovich et al 2003; Nordahl et al 2003; Simon et al 2000). Treatment for clients with cognitive dysfunction should be behavioural in nature. Counsellors should focus on teaching clients concrete skills to avoid high risk situations, prevent relapse and maintain abstinence. Indeed for such clients, abstinence is often the most realistic goal (Moore 1998). More specific tips for working with cognitively impaired clients are found in *Cognitive impairment* in the counsellor guide.

Cognitive impairment – best practice

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

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

24. Coerced clients

The issue of coerced clients is particularly pertinent to working with clients with AOD issues, especially given Western Australia's comprehensive diversion strategy, including diversion by police

for first offenders and a range of court diversion options for repeat offenders including a 'drug court' for the most serious offenders, and similar strategies nationally.

Thus far, the literature on coerced clients has primarily addressed the question of whether treatment works with such a population. A review of the literature by Hall (1997) indicates that while the evidence is derived primarily from the United States of America, there is general support for some forms of coerced drug treatment. Two major evaluations of community based drug treatment, the Drug Abuse Reporting Program (DARP) and the Treatment Outcome Program Studies (TOPS) showed "*that drug dependent individuals who entered community based therapeutic communities and drug free outpatient counselling under 'legal pressure' did as well as those individuals who were not under such 'legal pressure'*" (Hall 1997:112). While there is support to indicate that outcomes for coerced clients are essentially similar to voluntary clients (Hall 1997; Hough, 2002) the following caveats apply:

- the evidence is largely observational;
- the limited numbers of replications of more positive trials were undertaken in the United States from the 1950s-1970s and may not be applicable to Australian contemporary conditions;
- many of the programs were under funded, under resourced and poorly implemented; and
- the research is often plagued by conceptual and methodological problems.

There are a number of different types of coerced clients such as those required to complete a treatment program by the judicial system, those referred in relation to child protection issues, individuals required to engage in treatment by their place of employment, and adolescents referred by parents or schools. Coercion may come from sources such as the client's employer, partner, children, doctor or even landlord.

Issues of confidentiality, conflict of interest, working with resistance, and the appropriateness of harm reduction interventions are particularly pertinent when working with this client group. A related issue concerns clarifying the question, "who is the client?"

Confidentiality is particularly complicated when working with coerced clients. Difficulties can arise when a report is required upon the conclusion of therapy, for example when clients on a court order continue to use. To date there has been no systematic development of guidelines as to specifically how confidentiality works in such situations. However, confidentiality should be negotiated between all interested parties at the onset of any therapeutic enterprise.

For example, if a counsellor decides (or is required) to report a client's drug use to the relevant corrections officer, the counsellor needs to explain this to both the client and the corrections officer prior to the beginning of therapy. In line with this, counsellors also need to ensure that they are aware of the type of information that they may be required to give to a third party, such as the reporting requirements of the justice system. Open communication regarding the boundaries of confidentiality needs to occur with all parties when working with coerced clients (including parents, schools, partners etc) prior to engagement in treatment. Counsellors need to be honest with clients and not promise levels of confidentiality that can not be met.

Young people brought to treatment by their parents are often "coerced" in the sense that they don't want to be there. Parents of minors considered not sufficiently mature to give informed consent are legally entitled to information about their child's treatment. However, if the young person is considered to have the maturity to provide informed consent, then their wishes for confidentiality must be respected unless other legal constraints and obligations apply. This assessment is usually made around the age of 14 or 15 (see *Young People*). 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.

To reduce the possibility of conflicts of interest between referring bodies and professional integrity, it is necessary for agency staff to agree upon the purpose of therapy and boundaries of therapy. These discussions may need to take into account the competing needs of person other than the client, such as the victim of a drug related offence, the general public, the client's family, and the justice system. Thus, treatment issues such as relapse management may need to be carefully considered in the context of interagency protocol and on a case by case basis.

Working with coerced clients also often involves working with resistance (Teyber 2006). While clients may be coerced to attend treatment sessions, there are some opportunities for change in this environment. Barber (1991) suggests that rather than a model of client self determination as proposed by Rogers (1951, 1957) and Egan (1985), the initial encounter with coerced clients is essentially a conflict situation requiring mediation and negotiation skills. Rather than casework by concessions or casework by oppression, Barber (1991) has provided six steps to allow adoption of the role of negotiator or conflict manager. These steps are:

- clear the air;
- identify legitimate client interests;
- identify non negotiable aspects of intervention;
- identify negotiable aspects of intervention;
- negotiate the case plan; and
- agree on criteria for progress.

Teyber (2006) suggests that counsellors should learn to 'roll' with resistance and acknowledge it with the client, instead of working against it. This means that the resistance should be acknowledged, and accepted by the counsellor and discussed with the client, not confronted and viewed as something 'bad' that should be negated. Motivational interviewing is a useful technique for working with resistance. For example, the counsellor can ask the client to consider the good and not so good things about coming to counselling.

Harm reduction also requires careful consideration and management as treatment orders are likely to be based on an expectation of working towards abstinence. This expectation and the consequent place of harm reduction need to be clear.

Some clients may see the primary harm relating to drug use as the re-imposition of a prison sentence, for example, a parolee who engages in illicit drug use. Depending upon the court ordered requirements, even relatively low levels of illicit substance use may be associated with serious consequences for the client. Likewise, if when drug use is seriously affecting the ability to care for children, is associated with violence or other criminal behaviour, clinicians need to balance the appropriateness of harm against the harms to other 'indirect' clients. Those coerced clients who are not required to become abstinent may be more willing to consider strategies that will enable them to use more safely. Marsh and Dale (2006) suggest that working on the process of 'negotiating safety' (see ***Harm Reduction***) with these clients may strengthen the therapeutic relationship and, in turn, encourage the clients to address other issues.

Overall, it is most important that counsellors be honest with all concerned parties regarding the boundaries of treatment prior to the onset of any therapeutic enterprise. Agency protocols will reduce the possibility of conflict.

Coerced clients – best practice

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

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

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

25. Incarcerated clients

Much has been written about the link between crime and alcohol and drug issues, and it has long been accepted that one of the highest rates of drug use is found among the prison population. Consequently, it is becoming increasingly common for alcohol and other drug treatment services to be involved with the prison system (Vigdal 1995). Vigdal (1995) argues that incarceration can provide a prime opportunity for intervention that otherwise may not be possible. However, it is widely acknowledged that incarcerated clients are a notoriously difficult population to work with. Added difficulty may be encountered as counsellors work in a system not conducive to therapeutic change (Vigdal 1995).

Confidentiality is an important issue when working with this client population. Counsellors need to be clear regarding to whom they should report their clients’ activities and communicate this to their clients prior to therapy. Due to the restrictions when working in a prison, drug use may need to be discussed in a hypothetical sense. Alternatively, counsellors may find that clients are dishonest regarding their drug use activities.

Harm reduction is important when working with incarcerated clients. Reports indicate an extremely high incidence of sharing of injecting equipment (and consequently high rates of Hepatitis C infection; Macalino et al 2004) whilst in prison, and high rates of overdose following release. Clients and counsellors need to work together on a plan of harm reduction strategies that the client is willing to implement (Little & Even 1998).

Counsellors need to be aware of the debriefing and liaison process when incarcerated clients express suicidal ideation or are self harming. Counsellors have a duty of care to inform the centre psychologist and obtain increased support for the client.

Counsellors need to have a clear understanding of the policies and procedures relevant to working in prisons. This includes levels of command, to whom they should report, the type of information they should disclose and to whom, and having an overall knowledge of the general running of the prison.

The therapeutic approach with respect to negotiating a case plan and working with resistance are outlined in *Coerced Clients*.

Incarcerated clients – best practice

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

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

26. Significant others

There are a number of distinct issues pertinent to working with partners, families and friends of the AOD user. There are two levels of working with this group: working with them as clients in their own right; or, working with them as part of an individual's treatment. Quite different issues arise as a result of the context with which one is working and will be considered later in this chapter.

To work effectively with significant others in whatever capacity, agencies and individual counsellors need a sound understanding of family sensitive practice. The assumptions of family sensitive practice outlined below are adapted from the principles listed by the Bouverie Centre Family Institute in Victoria (<http://www.latrobe.edu.au/bouverie/mentalhealth/assumptions.html>).

26.1 Assumptions of family sensitive practice

- Working in an open, respectful and collaborative fashion with families and clients is usually likely to promote and enhance clinical goals.
- Being open, respectful and collaborative is highly complex and does not always fit well with traditional clinical practices.
- AOD problems in a family have a similar effect to major trauma in the sense that trauma puts extreme pressure on clients and family members and on their relationships with each other.
- Blame, guilt, grief, shame and frustration are natural companions of the trauma of AOD problems and major family difficulties in our culture.
- Families have needs of their own and a right to have their needs acknowledged.
- In general, families and AOD clients behave in ways to achieve 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 in return tend to generate good responses to clients and counsellors.
- The distinction between intention (which is usually good) and the effect of action is important in understanding why clients and families, at times, act in extremely unhelpful ways.
- Establishing a trusting relationship with families puts counsellors in a better position to assist families to overcome crises and problems. This often means time efficiencies in the long term.
- On occasions when family members behave in destructive ways, an appreciation of the family situation can help counsellors address this destructiveness more effectively.
- It is important to understand the family sensitive principles and assumptions at a personal level in order to be able to make a professional commitment to them.

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

26.2 Working with significant others as clients in their own right

Excessive AOD use is a cause of stress to families and friends of problem AOD users (Orford et al 2005). It is not uncommon for this client population to seek counselling for themselves in order to help them better cope with their family member's or friend's drug use. In these instances, Orford and colleagues (1994; 2005) suggest they be provided with support in their own right. This group is often experiencing heightened levels of anxiety and depression and commonly report feeling helpless and isolated (De Civita et al 2000). It is therefore important that they be provided with appropriate support. Goals and treatment plans for counselling should be negotiated. If the problem AOD user is in treatment with one counsellor, it is often appropriate for this support for families and friends to be provided by a different counsellor. This helps clinicians to avoid conflicts of interest and breaches of confidentiality. An exception to this is when the whole family is considered to be the client as in a treatment that has family therapy as a base, such as the Multidimensional Family Therapy (MDFT) approach (Liddle 2002) as described in the chapter *Young People*.

Steinglass et al (1988) and Helfgott (1997b) suggest that counsellors can assist the client to review their role as it relates to the problem drinker/drug user as well as assessing general life problems and developing ways to better cope with the problem drug use.

Anecdotal evidence indicates that this client population often seek help in order to find a strategy that can help them to stop their family member or friend from drinking and/or using. 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 alcohol and other drug information, which directly helps the client, and indirectly may assist the drinker/user through dissemination of information.

Copello and colleagues (2005) found the utilisation of the following five steps when working with a family member who is living with a substance-using relative to be effective in reducing the amount of strain (physical and psychological symptoms) experienced by the family member (or partner) and enhancing their coping mechanisms:

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

26.3 Working with significant others as an adjunct to an individual's AOD treatment

Traditionally, significant others were involved in AOD treatment in order to clarify facts provided by the problem AOD user. This information was then presented by the significant other, to the drug AOD user in order to confront and motivate them into changing their behaviour (Eliany & Rush 1992). Research indicates that these strategies generally result in higher drop out rates, lowered self esteem, greater levels of estrangement from families and high relapse rates (Feinstein & Tamerin 1972; Mattick et al 1998). Indeed, when surveyed clients discussed a preference for assertive actions from

their family members and peers when the context was one of concern rather than criticism (Krishnan et al 2001).

It is not uncommon for family members, partners or friends to contact the counsellor regarding the progress of the client. In such instances, it is appropriate for AOD information, information about the agency's services and how they are provided, and basic support (eg advice and empathy) to be provided. Counsellors need to be clear about issues of client confidentiality. Acknowledgment that someone is in therapy and disclosure of their progress requires the client to provide consent, unless they are minors and not judged sufficiently mature to provide informed consent. Maturity is a professional judgement, and the young person's intelligence, ability to think logically and abstractly, and to think through situations and consider their implications should be considered in making this judgement. Most young people would be considered to be "mature minors" by the age of around 14 or 15, in which case their wishes for confidentiality must be respected.

The inclusion of family members, partners and friends in treatment within a family system context is associated with positive treatment outcomes (Copello et al 2005; Fals-Stewart & O'Farrell, 2003; Fals-Stewart et al 2005; Miller & Hester 1986; Orford, 1994). Jarvis et al (1995) suggest that family therapy in an alcohol and other drug context should be oriented around four goals as follows:

- to change AOD related interactional patterns and develop interactions that support the change in AOD using behaviour;
- to help the family confront and resolve relationship conflicts without the client resorting to problem AOD use;
- to help mend rifts in relationships that have been aggravated as a result of the AOD use; and
- to help the family or couple develop shared activities that are rewarding and do not involve alcohol and drugs.

Jarvis et al (1995) warn that counsellors should be careful to avoid blame and should not highlight the AOD user as the problem.

Specific skills and specialist training is required to undertake family therapy effectively. In contrast, 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. De Civita et al (2000) note that the nature and quality of the relationship between the client and their family members also needs to be considered when including family members in the treatment process, with the degree and nature of their involvement structured according to these relational dynamics.

As young people's drug use has continued to grow and become more complex, and significantly more young people are living at home for longer than ever before, parents are at the front line struggling to cope with all the associated difficulties. Many of the clinical presentations exhibited by parents result from the stress experienced when a child is using drugs. Grief is another issue common to parents with a drug using child. This applies not only to the grief associated with a child's death, but also the grief of things not working out as planned and "lost dreams".

Parents' levels of anxiety and grief should be acknowledged prior to providing advice and working on child/parent strategies. High levels of stress and anxiety and low levels of self or parent efficacy may hamper parents' receptiveness to advice and their confidence in effectively utilising the advice provided. Therefore, the initial aim of working with parents should be to lessen their levels of anxiety and depression, feelings of isolation, raise their self awareness and increase their confidence in managing the situation. There is evidence that 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 (Toumbourou et al 1997).

Supporting parents in their parental role using a model of empowerment means the counsellor works alongside parents to achieve the agreed goals. Previous experiences (what has worked/what hasn't worked), the parent's value system and family norms should be taken into account when providing advice and information on strategies.

Advice/strategies that may be explored with parents include the following:

- knowledge of drugs and drug use issues;
- strengthening parenting role and parent's confidence;
- communication skills;
- conflict resolution;
- negotiating guidelines/boundaries;
- issues of attachment and commitment;
- responding versus reacting;
- remaining calm, consistent and credible;
- accessing additional support (parent support groups, family therapy);
- making time for self, other family members and friends; and
- behavioural contracts.

Most importantly, working with parents should not be seen as an additional or conflicting task but viewed as enhancing the therapeutic endeavour and maximising positive outcome for young people and their families.

Significant others – best practice

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

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

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

Working with significant others as clients in their own right

- Parents, partners, families and friends can be clients in their own right, with individual goals and treatment plans.
- Although not the purpose of intervention, working with this group can provide an avenue for the problem AOD user to seek assistance.
- Accurate AOD information and support should be provided to this group.

Working with significant others as part of an individual client's AOD treatment

- Involving family members is associated with more positive treatment outcomes for the drug user than individual treatment.
- It is often appropriate for significant others to be seen by a counsellor who is not seeing the problem AOD user.
- Counsellors need to be clear about client confidentiality as significant others often seek information regarding the progress of the client.

Significant others – best practice (cont.)

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

- assisting the family member to reduce their level of stress and anxiety;
- helping develop interactions that encourage self responsibility and promote positive change in the drinking/drug use behaviour;
- assisting the family member to deal with conflict in relationships; and
- helping the family member develop coping strategies to minimise the negative impact of the substance use on themselves and enhance their quality of life;

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

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

- knowledge of drugs and drug use issues;
- strengthening parenting role and parent's confidence;
- communication skills;
- conflict resolution;
- negotiating guidelines/boundaries;
- issues of attachment and commitment;
- responding versus reacting;
- remaining calm, consistent and credible;
- accessing additional support (parent support groups, family therapy);
- making time for self, other family members and friends; and
- behavioural contracts.

27. Young people

Working with young people is perhaps one of the more challenging areas in the AOD field. 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 (Brook et al 2006; Grella, 2006; Spooner et al 1996; Towers 1997), as well the risk and protective factors that are linked to problems the adolescent's development (Liddle 2002), and tailor their approach accordingly.

27.1 Developmental issues for young people

These developmental processes include the following.

- Adjusting to physical changes.
- Learning to understand and take responsibility for their sexuality.
- Working towards autonomy while maintaining an emotionally connected relationship with parents.
- Developing a sense of who they are, or personal identity.
- Developing social and working relationships.
- Choosing and making plans for their career.
- Being adventurous and experimental.
- Needing acceptance from their peers.
- Not thinking of the long term consequences of their actions.

- Taking risks.
- Feeling immortal.
- Being unpredictable in their moods and behaviour.
- Needing to rebel against the older generation in society.
- Learning about sexuality.
- Being excitable and restless.
- Finding it difficult to talk about feelings.

These developmental processes can make working with young people challenging, and many traditional counselling interventions are ineffective (Winters 1999). Winters argues that adolescents must be approached differently because of their unique developmental processes, physical differences, and differences in belief and value systems.

27.2 Risk and protective factors

Adolescent drug use occurs in the context of a range of developmental risk and protective factors, and it is these that need to be targeted in a multi-dimensional way in treatment. Risk factors can be grouped into individual, family, peer, school, neighbourhood/community, and societal factors, and these risk factors can influence and reinforce each other (Hawkins et al 1992). For example, parental psychological difficulties may be linked to insecure attachment of child to parent and associated affect regulation problems for the child, unemployment and poverty, poor family management skills, difficulty managing the challenges of a teenager and hence a poor parent-child relationship. The adolescent might react to these difficulties by joining a more accepting drug using peer group and using drugs to rebel and belong and also to cope with emotional distress. Or a teenager with a reactive temperament may influence family relationships and management. For example if the adolescent reacts with intense anger when parents attempt to put boundaries in place, the parents might become chronically frustrated with the adolescent, be less consistent in boundaries to maintain family peace, resulting in less parental monitoring and control over the adolescent and allowing the adolescent more freedom to become involved with drug using peers. Research indicates that higher numbers of risk factors are associated with a higher likelihood that an adolescent will develop a drug problem (eg Newcomb et al 1986; National Drug Research Institute and Centre for Adolescent Health 2004).

Protective factors occur in the same domains as risk factors, and involve connections to prosocial pursuits and relationships inside and outside the family (Liddle 2002). 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).

27.3 Treatment approach

The literature provides increasing evidence that involving families in drug treatment, particularly with young people, is “best practice” (Ozechowski & Liddle 2000). The majority of young people live with one or two parents and research indicates that parents, if appropriately resourced, can positively impact on youth behaviour, including substance use (Toumbourou et al 1997, Liddle, 2004). In addition, because adolescent drug use and associated problems occur in the context of a range of risk and protective factors that influence the course of adolescent development, intervention needs to be multidimensional, focused on reducing risk factors and increasing protective factors across a number of domains.

Multidimensional family therapy

One multidimensional treatment approach for adolescent drug problems that has been well researched and found to have positive outcomes is Multidimensional Family Therapy (MDFT) (Liddle 2002). MDFT is a manualised approach that is rated in recent research as a scientifically proven effective evidence-based treatment for adolescent drug use (National Institute on Drug Abuse 2001) with effectiveness indicated by greater number of good quality of controlled outcome studies and

investigations of the therapeutic process than other approaches (Rigter et al 2005). It is described by Liddle (2002: 228) as “a multicomponent, developmental-ecological treatment for adolescent drug abuse and related problems that seeks to reduce symptoms and enhance developmental functioning by facilitating change in several behavioural domains”.

MDFT is based on several evidence-based assumptions (Liddle 2002: 10):

- “The family is the primary context of healthy identity formation and ego development
- Peer influence is contextual; it interacts with the buffering effects of family against the deviant peer subculture.
- Adolescents need to develop an interdependent rather than an emotionally separated relationship with their parents.”

MDFT assesses and targets adolescent functioning in six domains including drug use, identity development and autonomy, peers and peer influence, bonding to prosocial institutions, racial and cultural issues, and health and sexuality.

MDF includes a number of dimensions (Liddle 2002).

- Outcome orientation. The therapist focuses on the optimal and “good enough” outcomes from every aspect of the intervention. Outcome incorporates immediate, short term, intermediate and long term therapeutic goals. These goals encompass outcome from for example a 5 minute phone call with a parent as well as broader treatment goals.
- Process. This refers to a conceptualisation and plan of how particular therapeutic outcomes can be achieved.
- Development. This refers to the knowledge base from which clinicians work. To work effectively with families and adolescents clinicians need to understand normal adolescent development tasks and processes, and expected and normal changes in the adolescent-parent relationship.
- Problem behaviours. These are conceptualised as deviations from normal development, linked to a range of risk and protective factors. These risk and protective factors that form the context for problem behaviours need to be carefully assessed and targeted in treatment.
- Ecology, which refers to the multiple social ecologies or contexts within which an adolescent operates, such as the family, school and peer group. Assessment and facilitation of change is needed across all problem areas and will often involve working with other organisations such as school and justice.
- Psychotherapy. The psychotherapy approach in the MDFT approach is influenced by behavioural, client centred and AOD-specific counselling approaches. It can address a range of issues including the adolescent’s AOD use, comorbid psychological difficulties and self esteem issues.
- Family therapy. Family involvement is central to an MDFT approach. MDFT has been influenced by several family therapy approaches including Structural-Strategic Family Therapy and Problem Solving Therapy. Family involvement is central.
- Treatment parameters. This refers to structural parameters such as number of sessions, where the sessions are held and so on. These parameters can be flexible and responsive to adolescent and family needs. The program is time limited, usually about 12 weeks, but can include intensive and varied forms of contact during that period.

MDFT treatment has three phases (Liddle 2002):

1. *Building the foundation.* This involves building therapeutic alliances and thoroughly assessing problem areas and potential areas of strength. Therapeutic relationships are developed with adolescents, parents, other family members, and other influential people such as school and justice staff as appropriate. Knowledge of normal adolescent development is used to devise appropriate therapeutic foci for each family member. It includes a counsellor seeing the adolescent and the parents separately.
2. *The working phase.* This phase aims to facilitate developmentally appropriate competence in all areas of the young person's life including individuals, family, peers, school etc. It includes teaching communication and problem solving, and working with key themes such as adolescent and parent beliefs and behaviours that cause family problems, and past hurts and traumas in the adolescent's life and family experiences. Helping the young person to access resources outside the family, such as job training or further education, is also important.
3. *Sealing the changes and exit.* In this phase the focus is on acknowledging and cementing changes that have been made, and enabling the family to continue with progress and generalise new ideas and behaviours. Positive change is expected on many fronts such as the adolescent's drug use, school attendance, criminal involvement and relationships; and the family's ability to handle difficult situations and resolve problems.

Liddle (2002) notes that most therapists using the MDFT approach have at least psychology masters degrees in clinical work, need to have a systems-oriented family therapy background, and need to be prepared to work intensively with the adolescent and the family and engage in supervision.

Whether or not counsellors adopt the manualised MDFT approach, it is recommended the general principles and approaches inherent in the approach be included in all treatment with adolescents with substance use problems.

Specific issues to be addressed in adolescent AOD treatment

Consistent with the MDFT approach, a number of specific issues should always be incorporated into treatment with adolescents.

Taking a multidimensional and practical approach

Many young people entering alcohol and other drug treatment experience a number of difficulties including family, psychological, accommodation, legal, education and training, social and recreational issues. It is important that the counsellor addresses these with young people, and where appropriate links them to additional services.

Including family members

Family is central to positive adolescent development and positive family relationships are protective against problematic adolescent behaviour, including substance use. Note that although counsellors need training to conduct family therapy, training is not needed for counsellors work with many young people and their parents to enhance family functioning. Family therapy proper is likely to be necessary for more complex family situations, however, and so it is recommended that AOD treatment agencies ensure they have trained family therapists on staff, and offer family therapy training to as many staff members as possible.

Being flexible in approach

It is important that agencies and counsellors be creative and flexible in their approach to young people. Working with alternative mediums (such as art and music) and outside the traditional treatment setting (talking while playing pool, going to a coffee shop etc) are often important components of effective treatment with adolescents. For example, Keen (2004) demonstrated the use of music during treatment to be a useful mechanism for gaining the trust and confidence of adolescent clients.

Providing practical and concrete strategies

For most young people, the most effective type of intervention involves providing them with concrete and practical coping strategies. A study conducted by Azrin et al (1994) cited in Spooner et al (1996) compared the relative efficacy of a behavioural treatment program and a supportive counselling program over 15 sessions and across 26 adolescents randomly assigned to one of the programs. The behavioural program consisted of stimulus control, urge control, social contracting, problem solving, relationship enhancement, anger management and communication skills training. They found that only 9% of the supportive counselling participants were abstinent versus 73% behavioural program participants at the month prior to follow up. Similar results cited by Kamier and Waldon (2006) have emerged in studies comparing cognitive-behavioural treatment programs and psychoeducational therapy (Kamine et al 2002). Research supports the use of motivational interviewing, problem solving, relapse prevention, social skills training, anger management, and cognitive restructuring (Kaminer & Waldon 2006; Spooner et al 1996). Note that although process oriented psychotherapy is usually not appropriate due to the levels of chaos and confusion that mark adolescence, it can be effective as another component of counselling with some young people by the time they reach late adolescence.

Working with other agencies already involved with each client

In order to ensure commonality of approach, open communication via case discussions between all the agencies involved with the young person is essential. In the event that a case manager has not been assigned to the young person, a shared case management approach may be appropriate (see ***Case Management***).

Linking clients to ancillary services

Counsellors should link clients to additional medical, psychological or psychiatric services when required.

Using harm reduction strategies where appropriate

Towers (1997) argues that it is unrealistic to expect many young people to completely cease using all substances and engaging in other risk taking behaviours (such as driving at high speeds, promiscuity), at least initially. Given that young people are more likely to present with non-abstinence based treatment goals (Adamson & Sellman 2001), it is important that counsellors include harm reduction strategies when working with this population.

Counsellor qualities

The literature also suggests that a number of counsellor qualities are important when working with young people (Spooner et al 1996; Towers 1997). These include understanding the developmental processes of adolescence, having a sense of humour, maintaining consistent limits, relating at the level of youth, setting clear boundaries, allowing young people some freedom of choice and honesty (Towers 1997).

Responding to psychological comorbidity

There is a high incidence of psychopathology and complex psychological difficulties among young substance users presenting for alcohol and other drug treatment (Brown & Ramo 2006; Burkstein et al 1989; Newcomb 1987; Young et al 1995). Such difficulties include mood disorders, conduct disorder, anxiety disorders, dissociative disorders, attention deficit hyperactivity disorder, schizophrenia and eating disorders (Jainchill 2006; Spooner et al 1996). Late adolescence is also the most common time for a psychotic disorder (eg schizophrenia, bipolar disorder) to initially present, and it can be difficult to distinguish between symptoms of a psychiatric disorder and the symptoms of a drug induced psychosis.

Research has consistently demonstrated that young people with co-existing psychological problems have less positive outcomes from traditional AOD treatment approaches than those without co-existing psychological difficulties (Grella 2006). Young people who have AOD problems as well as other psychological difficulties are also more likely to experience relapse following treatment for their substance use (Brown & Ramo 2006). This highlights the need to be vigilant at detecting co-occurring

psychological problems, thus enabling effective therapeutic response to the client's array of symptoms, which may often require referral for psychiatric assessment and intervention, as well as more intensive treatment (Grella).

27.4 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

Maturity is a professional judgement, and the young person's intelligence, ability to think logically and abstractly, and to think through situations and consider their implications should be considered in making this judgement. Most young people would be considered to be "mature minors" by the age of around 14 or 15. In this case there is no obligation to provide information to the parents unless other legal and reporting constraints operate, and confidentiality must be respected. In most circumstances, however, it is helpful to have parents involved in treating young people, and this should be discussed with the young person at the outset of treatment and their consent for parental involvement sought.

When working with young people who are unable to give voluntary informed consent, clinicians must protect the minor's best interests and consider their responsibilities to inform the parents or guardian. Parents or guardians have a right to information about the treatment of such a young person, as their legal responsibility for the young person's interest takes precedence over the wishes of the young person. However, counsellors should explain these limits of confidentiality to the young person and endeavour to gain their consent.

Young people – best practice

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

Research indicates that regardless of the family's relationship to the young person's problem, they always need to be involved in the solution, as treatment that does not include the family is less likely to be successful in the long run.

MDFT is an evidence-based treatment which has shown very good outcomes for adolescent AOD use and related problems. It is based on several evidence-based assumptions (Liddle 2002: 10):

- “The family is the primary context of healthy identity formation and ego development
- Peer influence is contextual; it interacts with the buffering effects of family against the deviant peer subculture.
- Adolescents need to develop an interdependent rather than an emotionally separated relationship with their parents.”

MDFT adopts a multidimensional approach to treatment with interventions targeted across a range of areas according to client needs, and incorporates family therapy as a central intervention. Counsellors should be familiar with the MDFT approach and ensure they incorporate key principles and approaches into their work with adolescent drug users and their families.

Effective treatment with young people should:

- be multidimensional and practical;
- include the family;
- be flexible in approach, using outreach services;
- providing practical and concrete strategies;
- include working with other agencies already involved with each client;
- include assessment of co-morbid mental health symptomatology and referral for psychiatric assessment as necessary;
- link clients to additional medical, psychological or psychiatric services when required; and
- include the appropriate negotiation of harm reduction strategies (see *Harm Reduction*).

Important counsellor qualities include:

- understanding the developmental processes of adolescence;
- having a sense of humour;
- maintaining consistent limits;
- the ability to relate to young people and their parents;
- setting clear boundaries; and
- allowing young people some freedom of choice.

The limits of confidentiality as regards disclosing information to parents and guardians are influenced by assessment of maturity of the young person to provide informed consent and by the treatment being provided. In most situations it is helpful to have parental involvement, and this should be discussed with the young person at the start of treatment. Consent must be obtained from “mature minors” for parental involvement.

28. Child protection

Although problematic AOD use does not necessarily result in poor parenting, it is often a contributing factor to negative child outcomes. Research suggests that between 22% and 62% of emotional abuse and neglect cases are the result of parental substance abuse (Angus & Hall 1996; Clark 1994; Dawe et al 2007; Forrester 2000; Kroll 2004; Semidei et al 2001). Indeed, children who have at least one parent with substance use problems are two times more likely to experience physical or sexual abuse (Walsh et al 2003). Research also documents that such children are at greater risk of developing emotional, behavioural or social problems (Christensen & Bilenberg 2000; Kelley & Fals-Stewart 2002).

Although AOD use is commonly implicated in child abuse and neglect, it is rarely the only factor. Usually there is a picture in “at risk” families of multiple disadvantage often also including domestic violence, mental health problems, parents who experienced abuse or neglect as children, financial problems and/or housing problems (Dawe et al 2007). It appears that rather than being related to substance use per se,

“adverse child outcomes are related to the complex interplay between parental substance abuse, parental psychopathology, parenting practices, family environment (including spousal relationship and the availability of social support), and socioeconomic factors such as unemployment and poverty. Each of these factors in and of themselves affects child outcomes.” (Dawe 2007: 44)

These findings indicate that when working with AOD using parents, counsellors must be equipped to:

- accurately assess and manage the potential risk of harm to a child in their AOD using client’s care, and
- work in a multi-systemic manner with the parents to address other areas of difficulty that impact on their parenting capacities.

28.1 Assessment and management of safety

Issues of childcare and risk to children should be raised gently and in the context of a supportive therapeutic relationship. During the initial assessment counsellors should establish whether the client currently has children in their care, or with whom they have access visits. If a level of suspicion exists as a result of the assessment interview, structured assessment instruments can be used to explore child safety in more detail.

The *Hearth Safety Assessment Tool* (Robinson & Camins 2001) is designed to help counsellors assess specific areas of risk and strengths to provide clinicians with an overall picture of the global level of the child’s risk of harm in a drug using environment. This tool has not been subjected to reliability and validity studies, but is nevertheless widely used in AOD treatment services in Western Australia. There are two components to the assessment, the first of which explores the impact of AOD use on the parent’s ability to respond to the needs of a child, and the second which assesses other factors that contribute to the safety of the child. When assessing risk, counsellors should consider the age of the child and the potential short and long term consequences of parent substance use. Short term consequences involve safety issues and the parent’s ability to respond to the physical needs of the child. Long term consequences arise from the parent’s ability to provide comfort, consistency and to be emotionally available. The *Hearth* instrument covers a number of important areas, but does not ask about violence in the relationship between the parents or towards the child, or about the child’s potential exposure to risk from associates of the parents, which should always be examined. Training is required to use the tool.

Another instrument to assist with assessing parenting and child safety in the context of parental drug use that is freely available on the web, does not require training, covers a range of important areas including violence and exposure to potential risk, though has also not been evaluated for reliability and

validity, is the *Risk Assessment Checklist for Parental Drug Use*¹³. This is an Australian instrument designed to assist clinicians and clients to make connections between drug use and parenting and to assist in identifying parenting problems and tracking improvements. It is freely available on the Drugnet website.

The Department of Health (2004) guidelines suggest that counsellors gather information from the following categories when assessing the safety of a child (for detailed questions see Child Protection Issues in the Counsellor Manual):

- The child's
 - age;
 - development;
 - functioning; and
 - behaviour.
- The parent's
 - attitudes to harm and receiving help;
 - relationship to the child;
 - functioning and parenting capacity; and
 - drug use.
- Protective factors in the child's environment
 - visibility in the community (eg attends child care, school);
 - access to supportive adults (eg teachers, other family members); and
 - engagement with other services.

The Drug and Alcohol Office (2007) recommends that the assessment of child safety be used to determine whether a child is currently at immediate risk or possible risk, following which appropriate management strategies should be implemented.

- Immediate risk is indicated if:
 - any physical abuse is present;
 - sexual abuse has been disclosed or evidenced;
 - threats or behaviours towards the child indicate a probable intent to harm the child;
 - the child has been left unsupervised or with irresponsible/unsafe adults;
 - the parent's ability to ensure the safety of a child is grossly impaired by their current level of intoxication;
 - the parent's behaviour is chaotic with escalating levels of unsafe substance use; or
 - increased risk is also indicated if the child is under 5 years of age.
- Managing immediate risk:
 - If the child is present at the time of assessment, delay the child from leaving the premises until consultation with a social worker and/or a referral to an appropriate child protection service has been made.
 - Record all relevant information and referral details in the client's file.
- Possible risk is indicated if:
 - the client's child is not engaged with any other services or other responsible adults who can monitor their safety (eg are not at child care centre, school or being cared for by other family members);
 - the child has a medical condition and/or disability;
 - there is evidence of inadequate housing, food, clothing or hygiene;

¹³ Available from Drugnet website: <http://www.drugnet.bizland.com/assessment/checklis1.htm>

- parent's mood/behaviour is unstable; or
 - increased risk is also indicated if the child is under 5 years of age.
- Managing possible risk:
 - Raise concerns with parent/s and advise them of counsellor's duty of care.
 - Document concerns.
 - Consult with social worker or medical consultant.
 - Encourage client to voluntarily engage with an appropriate child protection or parenting service to access support and services.
 - Continue to monitor the situation and if no improvement is noted or the situation escalates follow immediate risk management strategies.

Counsellors should always seek the advice and support from supervisors and specialised colleagues (eg social workers) regarding risk assessments and treatment plans. Counsellors can also consult anonymously with Department for Child Protection regarding child protection and safety issues.

28.2 Intervention to improve parents' lives

Intervention with AOD using parents involves balancing child protection with interventions to improve parents' lives (Dawe et al 2007; Knight & Wallace 2003). It involves multisystemic interventions to:

- enhance the protection and care for children; and
- improve the quality of life for parents, by helping them with a range of issues as necessary (eg parenting skills, drug related problems, family discord, co-occurring psychological disorders, support systems, safety of the familial environment, housing, education, employment, and support systems).

It has been shown that a reduction in children's exposure to emotionally disruptive familial influences improves their psychosocial functioning (Kelley & Fals-Stewart 2002). Many couples with AOD problems have conflicted and often violent relationships, and often they grew up with domestic violence and other childhood abuse (Dawe 2007). Counsellors can therefore reduce the risks experienced by children of parents with substance use difficulties by providing the parents with relationship counselling aimed at reducing levels of familial disharmony and associated incidents of verbal and/or physical aggression.

Dawe (2007) reviews evidence indicating that AOD clients commonly have co-occurring psychological disorders and report exposure to high levels of trauma, often in childhood. The psychological adjustment of the primary caregiver is recognised as a significant factor in child outcome. Indeed it is unclear whether AOD use alone is any more detrimental than psychopathology alone in terms of its impact on the child (Luthar et al 1998). What is consistently found, however, is that co-occurring disorders such as AOD and a psychological disorder, or multiple psychological disorders, have a greater impact on child outcomes than a single disorder (Dawe 2007). The implication of these findings is the importance of addressing not just on parental AOD problems, but also on mental health problems and their impact on parenting.

It is also important for counsellors to build on the current strengths of parents and families. For example, some research suggests that when working with parents with substance-related difficulties counsellors should consider the possibility that the sense of responsibility clients derive from their role as a parent may facilitate greater levels of motivation to change (Metsch et al 2001), a strength which can be drawn upon throughout the intervention. Specific parenting training can further build on this sense of strength. A significant protective factor for children experiencing a range of adversities including poverty, maltreatment or multiple risks is a secure relationship with parents achieved through sensitive and responsive caregiving (Dawe 2007). Enhancing the parent-child relationship by supporting parents, as well as educating parents about how to provide children with such a secure

relationship characterised by sensitive and responsive care is therefore crucial. Useful resources and handouts for parents (particularly those who have young children) can be found at <http://www.circleofsecurity.org/downloads.html>. Also important is providing direct parenting assistance with practical issues (eg education, problem solving, behaviour management, how to talk to children about their drug use). Assisting parents to increase the safety of the home environment is another important aspect of increasing sense of parenting efficacy (eg helping them to set boundaries around who comes into the house, not exposing the children to drug paraphernalia or intoxicated people).

Psychosocial interventions such as employment and vocational assistance, and building other support systems may also need to be incorporated into treatment as a means of improving the overall functioning of a family (Grella et al 2006).

Counsellors also need to be aware of the stigma associated with being a substance using parent accompanied by the pervasive fear about having their children taken away. Evidence suggests these feelings prevent many substance using parents from accessing treatment services (Barnard & Barlow 2003; Jessup et al 2003). As Street et al (2004) demonstrated, this lack of engagement with treatment programs increases the level of risk to the children. Those 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. It is imperative that the issue of childcare is raised extremely gently and in the context of a supportive therapeutic relationship. Clients who 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 (Grella et al 2006; Knight & Wallace 2003).

Research also suggests that drug using parents are often experienced as very difficult and frustrating clients to manage and treat (Semidei et al 2001), thus counsellors are encouraged to monitor their own countertransference reactions to avoid ruptures in the therapeutic relationship.

Mobility restrictions of many counsellors may preclude their visiting clients in the home and hence make it extremely difficult to conduct a risk assessment accurately and design an appropriate intervention plan. 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 (Semidei et al 2001). Therefore, strategies such as involving children at some point in the counselling process or involving the client's non using partner or other adult support can help to establish the child's situation. It may be necessary, particularly when there are young children, to refer the family to a service that has the capacity for home visits and intensive support. Such agencies in Western Australia include Attached (previously called Hearth, outpatient), Perth Women's Centre Pregnancy and Early Parenting Project (outpatient) and Saranna (residential). Referrals to more intensive services may also enable the complex issues often faced by families with substance using difficulties (including domestic violence, mental illness, trauma, economic/housing insecurity etc.) to be dealt with more effectively (Dawe et al 2007; Grella et al 2006; Semidei et al. 2001).

Some research also suggests that the responsibilities associated with parenting prevent women from making the effort to access treatment for their AOD difficulties (Knight & Wallace 2003). This may account for further research demonstrating that mothers who enter residential treatment facilities that allow their children to remain with them are more likely to remain in treatment (Grella et al 2006). Thus an integral part of addressing child protection issues among AOD clients may include the provision of appropriate treatment facilities that assist parents in the task of juggling their parenting responsibilities with their treatment efforts (Knight & Wallace 2003).

The perspective of children living with parents who have AOD problems is often neglected. Dawe (2007) reviewed this limited research which indicates that children generally know about parental drug use earlier than the parents were aware of, do not say anything about for fear of being rebuffed or separated from their parents, have fears for their parents' health and safety, have concerns about violence, and experience distress at concluding they come second to the drugs. She concluded that

children need to be provided the opportunity to talk about their experiences and have some help to understand their parents' drug use in an age-appropriate manner.

Child protection – best practice

Intervention with AOD using parents involves balancing child protection with interventions to improve parents' lives. It involves:

- enhancing the protection and care for children by accurately assess and manage the potential risk of harm to a child in their client's care, and
- helping improve the quality of life for parents by working in a multi-systemic manner with the parents to address other areas of difficulty that impact on their parenting capacities.

Assessment and management of child safety

Issues of child care and risk to children should be raised gently in the context of a supportive therapeutic relationship.

Counsellors should make inquiries regarding the family unit and the children's welfare as a routine part of assessment.

Involving the children or a client's non using partner or other adult support at some point in the counselling process can help to establish the child's situation.

Counsellors should assess the potential risk of harm to a child when working with a drug AOD using parents. This can be done by exploring information from the following areas:

1. child's functioning;
2. parents' functioning; and
3. protective factors in the child's environment.

Assessment instruments such as the *Risk Assessment Checklist for Parental Drug Use*¹⁴ or the *Hearth Safety Assessment Tool* may be useful if a level of suspicion exists.

If the risk is assessed to be either immediate or possible, appropriate management strategies should be implemented. Department for Child Protection can provide confidential consultation.

Interventions to improve parents' lives

In conjunction with the parent's substance use interventions a range of other issues often need to be addressed such as: parenting skills, drug related problems, family discord, co-occurring psychological disorders, support systems, safety of the familial environment, housing, education, employment, and support systems, and reducing barriers to treatment.

Children in AOD using families should be provided with opportunities to talk about and understand their experiences with their AOD using parents.

If it becomes necessary to involves Department for Child Protection or to refer the family to a service that has the capacity for home visits and intensive support, these interventions should be framed in positive terms as a way of providing help.

¹⁴ Available from Drugnet website: <http://www.drugnet.bizland.com/assessment/checklis1.htm>

29. Women

There has been debate as to whether services specific to women are warranted given the fact that men make up a larger proportion of the potential treatment population (Wodak 1992). The Final Report of the Select Committee Into the Misuse of Drugs Act 1981 (1998), on the basis of a review of research and consultation with practitioners, supported the notion of women receiving gender specific services. It was noted that special consideration should be given to women's issues in mixed gender services.

The literature cites a number of issues that services need to be conscious of when working with women regarding a substance dependence or abuse context. These issues reflect the notion that the life context in which harmful drug use is embedded is psychologically, physiologically and socially different for men and women (Bernard 1981; Cowen et al 2003; Hser et al 2005; Thomas 1997).

At a biological level, there are physiological differences between men and women in terms of the effects of drug use. While men tend to drink or use drugs in a more harmful fashion than women, women often experience physical effects of alcohol misuse sooner than their male counterparts (Thomas 1997). 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 (Baily 1991; Dunne 1988; Grupp 2006). Hence, it is important that counsellors working with women be well informed as to the specific risks associated with drug use.

Some research suggests that women's drug use needs to be viewed systemically, in relation to the roles and expectations placed on women by society (Copeland 1993; Cowen et al., 2003; Jarvis et al 1998; Swift & Copeland 1998). Thomas (1997) argues that society considers it much more unacceptable for women than men to have AOD problems, especially when the drug use is of an illegal nature. As a result women in AOD treatment may be more likely to suffer greater levels of shame, stigmatisation and powerlessness. All these issues need to be acknowledged and addressed during the course of treatment.

Research also indicates that depression, anxiety and somatic and personality disorders are particularly prevalent among women engaging in treatment (Darke et al 1992b; Deas et al 2006; Hser et al., 2005; Neale, 2004). Hall et al (1998) found that 46% of women with an AOD disorder also met the criteria for either an anxiety or affective disorder. Other research has demonstrated poor self esteem and self image, high rates of suicide attempts and co-morbid eating disorders as being particularly common to women with AOD issues (Copeland 1993; Klee et al 1991).

Histories of sexual abuse and assault are also common in women with AOD problems (Covington 1986; Grupp, 2006; Jarvis et al 1998; Neale, 2004; Rohsenow et al 1998; Swift & Copeland 1998; Swift et al 1996). In addition, many women presenting for treatment also experience higher levels of domestic violence than the general population (Miller et al 1989). In light of this evidence, Grupp (2006) and Cowen et al (2003) highlight the importance of treatment settings being capable of providing a safe environment for women, which is one of the rationales behind the provision of gender specific services.

From the literature it is recommended that women be offered the option of a female counsellor, and where appropriate and possible be provided with information and/or referral regarding women only AOD services. Research also suggests that women perform better in women only groups. Therefore, it is recommended that female clients be offered the option of gender specific therapeutic groups. Some evidence also suggests that women are more likely than men to participate in and benefit from self-help groups (Grella et al, 2005; Timko et al 2002).

The literature also suggests that treatment with female clients is more likely to be successful if any underlying issues (eg depression or anxiety) are treated directly, rather than treatment focusing primarily on drug use (Connexions 1997). Research also confirms the importance of social support to

successful treatment outcomes. Where appropriate, treatment programs should link women to social support groups and expand their support networks.

On a practical note, the Final Report of the Select Committee into the Misuse of Drugs Act 1981 (1998) repeats suggestions that treatment services should consider the provision of child care, and in residential services, should offer separate bedroom and bathroom facilities for men and women. Cowen et al. (2003) and Gossop (2003) suggest that providing access to childcare and the provision of parenting skills education may be an important component of relapse prevention.

Women – best practice

When working with women it is recommended that:

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

30. Pregnant women

While the issues relevant to working with women in general are also applicable to working with pregnant women, there are issues specific to this latter population. Due to the health risks associated with drug use during pregnancy, it is important that counsellors facilitate clients' engagement with appropriate medical personnel. Gossop (2003) argues that optimal care for women during the antenatal period involves the maintenance of good channels of communication between AOD counselling services, antenatal clinics and obstetric hospitals.

When working with pregnant women with AOD issues counsellors should liaise with and refer the client to relevant medical personnel, and facilitate engagement in antenatal chemical dependency units when they exist at local hospitals. Counsellor should not recommend the sudden cessation of drug use, especially opiates, without seeking medical assistance as some withdrawals have the potential to cause miscarriage (Ward et al 1998e).

Counsellors also need to be aware of the increased levels of shame and stigmatisation that AOD using pregnant women may suffer. It may also be useful to offer interventions aimed at developing parenting skills to reduce the risk of heightened stress following the birth of the child (Gossop, 2003).

Pregnant women – best practice

When working with pregnant women it is recommended that:

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

31. Men

There is general agreement that men respond better to more concrete, action oriented treatment approaches. Indeed, research suggests that men are more likely than women to employ concrete behavioural and cognitive coping strategies (eg problem solving) (Timko et al 2005). Therefore, cognitive behavioural treatment techniques are recommended when working with men.

Research also supports a strong link between drug use (especially drinking) and violence. There is also some evidence indicating high rates of antisocial personality disorders among male substance users (Grell, 2003; Mattick et al 1998). Similarly, among adolescent populations, there is a higher prevalence of conduct disorder behaviours among male substance users (Deas et al 2006). It is recommended that treatment involve an exploration of the consequences of anger, violence (including family violence) with specific skills training involving anger management strategies where appropriate.

Anecdotal evidence and research also suggests physical, emotional and sexual abuse in male clients seeking AOD treatment is common (Simpson & Miller 2002). As with women, this creates feelings of shame, guilt and powerlessness, which are often compounded by the feelings associated with dependency. Counsellors need to be aware of these issues when working with men and consider referral to an appropriate practitioner or service when necessary.

It is also important to consider the high rates of completed suicide among males as opposed to females. Men are much more likely to choose lethal means for suicide attempts and therefore, are much more likely to be successful. Counsellors should always explore suicidal ideation.

There is evidence to suggest that men perform better in mixed gender groups. Therefore, in order to respect the recommendations for working with women, it is recommended that men participate in mixed gender groups with women who also choose to be in mixed gender groups.

Men – best practice

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

When working with men the following is recommended that:

- counsellors are sensitive in their assessment of issues of past sexual or other abuse;
- counsellors be aware of the lethality of male suicide attempts and always explore suicidal ideation;
- where appropriate, men are encouraged to examine consequences of anger, violence, or domestic violence;
- where appropriate, anger management strategies are incorporated in the intervention;
- men are encouraged to examine alternative coping skills to alcohol and other drug use; utilisation of cognitive behavioural strategies is recommended; and
- where possible, men are included in mixed gender groups with women who also choose to be in mixed gender groups.

32. Culturally and linguistically diverse

With the population of Australia consisting of such a high level of migrants counsellors should be aware of issues pertaining to working with people who are culturally and linguistically diverse (CLD). In 2004-2005, 86% clients in AOD treatment services in were born in Australia and 95% reported Australian to be their preferred language (Australian Institute of Health and Welfare 2006). Although research indicates that the prevalence of AOD problems is generally lower in people from a CLD background than in the general population, they are nevertheless considered to be under-represented in treatment services (Donato-Hunt 2007). Reid et al (2001) argue that this low rate reflects the perception by CLD clients that services are unsuitable rather than a low prevalence of AOD problems in CLD communities and it is unrealistic to expect sufficient culture-specific AOD treatment services can be established (Drug and Alcohol Multicultural Education Centre [DAMEC] 2007). As a result, DAMEC (2007) states that “the best treatment outcome for a CLD client is likely to come from collaboration between AOD treatment agencies and ethnospecific services”.

Some of barriers to CLD clients and their families accessing AOD treatment include (DAMEC 2007; Houseman 2003):

- different expectations of treatment and difficulty clarifying these due to language barriers;
- lack of familiarity with what AOD treatment services are available;
- confusion about AOD dependence;
- language difficulties which make participation in AOD treatment programs difficult;
- counsellors at more culturally appropriate service (ethnospecific or bilingual such as a migrant resource centre) not having sufficient AOD knowledge; and
- wanting to seek treatment outside their own community for fear of the shame and stigma of being found out in their own community, yet fearing seeking help outside their community for fear of being judged.

DAMEC (2007) suggests several ways of improving treatment access for CLD clients:

- Manage expectations: explain that the client can request an interpreter, explain what is available in terms of treatment.
- Have an AOD worker conduct the initial assessment, with the aid of an interpreter if necessary, as the AOD worker’s expertise will be necessary for developing an appropriate treatment plan.

- If the client is then referred to an ethnospecific or bilingual service that does not specialise in AOD problems for ongoing treatment, the AOD service should provide support to the case worker working with the client.
- If an agency has a considerable number of clients of a particular ethnicity seeking AOD treatment, consider employing a bilingual worker who is trained or can be trained in AOD issues.
- Implement policies that promote collaboration between AOD workers and ethnospecific agencies and migrant resource centres.

Houseman (2003) argues the importance when working with CLD clients of understanding their AOD use in the context of their cultural base. She argues that gaining knowledge of their cultural base provides a context for understanding how they might be interpreting and feeling about their experiences with substance use and in AOD treatment, and helps the counsellor avoid making assumptions that may be wrong. Houseman suggests this involves gathering information about three aspects of clients' lives:

1. Context of the migration: why they left their country of origin, how they got to Australia, their legal status, whether they have residency, any trauma experiences in the context of their country of origin or migrating to Australia.
2. Subgroup membership: ethnicity, gender, sexual orientation, area in which they live, refugees or immigrants, religious affiliation
3. 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 the new ones; *assimilated* if they have completely given up their old beliefs, values and behaviours and adopted those of the new country.

Be aware that many clients from CLD backgrounds place a much higher value on extended family than non-CLD clients as they come from a collectivist rather than individualist perspective. Individualism refers to the tendency of people in some cultures to value individual identity, rights and achievements over those of the group, and for people to be expected to look after themselves and their immediate family. Collectivism refers to the tendency of people in other cultures to value group identity and concerns over individual concerns, and for people to be integrated into strong, cohesive in groups, which provide them with protection in exchange for unwavering loyalty (Hofstede 1991).

When working with CLD clients who come from a collectivist perspective, counsellors need to be particularly oriented towards family sensitive practice (see *Significant Others*), and when appropriate build a sensitive collaboration with families. Essentially family sensitive practice involves working in an open, respectful and collaborative fashion with families *if the primary client indicates they would like them to be involved*. If the client does not want them involved, it involves helping them to access support and counselling of their own.

Note also that the use of interpreters can be problematic. First, confidentiality needs to be carefully addressed. Second, feedback from CLD workers suggests that some CLD clients may be reluctant to use an interpreter in case the interpreter comes from their own community, and in case the interpreter is known to them, which can heighten shame. Third, some clients may be reluctant to disclose some things in front of an interpreter who is not a trained counsellor. Fourth, languages often can not be directly translated into English, and visa versa.

Culturally and linguistically diverse – best practice

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

Work from the principle that "the best treatment outcome for a CLD client is likely to come from collaboration between AOD treatment agencies and ethnospecific services" (DAMEC, 2007).

Be aware of potential difficulties for CLD clients seeking AOD treatment:

- different expectations of treatment and difficulty clarifying these due to language barriers;
- lack of familiarity with what AOD treatment services are available;
- confusion about AOD dependence;
- language difficulties which make participation in AOD treatment programs difficult;
- counsellors at more culturally appropriate service (ethnospecific or bilingual such as a migrant resource centre) not having sufficient AOD knowledge; and
- wanting to seek treatment outside their own community for fear of the shame and stigma of being found out in their own community, yet fearing seeking help outside their community for fear of being judged.

To make treatment more accessible and effective:

- Manage expectations: explain that the client can request an interpreter, explain what is available in terms of treatment.
- Have an AOD worker conduct the initial assessment (with the aid of an interpreter if necessary) as they have the expertise to develop an appropriate treatment plan.
- If the client is then referred to a specific or bilingual service that does not specialise in AOD problems for ongoing treatment, the AOD service should provide support to the case worker working with the client.
- If an agency has a considerable number of clients of a particular ethnicity seeking AOD treatment, consider employing a bilingual worker who is trained or can be trained in AOD issues.
- Implement policies that promote collaboration between AOD workers and ethnospecific agencies and migrant resource centres.

Understand the cultural b of the client's AOD use by the context of their migration, subgroup membership, and degree of acculturation.

Be aware of potential problems when thinking of using an interpreter, such as client concerns re confidentiality, the interpreter coming from their own community or being known to them, and difficulty translating some languages accurately.

Be aware of the potential need to include family members in treatment, particularly if the client comes from a collectivist perspective and wants family involvement.

33. Aboriginal people

Existing mainstream models of practice in the AOD field have been developed primarily within western systems of knowledge and may ignore an Aboriginal 'worldview'. Application of these models to working with Aboriginal people can be detrimental, to the extent that some approaches can directly undermine Aboriginal cultural ways of working resulting in Aboriginal people feeling disempowered as their cultural beliefs/values and family systems are ignored, misunderstood or disrespected. This can result in Aboriginal people disengaging from seeking support and treatment. In the past there have also been efforts to impose approaches from Indigenous people in other countries

on Aboriginal Australians. This can also have devastating outcomes as it weakens Australian Aboriginal culture and often these approaches are embedded in western disease ideology which is very different to an Aboriginal concept of holistic health and well being.

As a result of these concerns, AOD evidence based approaches that are central to Aboriginal ways of working have been developed. These new models, framed from within an Aboriginal cultural context and developed by Aboriginal people, appear to be more effective. These models are considered to be culturally secure in that they respect the legitimate rights, values and expectations of Aboriginal people and acknowledge the diversity within and between Aboriginal communities living in remote, regional and metropolitan areas. These models:

- 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; and
- work from within empowerment principles.

The concept of the spirit is also central to these new models. Casey and Keen (2006) at Drug and Alcohol Office in WA have developed a number of models and associated resources: Strong Spirit Strong Mind. In essence, Strong Spirit Strong Mind articulates the importance of strengthening our Inner Spirit to enhance good decision-making and support behavioural change, not only at an individual level but also at a collective level with family and community. This approach draws on work by Roe (2000) and should be considered as a way forward in our endeavours to address AOD related harm for Aboriginal Australians. The resource outlines how working with Inner Spirit can be applied in a therapeutic context and incorporates culturally secure Cognitive Behavioural Therapy (CBT) approaches. The models provide a framework for understanding the structure of traditional Aboriginal life, the implications of colonisation and the introduction of alcohol and other drugs, the effects of ongoing oppression and their continuing impact upon the lives of Aboriginal clients, their families and their communities.

It is important when working with Aboriginal clients that non-Aboriginal workers have an understanding of how these areas may impact on the client's life experiences and consider the underlying issues that often present with alcohol and other drug use problems. The Strong Spirit Strong Mind resource (Casey & Keen 2006) includes information about how to work with the client, family or community in culturally secure ways.

Considering how mainstream models apply to Aboriginal ways of working is also useful. Social Learning Theory (SLT) acknowledges drug use is learned and that people learn to use drugs in the environment they live. This approach complements traditional Aboriginal ways of learning as Aboriginal people have always learnt from their elders, other family and community members on a day-to-day basis through observing, listening and trying it out. This was applied to all aspects of life and remains an on-going process today. Since colonisation Aboriginal people have been predisposed to hazardous and harmful patterns of AOD use by the broader Australian society. Today this continues, but now the stronger influence is Aboriginal people learning hazardous and harmful patterns of AOD use from their own people. Although in keeping with traditional ways of learning, this has tragic consequences on the health and well being of Aboriginal people.

SLT also recognises that that people have reasons for using drugs, outcomes can be positive and negative, and multiple factors influence drug use. The complexity of interrelated physical, social, emotional, economic and environmental inequalities that contribute to and exacerbate AOD use

Aboriginal people means that a range of culturally secure principles need to be incorporated into responses:

- A whole-of-system approach across government and community organisations should be adopted to ensure that program design and service delivery is effective and makes best use of available resources. Partnerships and collaboration across levels of government as well as with mainstream non-government agencies, Aboriginal organisations and individuals are central.
- Capacity building for the individual, family, community and non-government and government sectors is needed, to assist them to better identify and address issues and gain the knowledge and experience needed to solve problems and implement change.
- Workforce development is needed in terms of increasing the number of skilled Aboriginal people employed and their effectiveness in contributing to the Aboriginal AOD area, and also providing support and increasing the skill non-Aboriginal employees in effectively working with Aboriginal people.
- Cultural awareness training should ideally be provided for non-Aboriginal workers prior to working with Aboriginal clients.
- Non-Aboriginal workers should receive on-going cultural supervision when working with Aboriginal clients.
- Aboriginal clients should be offered referral to or additional support from Aboriginal-specific AOD services where possible.
- When counselling an Aboriginal person, workers 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, including family members in the counselling as much as possible (Williams et al 2006).
- A flexible approach is needed when working with Aboriginal clients, as family, community, and cultural obligations will often take precedence over appointments.
- Counsellors should be aware of the high levels of grief and loss that are a constant factor in the lives of many Aboriginal people, their families and communities.
- Counsellors should be aware of the impact of intensely distressing levels of shame that many Aboriginal clients experience, this can become exacerbated when dealing with a Non-Aboriginal counsellor/worker.
- Cognitive behavioural approaches work well with Aboriginal people providing they are used in culturally secure ways.
- AOD workers should consider using Strong Spirit Strong Mind (Casey & Keen 2006) as a model and resource when counselling Aboriginal people with AOD problems.

Aboriginal people – best practice

Only culturally secure ways of working should be used when working with Aboriginal people, their families and communities.

Culturally secure ways of working respect the legitimate rights, values and expectations of Aboriginal people and acknowledge the diversity within and between Aboriginal communities living in remote, regional and metropolitan areas.

Culturally secure models of working:

- incorporate an Aboriginal holistic concept of health and well being;
- are grounded in an Aboriginal understanding of the historical factors, including traditional life, the impact of colonisation and the ongoing effects;
- aim to strengthen Aboriginal family systems of care, control and responsibility;
- address culturally secure approaches to harm reduction;
- work from within empowerment principles.

Social Learning Theory (SLT) should also be used to understand Aboriginal AOD use as it acknowledges that drug use is learned. This approach complements traditional Aboriginal ways of learning as Aboriginal people have always learnt from their elders, other family and community members on a day-to-day basis through observing, listening and trying it out.

The complexity of the factors contributing to AOD problems by Aboriginal people means that culturally secure responses need to occur at all levels of government, agencies and the community, and partnerships and collaboration between Aboriginal and non-Aboriginal agencies and individuals is essential.

AOD workers should consider using Strong Spirit Strong Mind (Casey & Keen 2006) as a model and resource when working Aboriginal people affected by AOD problems. This is a culturally secure model with resources for workers that incorporates the importance of strengthening the Inner Spirit to enhance good decision-making and support behavioural change. It also demonstrates how these principles can be applied in a therapeutic context and incorporates culturally secure Cognitive Behavioural Therapy (CBT) approaches.

34. Confidentiality

Confidentiality in relation to AOD treatment refers to how information obtained in a professional relationship is treated, with clinicians and services having an obligation to refrain from disclosing information received in confidence unless there are sufficient and compelling reasons to do so.

There is often a delicate balance between safeguarding the rights of clients, duty of care and the need for others to know information about the client.

It is important that clients are aware of the limits of confidentiality. These need to be explained at the onset of therapy. A common difficulty in relation to confidentiality is the willingness of some clients to disclose details of their illegal activities. Clients should be warned of the limits of confidentiality and counsellors are advised to discourage clients from disclosing details of illegal activities. In some instances confidentiality may need to be broken if case notes are subpoenaed to court or if the client threatens to harm themselves or others, such as a child “at risk” of abuse or neglect.

Counsellors also need to make it clear to the client that they will discuss what happens in their sessions with their supervisor, and that confidentiality is limited for coerced clients where reporting client progress to a third party is required and that information regarding minors may need to be disclosed to parents or guardians.

The literature cautions counsellors about confidentiality in their 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.

Agencies should also note that under the Commonwealth Freedom of Information Act 1982 and the Western Australian Freedom of Information Act 1992 clients can apply to have access to their own case notes and assessment information.

Confidentiality – best practice

Counsellors have an obligation to refrain from disclosing information received in confidence unless there is a sufficient and compelling reason to do so. Sufficient and compelling reasons include:

- disclosing information about clients during the course of supervision;
- if the client threatens to harm themselves or someone else;
- if a child is currently at risk of abuse or neglect; and
- if the counsellor or case notes are subpoenaed to court.

Counsellors should also consider the following in relation to confidentiality.

- Counsellors may also be required to disclose information regarding coerced clients, or clients who are minors.
- Counsellors should be honest regarding the limits of confidentiality prior to any therapeutic engagement.
- Written informed consent should be obtained from clients prior to an agency (or counsellor) sharing any client related information with associated professionals or otherwise.
- When sharing information about clients, counsellors should consider the possible lack of confidentiality when posting, faxing and emailing information.
- Under the Commonwealth *Freedom of Information Act 1982* and the Western Australian *Freedom of Information Act 1992* clients can apply to have access to their own case notes and assessment information.

35. Supervision and professional development

Well managed supervision and professional development improves the quality of client service, and provides staff with an opportunity for improved confidence, skills, staff relationships, positive feedback and enhanced career opportunities (Graham, 2004; Griffiths 1999). A successful organisation also creates a workplace which places a high value on all staff engaging in reflective practices and supporting the learning of others, and employing strategies such as coaching to support organisational development (Garvin 1993; Mink et al 1993).

Agencies should promote an environment which enables both self directed professional development and agency facilitated learning. This requires active planning and agency resource allocation to maximise the professional development possibilities.

Evidence based practice requires staff to integrate knowledge from the research and professional field as well as their own experiences into their clinical practice. This process requires:

- a range of learning opportunities both on the job and off site to update skills and knowledge;
- effective and supportive supervision to build a climate of continuous learning and support;
- organisational structures which allow for reflective practice to integrate acquired knowledge and skills into the workplace; and
- the ability to use both successes and mistakes as learning opportunities.

There are various ways in which learning and development occurs via work. These include supervision, opportunistic learning, intentional on the job learning, use of job aids, attending training events, action learning, and using successes and mistakes to aid learning.

Supervision

Supervision should occur regularly for all staff. For supervision to be most effective, both supervisor and supervisee should be familiar with common supervisory practices. On commencement of supervision role boundaries should be determined and goals identified. These should be reviewed over time.

Effective supervision involves a balance of support, feedback, problem solving and instruction. Supervisors should promote team problem solving while also making clear that therapists have primary clinical responsibility for their patients' care (Budney & Higgins 1998). The USA based Project MATCH developed a brief, 32 item Psychotherapy Supervision Questionnaire to evaluate the supervisory practices within the project. The areas in this instrument have been identified in the literature (Witte et al 1997:81) as important in the supervision process are as follows:

- level of comfort with a supervisor;
- level of congruence between the therapist and supervisor on interventions, goals, and strategies that could be utilised in psychotherapy with particular clients;
- rapport (ie openness, honesty, and respect); and
- supervision that is consistent with a particular theoretical model.

Supervision covers a range of practices including peer, professional or mentor and supportive supervision. Models of supervision include the control model (eg line management) and the growth model (ie coaching, clinical supervision). Both these aspects of supervision are required for optimal professional development, workplace performance and accountability.

The control model of supervision is usually provided by a line manager and includes:

- Administrative/accountability supervision, which involves accountability, workload management and task or decision making monitoring and giving guidance and direction as appropriate.
- Educative supervision, which involves giving advice, teaching skills and knowledge to address performance management issues.

The growth model of supervision includes:

- Coaching, which is a process that helps improve individual or team performance with an emphasis on learning, structured questioning and ongoing support. Peers, clinical mentors, line managers or external coaching specialists can conduct coaching.
- Mentor or clinical specialist supervision, which normally involves supervision by someone with more qualifications and/or experience in the supervisory domain. However, the ethic is still to enhance the worker's skills and knowledge through inquiry and expansion of existing skills & knowledge.
- Supportive supervision, which aims to enhance the worker's psychological and interpersonal resources needed to undertake service delivery effectively.

(The above points are adapted from the Family and Children's Services Case Practice Manual Section 1.10, 1996).

Opportunistic learning

Opportunistic learning requires staff and organisations to be aware of learning opportunities as they arise. Examples include case discussions, informal dissemination of new information, use of hard copy and electronic resource material as needed, casual conversations with colleagues, modelling of skills from more experienced co-workers, and opportunistic consultancy support from clinical specialists involved in shared case management.

Intentional on the job learning

Intentional on the job learning relates to scheduled time for clinical supervision, case review, journal club, 'topic a month', guest speakers and staff presentations at staff meetings, specific time allocated for access to resources such as books, journal articles, websites or videos, and consultancy support from clinical specialists from other fields.

Job aids

Job aids such as assessment instruments, treatment manuals, case summary sheets and referral forms can enhance professional development and performance by "*exerting their influence as references when the need to know arises*" Craig & Rossett (1996). These authors refer to this type of support as 'just in time learning' as compared with 'just in case' training. Job aids can assist learning by providing standardised cues to key steps or domains of complex tasks. They are particularly useful when there is a large turnover of staff.

Training events

Training events should be tailored to the specific needs of staff as they relate to work performance. Ideally, these needs are identified prior to training, couched in measurable learning outcomes and negotiated with the trainer. Workplace follow up is essential to integrate and reinforce learning outcomes.

Action learning

Other reflective practices include action learning, whereby a group of individuals (from all levels of the agency) come together on a regular basis to progress a specific project, issue or topic of interest in the workplace. Action Learning is a simple but disciplined method using an ongoing cycle of plan - act - review to achieve personal, professional and organisational goals.

Using successes and mistakes as learning opportunities

Regardless of which methodology is used, an important feature of learning organisations is how successes and mistakes are managed. Barrett (1999) put it this way: "*Failures must be redefined as collective learning opportunities. In visionary organisations everyone learns from everyone else's mistakes as well as their successes.*"

Much of the welfare field tends to have an inherent negative feedback loop. That is, clients deemed as successes are often not seen again while the “failures” continue to return. The disciplined focus on success and learning opportunities will improve professional and organisational growth, and promote a positive and energetic workplace.

Supervision and professional development – best practice

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

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

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

36. Ensuring service quality

There are various quality improvement programs available for agencies to use to ensure high quality AOD service standards. These programs involve a continuous process of:

- defining performance expectations
- internal or external assessment of agency functioning in relation to these performance expectations
- developing a work plan to address deficiencies, improve agency functioning, and ensure that the plan is regularly evaluated and updated
- implementing the work plan and documenting the process
- evaluating the effects of improvements and making modifications

The outcome of this process is the continuous development, review, implementation and modification of clinical practices. There a number of areas at which performance expectations are directed, and agency staff are encouraged to be specifically involved in at least one of these areas, as well as to provide feedback on work that emerge from all other areas. Involvement consists of being part of a committee that meets regularly to develop and then work through a work-plan. Staff are involved in providing verbal and written input, reviewing and revising clinical practices, writing policies and procedures, and providing feedback on clinical practices, policies and procedures developed by other groups. This process also involves wide consultation throughout the agency and with external agencies and stakeholders, including consumers.

For AOD agencies, the sorts of areas at which performance expectations are directed include:

- intake and referral of clients;
- evidence based treatment;
- consumer focused practice;
- staff development, support and supervision;
- client records;
- risk management;
- organisational governance and management; and
- agency and client rights and responsibilities.

In WA, all agencies have adopted the “Western Australian Alcohol and Other Drug Sector Quality Framework”, with various government and non government agencies applying additional frameworks as well. In terms of performance expectations, the different frameworks are very similar.

Ensuring service quality – best practice

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

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

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

AOD agencies should be involved in a quality improvement program.

37. Best practice outcome performance indicators

Core performance indicators involve changes in scores on measures of a number of key areas of client functioning from the beginning to the end of treatment, and at follow up at 1 and 3 months following treatment (where possible). The assessment of client satisfaction is also a core performance indicator.

For AOD treatment evaluation purposes, there is general agreement about a number of key domains of client functioning for standardised assessment (Commonwealth Services and Health Training Australia 1997; Darke et al 1992; Gowing et al 2002; Lawrinson et al 2005; Marsden et al 1998). These domains include:

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

Performance indicators of agency functioning are also important. Agency performance indicators should reflect those at which expectations are directed for ensuring high quality service standards (see *Ensuring Service Quality*). There should be quality improvement process in place at each agency, in which staff are involved, which ensures the development, maintenance, review and revision of clear policies, procedures and practices developed around:

- intake and referral of clients;
- evidence based treatment;
- consumer focused practice;
- staff development, support and supervision;
- client records;
- risk management;
- organisational governance and management; and
- agency and client rights and responsibilities.

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