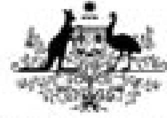

Australian Government
Department of Health and Ageing

Treating Alcohol Problems: Guidelines for Alcohol and Drug Professionals

National Alcohol Strategy February 2004

Written by Fiona Shand and Jennifer Gates,
The National Drug and Alcohol Research Centre, 2003

This booklet is based on the **Guidelines for the Treatment of Alcohol Problems** and the supporting document, **The Treatment of Alcohol Problems: A Review of the Evidence.** The project has been funded by the Australian Government Department of Health and Ageing, and developed by the National Drug and Alcohol Research Centre.

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Disclaimer

This booklet has been developed to assist health professionals. The diagnosis and treatment of alcohol problems require the consideration of an individual's particular circumstances by a qualified medical practitioner. This booklet is not a substitute for such advice, and should not be used to diagnose or prescribe treatment for any alcohol problem.

Copies of this booklet can be obtained from the Australian Government Department of Health and Ageing or the National Drug and Alcohol Research Centre.

Acknowledgements

Our thanks to Astrid Przezdziecki of the Royal Prince Alfred Hospital Drug Health Services and Angie Campillo of Rozelle Drug Health Services for their helpful comments and for helping us to organise drinker's focus groups. Thank you to the staff at Rozelle Drug Health Services and to Jennifer Holmes, Janet Falconer and staff at the Langton Centre for their assistance during the development of these guidelines.

ISBN: 0 642 82410 X
PAN: 3400

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Introduction

Although moderate alcohol consumption has some health benefits for older adults, excessive drinking has negative health and social consequences. Approximately six per cent of Australia's adult population meet the criteria for an alcohol use disorder, abuse or dependence and about ten per cent are considered risky or binge drinkers. People under 25 years have the riskiest drinking habits.

The most effective treatment strategy is to intervene early with risky drinkers to prevent them from becoming heavy regular or dependent drinkers. If a person becomes dependent on alcohol, withdrawal can be complicated and it is not easy for them to stop drinking.

The harms associated with risky drinking and alcohol dependence include:

- Increased risk of depression, anxiety and other psychological problems
- Physical harms such as heart and liver disease, high blood pressure and accidents
- Memory and cognitive impairment
- Social, work, family, financial and legal problems
- For pregnant women, possible fetal alcohol effects and birth defects

This booklet describes the most effective ways to screen, assess and treat risky or dependent drinkers, and provides sources of further information about how to carry out the treatments described.

The booklet is not a treatment manual and does not replace proper training in the techniques described. It is a brief version of the Guidelines for the Treatment of Alcohol Problems, available at:

http://www.health.gov.au/pubhlth/publicat/document/alcprobguide.pdf.

The guidelines are based on the best available evidence at the time of publication.

Other booklets in this series are:

- Guidelines for General Practitioners
- Guidelines for Hospital Staff
- Drinking Decisions: A Guide for Drinkers
- Drinking Decisions: Young People and Drinking

How much alcohol is too much?

The low-risk levels of drinking described below are **not** recommended for people who:

- Have a condition made worse by drinking (e.g. diabetes, liver disease)
- Are on certain types of medication (e.g. tranquilisers)
- Are under 18 years of age
- Are pregnant
- Are frail or elderly
- Are about to engage in activities involving risk or a degree of skill (e.g. driving, flying, water sports, operating machinery)

The drinks referred to below are standard drinks, i.e. 10 grams of alcohol in 100ml wine, 30ml spirits, or 285ml standard beer.

For non-pregnant healthy adult women:

- Low risk drinking is an average of two standard drinks per day, no more than four drinks on any one day, and no more than fourteen drinks over a week, with two alcohol-free days per week.

Source: NHMRC, 2001.[1]

For healthy adult men:

- Low risk drinking is an average of four standard drinks per day, no more than six drinks on any one day, and no more than twenty eight drinks over a week, with at least two alcohol-free days per week.

Source: NHMRC, 2001.[1]

Alcohol dependence

Alcohol dependence is a psychological and biological syndrome. It can range from mild to severe. To be diagnosed as alcohol dependent, your client should show three of the following characteristics within a 12 month period:

1. Tolerance - a need for increased amounts of alcohol to achieve intoxication, or a diminished effect with continued use of the same amount of alcohol.
2. Withdrawal - either a characteristic alcohol withdrawal syndrome, or drinking to relieve or avoid withdrawal symptoms.
3. Alcohol taken in larger amounts or for a longer period than intended.
4. A persistent desire or unsuccessful efforts to control drinking.
5. A great deal of time is spent in activities necessary to obtain alcohol, use alcohol, or recover from its effects.
6. Important social, occupational or recreational activities are reduced or given up because of drinking.
7. Drinking is continued despite knowledge of having persistent or recurrent physical or psychological problems that are likely to have been caused or exacerbated by alcohol.

Source: American Psychiatric Association, 1994.[2]

How do I screen for drinking problems?

Screening for risky drinking can be carried out quickly and effectively:

General signs

Certain physical disorders or signs can suggest high levels of drinking. Common physical indicators include hypertension, a pattern of accidents, dilated facial capillaries, blood shot eyes, hand or tongue tremor, history of gastrointestinal disorders, duodenal ulcers and cognitive deficits.[3,4] Conditions such as liver cirrhosis and pancreatitis can be alcohol-induced. Subtler signs include work, financial, marital and relationship problems, interpersonal violence, insomnia, depression and anxiety.[5]

While the above problems may indicate heavy drinking, they are not conclusive. Nor does their absence rule out the existence of risky alcohol consumption, hence the need for the standardised screening techniques described below.

The quantity-frequency index

The Quantity-Frequency Index (QFI) asks respondents to indicate the number of occasions during the previous thirty days on which they have consumed seven to ten drinks for men, and five to eight drinks for women. Any client who identifies an occasion of drinking above those levels may be classified as a risky or binge drinker.[6] The QFI takes, on average, less than two minutes to complete.

Brief questionnaires

The AUDIT

The AUDIT is a ten-item questionnaire developed by the World Health Organization. It is easy for the client to complete and for you to score. It is effective for identifying problem drinking among a wide range of people including men, women, adolescents, drug-dependent clients, cross-cultural groups, drink drivers, emergency ward patients, and psychiatric clients. The AUDIT is shown at the back of this booklet on page 28.[7]

The TWEAK

The TWEAK is as effective as the AUDIT for screening in the general population, and can easily be incorporated into a clinical interview. The TWEAK is shown at the back of this booklet on page 32.

The retrospective diary

This is a matter of asking your client to identify the type and quantity of alcoholic beverage consumed, beginning with the previous day and working back through each day of the week. It takes, on average, four minutes to complete. [6]

Screening for risky drinking in pregnant women

There are two brief questionnaires that are more effective than other screening methods when used with pregnant women. The T-ACE consists of four questions and the TWEAK contains five questions, shown at the back of this booklet on page 32.

How do I engage my client in treatment?

Your client may be ambivalent about changing his or her behaviour. The Stages of Change model suggests that a person may:

1. not be considering change right now (precontemplative stage),
2. be thinking about change but is not ready to take steps (contemplative stage),
3. be thinking about change and ready to take steps (preparation stage),
4. be taking steps to change (action stage),
5. have taken steps and needs to maintain the change (maintenance stage).[8]

This model sometimes includes a relapse stage to indicate that dependence is a chronic and relapsing disorder, however caution should be used to ensure that messages of hopelessness are not conveyed to the client.

While it is important to know that your clients may present with different levels of readiness to change, it is also important to note that people do not normally move smoothly from one stage to the next. They can move forwards, backwards or skip a stage.

Treatment retention

Engaging and retaining your client in treatment is one of the most important factors in bringing about treatment success. From the first contact with the client there is a need to instil in them a sense of hope and a belief that change for them is possible. This is especially important in clients who have previously tried to alter their drinking and failed. **Your client's confidence that he or she has the ability to change will have a big impact on motivation.** These beliefs can be influenced by the quality of the relationship between client and clinician.[9]

Competent, empathetic clinicians achieve better treatment outcomes for clients. A number of other factors influence the long term outcomes for the client, including the strength of the therapeutic relationship, perceived helpfulness of the treatment services, removal of practical barriers to treatment, and relapse prevention training.

Motivational interviewing

Most change involves positive and negative aspects. Drinking is no different. Alcohol may serve a number of purposes for long-term drinkers, such as relaxation, escape from depression, or a boost in social confidence, so ambivalence about changing their drinking is quite normal. The motivational enhancement strategies described below are commonly used in managing alcohol problems. They can be incorporated into other forms of treatment whenever the client is experiencing ambivalence about change, used as a lead-in to other treatment, or as a stand-alone strategy.

Motivational interviewing guides the client towards considering change by eliciting reasons for change **from the client**, emphasising that their behaviour change is voluntary, and by placing responsibility for decisions and results of behaviour change with them, with your support.[10]

There are four broad, guiding principles that underlie motivational interviewing:

1. Expressing empathy by listening and reflecting your client's concerns, thoughts and feelings.
2. Developing discrepancy between their drinking behaviour and their other goals (e.g. 'on the one hand you're worried about how drinking is affecting your work, yet you're not sure if you can stop drinking right now.')
3. Rolling with resistance. If your client is arguing, defending, or remaining silent, do not argue back. Instead, use active listening and reflection to avoid increasing their resistance.

4. Supporting self-efficacy. Self-efficacy is the person's confidence in their own ability to achieve their goals. Highlighting even small gains can help (e.g. a client might not have stopped drinking but may have managed to cut down or have had one or two alcohol-free days in the week.)

There are two main phases to motivational interviewing.

Phase 1: building motivation for change uses strategies such as:

- Eliciting self-motivational statements
- Listening with empathy (active listening or reflection)
- Questioning rather than telling
- Presenting assessment feedback, including health effects
- Affirming the client
- Rolling with resistance
- Reframing
- Summarising

Phase 2: strengthening commitment to change uses strategies such as:

- Recognising change readiness
- Discussing a plan
- Communicating free choice
- Discussing consequences of action and inaction
- Providing information and advice as requested
- Emphasising abstinence for dependent clients
- Dealing with resistance
- Summarising and seeking commitment to change

In practice, the strategies you use will depend on your client's readiness to change, which may fluctuate throughout treatment.

How serious is my client's drinking problem?

Determining the severity of your client's alcohol problems can be done by using the diagnostic criteria for alcohol dependence during an assessment interview, and by applying the standardised questionnaires listed in (Table 1). Although not all clients will meet a diagnosis of dependence, if alcohol is causing impairment or distress intervention is worthwhile. There are a number of areas that are important to assess:

- Your client's motivation or desire to change
- Amount and pattern of alcohol consumption
- The severity of dependence
- Physical wellbeing
- The nature and extent of their family and social support
- Any signs of cognitive impairment
- Other mental health disorders or symptoms such as depression and anxiety

This will give you a better picture of how serious their drinking problem is, and can help you to decide what treatments to offer and which problems to target first.

Cognitive impairment and mental health problems may improve after a period of abstinence from alcohol. If you suspect that medication such as anti-depressants may be required to treat depression, your client will need to be assessed by a psychiatrist, who can prescribe medications.

Table 1: Standardised assessment methods[1]

Assessment of:	Method/Instrument
Motivation to change	University of Rhode Island Change Assessment Scale (URICA)
Alcohol consumption	Timeline Follow Back Method
Severity of dependence	Short Alcohol Dependence Data Questionnaire (SADD)[2] Severity of Alcohol Dependence Questionnaire Form-C (SADQ-C) Alcohol Dependence Scale (ADS)
Other mental health problems	Kessler Psychological Distress Scale (K10) Depression Anxiety Stress Scales (DASS)
Cognitive functioning	Mini-Mental State Examination (MMSE)[3] (b)

1 For more information on standardised assessment methods, refer to Dawe et al., 2002. 11

2 See page 30 for a copy of the SADD. Can be reproduced.

3 The MMSE is not conclusive and a full assessment may still be required.

What is a suitable treatment goal and plan for my client?

The results of assessment should guide the treatment goals and plan for your client. Asking clients about treatment goals and offering them options may lead to improved treatment retention and better outcomes. [12, 13]

Treatment goals

There may be good reasons to encourage abstinence, for example, moderate to severe dependence, existing liver disease, psychological problems made worse by drinking, pregnancy, or a history of relapse. You should always provide a clear rationale to the client for your recommendations.

As a guide, moderating alcohol consumption may be an appropriate goal for risky drinkers. For mildly dependent drinkers, abstinence at least in the short term is important so that their alcohol withdrawal can be managed, physical health improved and any alcohol-induced anxiety or depression abates. Once this is complete, moderated drinking may be achievable. For moderate to severely dependent drinkers, long-term abstinence is generally the best option (Table 2). The level of dependence can be assessed using the SADD, shown on page 30, the SADQ-C, or the ADS.

It is important to consider harm reduction as a goal for all clients, including those who are not ready or able to stop drinking. Harm reduction can include suggesting the consumption of light beer and increasing their intake of thiamine to help prevent cognitive impairment.

Table 2: Suggested scores on three measures of alcohol dependence to determine treatment goal and intensity

Scale	Low dependence; Moderation goal; Brief intervention	Moderate dependence; Moderation/abstinence: Brief or intensive intervention	Severe dependence; Abstinence goal; Intensive intervention
SADQ	0 – 20	21 – 40	41 – 60
SADD	0 – 9	10 – 19	20 – 45
ADS	0 –13	14 – 30	31 – 51

Source: Heather, 1989 [14]

Improvements in other areas of life such as work, social functioning, mental and physical health, and relationships are equally important. In the longer term, these improvements will help your client to stay well.

The treatment plan

In developing the treatment plan (see page 24 & 25, Putting it all together), decisions need to be made about:

- appropriate withdrawal management
- residential vs non-residential treatment
- the frequency of visits for non-residential treatment
- the likely duration of treatment
- the type of psychological treatment to be delivered
- relapse prevention and extended care strategies
- whether pharmacotherapies are required

For risky or problem drinkers, a brief intervention of one or two sessions may be all that is required to help them moderate their drinking.

For mildly dependent drinkers, withdrawal management followed by four to six treatment sessions which include relapse prevention strategies can help. Relapse prevention is described later in this section.

More severely dependent drinkers may need to undergo supervised and/or medicated withdrawal. They may need fairly intensive medical intervention over the first five days, and then ongoing support in the form of psychological intervention and practical assistance with housing and lifestyle matters. Relapse prevention strategies, including medication, may help. Referral to community-based self-help groups will be of assistance to some clients.

Which treatments work?

This section covers withdrawal management, brief interventions, psychological interventions, relapse prevention, pharmacotherapies, and extended care.

Withdrawal management

People who are physically dependent upon alcohol are likely to experience withdrawal symptoms 6 to 24 hours after the last drink is consumed. The alcohol withdrawal is usually self-limiting and uncomplicated, resolving within five days with minimal or no intervention. However, this depends largely on the person's drinking pattern, frequency, duration and quantity. While for most people the alcohol withdrawal syndrome is short-lived and inconsequential in others it increases in severity through the first 48 to 72 hours of abstinence. Therefore it is important to monitor clients carefully during the alcohol withdrawal period to identify clients at risk of complications.

Monitoring scales

The Clinical Institute Withdrawal Assessment for Alcohol revised (CIWA-Ar)[4] is a 10-item scale and is helpful in assessing the severity of the alcohol withdrawal. An alternative scale is the Alcohol Withdrawal Symptoms - Rating Scale (AWS)[4]. The AWS has not been validated. However, the AWS is widely used and is considered acceptable for use in hospitals and non-medicated environments. If the CIWA-Ar scale is not available then the AWS may be used.

Withdrawal management settings

A range of alcohol withdrawal management settings currently exist. The appropriateness of each of the settings (discussed below) to an individual drinker's case will depend upon good clinical judgement of the actual or likely severity of the alcohol withdrawal syndrome; the presence of other physical and psychiatric conditions; and the choice made by the drinker.

Home-based withdrawal management involves the client withdrawing from alcohol at home in a supportive setting or group accommodation, such as a hostel or halfway house. Client's withdrawal symptoms are usually monitored by visits from a health care worker and via telephone calls. Medications are usually managed by the client or lay carer. A 24-hour telephone support line is usually available.

Home-based withdrawal management may be appropriate for those who are likely to suffer from mild to moderate alcohol withdrawal, may not require sedative medication, have no known co-existing medical or psychiatric history, and for groups of people who may have difficulty reaching inpatient withdrawal settings, such as women who have children at home, or people from cultural groups who value intensive family or community support that cannot be readily provided by residential settings.

4 The CIWA-Ar and AWS can be found in the NSW Detoxification Guidelines at www.health.nsw.gov.au/public health/dpb/publications/pdf/detoxificationclinicalpractice_guidelines.pdf or in the Guidelines for the Treatment of Alcohol Problems at www.health.gov.au/pubhlth/publicat/document/alcprobguide.pdf

The failure rate of home-based withdrawal management may be higher than for inpatient withdrawal management if the above factors are not considered.

Outpatient withdrawal management is similar to home-based withdrawal management; however the client attends a clinic or outpatient withdrawal management setting for observation, assessment by trained staff and to collect alcohol withdrawal medication, usually on a daily basis.

Outpatient withdrawal management, like home-based withdrawal management, may be appropriate for those who are likely to suffer from mild to moderate alcohol withdrawal, are not in need of sedative medication, have no known coexisting medical or psychiatric history, and for people who may have difficulty attending inpatient services.

Inpatient withdrawal management settings may be a community residential setting or a dedicated acute hospital bed with trained clinicians available for the care of dependent drinkers at risk of alcohol withdrawal complications. Community residential settings are different to acute hospital beds, in that they are a more domestic/home like environment, clients are ambulatory, and are either supervised medically or non-medically. Community residential settings may also provide group programs focusing on strategies such as relapse prevention, how to cope with symptoms, and stress management.

Circumstances where inpatient withdrawal management is indicated include: medical or psychiatric disorders, an unsafe home environment, homelessness, living with other addicted individuals, and/or a history of failed attempts to abstain in either a home-based or outpatient withdrawal setting.

Medicated withdrawal

A supervised medicated withdrawal is required for people who are at risk of, or suffer from, alcohol withdrawal complications. Diazepam (a benzodiazepine) is a suitable medication for use in alcohol withdrawal and is considered to be the "gold standard" and first line treatment for alcohol withdrawal management (Table 3).

Major tranquillisers or anti-psychotic medication should only be made available to clients experiencing hallucinations where benzodiazepines are not effective. Anticonvulsant medications should not be used in routine practice, as they are not effective in preventing alcohol withdrawal complications such as seizures. However, anticonvulsants should be made available for clients currently taking them for other medical reasons. If psychotic symptoms persist, a psychiatric evaluation may be required. All pharmacotherapies should be used with an alcohol withdrawal rating scale such as the CIWA-Ar or the AWS.

For more detail on managing withdrawal go to www.health.nsw.gov.au/ public health/dpb/publications/pdf/detoxification_clinicalpractice_guidelines.pdf

Table 3: Typical diazepam regime for alcohol withdrawal

Day 1	10mg six hourly with up to 2 additional 10mg doses PRN.
Day 2	10mg six hourly with up to 2 additional 10mg doses PRN.
Day 3	10mg six hourly.
Day 4	5mg morning and night.
Tapering dose may be required over the next two days.	
PRN - taken as required for symptom relief.	

Source: New South Wales Health Department, 1999 [15]

Brief interventions

Brief interventions can be delivered in many settings such as community and primary health care settings, or in specialist settings. Such an intervention may consist of a brief assessment, feedback of the assessment results using the FRAMES approach (Figure 1), plus a follow-up visit. More brief intervention resources are shown at the back of this booklet.

Figure 1: The FRAMES Approach

Common Elements of a Brief Intervention	
Feedback	Personal **Feedback** about the risks associated with continued drinking based on current drinking patterns, problem indicators, and health status.
Responsibility	Emphasis on the individual's personal **Responsibility** and choice to reduce drinking behaviour.
Advice	Clear **Advice** about the importance of changing current drinking patterns.
Menu	A **Menu** of alternative change options. This emphasises the individual's choice to reduce drinking patterns and allows them to choose the approach best suited to their own situation.
Empathy	**Empathy** from the person providing the intervention is an important determinant of client motivation and change. A warm, reflective and understanding brief intervention is more effective than an aggressive, confrontational or coercive style.
Self-efficacy	**Self-efficacy** involves instilling optimism in the client that their chosen goals can be achieved. It is in this step, in particular, that motivation-enhancing techniques are used to encourage clients to develop, implement and commit to plans to stop drinking.

Source: Bien, Miller and Tonigan, 1993 [16]

Psychological interventions

Once withdrawal is complete, your client will need ongoing help to stay well. The following strategies have demonstrated effectiveness in clinical trials.

Clinician skills and characteristics

General counselling and associated skills are effective for counselling people with alcohol problems. Clinicians who are more interpersonally skilled, less confrontational, more empathetic, competent, and organised achieve better treatment outcomes. Confrontation is associated with increased client resistance and higher levels of drinking. A warm, supportive relationship between clinician and client is important.

However, unstructured counselling alone is not usually sufficient to change drinking behaviours and should be supported by the more specific techniques described below.

Cognitive behavioural therapies

Cognitive behavioural therapy (CBT) is more effective than general counselling. Cognitive-behavioural interventions give the client a set of thinking and behaving strategies that can be used to assist in change. Skills training may form part of CBT, however it should only be provided where a skills deficit is evident. CBT includes specific components such as:

Cognitive restructuring

Cognitive restructuring works with the client's current beliefs and attitudes and is designed to help the client identify and change unhelpful beliefs, especially where these contribute to continued drinking.

Cognitive restructuring is particularly effective when combined with skills training, and is also helpful in the treatment of other disorders, particularly anxiety and depression. [17]

Skills training

There is consistent evidence that skills training helps to reduce alcohol consumption in both the short-term and the long-term. The following skills training may be useful:

- social skills
- problem solving skills
- assertiveness skills
- communication skills
- drink refusal skills

For more information on CBT, motivational interviewing and other psychological interventions, go to: www.crufad.com/cru_index.htm

Behavioural self-management

Behavioural self-management training involves a series of strategies such as:

- self-monitoring
- setting drinking limits
- controlling rates of drinking
- identifying problem drinking situations
- self-reward for limited drinking

Behavioural self-management is intended for those clients who wish to cut down rather than abstain from drinking. However, some of these procedures could be usefully taught as relapse prevention strategies to drinkers who have a goal of abstinence. This procedure might be especially useful for those drinkers whose lives are enmeshed in a drinking culture, where non-drinking is extremely unlikely.

Couples therapy

Couples therapy involves the partner of the drinker and can help motivate initial commitment to change in the drinker. Behavioural couples therapy can produce better drinking and relationship outcomes compared to approaches that do not include the partner. However, it is only appropriate when there is agreement between the client, the client's partner and the clinician that the partner's involvement is likely to be helpful. The overall goal of behavioural couples therapy is to improve the couple's relationship and communication in a way that will aid a change in drinking. Couples therapy requires specialist skills.

Cue exposure

Cue exposure assumes that people, places and events that regularly precede drinking become associated with the pleasant effects of alcohol, and alcohol consumption becomes a conditioned response to these cues. Alcohol-related cues include the sight and smell of an alcoholic drink, mood states or situations in which drinking has previously occurred, and people, places and times that have previously been associated with the pleasant effects of alcohol.

Cue exposure is a specialist treatment intervention and should only be offered by suitably qualified professionals.

Self-guided materials

There are now several self-help manuals available for use by drinkers who wish to cease or cut-down drinking without the aid of professionals.[18, 19] There is evidence that the use of these manuals is associated with a marked reduction in drinking.[20, 21] These materials can be used either in conjunction with a brief intervention or as a stand-alone intervention.

Residential treatments (post-withdrawal)

Most clients do as well in non-residential treatment as they do in residential programs. However, clients with a history of chronic relapse, those with significant mental health problems, cognitive impairment, or a social environment that supports drinking, and homeless clients, may do better in residential care.

Preventing relapse

Alcohol dependence is a chronic disorder, so relapse is common. Relapse is broadly defined as a return to heavy or problem drinking. The main goal of relapse prevention is to teach the drinker to recognise and cope with the high-risk situations that might lead to a lapse (e.g. having a few drinks on a single occasion), and to modify the drinker's reaction to a lapse so that it does not become a full-blown relapse. The following strategies are useful in identifying relapse risks and preventing relapse:

Identifying high-risk situations

- Ask questions about why the client drinks, what thoughts or feelings trigger off a desire to drink, and what situations or events are most likely to make him or her feel like drinking.[22] You can ask about the circumstances under which they drank heavily in the past. Self-monitoring before drinking ceases can provide useful information.
- Ask questions about the client's beliefs about alcohol dependence as a disease, beliefs about their capacity to avoid relapse and cope with lapses, their strategies for coping with high-risk situations, their mood, and social/family support.
- Assist the client to recognise their particular high-risk situations. Typically this will involve reviewing a list of common relapse situations, identifying those that are likely to cause difficulty for the drinker, and devising methods to either avoid these situations or cope with them without drinking.

Coping with high-risk situations

- Highlight that drinkers can relapse in unexpected situations. Help your client to develop their problem solving skills, and to develop strategies that will allow him/her to manage these situations if they arise. However, the client should be encouraged initially to avoid the high-risk situations.
- Cognitive restructuring, contracts to limit extent of use, reminder cards, relapse rehearsal, and stress management can assist.[23] The skills training described earlier contributes to preventing relapse by allowing the client to practice assertiveness and drink refusal skills.
- Encourage behavioural coping responses such as physical or some other distracting activity, the consumption of food or non-alcoholic drink, escaping the situation, and relaxation procedures.

- Encourage cognitive coping responses such as thinking of the positive health consequences of not drinking and the negative consequences of resuming excessive drinking, and using thoughts related to delay or distraction.
- Teach the client to view a lapse as a temporary return to drinking or excessive drinking and not as a complete failure. A single lapse can result in a complete return to drinking if the drinker sees the lapse as an indication of powerlessness over alcohol.[22] The emphasis is on learning from the events preceding the lapse and making plans for limiting future lapses.

Broader relapse prevention strategies

A final part of the approach is helping the client to make changes to his or her lifestyle in ways that decrease the likelihood of drinking. The aim is to increase the client's overall capacity to cope effectively with background stress levels. For example, therapy may focus on encouraging the client to develop recreational activities and behaviours that are incompatible with drinking alcohol, substituting indulgences, using coping imagery, and developing new social networks.[23]

What do I do if my client keeps relapsing?

Some clients will continue to relapse but if they stay in touch with treatment services, the severity of relapse may reduce and the time between relapses increase. As a clinician, it is important to maintain hope for your client since this will have a positive impact on their self-efficacy and hence their treatment outcomes. You may need to continue using motivational enhancement techniques in order to shift your client towards reducing or stopping their alcohol intake, and in the meantime focus on their other goals. It may also be time to review your treatment strategy by discussing with your client what is working and what is not. More intensive or residential treatment may be needed.

Pharmacotherapies

When combined with psychological treatments, acamprosate and naltrexone can reduce alcohol intake and increase time to relapse among moderate to severely dependent drinkers. Pharmacotherapies should only be used as an adjunct to treatment and can only be prescribed by a doctor or psychiatrist. More detailed information about the drugs described below is available from the MIMS and the Australian Medicines Handbook.

Naltrexone (Re Via®)

Naltrexone can be started at 25mg for one to two days and then increased to the standard dose of 50mg daily. It is an opioid antagonist and may lessen the subjective 'high' that drinkers experience from alcohol. It can also reduce cravings and increase the likelihood of your client remaining abstinent.

The most common side effects are nausea, dizziness, headache, fatigue, insomnia, anxiety and sleepiness. There are some reports of flattened affect so caution should be taken when treating clients who are depressed. Side effects are usually mild and resolve within two to three weeks.

Naltrexone can have toxic effects on the liver so liver function should be monitored. It is contraindicated for clients with liver dysfunction or damage, pregnant women, those who are currently using opiates, and clients who cannot achieve abstinence for at least five days prior to starting medication.

There is no known withdrawal syndrome associated with naltrexone. Recommended treatment duration is three to six months and in some cases, up to twelve months.

Acamprosate (Campral®)

Acamprosate is taken as two 333mg tablets three times per day. The recommended dose for adults is 1998mg/day. Adults under 60kg should take 1332mg/day (two tablets twice daily).The reason for the frequent dosage is that the drug is not metabolised by the liver and is excreted in the urine, so does not remain in the body for long.

Acamprosate's main action appears to be stabilising the neurotransmitters that are disturbed during alcohol withdrawal (the GABA and glutamate systems), thereby reducing the central nervous system effects induced by withdrawal. Trials show that acamprosate can reduce the risk of relapse and extend the length of time to first relapse. There is some evidence that it has an effect on cravings.

The most common side effects include diarrhoea, nausea, stomach pain, and an allergic skin reaction (pruritus). Most side effects resolve within a few weeks of treatment. It is best to take the medication with food to help avoid stomach upset.

It is contraindicated for clients with renal impairment or severe liver failure, and pregnant women.

There is no known withdrawal syndrome associated with acamprosate. Recommended treatment duration is three to six months and in some cases, up to twelve months.

Disulfiram (Antabuse®)

Disulfiram may be of some use for clients who are motivated and have somebody to supervise their use of the medication. Beyond that, its effectiveness is limited, so it is not recommended as a first line treatment.

Increasing adherence to pharmacotherapies

Clients who take their medication consistently have better treatment outcomes than those who don't even when other factors such as motivation are taken into account. However, compliance with such medication is often less than 50 per cent. There may be several reasons that a client is reluctant to adhere to pharmacological treatment: [24]

- Stigma attached to taking the medication. Many clients believe that they should have sufficient willpower to conquer the disorder unassisted.
- Naltrexone may block the reinforcing effects of alcohol. So although it probably reduces craving for alcohol, there is no inherent reward for complying with it.
- These medications can have unpleasant side effects.
- Many clients probably won't know anything about the medication and may be quite fearful about taking it.
- Cost. Although acamprosate and naltrexone are subsidised, clients may be reluctant to make co-payments and this should be clarified at the time of commencing treatment.

Compliance therapy, using cognitive-behavioural and motivational interviewing techniques, may be effective in helping clients to take their medication more consistently, to stay in treatment, and to achieve better outcomes. [25, 26] It addresses the client's concerns about taking medication, including beliefs about needing to change without assistance, concerns about side effects, and the pros and cons of taking medication, staying in treatment, and changing drinking behaviours.

What about my client's other mental health problems?

Alcohol dependent clients often have a range of problems other than drinking, including depression, anxiety, psychosis, or personality disorders. They may also be polydrug users, have a gambling problem, marital problems, be homeless or unemployed, and have significant physical illness.

In some instances, depression and anxiety may be caused by drinking or withdrawal from alcohol. These problems may improve once withdrawal is complete and the person's neurochemistry and physical health begins to return to normal.

For a significant proportion of heavy drinkers, their psychological problems pre-date their drinking problem. These clients may need additional treatment in the form of medications and cognitive behavioural therapy. A range of anti-depressant and anxiolytic medications are available which require regular monitoring and review. Research suggests that concurrent treatment of problems is more effective than treating a single problem alone.

A good self-guided book for clients with anxiety and depression is "Mind over Mood" by Dennis Greenberger and Christine A. Padesky (The Guildford Press, 1995).

The following website has information on therapies for anxiety and depression: www.crufad.com/cru_index.htm

For more resources on depression, go to:
www.beyondblue.org.au/site/usergroup/health.asp

Extended care and support groups

For dependent clients, long-term contact with treatment services may improve their chances of remaining well. This could take the form of booster sessions scheduled at three-monthly intervals for the first 12 months post-treatment, tapering off into the second year. A reminder letter or phone call just prior to the appointment will help, as will following up and rescheduling missed appointments. Referral to a local Alcoholics Anonymous (AA) group has been shown to be helpful for some clients who wish to maintain abstinence and who lack social support for non-drinking behaviour.

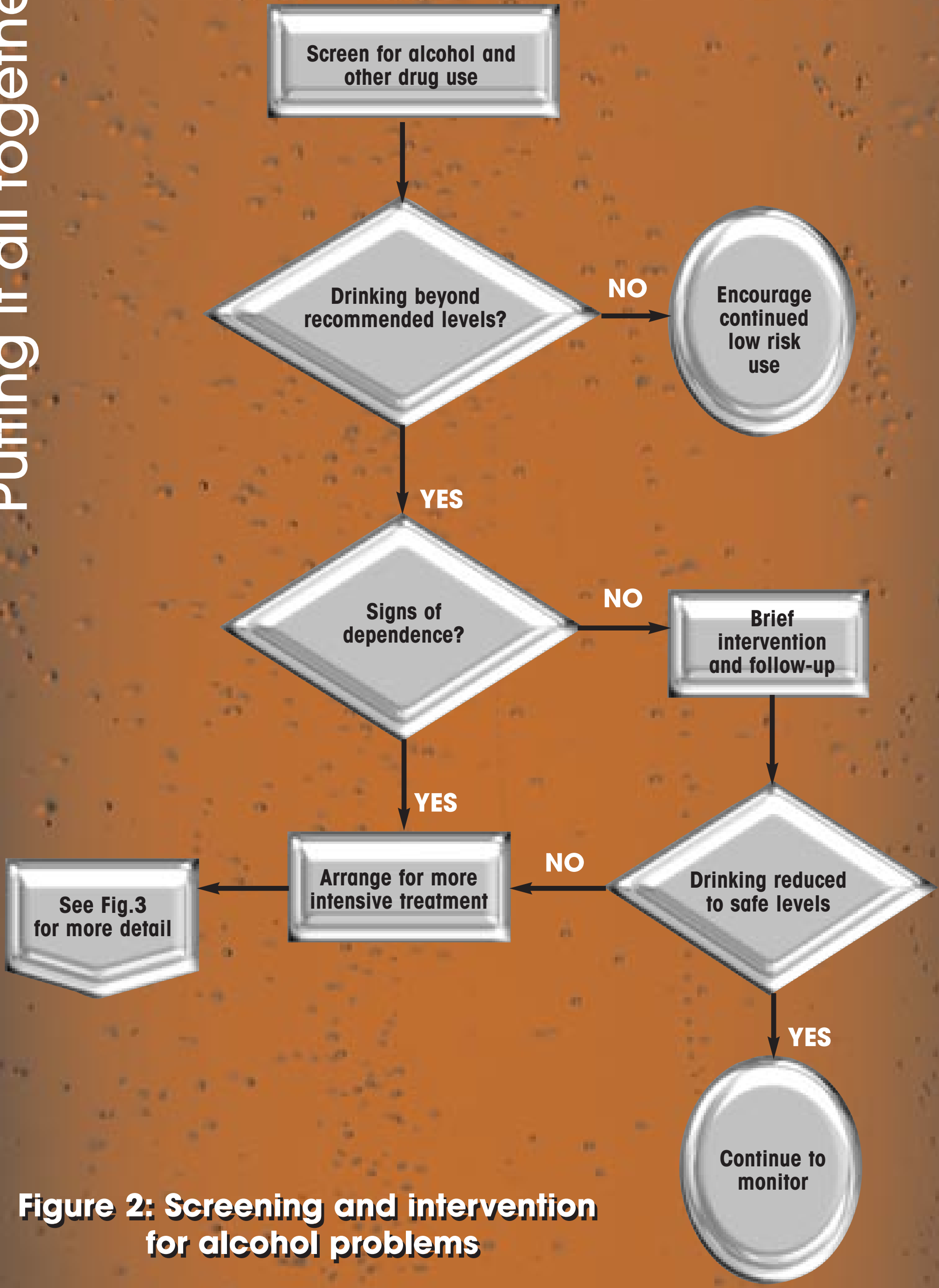

Figure 2: Screening and intervention for alcohol problems

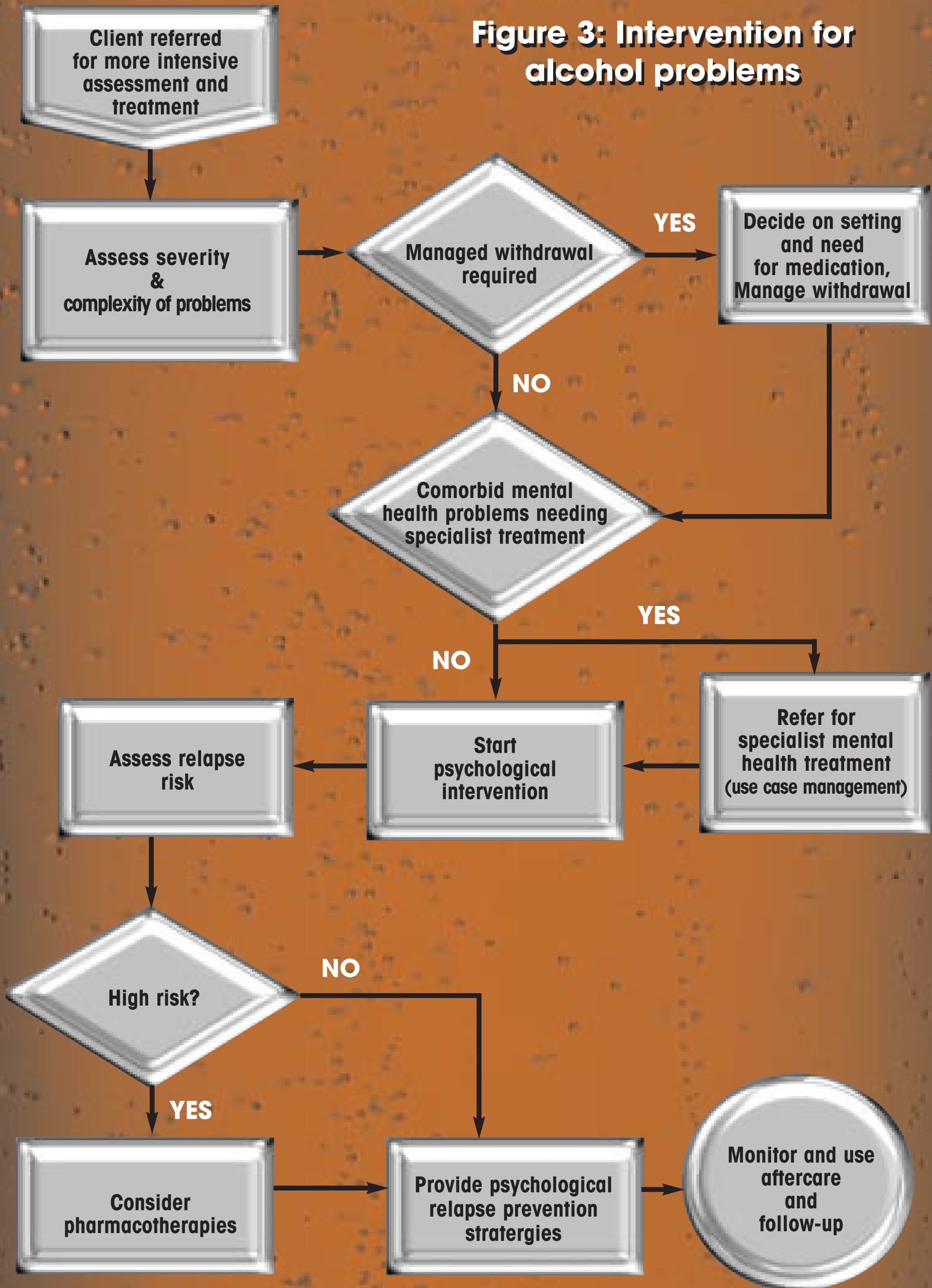
Figure 3: Intervention for alcohol problems
Client referred for more intensive assessment and treatment
Assess severity & complexity of problems
Managed withdrawal required
YES
Decide on setting and need for medication, Manage withdrawal
NO
Comorbid mental health problems needing specialist treatment
YES
NO
Refer for specialist mental health treatment (use case management)
Start psychological intervention
Assess relapse risk
High risk?
NO
YES
Consider pharmacotherapies
Provide psychological relapse prevention stratergies
Monitor and use aftercare and follow-up

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Alcohol screening questionnaires

The Alcohol Use Disorders Identification Test (AUDIT)

Please circle the answer that is correct for you.

1. HOW OFTEN DO YOU HAVE A DRINK CONTAINING ALCOHOL?

Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week
(0)	(1)	(2)	(3)	(4)

2. HOW MANY DRINKS CONTAINING ALCOHOL DO YOU HAVE ON A TYPICAL DAY WHEN YOU ARE DRINKING?

1 or 2	3 or 4	5 or 6	7 to 9	10 or more
(0)	(1)	(2)	(3)	(4)

3. HOW OFTEN DO YOU HAVE SIX OR MORE DRINKS ON ONE OCCASION?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
(0)	(1)	(2)	(3)	(4)

4. HOW OFTEN DURING THE LAST YEAR HAVE YOU FOUND THAT YOU WERE NOT ABLE TO STOP DRINKING ONCE YOU HAD STARTED?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
(0)	(1)	(2)	(3)	(4)

5. HOW OFTEN DURING THE LAST YEAR HAVE YOU FAILED TO DO WHAT WAS NORMALLY EXPECTED FROM YOU BECAUSE OF DRINKING?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
(0)	(1)	(2)	(3)	(4)

6. HOW OFTEN DURING THE LAST YEAR HAVE YOU NEEDED A FIRST DRINK IN THE MORNING TO GET YOURSELF GOING AFTER A HEAVY DRINKING SESSION?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
(0)	(1)	(2)	(3)	(4)

7. HOW OFTEN DURING THE LAST YEAR HAVE YOU HAD A FEELING OF GUILT OR REMORSE AFTER DRINKING?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
(0)	(1)	(2)	(3)	(4)

8. HOW OFTEN DURING THE LAST YEAR HAVE YOU BEEN UNABLE TO REMEMBER WHAT HAPPENED THE NIGHT BEFORE BECAUSE YOU HAD BEEN DRINKING?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
(0)	(1)	(2)	(3)	(4)

9. HAVE YOU OR SOMEONE ELSE BEEN INJURED AS A RESULT OF YOUR DRINKING?

No	Yes, but not in the last year	Yes, during the last year
(0)	(1)	(2)

10. HAS A RELATIVE OR FRIEND OR A DOCTOR OR OTHER HEALTH WORKER, BEEN CONCERNED ABOUT YOUR DRINKING OR SUGGESTED YOU CUT DOWN?

No	Yes, but not in the last year	Yes, during the last year
(0)	(1)	(2)

Go to page 33 for scoring instructions

The short alcohol dependence data questionnaire (SADD)

SADD: The following questions cover a wide range of topics to do with drinking. Please read each question carefully but do not think too much about its exact meaning. Think about your MOST RECENT drinking habits and answer each question by placing a tick under the MOST APPROPRIATE heading. If you have any difficulties ASK FOR HELP.

	Never	Some times	Often	Nearly always
1. Do you find difficulty in getting the thought of drink out of your mind?	______	______	______	______
2. Is getting drunk more important than your next meal?	______	______	______	______
3. Do you plan your day around when and where you can drink?	______	______	______	______
4. Do you drink in the morning, afternoon and evening?	______	______	______	______
5. Do you drink for the effect of alcohol without caring what the drink is?	______	______	______	______
6. Do you drink as much as you want irrespective of what you are doing the next day?	______	______	______	______
7. Given that many problems might be caused by alcohol do you still drink too much?	______	______	______	______
8. Do you know that you won't be able to stop drinking once you start?	______	______	______	______
9. Do you try to control your drinking by giving it up completely for days or weeks at a time?	______	______	______	______

	Never	Some times	Often	Nearly always
10. The morning after a heavy drinking session do you need your first drink to get yourself going?	______	______	______	______
11. The morning after a heavy drinking session do you wake up with a definite shakiness of your hands?	______	______	______	______
12. After a heavy drinking session do you wake up and retch or vomit?	______	______	______	______
13. The morning after a heavy drinking session do you go out of your way to avoid people?	______	______	______	______
14. After a heavy drinking session do you see frightening things that later you realise were imaginary?	______	______	______	______
15. Do you go drinking and the next day find you have forgotten what happened the night before?	______	______	______	______

Source: Raistrick, et al. 1983 [27]

Go to page 33 for scoring instructions

T-ACE

T **Tolerance:** how many drinks does it take to make you feel high?

A Have people **Annoyed** you by criticizing your drinking?

C Have you ever felt you ought to **Cut** down on your drinking?

E **Eye opener:** Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

TWEAK

T **Tolerance:** how many drinks can you hold?

W Have close friends or relatives **Worried** or complained about your drinking in the past year?

E **Eye Opener:** do you sometimes take a drink in the morning when you get up?

A **Amnesia:** Has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?

K(C) Do you sometimes feel the need to **Cut** down on your drinking?

Scoring the AUDIT

Add up the scores in the brackets from questions 1 to 10.

Total AUDIT score:______

What do the scores mean?

Less than 8	low risk
8 to 15	risky to high risk
16 to 19	high risk, may be dependent
Above 20	probably dependent

Scoring the SADD

Never = 0 sometimes = 1 often = 3 nearly always = 4

Add all scores for the total score

1-9 indicates low dependence

0-19 medium dependence

20 or more high dependence

Scoring the T-ACE and the TWEAK

1. For the first question, more than 2 drinks equals a score of 1.
2. For the remaining questions, a 'yes' equals a score of 1.
3. Total score is obtained by adding the score for each question. A score of 2 or more on either questionnaire may indicate drinking at high risk levels and a score of 1 may indicate moderately risky drinking.

The Australian Alcohol Guidelines state that "It is difficult to identify exactly the lower levels of drinking at which alcohol may cause harm to the child and, for this reason, a (pregnant) woman may consider not drinking at all." (p.19). The recommended safe drinking limit for pregnant women who choose to drink is less than seven standard drinks per week, no more than two drinks on any one day, and as per the general guidelines, two alcohol free days per week. Pregnant women should never become intoxicated. [1]

Sources of information

The following list is intended to give you easy access to useful information about alcohol and treatment. It is not exhaustive.

Resource	**Author/Source organisation**
Information about alcohol:	
Alcohol: The Facts	National Drug and Alcohol Research Centre, Sydney, NSW. www.med.unsw.edu.au/ndarc
The Australian Alcohol Guidelines: Health Risks and Benefits, 2001	National Health and Medical Research Council, Canberra, ACT. www.alcoholguidelines.gov.au
General treatment:	
Treatment Approaches for Alcohol and Drug Dependence: an Introductory Guide, 1995	Jarvis, T.J., Tebbutt, J., & Mattick, R.P. John Wiley & Sons, West Sussex, England.
Guidelines for the Treatment of Alcohol Problems, 2003	www.health.gov.au/pubhlth/publicat/document/alcprobguide.pdf
Alcohol, Tobacco & Other Drugs: A Framework for Policy & Clinical Practice for Nurses and Midwives Clinical Guidelines.	Drug and Alcohol Services Council of South Australia. www.dasc.sa.gov.au/site/page.cfm Go to publications and resources to download the guide.
Withdrawal/detoxification:	
New South Wales Detoxification Clinical Practice Guidelines, 1999.	NSW Drug Programs Bureau. www.health.nsw.gov.au/public-health/dpb/publications/pdf/detoxification_clinicalpractice_guidelines.pdf

Assessment instruments

University of Rhode Island Change Assessment Scale (URICA)	Free. Available from Carlo C. DiClemente, University of Maryland, Psychology Department, 1000 Hilltop Circle Baltimore, MD 21250, or go to www.uri.edu/research/cprc /Measures/urica.htm
Timeline Followback Method	Copyrighted, but no charge for paper/pencil version. Available from Linda Sobell at sobelll@cps.nova.edu
Kessler Psychological Distress Scale (K10)	Free. Go to www.hcp.med.harvard.edu/ncs/K6-K10/index.html
Mini-Mental State Examination (MMSE)	Go to www.minimental.com/
Depression Anxiety Stress Scale (DASS)	Free. Go to www.psy.unsw.edu.au/Groups/Dass/
Beck Depression and Anxiety Inventories	The Psychological Corporation. marketplace. psychcorp.com /PsychCorp.com/Cultures/en-US/default.htm

CBT and motivational interviewing:

Clinical Research Unit for Anxiety and Depression website	www.crufad.com/cru_index.htm
Clinician's Guide to "Mind Over Mood", 1995.	Greenberger, D., & Padesky, D.A. The Guildford Press.
Clinical Treatment Guidelines for Alcohol & Drug Clinicians Series – Motivational Interviewing and Relapse Prevention, 2001.	Turning Point Alcohol and Drug Centre Inc, Fitzroy, VIC. www.turningpoint.org.au
Clinical Skills Series: Effective Approaches to Alcohol and Other Drug Problems. Motivational Interviewing, 1998. Training Video and book.	Baker, A., & Reichler, H. Available from Training, Health and Educational Media Pty Ltd PO Box 2131 Bendigo Mail Centre Victoria 3554 Phone: 0354417673 email: front_desk@themedia.com.au
Motivational Interviewing: Preparing People for Change, 2002.	Miller, W. R., & Rollnick, S. The Guildford Press, New York.

Screening and brief intervention:

The Alcohol Use Disorders Identification Test: Guidelines for Use in Primary Care, 2001.	Babor, T.F., Higgins-Biddle, J.C., Saunders, J.B., & Monteiro, M.G. World Health Organization. www.who.int/substance_abuse/PDFfiles/auditbro.pdf
Drink Less Intervention, 2003.	Discipline of Psychological Medicine, University of Sydney katec@med.usyd.edu.au

Counselling skills:

The Skilled Helper, 1998.	Egan, G. Brooks/Cole Publishing Co, Pacific Grove, California, USA.

Compliance therapy:

Compliance Therapy Training Video	Kemp, R., Hayward, P., & David, A. King's College School of Medicine & Dentistry and Institute of Psychiatry, London.
Manual for Compliance Therapy in Alcohol Pharmacotherapy. NDARC Technical Report No 157.	Teesson, M., Sannibale, C., Reid, S., Proudfoot, H., Gournay, K., & Haber, P. www.med.unsw.edu.au/ndarc

Treatment for Indigenous clients:

National Recommendations for the Clinical Management of Alcohol Related Problems in Indigenous Primary Care Settings, 2000.	Hunter, E., Brady, M., & Hall, W. www.health.gov.au/oatsih/pubs/pdf/rec.pdf

Pharmacotherapies:

MIMs Annual, 2003	MIMS Australia, Crows Nest, NSW.
Australian Medicines Handbook, 2003. Online and hard copy available.	Australian Medicines Handbook Pty Ltd Adelaide, SA. www.amh.net.au.

Self-help and other resources:

"Mind over Mood" Change How You Feel by Changing the Way You Think, 1995	Greenberger, D., & Padesky, D.A. The Guildford Press.
The Right Mix: Your Health & Alcohol.	Department of Veterans' Affairs, Canberra, ACT. www.therightmix.gov.au
The Drinker's Guide to Cutting Down or Cutting Out, 1995.	Drug & Alcohol Services Council (DASC), South Australia. www.dasc.sa.gov.au. Go to publications and resources to download the guide.

Telephone and other services for clients

New South Wales
Alcohol & Drug Information Service (02) 9361 8000, free call 1800 422 599

Queensland
Alcohol & Drug Information Service (07) 3236 2414, free call 1800 177 833

Victoria
Direct line free call 1800 888236

Western Australia
Alcohol & Drug Information Service (08) 9442 5000, free call 1800 198 024

South Australia
Alcohol & Drug Information Service 1300 131 340

Australian Capital Territory
Alcohol & Drug Information Service free call 1800 422 599

Tasmania
Alcohol & Drug Information Service free call 1800 811 994

Northern Territory
Alcohol & Other Drug Service (08) 8922 8399
Amity Community Services free call 1800 629 683 www.amity.org.au

Alcoholics Anonymous National Office
Arncliffe, Sydney, NSW. (02) 9599 8866 AA Helpline (02) 9799 1199
www.aa.org.au

Lifeline 13 11 14

Family Drug Support A website for family and friends affected by alcohol and drug use. (02) 9818 6166 or 1300 368 186

Kids Help Line free call 1800 551 800 www.kidshelp.com.au

Reach Out! A website about young people and mental health
www.reachout.com.au

Multicultural Mental Health Australia
02 9840 3333. www.mmha.org.au

The National Drug and Alcohol Research Centre
02 9385 0333. www.med.unsw.edu.au/ndarc

The National Alcohol Campaign
Department of Health and Ageing.
www.nationalalcoholcampaign.health.gov.au

Advisory services for health professionals

Numbers for health professionals only. Not to be given to the public.

Victoria
Drug & Alcohol Clinicians Advisory Service (03) 9416 3611,
free call 1800 812804

Northern Territory
Drug & Alcohol Clinicians Advisory Service free call 1800 111 092

Tasmania
Drug & Alcohol Clinicians Advisory Service free call 1800 630 093

New South Wales and the ACT
Drug & Alcohol Specialists Advisory Service (02) 9361 8006,
free call 1800 023687

Queensland
Queensland Drug Information Service (07) 36367098

Western Australia
Drug & Alcohol Clinical Advisory Service (08) 9442 5042

South Australia
Drug & Alcohol Clinical Advisory Service 1300 131 340

National Prescribing Service Therapeutic Advice and Information Service 1300 138 677