NSW Health Drug and Alcohol Psychosocial Interventions

Professional Practice Guidelines

NSW HEALTH

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Contents

Executive Summary

The *Drug and Alcohol (D&A) Psychosocial Interventions Professional Practice Guidelines* are the first generic professional guidelines for psychosocial interventions to be developed in NSW for drug and alcohol practice. The Guidelines take a stepped care approach to drug and alcohol treatment, which focuses on the adoption of best practice models for people with drug and alcohol issues, and reflects current best evidence and practice in the drug and alcohol counselling field.

Responsibility for implementation of the Guidelines is shared across all levels of drug and alcohol clinical practice, and the Guidelines aim to increase the effectiveness of staff as psychosocial clinicians and systematise the use of psychosocial interventions for problematic drug and alcohol use across NSW. The Guidelines are intended to be applicable across the various allied health disciplines within drug and alcohol specialist services that are providing clinical psychosocial interventions. This includes Specialist and Generalist D&A professionals across public and private sectors.

These Guidelines are not intended to provide detailed information relating to the implementation of all psychosocial therapies relevant to problematic drug and alcohol use. Rather, a range of psychosocial models are described with reference to the available evidence base for treating problematic drug and alcohol use, with readers referred to a range of additional resources, texts, and training courses that can provide advice and skills in the use of these psychosocial models.

A range of treatment processes are described in Section 3 of these Guidelines, which are considered fundamental to any psychosocial intervention, regardless of the theoretical model on which the intervention is based. These elements include:

■ The importance of strategies for engaging and retaining drug and alcohol clients in treatment

■ Integration of psychosocial strategies with other treatment modalities (eg. pharmacological options, inpatient/outpatient settings, public/private and Non-Government sectors, face-to-face and internet-based approaches, etc)

■ The development and maintenance of clinical partnerships with professionals working in other treatment modalities and settings.

Once a client is engaged with a service and/or D&A professional, the following components will also form part of any psychosocial treatment strategy that is offered:

■ **Intake and screening** regarding acuity of presentation (intoxication, need for withdrawal management, etc), problematic drug and alcohol use, concurrent mental health problems (depression, anxiety, etc), social/other health problems, welfare issues and other risk management issues that need attention prior to engaging with a drug and alcohol treatment program

■ Informal and formal **comprehensive assessment** of the presenting drug and alcohol issues of the client, background and personal history, drug and alcohol history, readiness to change, and screening for psychological problems

■ Provision of **feedback to the client** about the outcomes of the assessment

■ **Development of a treatment plan** in collaboration with the client, including decisions about abstinence versus harm reduction goals, preventing relapse, strategies for achieving goals and methods for evaluation progress and outcomes

■ **Implementation of interventions** based on the treatment plan

■ Regular measurement and **review of progress and outcomes** in response to interventions provided

■ Consideration of the need for **continuing care**

■ **Discharge and onward referral** when appropriate.

Specific psychosocial interventions for problematic drug and alcohol use will be offered, based on the agreed treatment plan developed by the D&A professional and the client. Regardless of the background, training and experience of D&A professionals, it is important that a range of therapeutic tools and approaches to assisting clients with problematic drug and alcohol use is made available. Such approaches will include brief and intensive psychosocial treatments, group therapies for couples/families, etc, self-help materials and so on.

In particular, all D&A professionals implementing psychosocial treatments should be able to provide Cognitive Behavioural Therapy, and be competent in the use of one additional intensive psychosocial treatment with a strong evidence base for use with problematic drug and alcohol use.

In Section 4, a range of specific psychosocial interventions is reviewed and evaluated in terms of the available evidence for treating problematic drug and alcohol use. These interventions are associated with a '★' to '★★★' recommendation system (increasing number of '★' associated with increasing strength of recommendation and increasing strength of evidence of effectiveness in problematic drug and alcohol use).

Psychosocial interventions with a '★★★' rating and the strongest evidence and expert consensus for treating problematic drug and alcohol use are:

■ Assessment and Brief Intervention

■ Motivational Interviewing

■ Contingency Management

■ Cognitive Behaviour Therapy

■ Psychodynamic Therapy

■ Dialectical Behaviour Therapy

■ Self-Help Approaches (including web-based where available)

■ Continuing Care.

Psychosocial interventions with a '★★' rating for treating problematic drug and alcohol use are:

■ Mindfulness-Based Stress Reduction

■ Acceptance and Commitment Therapy

■ Couple/Family Therapy

■ Self-Help Groups.

Psychosocial interventions with a '★' rating and evidence based mainly on expert opinion suggesting effectiveness in treating problematic drug and alcohol use are:

■ Solution-Focussed Brief Therapy

■ Systemic Therapy

■ Narrative Therapy

■ Management of Crisis Situations.

Strategies for improving sleep and dietary habits of drug and alcohol clients are also provided, along with tips for the D&A professional in managing specific types of problematic drug and alcohol use (tobacco, alcohol, cannabis, amphetamines/other stimulants, heroin/other opiates, ecstasy/other club drugs and polydrug use).

Given co-morbidity (concurrent physical, mental health and problematic drug and alcohol use issues) is increasingly common among drug and alcohol clients, a range of strategies and considerations are presented for drug and alcohol clients who also have co-morbid issues of depression, anxiety, psychosis, personality disorder, trauma, anger/aggression, pain and blood-borne viruses. In general, a thorough assessment of all presenting conditions should be conducted by D&A professionals, with most severe symptoms being prioritised for treatment.

From here, a focus on the impairment and distress experiences by the client, rather than on the establishment of a primary/secondary diagnosis of drug and alcohol disorder is recommended. D&A professionals should consider using a clinically-integrated treatment approach, incorporating psychosocial strategies relevant to both the problematic drug and alcohol use and the concurrent condition into the same intervention, while ensuring the development and maintenance of good rapport and strategies to actively engage clients in treatment.

Since co-morbidity is often a complex treatment challenge, D&A professionals are advised to seek specific co-morbidity training to increase confidence in addressing these issues in drug and alcohol clients.

Care co-ordination and case management practices will also form part of the interventions offered by D&A professionals. In particular, the core activities of intensive case management should include:

■ Screening and assessment across all factors relating to the client's presentation

■ Development of comprehensive, individual treatment or care plans

■ Co-ordination of treatment or care plan implementation

■ Facilitation of access to specialist treatment for drug and alcohol disorders

■ Facilitation of access to other health services including mental health, hepatology, emergency etc as required

■ Facilitation of access to a broad range of community services

■ Maintenance of contact with and support for the individual client

■ Monitoring progress and outcome across the care plan

■ Review and revision of individual care plans.

A range of additional strategies is provided in Section 7, which are important for use among special groups within the community who will also access treatment for problematic drug and alcohol use. These groups include:

■ Aboriginal people and communities

■ Sexual and gender diverse groups

■ Ageing population

■ Coerced clients (including those from criminal justice settings)

■ People from diverse cultural and linguistic backgrounds

■ Rural communities

■ Parents with drug and alcohol issues (including issues with pregnant clients)

■ Young people with emerging problems.

Also contained within Section 7 are tips for working with and accessing services for domestic violence, family violence and child protection.

In the final Section of these Guidelines, the important issue of clinical governance is addressed for individual clinicians, clinical teams and services, and at the managerial level. It is suggested that individual D&A professionals are responsible for their individual clients, and need to have sufficient skills, training and competence regarding the treatment of presenting complaints of clients accessing their service, be it in individual or group practice, in the public, private or Non-Government sector. However, D&A professionals are not expected to be an expert in the treatment of every issue or problem a client presents with, and thus should not work in isolation of other service teams, drug and alcohol agencies and services.

At the service level, D&A professionals should have access to regular clinical supervision (not provided by the D&A professional's clinical line manager), clinical review/ support practices (either with or without clinical line managers), and access to a senior person or clinical line manager who is familiar with and knowledgeable about the range of psychosocial treatments appropriate for drug and alcohol clients and the complex issues involved in delivering these treatments.

Clients are also important partners in the clinical governance process, most often as active participants in their individual clinical reviews (eg. treatment planning and review) that form part of good clinical practice, with strategies for client collaboration, and the engagement of significant others, communities and other support people are outlined in Sections 3, 4 and 7.

A comprehensive reference list is provided in Section 9 of these Guidelines, providing D&A professionals with a number of additional sources of information and detail about the above issues.

SECTION 1

Introduction

These guidelines aim to provide services involved in the delivery of drug and alcohol (D&A) treatments with a benchmark for the delivery of quality psychosocial interventions. Each D&A professional needs to use these guidelines within the context of their role and scope of practice, and update their knowledge by accessing new research and clinical guidelines as they emerge.

1.1 About these guidelines

These guidelines were developed by the NSW Health Drug and Alcohol Allied Health Workers Advisory Committee, which is a sub-committee of NSW Health Drug and Alcohol Council. The Allied Health Workers Advisory Committee acted as the steering committee for the Guidelines. A consultant, Dr Frances Kay-Lambkin, was appointed by the then Centre for Drug and Alcohol, NSW Health, in 2006 to assist in the writing and editing of the guidelines. A list of key informants and committees consulted is included in Appendix A.

A number of key factors created the impetus for the NSW Health Drug and Alcohol Council to support the development of these Psychosocial Interventions Professional Practice Guidelines. These included a growing recognition of the value and importance of psychosocial interventions within the drug and alcohol field, a desire to provide support to its professional implementation, and the need for a greater level of understanding about the purpose and benefits of psychosocial interventions. Indeed, the 2004/5 Annual report on the NSW Minimum Data Set for drug and alcohol treatment services indicated that psychosocial interventions are the most common interventions offered in treatment (eg. 33.1% of closed episodes of treatment were for counselling interventions, 1).

The Guidelines are aligned with the NSW Health Drug and Alcohol Plan 2006 - 2010, and aim to provide a professional framework to those workers who deliver specialist drug and alcohol psychosocial interventions. The Guidelines are not a policy directive and are not intended to replace or take precedence over local policies and procedures. Rather, they are intended to provide a broad overview of the main issues involved in delivering psychosocial interventions within drug and alcohol treatment settings, and direct the reader to more detailed information where it is available.

These Guidelines are based on a review of the existing evidence for the effectiveness of psychosocial assessments and interventions among people using drugs and alcohol. In cases where limited research literature exists on the approaches described herein, expert opinion has been used as the basis for recommendations. At the time of writing these Guidelines, an important Australian text on counselling for addictive disorders was published by Ali Marsh and Ali Dale (2). While this text covered many domains relevant to these Guidelines, there were important gaps in relation to providing psychosocial interventions for drug and alcohol clients, at least in NSW, which still needed to be addressed. As such, these Guidelines draw heavily on the Marsh and Dale text where appropriate (2), and attempt to fill these gaps with additional literature and expert opinion. Key references also include practice guidelines published by the American Psychiatric Association (http://www.psych.org/psych_pract/treatg/pg/prac_guide.cfm), Managing Alcohol and Other Drug Problems (3), and the World Health Organisation's Management of Mental Disorders (4). A number of NSW Health Clinical Practice Guidelines, Discussion Papers and circulars are also relevant, and are available at http://www.health.nsw.gov.au/pubs/a-z/a.html and the Centre for Drug and Alcohol website http://www.health.nsw.gov.au/public-health/dpb/publications.htm. These include:

- Clinical Guidelines for methadone and buprenorphine treatment (5)

- Withdrawal Clinical Practice Guidelines (6)

- Case Management in drug and alcohol treatment (7)

- Stepped Care in drug and alcohol treatment (8)

- Framework for Suicide risk assessment and management (9)

- Clinical Supervision Guidelines (10).

1.2 Drug and Alcohol services in NSW

The NSW Health Drug Treatment Services Plan (11) describes the following activities as core within the drug and alcohol service setting:

- Outpatient services (triage, assessment, case management, day programs, medical care)

- Withdrawal (inpatient and community)

- Pharmacotherapy

- Residential Rehabilitation (intensive rehabilitation)

- Infrastructure (essential components of service delivery such as training, early intervention, consultation and liaison).

Likewise, within the non-government sector, drug and alcohol services are provided around the same core activities, such as service delivery, policy development and advise through Peak Organisations and advocacy on behalf of clients with problematic drug and alcohol use. Psychosocial approaches are easily integrated into each of these core treatment activities across government and non-government sectors.

1.3 Who are these guidelines intended for?

The Guidelines are intended to be applicable across the various allied health disciplines within drug and alcohol specialist services that provide direct clinical psychosocial interventions. This includes professionals working in 'specialist' drug and alcohol services, such as psychologists, social workers, health education officers, nurse Drug and Alcohol Workers as well as positions that are classified more generally as 'Drug and Alcohol Worker'. They also include student Drug and Alcohol Workers who are undertaking placements at services and students completing TAFE-based traineeships in drug and alcohol issues. In addition, these guidelines will be relevant to professionals in 'Generalist' roles who provide drug and alcohol interventions, such as medical practitioners, school

counsellors, etc They are also applicable for both the government and non-government sector in relation to community-based services. The recently released drug and alcohol treatment guidelines for residential settings (12) is the appropriate resource for residential settings and therapeutic communities. A significant number of professionals in the private sector will also assess and treat clients with problematic drug and alcohol use. Private sector drug and alcohol workers will include a range of drug and alcohol specialist and generalist professionals as outlined above, working either in collaboration with drug and alcohol services or in isolation of them. These Guidelines can also be used by private sector D&A professionals to guide the psychosocial interventions they provide to clients with problematic drug and alcohol use, and potentially offer some suggestions as to how the public and private sector can work together to deliver a comprehensive program of drug and alcohol treatment.

Access to comprehensive health care is every individual's right. D&A professionals need to ensure that their own attitudes, value judgments and personal experiences do not interfere with a client's right to quality care. Clients have the right to be engaged routinely in direct clinical care, with D&A professionals also providing links to referrals and case management services.

More specifically, the focus of drug and alcohol psychosocial services aims to give equal regard to the physical, psychosocial and cultural wellbeing of all people receiving care. All practice should therefore include a comprehensive substance use assessment, and offer suitable interventions and harm reduction strategies to all clients identified as being at risk of, or experiencing, problems associated with substance use. These problems may include intoxication, regular/harmful use, withdrawal and/or dependence, and related health and social issues. D&A professionals have an important advocacy role to play for clients in terms of improving access to the range of these services in a timely and equitable manner.

1.4 The nature of the problem

Substance use disorders tend to be chronic in nature with genetic, psychosocial, and environmental factors influencing their development and manifestation (13). People with substance use disorders have a pattern of use that is characterised by continuous or periodic impaired control over their use of alcohol or drugs, preoccupation

with the substance, use despite adverse consequences, and distortions in thinking, most notably denial (14).

Problematic drug and alcohol use can give rise to many areas of concern. There are often social, cultural and economic consequences of problematic drug and alcohol use, in addition to a range of physical, psychological and other health consequences. As such, any treatment for these conditions must consider a range of physical, psychological and social/environmental approaches. These Guidelines describe how such approaches may be combined to provide the best response to the client's needs.

The primary goals of treatment for problematic drug and alcohol use should be concerned with reducing harms associated with the use of substances, if not actually reducing or ceasing the use of drugs and or alcohol altogether. These harms can be categorised according to the pattern of use of the substance in which the client engages. That is, the greater the quantity and frequency of problematic drug and alcohol use, the more severe the potential for substance dependence, and the more severe the medical and psychosocial consequence of use (15). Four core diagnoses are typically used to describe a client's drug and alcohol use (15):

■ Non-user/abstinent

■ Non-hazardous use

■ Hazardous or harmful use

■ Substance use disorders (including abuse and dependence).

Non-hazardous use would include low levels of drug and alcohol use, which may not necessarily warrant clinical intervention. Potential harms would be those associated with intoxication, and encompass overdose, risk taking activities, hangovers, poor work and study performance etc (2). Hazardous or harmful use characterises drug and alcohol use that is clinically significant and regular, but not sufficient to meet formal diagnostic criteria for abuse or dependence (16). Functional impairment and distress may be evident at this level of misuse across a number of social, occupational, physical, legal domains, and it may also act as an early warning sign for the development of a formal substance use disorder (2, 16). The American Psychiatric Association (16) suggests that brief interventions, for example, can be used to reduce this risk.

Substance use disorders include abuse and dependence, intoxication, withdrawal, and various mental states (dementia, psychosis, anxiety, mood disorder, etc) that the substance induces when it is used. Understanding the patterns of alcohol and drug use and related harms will assist the D&A professional to work with the client to identify clear targets for treatment.

Criteria for Substance Abuse (14)

A pattern of drug and alcohol use leading to one or more of the following within the same 12-month period:

■ Failure to fulfil major role obligations

■ Recurrent use in physically hazardous situations

■ Recurrent drug and alcohol-related legal problems

■ Continued use despite having persistent or recurrent problems.

Criteria for Substance Dependence (14)

A pattern of drug and alcohol use leading to three or more of the following within the same 12-month period:

■ Tolerance

■ Withdrawal

■ Substance taken in larger amounts or over longer period than intended

■ Persistent desire or unsuccessful efforts to modify use

■ Great deal of time spent in activities necessary to obtain the substance

■ Important social, occupational, recreational activities given up or reduced

■ Drug and alcohol use continues despite knowledge of problems.

In the literature and clinical practice, the terms 'addiction' and 'dependence' tend to be used interchangeably to characterise problematic drug and alcohol use, and depending on the context of the discussion. The World Health Organisation and the American Psychiatric Association advocate the use of the term "substance dependence" rather than "drug addiction" in their formal publications (17). The term addiction, however, can draw attention to the

behavioural components of the problematic drug and alcohol use, highlighting that there are psychological as well as physiological components of dependence (17).

This is important, as treatment planning needs to address both the psychological as well as physiological aspects of a client's problem in order to maximise outcomes.

Different parts of the brain are involved in the psychological and physiological dependence (13). For example, psychological dependence is primarily developed through the 'reward pathway' in the brain, involving different structures and pathways from those involved in the development of physiological dependence.

The important psychological aspect of dependence is the chronic, relapsing pattern of behaviour in which compulsive drug seeking and drug taking persists, despite serious negative consequences. Continued use of addictive substances induces adaptive changes in the central nervous system, which leads to tolerance, physical dependence, craving and relapse. Individuals vary in how long this process takes, with the psychological impact of the drug a likely major determining factor. The psychological component of addictive behaviour is determined to a large extent by the reasons why drugs are used and the beliefs and attitudes towards the drug.

In contrast, the two main physiological features of substance dependence are tolerance and withdrawal. Tolerance develops when the central nervous system responds to reduce the effects of a drug, and develops at different rates to the different effects of a drug. For example, tolerance to the euphoric and analgesic effects of opiates develops rapidly but there is little tolerance to the effects on the bowel. The tolerance level a client has to a particular drug tends to fall when the drug has not been used for some time. For some, drugs tolerance can rise to a high level but small increases beyond this level can be fatal. That is, the margin between the 'effective' and lethal doses of a drug can become narrow in highly dependent users. In summary, comprehensive models of problematic drug and alcohol use involve multiple components, most notably biological, psychological and social factors (18). In addition, a client may have both genetically determined and acquired vulnerabilities that interact with their ongoing life experiences to influence the development of problematic drug and alcohol use, substance dependence/addiction. From a treatment perspective problematic drug and alcohol use is determined by biological, psychological and social factors all of which need to be addressed if treatments are to be effective.

1.5 Key definitions

For the purposes of these guidelines, the term 'drug and alcohol (D&A) professional' refers to anyone with responsibility for the provision of direct clinical psychosocial interventions either individually or in a group setting. The term 'client' refers to the recipient of any of these services. The client may be an individual, couple, family, group, organisation or other social unit. 'Problematic drug and alcohol use' will be used throughout these Guidelines as a way of describing patterns of drug and alcohol use that is considered problematic and warranting intervention by D&A professionals. This includes substance misuse and substance use disorders such as abuse and dependence.

In 1992, Australia became the first country in the world to introduce harm reduction principles into drug policies (19), and a 'harm reduction' approach is recommended for all psychosocial interventions with drug and alcohol clients. Harm reduction approaches take a realistic and practical approach to the issues of problematic drug and alcohol use, and focus on reducing the harms (negative effects) associated with a client's problematic drug and alcohol use, reinforcing any positive changes a client is able to make (20). It is important to note that harm reduction approaches to problematic drug and alcohol use recognise abstinence as the only safe goal for some severely substance dependent individuals.

However, for many drug and alcohol clients, abstinence is not always a realistic goal (19). Instead, clients and D&A professionals work together to build a hierarchy of goals for the client to work towards around their problematic drug and alcohol use, which may or may not culminate in total abstinence (19, 21). For a heroin user, this may include not sharing needles, participating in a needle/syringe program, engaging in safe sex, using methadone maintenance treatment, using other health services for relevant health issues, changing to oral or inhaled forms of heroin, etc (19).

Harm reduction approaches are broadly grouped into three main categories: prevalence reduction (encouraging a reduction in problematic drug and alcohol use in society, eg through education about the harms of use;) quantity reduction (reducing the frequency and amount of drug and alcohol used); and harm reduction (managing the other negative effects of problematic drug and alcohol use, 22). More information on how to apply these strategies is available in MacCoun (22) and Marlatt (19).

1.5.1 A Note on Psychosocial Interventions

Clients with problematic drug and alcohol use will report multiple health and social problems (18). It is often difficult to establish whether these problems were the cause or effect of the client's problematic drug and alcohol use (15). In addition, emotional and psychological difficulties will act as both predictors and outcomes of alcohol and drug use problems (2). Peers will exert considerable influence on problematic drug and alcohol use, with clients often limiting their social networks to those that reinforce their drug taking behaviours (2). As such, considering the 'psychosocial' factors of problematic drug and alcohol use in any treatment plan is important. The American Psychiatric Association (16), in the revised Practice guideline for the treatment of clients with substance use disorders, highlight psychosocial treatments as essential components to any comprehensive treatment program.

The term 'psychosocial' is used widely but is not well defined. In general, the National Institute on Alcohol Abuse and Alcoholism (National Institutes of Health, USA) and the American Psychiatric Association uses the term 'psychosocial' to describe the social and psychological behaviours involved in problematic drug and alcohol use (23, 24). Specifically, this may include:

■ The emotions, attitudes and behaviours that are characteristic of an individual (Psychological, internal context)

■ The social/external context (family, community, cultural factors) that is characteristic of the environment in which the individual lives

■ The interaction between these two sets of factors.

The range of psychosocial issues affecting clients with problematic drug and alcohol use is described in Hulse, White and Cape (pg 25, 15).

Psychosocial interventions provide individuals an opportunity to explore, discover and clarify ways of living more resourcefully, with a greater sense of well-being and encompass the physical, psychological, spiritual, environmental, family and cultural values. More specifically, clinicians whose main focus is psychosocial interventions need to have the skills and ability to integrate a number of differing theoretical models and approaches to help clients resolve specific problems, make decisions, cope with crises, work through conflict, improve relationships with others and improve their sense of self. These Guidelines aim to direct the D&A professional towards the key strategies, techniques and texts that will facilitate the delivery of an evidence-based, effective psychosocial intervention.

Psychosocial interventions should focus both on content and process throughout treatment in order to maximise outcomes (2). Content refers to the skills, strategies and theoretical orientations of the treatment itself, such as those interventions described in Section 4. On the other hand, process refers to the interaction between the D&A professional and the client whilst engaged in therapy, the therapeutic relationship and interpersonal processes that occur during the therapy session (2). These strategies are discussed in Section 3.

1.6 Levels of evidence and strength of recommendation

In Sections 3, 4 and 5 of these Guidelines, the available literature on the process and content of psychosocial treatments has been reviewed, and rated according to the strength of evidence supporting its use among clients with problematic drug and alcohol use. As a guide, the following system of classifying the research has been used, which is based on the recommendations provided by the National Health and Medical Research Council (see Table 1) (25).

Randomised controlled trials remain the gold standard in determining the scientific quality of treatments. These studies will typically involve an active treatment group and a control group (who receive no treatment, reduced treatment, or placebo medication). Allocation to active treatment and control conditions occurs by chance, i.e. is randomly determined. Baseline measures will be taken prior to treatment allocation and provision, and these will be repeated at various stages following completion of the active treatment period, eg at six- and 12-months, by people who are unaware of the treatment allocation of the participant. Given that randomised controlled trials are not common for a number of the techniques described within these Guidelines, recommendations from Clinical Experts have been combined with the

available evidence to assist the D&A professional to select the most appropriate psychosocial intervention for their client. To facilitate this, the National Health and Medical Research Council have provided the following outline for providing recommendations about treatments where randomised controlled trials are not available (see Table 2) (25).

Table 1 - Levels of evidence used to classify the range of psychosocial interventions described in these Guidelines.

Level of Evidence	Study Design
1	A number of randomised controlled trials with similar findings indicating the efficacy of the intervention
2	At least one randomised controlled trial indicating the efficacy of the intervention
3-a	Several well-designed controlled studies (non-randomised) indicating the efficacy of the intervention
3-b	Several comparative studies, cohort studies, or case-control studies indicating the efficacy of the intervention
4	Single case studies, or expert editorials/commentaries indicating efficacy of the intervention

Table 2 - Strength of recommendations made for approaches described in these Guidelines, combining the available evidence and expert clinical opinions (25).

Strength of Recommendation	Description
★★★	The recommendation is supported by at least Level 2 research and expert clinical opinion
★★	The recommendation is supported by at least Level 3 research and expert clinical opinion
★	The recommendation is based on expert opinion

SECTION 2

Professional framework

This Section outlines the key elements involved in good professional practice for D&A professionals working with clients with problematic drug and alcohol use. Specialist D&A professionals should also refer to individual professional practice guidelines appropriate to their specialty area.

2.1 Physical settings

The diversity of settings within which psychosocial services are delivered requires careful consideration. The D&A professional working alone, or in collaboration with another D&A professional and/or Health worker, may provide drug and alcohol treatment services. These services will take place in a range of physical settings, including:

- Inpatient settings (ward, meeting rooms, hospital grounds, etc)

- Outpatient settings (community centres, consultation rooms, primary care services, etc)

- Client homes (eg. For community-based withdrawal, outreach work, etc).

Most work is undertaken face-to-face, but there are also a growing number of telephone and online services available. Some D&A professionals are moving between these different settings and modes of delivery during the course of their work and are therefore required to consider what constitutes good practice in different settings.

2.2 Professional practice

D&A professionals are responsible for setting and monitoring professional boundaries, and making this explicit to the client. These might include the times and frequency of counselling sessions, through to clarifying roles, expectations for therapy and the limits to the therapeutic relationship (26). Having more than one type of relationship may lead to enmeshment of relationship boundaries, misuse of power, and impaired professional judgement, increasing the potential for harm to the

client. Examples of such relationships include, but are not limited to, familial, social, financial, business, or close personal relationships with clients.

Individual factors within the D&A professional will also impact on the psychosocial intervention provided (2). These factors include flexibility, warmth, respectfulness, confidence and interest in the client and the issues with which they present, as well as personal presentation, vocabulary, attachment and relating style of the D&A professional. All D&A professionals encounter the challenge of responding to the diversity of their clients and finding ways of working effectively with them.

Psychosocial activities are to be undertaken **only** with professional intent, and not casually and/or in extra-professional relationships. D&A professionals are responsible for:

- Using agreements/contracts that clearly outline the expectations and parameters of psychosocial services

- Communicating these parameters and expectations to the client

- Disclosing any conflict of interest; and

- Obtaining supervision.

2.3 Ethics and codes of conduct

Ethical standards are important in promoting safe and professional psychosocial practices that cater to the best interests of clients and the public at large. Professional accountability is also critical in ensuring clients' confidence in the psychosocial services provided.

D&A professionals need to be compliant with relevant codes of conduct, ethics and professional practice. The *NSW Drug and Alcohol Clinical Supervision Guidelines* (10) provide a summary of key ethical issues that are relevant in the drug and alcohol treatment context. All D&A professionals must also comply with the following:

- Mandatory reporting requirements under the Children and Young Persons Care and Protection Act

- The legal obligations outlined within the NSW Health *Policy for Identifying and Responding to Domestic Violence*

- The local Area Health Service Code of Conduct

- Local service ethical codes and requirements under funding agreements for NGO's.

D&A professionals, regardless of the setting in which they are practising (eg. NSW Health, NGO, private sector) also need to be familiar with the above documents and have a sound understanding of compliance as it relates directly to the provision of psychosocial services for problematic drug and alcohol use. In addition, there are also specific professional and ethical codes that apply to some individual professions. In summary, these codes are:

- The NSW Medical Board Code of Professional Conduct

- Code of Ethics for Nurses in Australia

- Code of Professional Conduct for Nurses in Australia

- Australian Association of Social Workers Code of Ethics

- NSW Psychologists Registration Board Code of Professional Conduct

- The Australian Psychological Society Code of Ethics

- Australian Psychosocial Association Code of Conduct.

2.4 Confidentiality

There is a need to ensure the confidentiality of individual psychosocial sessions in order to provide a safe and constructive environment for the client, and to encourage a sufficient level of disclosure from them. On the other hand, there is a need to ensure that any sufficiently serious issues related to clinical practice are dealt with appropriately and transparently.

D&A professionals must refrain from disclosing information received in confidence, unless there is a sufficient and compelling reason to do so. Sufficient and compelling reasons include:

- Having the written consent of the client to disclose confidential information eg about the client during the course of supervision, or when referred by other agencies for treatment. Some agencies (eg. Department of Community Services (DoCS), the Courts) may have legal authority to require reports;

- If the client threatens to harm her/ himself or someone else

- If a child is currently 'at risk' of abuse or neglect;

- If the D&A professional or case notes are subpoenaed to court.

D&A professionals may also be required to disclose information about clients who are mandated to attend treatment or clients who are minors.

As Health Systems move towards integrating client/ client files, it needs to be recognised that all health professionals responsible for the care of the client may have access to information placed in files. In addition, the requirements of providing adequate clinical governance such as clinical reviews, as discussed in Section 8, will often result in relevant client details being discussed at team meetings, with clinical line management or in clinical supervision. Such sharing of information is allowed under the *NSW Health Privacy Manual* (Version 2, 27) or with the consent of the client.

Confidentiality and the limits of confidentiality need to be negotiated with the client where appropriate, and clearly articulated by the D&A professional in the case of mandatory reporting requirements (2). D&A professionals should follow the guidelines outlined in the *NSW Health Privacy Manual* (Version 2, 27) and if they are unclear at any stage about the appropriateness of disclosing information, they should seek advice or consultation with their line manager and/or their medico-legal department.

SECTION 3

Treatment processes

This Section describes the basic components of psychosocial interventions that should be present regardless of the specific type of psychosocial treatment being delivered by the D&A professional. There is strong evidence to suggest that one of the most important ingredients of a successful intervention is the effectiveness of the D&A professional in building rapport and therapeutic alliance (28). These general counselling skills, such as supportive, non-judgmental discussions about the client's problematic drug and alcohol use, have been associated with improvements in alcohol use in a few studies (Level 3-b evidence). However, they have not been researched as a stand-alone treatment for problematic drug and alcohol use in the research literature (29).

A few studies do exist to suggest that good interpersonal skills, empathy and the ability to provide clients with a warm, supportive environment in which to discuss their problematic drug and alcohol use, while not sufficient on their own to produce long term change, are associated with increased treatment effects (Level 2 evidence) and better outcomes for clients (Level 3-a evidence) when combined with specific psychosocial treatments (2, 28, 29, see Section 4). It is generally accepted that, regardless of the treatment applied, therapeutic alliance and environment are likely to have a significant impact on client outcomes (29).

3.1 Stepped Care Framework and the Importance of Client-Centred Care

In the stepped care approach to treatment, a set of empirically-based guidelines determine what treatment to start with and when to progress to an additional or more intensive treatment (30-32). The principle of Stepped Care as outlined by Schippers (32) states that "a more intensive or different form of care or treatment is offered only when a less intensive form has been insufficient". For drug and alcohol treatment, this would involve monitoring the results of interventions and changing the intervention in some way if the outcome in relation to treatment goals was poor (8).

Stepped care models for psychosocial treatments can sidestep the often difficult task of predicting from the outset of treatment which strategies will be most appropriate for a particular client at a particular point in time (33). In addition, stepped care treatment models offer an alternative way to manage existing treatment resources more efficiently (eg. time), and are flexibly able to incorporate new evidence directly into practice as it becomes available (33). Stepped care approaches to treatment have been tested in several different settings, including: depression (34); anxiety (35); alcohol problems (30); smoking (36); heroin dependence (37); and recently for people experiencing mental health and substance use co-morbidity (38).

A proposed model of stepped care for psychosocial treatment of problematic drug and alcohol use is illustrated opposite (Figure 3.1). It should be noted that the stepped care model in Figure 3.1 is a simplified model, and is not intended to cover the range of individual variations in treatment plans and clients likely to be encountered by D&A professionals. Further, the model in Figure 3.1 applies only following an initial intake process, where issues related to risk management, withdrawal, and rehabilitation options have been ruled out and a psychosocial intervention is indicated. See the range of NSW Health clinical practice guidelines on withdrawal (6) and detoxification management (39) and residential rehabilitation options (12) for more information on these issues.

Within a stepped care model, D&A professionals and clients should discuss commencing treatment at any of the levels outlined in Figure 3.1, and following a comprehensive assessment phase. Usually, a first step in the management of these conditions is to gain an understanding of the range of issues impacting on the client with problematic drug and alcohol use, and set some immediate goals for change that are relevant to the client at that point in time (first tier of intervention). Client distress may need to be triaged within this first step, with immediate pressing concerns such as suicidality, emergency accommodation or other crisis issues given priority over others (30). For further

Figure 3.1: A simplified stepped care model for delivering psychosocial interventions to clients accessing drug and alcohol (D&A) treatment.
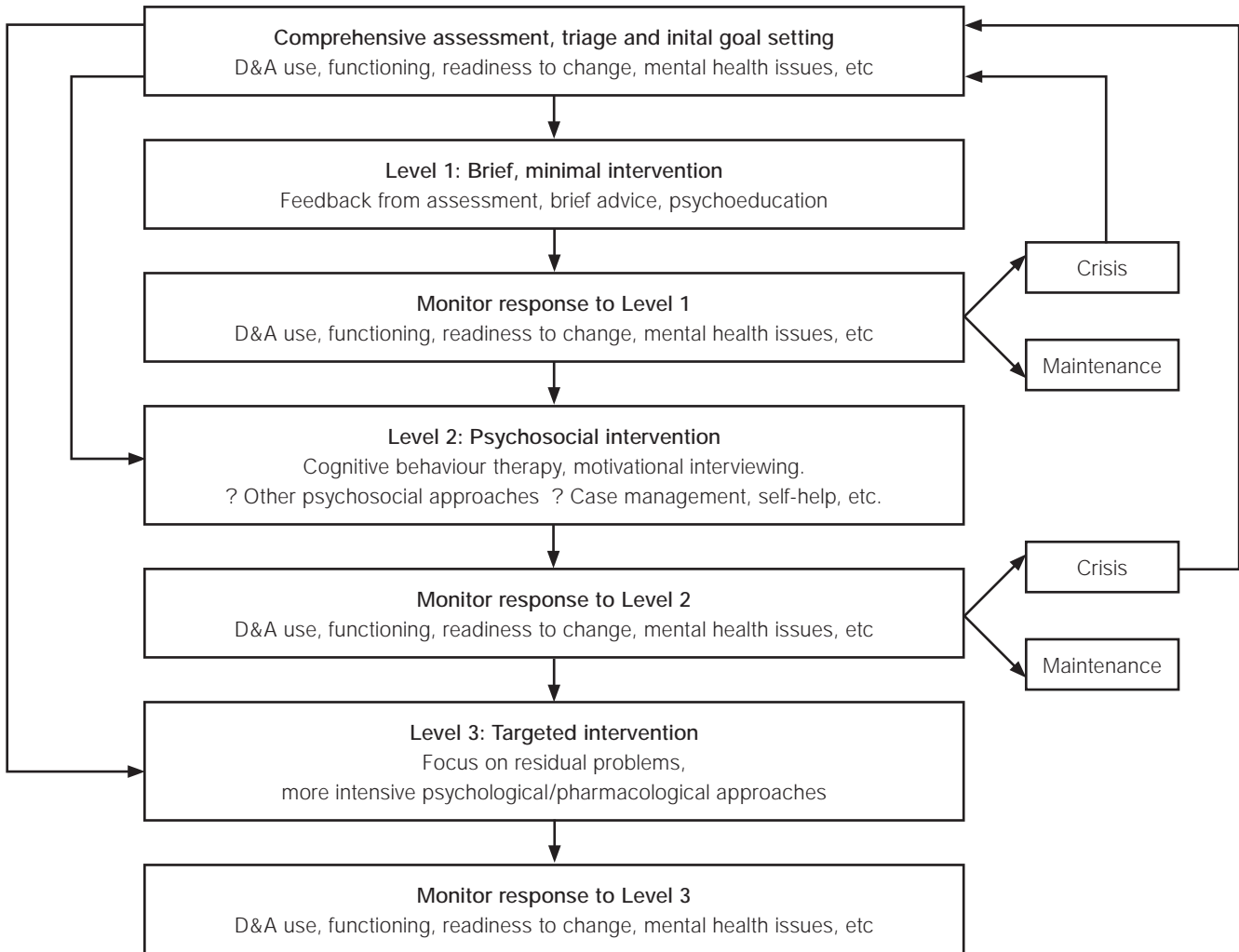
information about the management and assessment of suicide risk, refer to NSW Health Department Policy PD2005_121 'Management of clients with possible suicidal behaviour.' Alternatively, D&A professionals working outside the public sector should refer to their own body's professional practice guidelines for information relating to this issue.

Following assessment, a minimal intervention could be offered that addresses the client's immediate goals for change (second level intervention). This may take the form of education about symptom management, and information about non-hazardous drug and alcohol use or other self-help booklets as appropriate. Brief advice or suggestions about other lifestyle factors that might be enhanced or reduced may also be included at this time.

Following the brief (minimal) intervention, response to treatment should be assessed to determine the need for

continued monitoring, referral, crisis support or more intensive intervention (third level intervention). At this time, issues that need crisis intervention and immediate action may be identified, such as suicide risk, risk to others, urgent medical care, withdrawal etc At this monitoring point, the plan may be to continue with regular monthly monitoring, as negotiated between D&A professional and client, with the option to re-enter a more active treatment or be discharged from the service at a later stage. Clients who have not responded to the brief intervention could be offered the next step of treatment.

If there has been no response to the brief intervention, and/or the client has some residual symptoms or issues to address, a more intensive intervention is suggested. At this step, psychosocial intervention (eg. Cognitive Behaviour Therapy) is recommended, given its potential to prevent relapse and continue to produce improvement outside the active treatment phase (34).

Following completion of the second tier of treatment and a monitoring period, residual symptoms and other problems may still require attention. For example, if alcohol issues persist at this stage, a focus on this issue could occur. Extended treatment programs may be an essential next step among clients with problematic drug and alcohol use who have not made significant improvements in outcome following the completion of a brief program of treatment (40).

Several options exist for extended, targeted interventions at this stage of treatment, including pharmacotherapy, extended psychotherapy, and inpatient treatment. These will vary in length and frequency of contact (40). Consequently, longer programs of psychological treatment, if available, could also be considered. Other interventions might focus on relapse prevention, community intervention, relationship counselling, trauma intervention etc as suggested by the ongoing monitoring process (38, 41). These approaches are described in more detail in Section 4.

The next and any subsequent steps in treatment would be determined by the results of ongoing monitoring and assessment, following completion of a previous step in treatment.

3.2 Treatment process issues

3.2.1 Engagement and Retention in Treatment

Central to the provision of any psychosocial intervention is a strong bond and working alliance between the client and the D&A professional (28). Indeed, the focus of early interactions with the client should be on maximizing their engagement with the Service/D&A professional and fostering a sense of collaboration in working through the set of issues and distress that the client brings to treatment (42). An empathic, non-confrontational approach from the D&A professional is often associated with better client outcomes (Level 3-a evidence, 29).

D&A professionals must respond to clients in a different way from the other people in the client's life who contribute to their ongoing problems (2). By doing so, the client can learn new ways of responding to and thinking about old, recurrent situations.

Clients will bring a range of reactions and behaviours into the counselling relationship that mirror the problems they experienced in their early development with parents who were under- or over-involved (15). In these cases,

the challenge for the D&A professional is to respond to these behaviours in a way that does not exacerbate or perpetuate them. To best address these issues, D&A professionals need to gather as much information as possible about the client's early developmental experiences, (eg. how loved and accepted they felt, how secure they felt and the extent to which they were encouraged to establish their independence etc), while working hard at establishing a safe and warm therapeutic bond with the client. Marsh and Dale (2) describe these issues in more detail, and provide a detailed discussion on working with clients with unmet developmental needs.

D&A professionals can use a variety of tools to encourage these processes. For example, testing out the relationship between the client and D&A professional within sessions can be useful in clarifying the reactions and behaviours of clients (2). In addition, a range of 'self-involving' statements can be made by the D&A professional to enhance collaboration and bond, and to process any negative reactions (2, pgs 221-225):

"I'm feeling kind of stuck right now...like we are going around in circles...I wonder if you are feeling the same...?"

"You seem to be finding it really hard to look at me today, and I wonder if you are feeling unsafe..."

"As I listen to you talk about what happened, I find myself feeling sad too..."

"How were you feeling about coming to see me today...?"

What do you think I expect you to do...?

"I noticed that you went really quiet just then...I wonder what you think I meant when I said...?"

Clients will need different types and durations of process work relative to content work. These issues are explored in more detail by Marsh and Dale (2), who also recommend that these specific process tools only be used when the D&A professional has observed a particular reaction or behaviour several times and is reasonably confident about their observations.

The challenge for the D&A professional is to monitor client reactions to them, work with these issues, and balance these process issues with the content of the psychosocial intervention. Supervision for the D&A professional is central to identifying and working through these issues (2).

3.2.2 Integration within other treatment modalities

A range of options should be presented to clients with substance use problems (29). This will include pharmacological and/or psychosocial options, inpatient programs, outpatient programs, public, private and Non-Government sectors, etc. In addition, a range of modalities is available for the delivery of psychosocial interventions, including face-to-face approaches, internet-based treatments, and other forms of self-administered interventions. D&A professionals can help clients to weigh up the positives and negatives associated with each treatment option, and decide on a course of action that best suits their needs (42, 43). The American Psychiatric Association (16) suggests that this integrated approach is associated with improved rates of treatment retention and better treatment outcomes.

There is a wide range of modalities and settings in which psychosocial interventions can be delivered to clients with problematic drug and alcohol use. Accordingly, D&A professionals need to be aware of, and able to discuss the range of available treatment options with clients, provide advice around these issues and integrate the most appropriate options into the drug and alcohol treatment plan developed for each client.

3.2.3 Clinical partnerships

To facilitate an integrated treatment program for the client, D&A professionals need to develop and maintain strong clinical partnerships with professionals working with other treatment modalities, and in other treatment settings. Formalising these partnerships, particularly between government and non-government sectors, can enhance treatment provision, and ensure a co-ordinated, consistent approach to the client's care is maintained. If the service within which the D&A professional is operating does not have links with particular relevant services, the D&A professional can create and foster these partnerships with individual workers within other clinical settings. This way, arrangements can be formalised for the responsibility of service provision to the client, and the release/sharing of client information (with client consent).

3.3 Common treatment processes in psychosocial interventions

The basic components of any psychosocial intervention, regardless of the theoretical underpinnings, include:

measurement (screening and assessment), treatment planning and goal setting, implementation of the specific intervention, evaluation of outcomes, and follow-up (44). These core components are described in detail below.

3.3.1 Intake and screening

The evidence for the benefits of routine screening for problematic drug and alcohol use across a range of health settings is strong (28). Routine screening upon intake should occur for acute presentations, such as intoxication and withdrawal (15), along with sufficient information about problematic drug and alcohol use such that an appropriate service can be mobilised to assist with the management of the client (15). Given the high co-morbidity of mental health problems among clients with problematic drug and alcohol use, screening for common mental health problems (such as depression, anxiety, etc) should be considered as part of the routine intake and screening procedures across drug and alcohol settings (private sector, public sector, inpatient, outpatient, etc (45)).

Upon intake, a range of information needs to be gathered to assist in directing the client to the most appropriate treatment service. This information is summarised below (4).

Example of Information to be Collected upon Intake (4)

- Does the client's problematic drug and alcohol use warrant treatment?

- What is the most suitable treatment for this client?

- Can this treatment be provided by the available staff members? If not, what referral options are there?

- Is there a past history of withdrawal management or substitution maintenance that is important in deciding on an appropriate treatment plan?

- Are there any concurrent mental health, social, or other health problems that need urgent attention before drug and alcohol treatment is commenced?

- Are there any immediate welfare issues that need to be addressed? (eg. homelessness)

- Are there any other risk management issues that require urgent attention? (eg. children living at home with the client).

A comprehensive list of screening instruments for use with problematic drug and alcohol use is available (see 46). For further information, refer to the *NSW Drug and Alcohol Program, Centralised Intake Guidelines*, June 2004 (47).

3.3.2 Comprehensive assessment

Both informal and formal assessment needs to occur prior to the development and implementation of a treatment plan (2). This will include assessments of the presenting issues of the client, their background and personal history, alcohol and drug use history (including current use), readiness to change current issues, and screening for psychological problems. Informal discussions around these issues can be supplemented by the use of standardised assessment instruments (2, 28). The specifics of a comprehensive pre-treatment assessment are described in Section 4.

During the assessment, the need to raise sensitive issues will arise for the D&A professional (2). This is particularly the case when discussing problematic drug and alcohol use with a client who is not yet ready to engage in treatment for these issues. Focusing too soon on substance use in these situations will most likely elicit resistance from the client and interfere with rapport building. In these cases, the critical conditions for promoting change and reducing resistance are: accurate empathy, non-possessive warmth and genuineness (48).

Tips for Raising Sensitive Issues (48)

■ A good general approach is to ask open-ended questions, to listen reflectively, affirm the client and summarise throughout

■ Begin by asking generally about the client's lifestyle, using any preceding discussion as a guide: "The information we have talked about in this session has given me a bit of an idea about what is going on in your life at the moment. But, I really don't know a lot about you and the kind of life you lead. Perhaps we can spend a few minutes with you telling me about a typical day in your life, so that I can understand in more detail what happens? Tell me a bit more about the things you struggled with and how you felt at the time. Can you think of a typical recent day from beginning to end...You got up..."

3.3.3 Feedback to client

Providing feedback to the client on the outcomes and impressions gained from the pre-treatment assessment is an important tool in the psychosocial intervention. Feedback about the client's disorder (if relevant), the nature and effects of problematic drug and alcohol use, medical and behavioural harms associated with specific substances, and the importance of treatment should also be provided (16). To maximise the potential benefits of this process, an emphasis on the client's strengths as well as their weaknesses, communicated in an honest and encouraging manner, is recommended (2). Feedback from the assessment phase should be linked explicitly to clear goals for treatment (2). In addition, clients should also receive education about their substance use problems, information about different treatment options, and guidance as to how family members and friends may be engaged to promote recovery and reduce risk of relapse (16, 29).

Tips for Providing Feedback (2, pages 53-54)

■ Focus first on the client's strengths

■ Gently and tactfully outline the client's difficulties

■ Focus on the pattern of results, rather than an overall score

■ Pull the assessment results together and create a 'story' of how the client came to be in their current situation, and how they explain their current difficulties with alcohol/drugs, work, relationships, the law, and other life areas

■ Explore the client's reactions to the feedback provided.

3.3.4 The treatment plan

A useful place to start the treatment planning process is by asking the client what brings them to treatment. This will assist the D&A professional to develop a broad idea of the client's goals for therapy and then tailor a treatment plan accordingly. Clients will likely describe their presenting concerns in very general terms (eg. 'I'm worried about my use of ...'), and the D&A professional will need to work with the client to refine these into concrete, measurable goals for change. In addition, the client and the D&A professional must have a shared understanding of the course of psychosocial treatment, in terms of its duration, regularity, review and termination procedures (2).

Feeding back the results and impressions gained from assessment leads into a discussion around setting goals for treatment. Treatment that is planned and implemented according to a shared set of goals between client and D&A professional is associated with improved clinical outcomes (49). In addition, setting clear, concrete goals will also provide the D&A professional with a firm idea as to whether he/she has the skills necessary to assist the client to work towards and achieve these goals (2, 44). In general, psychosocial interventions will have five main goals (16, 44):

1. Engage the client in treatment

2. Reduce problematic drug and alcohol use to non-harmful levels (may mean abstinence)

3. Prevent relapse to pre-treatment levels of problematic drug and alcohol use

4. Address lifestyle issues to encourage adherence to drug and alcohol goals

5. Improve the psychosocial status of the client.

Tip for Commending Goals of Abstinence

If the client has identified abstinence as a goal, then offer the following:

"Successful abstinence is a safe choice. That is, you can be sure that you won't have problems because of D&A use. There are good reasons to at least try a period of abstinence (eg to find out what it's like to live without alcohol/other drugs, and how you feel, to learn how you have become dependent on it, to break habits, to experience a change and build some confidence, etc).

Some people experience withdrawal symptoms when they cut back or stop alcohol, which can be uncomfortable as well as physically harmful. So, if you have a GP, and you decide to try a period of abstinence, please let him/her know, so that they can monitor your health during that period."

Clients unwilling to discuss immediate and long-term abstinence might be more responsive to a short-term (trial) abstinence period ("a holiday from alcohol") or tapering off their substance use toward abstinence. Miller & Rollnick (49) describe the following alternatives to immediate abstinence:

1. Negotiate a period of trial abstinence

2. Commence a process of gradual tapering down toward abstinence, or

3. Commence a period of trial moderation. Moderation may be an appropriate goal to start with, even though abstinence may be the longer-term outcome.

It is important to provide education about the potential risks of eliminating problematic drug and alcohol use completely after a period of heavy use. In cases of severe alcohol dependence, any client wanting to abstain totally from alcohol should be advised to do so only under medical supervision. In cases where medical staff are unavailable, then the NSW Drug and Alcohol Specialist Advisory Service is available for consultation.

A goal of abstinence may need to be suggested if the client has co-existing medical conditions, psychological problems that are likely to be exacerbated, uses medications that are hazardous in combination with drugs and alcohol, is pregnant, or has a history of severe abuse and dependence.

Tip for Recommending Abstinence When Indicated

Consider whether it is appropriate to advise abstinence as a goal, and if so, use the following approach:

"It's your choice of course. I want to tell you, however, that I'm worried about the choice you're considering, and if you're willing to listen, I'd like to tell you why I'm concerned."

The client needs to choose his or her own goal(s) within the treatment plan, rather than having the D&A professional 'impose' standards on their change process. While abstinence may be the desired goal for the D&A professional, this prospect may be overwhelming for a client to contemplate. It is far more important to maintain rapport and a good working alliance, and to start with goals that he or she is motivated to achieve. Accordingly, clients may prefer a non-abstinence or controlled-use goal for their drug and alcohol use, and will need similar assistance in planning for this and in harm reduction strategies to assist in achieving this goal.

Controlled-use goals also need to be concrete, specific and realistically achievable. For example, the goal of "*quitting alcohol*" is not as specific or concrete as "*I will stop drinking completely by XXX date.*"

Central to the goal setting and treatment planning process is negotiation (2). Clients should feel that goals and treatment plans target their wants and needs, even in cases where these options conflict with the D&A professional's ideas about what is in the client's best interests. The exception to this is in cases of mandatory reporting, such as when the client is a danger themselves or others, or is breaking the law, etc the use of back-up

or alternative plans is also important in case the client's first option does not work out in the way they intend (2, 50). In addition, the client needs to decide whether their major goal needs to be broken down into smaller, short-term goals, as this approach will allow for positive reinforcement of any changes made in the direction of the ultimate goal, and maximise chances for success (44).

It is probable that over the next few years, the number of clients entering services through Court Diversion Programs and/or directed to attend by other agencies (eg. DoCS) will increase. This requires the counsellor to manage a range of possible conflicting agendas - see Section 7.6. Coerced Clients.

Taking a strengths-based approach to treatment planning and implementation will help counter the messages clients receive and internalise about their problematic drug and alcohol use, and encourage self-efficacy for change (2, 44). The D&A professional can help the client to focus on the things they already do well, and provide some practical skill development. In this way, confidence and motivation to change and make improvements to the situation are likely to be enhanced (2, 51).

The treatment plan should be developed in collaboration with the client (and, where appropriate, external agencies) and recorded formally for both the client and D&A professional. This will serve as a summary of the intended psychosocial intervention that lies ahead (2, 52).

Tips for Creating a Treatment Plan (2, pgs 87-89)

- A review of the client's situation, including strengths
- A statement of client goals
- A statement of current support needs
- Strategies for achieving goals
- Methods of recording progress and evaluating outcomes.

3.3.5 **Implementation of interventions**

The decision about which specific psychosocial intervention is to be used with the drug and Alcohol client should be made by both the client and D&A professional, and be related to the list of problems and goals generated in the above phases (52). Where possible, the choice of intervention should be based

on supporting evidence suggesting its effectiveness for the client's issues, along with the skill and expertise of the D&A professional in delivering the intervention (52). Adjunctive therapies should also be considered (eg. pharmacotherapy, etc) and appropriate referrals made at this time. Both the client's and D&A professional's expectations for treatment should be clarified, including a discussion about each client's role/boundaries for treatment. These issues should be documented in the clinical notes.

In addition, decisions need to be made about the modality of treatment (eg. Individual, group-based, telephone-based, etc) and the frequency with which psychosocial treatment sessions will occur (eg. Once weekly, fortnightly, etc). Ideally, the timing and physical location of the intervention sessions should be as consistent as possible to maximise treatment attendance, optimise the establishment of a working rapport with the D&A professional and assist the client in becoming comfortable with the therapeutic arrangements. All of these decisions should be made in conjunction with the client, discussed openly with them, and documented in the clinical file.

The client and D&A professional should discuss and agree on a way to prevent and manage missed appointments, which are a relatively common occurrence among clients with problematic drug and alcohol use, especially those with co-morbid mental health and other issues (15, 53). Pre-appointment reminder phone calls, letters or mobile phone text messages may be considered by the D&A professional as a way of encouraging treatment attendance. Assertive follow-up of missed appointments by the D&A professional is recommended within two working days of the missed appointment to maximise the likelihood of the client's return (50). If a reasonable explanation for the missed appointment is not offered, this should be explored with the client to determine whether the missed appointment is reflective of any of the following: uncertainty about whether or not treatment is necessary; ambivalence about making a change; frustration/anger for participating in treatment. These issues can be handled by the D&A professional in a manner consistent with a motivational interviewing approach (see Section 4, 50).

Finally, the client and D&A professional should agree on the duration of the treatment program. This may be governed by service policies, the service setting, etc or freely negotiated between the client and D&A professional. If the duration of treatment is based on the achievement of the client's goals, then regular monitoring and review sessions should be planned to assess progress in relation to these goals. Again, these issues should be documented in the clinical file for the client as a record of this discussion.

Tips for Follow-up of Missed Appointments (50, 54)

■ Negotiate a pre-appointment reminder (eg phone call, text message) with the client.

■ The follow-up of missed appointments can be via telephone or letter.

■ If by telephone: speak with the client and clarify the reasons for the missed appointment; affirm the client - reinforce him/her for having previously attended; express eagerness to see the client again; briefly mention any serious concerns that emerged and an appreciation (as appropriate) that the client is exploring these; express optimism about the prospects for change and reschedule the appointment.

■ If by letter: provide contact details to enable the client to re-establish contact if another appointment is required, affirm the client - reinforce him/her for having previously attended; express your eagerness to see the client again; provide a timeframe for the client to re-establish contact and reschedule the appointment.

■ Regardless of the mode of contact, Drug and Alcohol professionals should take steps to maintain the confidentiality of the client. This includes refraining from identifying themselves as being from a Drug and Alcohol Service when speaking to people other than the client and/or leaving phone messages, and using plain envelopes (without service logos, etc) when mailing clients.

3.3.6 Outcome measurement

An important part of the psychosocial treatment program is regular review and assessment of the client's progress in relation to their treatment goals (4). Some of these factors can be carried out informally during each treatment session (eg. assessing withdrawal symptoms, implementation of strategies discussed during session, medication side effects, etc), with treatment tailored accordingly (16).

However, it will also involve the formal measurement/review of relevant outcomes, such as quantity/frequency of problematic drug and alcohol use, psychiatric symptomatology, biological measurements (blood, urine, etc) as guided by the initial assessment, and/or the service policy within which the D&A professional is operating. Formal, objective outcome measurements are essential to this process, as they minimise the risk of both clients and D&A professionals overestimating the effect of a treatment program, and of focusing too much on one domain of the client's presentation, when another area may be deteriorating (4).

Within a stepped care framework, the results of these measurements can be used to inform decisions to 'step-up' or 'step-down' the intensity, duration and content of the psychosocial intervention (8). The D&A professional should use their clinical judgement to decide on an appropriate course of action, taking into account the need for crisis intervention, the severity of conditions, client stage of change and engagement with the treatment program (33). Importantly, however, if the results of these outcome measurements indicate that the client can be discharged from the service, then arrangements should be made for either a further review/follow-up session, or to re-engage with the service/D&A professional in the case of an exacerbation in problematic drug and alcohol use (53).

There are no firm rules guiding the frequency with which outcome measurement and monitoring should occur, and often it is left to the D&A professional to use their judgement about the most appropriate measurement timeframe (4). Several authors have suggested for any intervention, if a client is going to respond to the intervention, they will have usually done so within one-month of delivering the treatment, depending on the frequency of contact with the D&A professional (34, 38, 55). However, in some service settings, three-monthly assessment/review sessions are recommended.

3.3.7 Continuing Care

Continuing care following discharge from an inpatient facility is associated with improved substance use outcomes (16). Indeed, the lowest rates of relapse to alcohol use have been shown when a formal program of continuing care has been provided, following discharge from a detoxification unit (2).

A standard program of continuing care has been described as regular contact (usually monthly) with a psychiatrist/medical professional for medication monitoring, along with access to a case manager for service co-ordination, outreach, etc (53). Within a stepped care framework, these contact points could again be used as a trigger to 'step-up' or 'step-down' treatment for the client.

3.3.8 Discharge and onward referral

Termination of treatment needs to be a carefully negotiated process with the client and the D&A professional, as it can be a difficult time for both (2). Termination can be 'natural', whereby the client has achieved all the goals set down in the treatment plan, or 'artificial', as often happens when treatment is time-limited because of policy, or D&A professional preference (2). Regardless of nature of the termination, it is important that the time limits for treatment have been clearly articulated in the treatment planning phase (i.e. work will continue until all goals are met, or six sessions of psychosocial intervention is available, etc), and by formally processing the termination of psychosocial treatment towards the end of therapy (4).

For example, any areas that are yet to be addressed should be acknowledged, as should the gains clients have made throughout treatment. D&A professionals should give the client the opportunity to discuss their feelings about the termination of treatment and, where appropriate, leave the door open for re-engagement with the service at a future date (2). In addition, offers of referral should be made to the client, to assist them in tackling their remaining goals. Marsh and Dale (2) discuss the issues around successful termination of treatment in more detail.

There are no rules governing the process of referral. Rather, referral should be considered throughout the assessment and treatment processes as D&A professionals consider their ability to assist the client to

work through his/her presenting issues and treatment plan. This includes any limits within the service that may impact on the type of, and extent to which, psychosocial and other interventions may be offered (2). This process means that the D&A professional must have a clear idea of the types of issues he/she is able to help with, both from an individual and service perspective.

Tips for Effective Referrals

■ Occurs with the agreement of the client

■ Knowledge of available facilities (specific, current information)

■ Skill in selection

■ Provide rationale for referral and allow client to raise concerns

■ Objectivity (across disciplines and sectors)

■ Timing (early, to maximise engagement)

■ Includes follow-up.

In addition, a range of strategies will assist the D&A professional and client maximise the success of a referral process. It is suggested that good practice in referral includes a written letter to the referral service in which the following issues are clearly articulated:

■ The reasons for referral

■ Issues already covered by the D&A professional with the client

■ The clients understanding of the reason for the referral;

■ Any arrangements made with the D&A professional and client to continue contact

■ A suggested avenue for communicating the outcomes of the referral with the D&A professional.

A copy of this letter should be provided to and discussed with the client.

To assist the client in attending a referral appointment, the following issues should also be discussed by the D&A professional, prior to the appointment:

■ Name, phone number, address and directions of the referral service

■ Discussion around transport to and from the referral service appointment

■ What the client can expect upon arrival at the referral service, along with the nature, purpose and value of the referral

■ Written material about the referral service (if available);

■ A method of contacting the D&A professional.

In cases where the referral is related to a risk management issue (eg. suicidality), it may by appropriate for the D&A professional to discuss being alerted by the referral service about whether the client attended the appointment.

Psychosocial interventions

Psychosocial treatments are considered to be the foundation of drug and alcohol treatment, especially for substances where pharmacological treatments have not been sufficiently evaluated (16). Pharmacotherapy is most successful when clients are motivated to change and willing to comply with their prescribed medication regime, and is commonly indicated for clients who are using drugs and alcohol at the severe end of the spectrum (16, 28). A review of psychosocial and pharmacological treatments for problematic drug and alcohol use suggested that outcomes are enhanced by combining pharmacological and psychosocial treatment approaches (44, 56, 57). Furthermore, pharmacotherapy may often be useful within the context of psychological support and intensive psychosocial treatment programs to promote improvements in lifestyle, thinking and coping strategies, leading to longer-term change and the prevention of relapse (44, 57, 58).

Psychosocial treatment may be offered in an individual- or group-based format, according to client need. It is important to note that group-based treatments are not suitable for everyone with problematic drug and alcohol use (eg. when given the choice, some clients will not elect group-based therapies, or will have too many immediate issues of concern to participate in a group program, 59).

It is good practice to provide clients with information sheets containing basic information about the type of psychosocial intervention being provided to them. This basic information can include the rights and responsibilities of both the client and D&A professional, a brief description of the treatment, a summary of what the client can expect during treatment and tips for troubleshooting potential barriers to treatment.

4.1 Specific interventions

It is important to note from the outset that the majority of drug and alcohol research has been carried out for the psychosocial intervention, Cognitive Behaviour Therapy (CBT), which includes relapse prevention, problem-solving etc being a highly structured therapy, CBT lends itself well to the traditional methods of research and evaluation (eg. randomised controlled trials). Several other psychosocial treatments are described in this section, in addition to CBT, as many D&A professionals find these approaches very useful with a number of clients. Based on the levels of evidence set out for use in these guidelines (see Section 1), recommendations provided for the use of these additional therapies is not as strong as for CBT. This is not to imply that these therapies should not be used for clients with problematic drug and alcohol use, nor that they are ineffective in treating problematic drug and alcohol use. Rather, this is an effect of the lack of a research agenda for these approaches for clients with these problems. Indeed, many of these treatments have a strong evidence base in mental health and other settings. There is clearly a need for more comprehensive research to be conducted across the full range of treatment modalities for psychosocial interventions in problematic drug and alcohol use. It is especially important that D&A professionals have available a range of therapeutic tools and approaches to assisting clients in managing problematic drug and alcohol use, as different clients will be better suited to different therapeutic models or approaches.

Recommendation (★★★)

All drug and alcohol professionals providing psychosocial treatments should be able to provide cognitive behavioural therapy and be competent in the use of one additional intensive psychosocial treatment with a strong evidence base for use with problematic drug and alcohol use.

4.1.1 Assessment

Drug and Alcohol services will likely have a core list of assessments to be administered to clients, and these should be used by the D&A professional in assessing a client's presenting condition. Usually, a comprehensive drug and alcohol assessment will include the following components (pg 478, 4):

- Severity of dependence (using standardised scales such as the severity of dependence scale, 60)

- Signs and symptoms of withdrawal (as indicated by each drug type)

- Physical health consequences of problematic drug and alcohol use (such as liver disease, heart problems, hypertension, nutritional problems, ulcers, hiv, hepatitis, etc)

- Risk taking behaviours associated with problematic drug and alcohol use

- Stages of change of drug and alcohol use (using scales such as the readiness to change scale, 61)

- Pattern and context of problematic drug and alcohol use (including reasons for use, and quantity and frequency of use, using scales such as the BTOM or the Opiate Treatment Index, 62, or the Alcohol Use Disorders Identification test, 63)

- Previous attempts to stop problematic drug and alcohol use (including treatment history, high-risk situations, causes of relapse, etc).

Suicide ideation and behaviour is significantly higher among people using substances than in the general population (16). At all assessment and monitoring points throughout the psychosocial intervention, suicidal ideation should be assessed and reviewed. This enables effective and appropriate crisis intervention if necessary (4). In addition, given the high co-occurrence of mental health issues with problematic drug and alcohol use (see Section 5), screening for mental health conditions, such as depression and anxiety, should also be included in the assessment (4).

A comprehensive list of diagnostic and screening instruments for problematic drug and alcohol use is also available (see 46).

Clients will differ in both the extent to which they are motivated to discuss and address their use of substances, and in their insight into their problems. As a result, the content of assessment will need to be altered to reflect this (eg. extending the assessment over a longer period of time, providing education about key issues, focusing on building rapport and engagement, etc, 16). As trust and rapport develops between the client and the D&A professional, the client will likely feel more comfortable

discussing the extent and impact of their problematic drug and alcohol use (64). For this reason, the initial assessment should continue to be re-visited as the therapeutic relationship develops, with initial assessment results modified as more comprehensive and accurate information becomes available (4).

Consulting multiple sources of information will assist in gaining an accurate picture of the client's presenting condition. These additional sources could include other treatment professionals (primary care providers, mental health professionals, other medical or allied health professionals), clinical records for the client (if available) and family members, friends or relatives who can provide corroborative information about the client's problematic drug and alcohol use (current and previous, 64). This will be particularly important if the client is intoxicated, has difficulty remembering details of problematic drug and alcohol use, and/or is experiencing some impairment of memory or functioning (4). An essential part of collecting this information, however, is to discuss these activities with the client prior to consulting additional sources, and gaining their explicit consent for you to do so (64).

> **A caveat about assessment (pg 33, 28)**
>
> If the client feels that little progress is being made, motivation to engage with treatment may decrease. As such, it is important to balance the need for a complete assessment with the overriding goal of engaging a client in drug and alcohol treatment.

4.1.2 Brief interventions

Brief interventions are generally between 5-30 minutes in duration, and can be delivered across a range of health settings (eg. general practice, hospital wards, emergency departments, community, etc, 50, 65). Because of the brief nature of these interventions, they can be delivered opportunistically in both inpatient and outpatient settings by a range of specialist and generalist professionals who have been trained the use of these approaches (28). Brief interventions can be an effective first level of treatment offered to drug and alcohol clients within a stepped care framework (38, 65).

Typically, brief interventions involve the provision of formal feedback from the assessment phase, and

brief advice regarding how best to reduce the harms associated with the client's problematic drug and alcohol use. This advice needs to be delivered in a sensitive, non-confrontational manner, as clients may not have previously considered that their drug and alcohol use is problematic. As such, the positive interpersonal style associated with motivational interviewing will be important to adopt in these brief interventions (42). The most effective brief interventions will combine good general counselling skills with motivational interviewing techniques, using the FRAMES approach (28, 66).

Elements of a brief intervention (29, 66)

Feedback (risks, indicators, health status)

Responsibility (communicate choice to change)

Advice (importance of change, with permission)

Menu (variety of change options - harm reduction)

Empathy (warm, non-judgmental, non-confronting)

Self-efficacy (optimism to attain chosen goals)

More detailed information on the provision of brief interventions for drug and alcohol clients can be found in Shand (28), Bien, Miller and Tonigan (66, 67), and Hulse (68).

The effectiveness of brief opportunistic interventions has been established primarily for alcohol use problems, although they have been applied to clients using a range of other substances. Currently, there is Level 1 evidence supporting the benefits of brief interventions for reducing alcohol use among people drinking in excess of recommended guidelines (28, 65). In addition, brief interventions for alcohol use problems produce greater reductions in alcohol consumption relative to no treatment at all (Level 1 evidence, 28).

This is the case when both generalist health professionals or those with specific drug and alcohol training deliver the intervention, in both generalist and specialist settings (65). The same is likely true for other drugs in addition to alcohol, however the evidence has only begun to emerge to support this for cannabis (Level 3-b evidence, 69) and amphetamine use (Level 2 evidence, 70), with effectiveness for other illicit drugs yet to be tested. In light of this, and the clinical utility of this approach, brief, opportunistic interventions should be used routinely in clinical practice.

Recommendation (★★★)

Brief, opportunistic interventions, using the frames approach, should be used routinely in all clients with problematic drug and alcohol use across a range of settings by specialist and generalist drug and alcohol professionals

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4.1.3 Motivational interviewing

Motivational interviewing strategies are detailed in Marsh and Dale (2), and Miller and Rollnick (49). While these techniques are useful stand-alone therapeutic tools, a motivational approach should be adopted throughout the psychosocial intervention (2).

Brief motivational interventions have been applied in inpatient and outpatient contexts, and by practitioners with little formal clinical (psychological) training. Typically, brief motivational interventions are of between one and four-sessions in duration, in addition to assessment (71, 72). Within a stepped care framework, motivational interviewing can be used for drug and alcohol clients who have been non-responsive to an initial brief intervention, or it can be combined with brief interventions as a first-line treatment option (38).

Motivational interviewing is based on the stages of change model, developed by Prochaska and Diclemente (73). This model suggests that people will progress through a series of five stages in deciding and acting upon a plan to change a particular behaviour. These stages include: (i) precontemplation, (ii) contemplation, (iii) preparation, (iv) action, and (v) maintenance, each characterised by the balance between the benefits/losses of maintaining current behaviour versus the benefits/losses of changing that behaviour.

For people in the earlier stages of change, the balance tends to favour no change to current behaviour. As the benefits/losses of staying the same are outweighed by the benefits/losses of changing, the client progresses through to the later stages of action and maintenance. Movement through these stages is not always linear, and people may shift backwards and forwards through each stage before eventually reaching the point where they can maintain the change in behaviour.

Motivational interviewing can be used to help tip the balance of benefits and losses in favour of reducing/

quitting problematic drug and alcohol use (74). Each stage of change has a range of motivational strategies for the D&A professional to implement, that are matched to the wants, needs and attitudes of clients within that stage (43). In this way, motivational interviewing seeks to promote engagement, minimise resistance and defensiveness, and encourage behaviour change. It should be noted, however, that while the client's stage of change is a useful tool in assessing how they currently regard their problematic drug and alcohol use, care should be taken not to overemphasise the importance of stage of change in deciding on an appropriate treatment strategy.

For example, recent evidence has emerged suggesting that movement toward the action stage of change is not necessarily associated with actual behaviour change (75). Also, clients will often be at different stages of change for different drugs, and this also needs to be accounted for in providing treatment.

> The main features of motivational interviewing (2, 49):
>
> ■ Discussion about the good and less good things about problematic drug and alcohol use and the importance of these factors in their decision to change use
>
> ■ Assessing client concerns about current levels of use
>
> ■ Assessing confidence in making changes to current levels of use.

If the client's balance of issues raised during the discussion outlined above is in favour of the good things about their problematic drug and alcohol use, the following strategies are employed to tip the balance in favour of change (2, 48):

■ Summarising with an emphasis on the less good things of greatest concern to the client

■ Highlighting and creating discrepancies in the client's assessment of their use (eg. looking to the future, exploring past goals and expectations, contrasting the self with the drug and alcohol user).

In addition, the aim is to elicit self-motivational statements from the client about the arguments for change (49). Self-motivational statements fall into the following categories (48):

■ Problem recognition: *"I guess there is more of a problem than I thought"*, *"I never realised it was as serious as this"*

■ Expression of concern: *"I'm worried about this"*, or nonverbal cues such as tears, gestures etc

■ Intention to change: *"this isn't how I want to be"*, *"maybe it's time to think about changing"*

■ Optimism about change: *"I think I can do it"*.

The evidence suggests that motivational interviewing on its own is particularly effective in increasing treatment engagement and adherence for people with problematic drug and alcohol use (Level 1 evidence, 76). This approach is strongly recommended in all phases of assessment and treatment for drug and alcohol clients.

A sub-type of motivational interviewing, compliance therapy, has been specifically developed to increase compliance with prescribed pharmacotherapy regimes and behavioural treatment plans. Specifically, compliance therapy uses motivational techniques to target those factors within a client that may impact on their ability to be compliant with their treatment (eg. ambivalence about medication, insight into illness, misinformation about the effectiveness of medication, etc, 77). Typically, compliance therapy has been evaluated in mental health settings (eg. among clients with psychotic disorders, 78). However, one Australian study has used compliance therapy among clients with alcohol dependence to improve compliance with acamprosate (Level 2 evidence, 77). Results indicated that those clients who completed three or more sessions of compliance therapy reported significantly greater levels of adherence to medication and improved treatment outcomes relative to a control group who received usual medical care (77). This result awaits further replication and expansion to other types of problematic drug and alcohol use.

> Recommendation (★★★)
>
> Motivational interviewing can be used in all phases of assessing and treating drug and alcohol clients to increase treatment engagement and adherence.

A review of the alcohol treatment literature revealed that brief motivational interventions, were among the best approaches in reducing alcohol use (Level 1 evidence, 74). Evidence is also emerging to support its use among clients with cannabis use problems (Level

2 evidence, 79, 80) and problematic amphetamine use problems (Level 2 evidence, 70). However, the application of motivational interviewing to people with other drug use problems has not yet been fully tested (79). Although it can be used as a stand-alone treatment, in general, motivational interviewing is combined with other psychosocial techniques as a means of encouraging a reduction in problematic drug and alcohol use (79).

Recommendation (★★★)

Motivational interviewing should be combined with other psychosocial approaches by suitably trained drug and alcohol professionals to reduce problematic drug and alcohol use.

4.1.4 Contingency Management

Contingency Management is a common component of many psychosocial treatments offered by D&A professionals in clinical practice (81). This approach to treatment is based on the behavioural principles of reinforcing behaviours that are 'desirable' or that the client wishes to continue into the future (82). For example, clients receive positive attention, vouchers or other incentives to encourage/reinforce the maintenance of abstinence, medication compliance, attendance at treatment sessions and other treatment-related goals (83). Equally, negative reinforcement (withholding of incentives, reports to other professionals, etc) can occur in response to less-desirable behaviours (83).

Several studies exist to support the effectiveness of contingency management in encouraging clients to comply with medications designed to reduce/eliminate drinking (Level 2 evidence), to maintain abstinence from alcohol (Level 3 evidence), cocaine (Level 2 evidence), adherence to opiate substitution programs (Level 2 evidence), and to encourage treatment attendance at a drug and alcohol service (Level 2 evidence, 83).

Level 2 evidence exists for the use of contingency management strategies to encourage and maintain abstinence and to encourage treatment compliance and attendance among clients with problematic drug and alcohol use.

An important caveat exists for the use of contingency approaches in treating problematic drug and alcohol use, namely that the implementation of this treatment is considered in line with the client's treatment goals and that it is used in the context of other psychosocial approaches (82-84). That is, contingency management has generally been successful with clients working towards a goal of abstinence, however only recently is being modified and tested as it applies to other treatment-related goals, such as engaging in positive non-drug and alcohol related activities (84). Further, these strategies need to be embedded within a range of other treatment approaches, to encourage clients to take ownership of their goals and the treatment process, following withdrawal of the reinforcement strategy.

Recommendation (★★★)

Contingency Management can be combined with other psychosocial approaches by suitably trained drug and alcohol professionals to reduce problematic drug and alcohol use.

4.1.5 Intensive psychosocial therapies

Evidence is emerging that for some drug and alcohol clients, more intensive and longer interventions are required to produce improvements in their psychosocial outcomes and levels of problematic drug and alcohol use (85). A range of intensive interventions can be offered to clients with problematic drug and alcohol use, according to their level of dependence, history of withdrawal symptoms and current lifestyle issues. These interventions can be offered in a range of settings, with the following psychosocial interventions forming part of the intervention provided. Residential rehabilitation and therapeutic community settings can be regarded as intensive drug and alcohol treatments, however these interventions are not specifically discussed in this section (or in these guidelines). Refer to (12) for more information about these treatments.

Typically, intensive psychosocial interventions are regarded as being of eight or more sessions in duration (72), and should only be used by specially trained and experienced D&A professionals. Within a stepped care framework, intensive interventions can be combined with a motivational approach and general counselling skills as a first-line treatment for people with severe levels of drug and alcohol use (38). For those with mild-moderate levels of use, intensive psychosocial interventions can be offered as a second tier of

treatment, following provision of a brief intervention or motivational interview to which the client has not responded (38). A number of intensive psychosocial interventions appropriate for use with problematic drug and alcohol use are described below.

4.1.5.1 Cognitive Behavioural Therapies (CBT)

CBT was developed by Aaron Beck in the 1960's as a time-limited, structured treatment that combines behavioural approaches (such as self-monitoring, pleasant events scheduling) with cognitive strategies to address the client's perception and beliefs about their world (51, 86). It is based on the premise that events or situations are not the cause of feelings or behaviour; rather interpretations (or thoughts/cognitions) about those events will lead to actions and emotions.

A summary of common CBT techniques

Typical cognitive strategies (16):

- Identifying and challenging dysfunctional thoughts about substances

- Recognising seemingly irrelevant decisions that lead to a relapse

Typical behavioural strategies (16):

- Coping with cravings for substances

- Cue exposure

- Promotion of non-drug related activities

- Contingency management

- Relaxation training

- Preparing for emergencies

- Coping with relapses

Other elements of CBT (29, 87):

- Social skills training (effective communication, refusal skills)

- Problem solving skills

When clients are using drug and alcohol in a problematic way, it is common for them to have narrowed their behaviours to those associated with using. As such, they tend to over-emphasise the importance of using in their day. This distorted view of the world will influence the way they interpret daily situations and events, keeping them in a cycle of distress and problematic drug and alcohol use. The overall objective of CBT is to identify and challenge these dysfunctional beliefs that maintain problematic patterns of thought and behaviour, and replace them with more adaptive beliefs and behaviours (51, 86). The key CBT techniques designed to encourage these changes are listed in the previous box.

There are a number of detailed textbooks and intervention manuals describing how the above skills may be applied within a CBT treatment program. These include, but are not limited to, Marsh and Dale (2), Beck (51), and Persons (52). In general, behavioural strategies should be introduced first, with the cognitive strategies commenced later in the treatment program, when thinking may be clearer, problematic drug and alcohol use may have reduced and negative mood states lifted (51, 86).

Tips for Planning a CBT Program (51, 86)

- Prioritise problematic drug and alcohol use in the early stages by using behavioural strategies

- Move into using cognitive strategies when the client feels able to address these internal process

- Structure each session using the following:
  Phase 1 (approximately 20 minutes): review of previous week and set agenda for current session, review homework activities,
  Phase 2 (approximately 20 minutes): introduce new CBT strategy, in-session practice),
  Phase 3 (approximately 20 minutes): review session, set homework for upcoming week, review progress, address any outstanding issues from agenda.

CBT has the best-documented efficacy of the psychosocial approaches for the treatment of clients with problematic drug and alcohol use (29, 51). This is because it is the most thoroughly research psychosocial intervention. There is Level 1 evidence for the use of CBT as a means of effectively reducing problematic alcohol use (28), cannabis use (79, 80), amphetamine use (70, 87), cocaine use (88), heroin use (16, 87), and injecting drug use more generally (89, 90). In addition, there is specific Level 1 evidence for the addition of cue exposure techniques to a CBT intervention to assist clients in working towards a goal of abstinence among heroin-dependent clients (91)

and clients with problematic alcohol use (92), and for moderation of drinking among clients with alcohol use problems (93-95).

Level 1 evidence for the use of CBT exists for:
- Alcohol
- Cannabis
- Amphetamines
- Cocaine
- Heroin
- Injecting drug use.

CBT is often rated as the most effective approach to treatment with a drug and alcohol population (96, 97), has been shown to have equivalent effectiveness to pharmacotherapy (16), and is accepted well by clients (98-100). Furthermore, the benefits of CBT may extend beyond the treatment period, with research revealing that CBT can "protect" clients against relapse or recurrence after treatment termination (101).

Recommendation (★★★)

CBT should be used with all drug and alcohol clients to improve psychosocial outcomes, reduce problematic drug and alcohol use, and reduce risk of relapse

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4.1.5.2 Psychodynamic and Interpersonal Approaches

Psychodynamic Therapy grew out of the psychoanalytic school of Psychology, as a less intensive and less expensive form of psychoanalysis (102). In contrast to CBT, which focuses on the effect of external stimuli on the client, Psychodynamic Therapy encourages the client to look at the unconscious meaning and motivation behind behaviours and symptoms (102). Typically, sessions of psychodynamic therapy are of 45-50 minutes duration, and occur from one to three times per week (103). A program of treatment will be of at least 16 sessions, but can continue for several years.

Typically, Psychodynamic Therapy assumes that clients have an unconscious mind, and that defences are built up over time to avoid experiencing the pain of feelings held in the unconscious (104). When a client accesses treatment, it is usually because these defences are not

working and are causing harm (102). One example of a defence is denial (104).

Together, the Psychodynamic Therapist and client work through these feelings in an 'expressive' or 'supportive' manner (104). An 'expressive' approach encourages the client to develop insights into the cause of the painful feelings in their unconscious, by bringing their awareness of these feelings into conscious thought (104). In contrast, a 'supportive' approach focuses on addressing the immediate distress experienced by the client, providing a safe environment for the client to explore these issues (104). During a program of psychodynamic therapy, a strong focus on the development of therapeutic alliance is taken, and attempts to use the therapeutic relationship to demonstrate to the client how they are feeling (105).

Psychodynamic Therapy has been subject to several randomised controlled trials for conditions such as depression, anxiety and personality disorders (106). In addition, four trials exist which examine psychodynamic therapy among opioid users, cocaine users and alcohol users (Level 2 evidence, 106, 107). These studies generally indicate that psychodynamic therapy of between 12-36 sessions, combined with general drug counselling, was associated with improvements in the problematic drug and alcohol use targeted in treatment, and a range of psychosocial outcomes (106).

In addition, several case studies suggest that with experienced clinicians, Psychodynamic Therapy is associated with improvements in problematic drug and alcohol use (Level 4 evidence, 103). Importantly, across the range of research trials in this area, different models of Psychodynamic Therapy have been applied in different studies. In a major review of evidence for CBT and Psychodynamic Therapy (108), the reviewers could not identify one psychiatric disorder for which the same model of Psychodynamic Therapy had been applied across different studies and different research groups. Thus, more research is required to determine if the results reported in one study of Psychodynamic Therapy can be generalised to other studies and/or disorders or drug types, etc (108). Level 2 evidence exists for the use of Psychodynamic Therapy in the treatment of problematic drug and alcohol use.

A variation of Psychodynamic Therapy is Interpersonal Therapy (IPT), and has been used and tested in the treatment for depression (Level 2 evidence, 109). However, there is *no evidence* for the use of IPT in the

treatment of problematic drug and alcohol use. IPT is divided into three phases (109):

- Phase 1 (1-3 sessions): diagnostic evaluation and assessment of current situation, social functioning, role obligations, etc, and the D&A professional determines which of four interpersonal problems are most relevant to the client (grief, interpersonal role disputes, role transitions, interpersonal deficits)

- Phase 2 (7-14 sessions): the D&A professional assists the client in exploring the relevant interpersonal problem, using an active but supportive relating style

- Phase 3 (1-2 sessions): enhances confidence in new insights and reinforces therapeutic gains.

Although the principles of Psychodynamic Therapy and IPT may seem clear, extensive training in these techniques is essential, prior to engaging in this therapy (109). In addition to training, ongoing supervision is important to ensuring the D&A professional is coping well with the demands of this psychosocial treatment. Experts suggest that, given the nature of these approaches, psychodynamic and interpersonal therapies generally require clients to be well-motivated and prepared to undertake longer-term therapy involving periods of non-specific treatment and introspection (107).

Recommendation (★★★)

Psychodynamic therapy can be used to treat problematic drug and alcohol use, but should only be used by suitably qualified, trained and well supervised clinicians (109). This treatment is most suitable for well-motivated clients who are willing to address a range of internal issues in addition to their presenting problematic drug and alcohol use (107).

4.1.5.3 Emotion regulation

Therapeutic approaches to managing emotion regulation among drug and alcohol clients have increased in popularity in the last decade, given the clear association between mood states and problematic drug and alcohol use (110, 111). Typical emotion regulation approaches include Dialectical Behaviour Therapy (DBT), Mindfulness-Based Stress Reduction (MBSR) and more recently, Acceptance and Commitment Therapy (ACT).

4.1.5.3.1 Mindfulness Based Stress Reduction

The application of MBSR to clients with problematic drug and alcohol use has occurred with increasing frequency (112). MBSR is a meditative practice originating in Buddhism (113), and involves intentionally bringing one's attention to a range of physical, emotional and cognitive experiences in the present moment (49). MBSR has been used as a stand-alone treatment for urge management and relapse prevention in drug and alcohol treatments. It has also been added to other therapies such as CBT and DBT to augment the strategies taught to people with eating disorders and borderline personality disorder (114). Very little research exists to test the effectiveness of MBSR among drug and alcohol clients. However, one study examined a program of MBSR among a sample of prison inmates and among the general community (114). Over the six-month follow-up, participants in both groups reported reductions in problematic drug and alcohol use, improved psychiatric symptomatology and improved readiness and motivation to change problematic drug and alcohol use (Level 3-b evidence, 115).

Level 3-b evidence exists for the use of MBSR in the treatment of problematic drug and alcohol use.

Detailed information about the use of MBSR is also available (49, 114).

Recommendation (★★)

MBSR can be used to treat problematic drug and alcohol use problems by suitably trained and experienced drug and alcohol professionals.

4.1.5.3.2 Dialectical Behaviour Therapy

DBT was developed by Marsha Linehan (113) for the treatment of clients with borderline personality disorder. Given the high co-morbidity of problematic drug and alcohol use and the increased impulsivity associated with borderline personality disorder, DBT seems suitable for use in treating problematic drug and alcohol use (116). Typically, DBT draws on CBT and MBSR to provide treatment components such as group skills training, telephone counselling, behavioural and cognitive modification of problem behaviours, reflection, empathy and acceptance (116). Individual sessions are combined with group-based skills training sessions over a 12-month period, with participants also permitted access to a 24-hour telephone line for crisis situations (eg. threat

of self-harm, 113). Several large-scale randomised trials exists indicating the effectiveness of DBT in reducing self-harm behaviours among people with borderline personality disorder (Level 1 evidence, 117). However, in these trials, DBT had no demonstrable effect on reducing problematic drug and alcohol use among the sample (116, 117).

In recognition of the high rates of co-morbid problematic drug and alcohol use among people with borderline personality disorder, DBT was modified to directly target problematic drug and alcohol use, develop coping skills for managing withdrawal and cravings, increased use of case management, and options for pharmacotherapy (117, 118).

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Modifications to traditional DBT to better address problematic drug and alcohol use (117-119)

- Direct discussion of problematic drug and alcohol use

- Skills for coping with cravings and withdrawal

- Increased use of case management

- Options for pharmacotherapy

- Development of a set of attachment strategies to encourage treatment engagement and retention and reduce missed appointments

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To date, two randomised controlled trials have been conducted using this modified version of DBT, with participants reporting improved drug and alcohol use outcomes relative to a no-treatment control group (Level 2 evidence, 117, 119)

Level 2 evidence exists for the use of modified DBT for problematic drug and alcohol use in the treatment of drug and alcohol problems.

Detailed information about the implementation of DBT is available elsewhere (113, 119).

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Recommendation (★★★)

Modified DBT (for drug and alcohol use) can be used in the treatment of problematic drug and alcohol use by suitably trained and experienced drug and alcohol professionals.

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4.1.5.3.3 Acceptance and Commitment Therapy

ACT grew out of Cognitive Behaviour Therapy and mindfulness-based approaches to managing a range of conditions, such as pain, chronic illness and stress (120). Generally, ACT aims to retrain clients who have typically been avoiding painful events such as thoughts, memories, feelings and bodily sensations, to feel more comfortable experiencing these events (121). This 'approach' to problems, rather than avoidance of them and situations that stimulate experience of these problems, is thought to increase the client's capacity for change (121). Given clients are asked to explore a range of deep emotional issues, a strong therapeutic relationship, built solidly on trust, is fundamental to the use of ACT (120).

Research on the effectiveness of ACT is in its development phase, with few large scale studies currently available (120). However, evidence is starting to emerge to indicate that ACT is effective in the treatment of stress management, depression, pain, and chronic illness (Level 2 evidence, 120, 121). One small study involved clients using methadone maintenance for opiate dependence, who were randomised to receive solely this treatment, or 16-weeks of adjunctive 12-step therapy or ACT (Level 2 evidence, 122).

Results indicated that ACT, in combination with methadone maintenance, was associated with reduced opiate use and total drug use relative to clients receiving solely methadone maintenance. No differences were noted between the 12-step and ACT conditions (122). An additional study randomised 76 clients with nicotine dependence to receive either nicotine replacement therapy or ACT for smoking cessation (Level 2 evidence, 123). No differences in smoking outcomes were reported between the groups at post-treatment, however ACT participants reported improved smoking outcomes at 12-month follow-up (123).

Level 2 evidence exists for the use of ACT for drug and alcohol use in the treatment of problematic drug and alcohol use.

Detailed information about the implementation of ACT is available elsewhere (121, 124).

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Recommendation (★★)

ACT (for drug and alcohol use) can be used in the treatment of problematic drug and alcohol use by suitably trained and experienced drug and alcohol professionals.

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4.1.5.4 Family Approaches

A range of psychosocial approaches stem from the family therapy school of treatment, whereby treatment is focussed on the interactions of the family and its individual family members (125).

4.1.5.4.1 *Couple/Family Therapy*

Given the toll that problematic drug and alcohol use can take on the family and partners of clients, the importance of couple and family-based strategies cannot be over-emphasised (16). Partners and other family members can also act as useful supports in assisting clients with goals and strategies for change.

Within the drug and alcohol context, couples and family therapies should focus on the drug and alcohol issues relevant for the client, how these issues impact on the relationships within the family/couple setting, and increasing effective communication between family members and the client (28). Although a range of other issues may warrant clinical attention (eg. long-standing marital problems, parenting skills, aggression and violence within the family, etc), it is strongly recommended that these be addressed by a clinician with specific training and expertise in how to manage these issues, rather than by the D&A professional (28). The first priority for the D&A professional is to ensure the needs of the client are being met in terms of his/her problematic drug and alcohol use and related issues. A partner/family member could be engaged in the treatment process, particularly in the context of offering assistance and support or where the additional problems are of a low-moderate nature. It is important that a dual relationship with the client and family

members should not be entered into (28), and referral for any significant additional issues is important when they exist.

Very little evidence exists that examines the effectiveness of couples/families therapy among drug and alcohol clients (28). Despite this, clinical experts agree that it forms an important part of any drug and alcohol intervention. However, behavioural marital therapy, which focuses on increasing caring behaviours, increasing joint recreational, non-drug and alcohol related activities and enhancing communication on the part of the drug and alcohol client has also shown to be an effective intervention among people with alcohol use problems (Level 3-a evidence, 29).

Level 3-a evidence exists for the use of behavioural marital/family therapy in the treatment of problematic drug and alcohol use.

Drug and alcohol clients may like to invite a support person to their treatment sessions, but this should only occur with the full consent of both parties. An appropriate support person will be someone who cares about the client, and often will be affected by any changes the client makes. The support person's input will be valuable in setting goals and developing strategies, and he/she may be of practical help in working towards whatever goal the client chooses. Although change is the client's responsibility, the support person may facilitate the process of change, and help to maintain these changes over the longer term (28).

There are a range of strategies for including input from support people within a drug and alcohol treatment session, all of which take a motivational interviewing approach. For example, the session could commence by inviting the support person to explore their reasons for attending the session using the following prompts:

"What has it been like for you?"

"What have you noticed about [client's] drinking/using?"

"What has discouraged you from trying to help in the past?"

"What do you see that is encouraging?"

Emphasise the client's positive attempts to deal with the problem. Reframe the negative experiences as normative, or common within families with problematic

drug and alcohol use issues. Elaborate on risks and costs of the problem behaviour with the support person in the following way:

"How has the drinking/using affected you?"

"What is different now that makes you more concerned about the drinking/using?"

"What do you think will happen if the drinking/using continues as it has been?"

It is important to avoid overwhelming the client by eliciting statements from the support person, especially if feedback from the support person is particularly negative towards the client. The support person can be asked questions to elicit supportive and affirming comments. Examples include:

"What are the things you like most about [client] when s/he is not drinking/using?"

"What positive signs of change have you noticed that indicate [client] really wants to make a change?"

"What are the things that give you hope that things can change for the better?"

Supportive and affirming statements outlined above help to enhance commitment to change. It is also important to elicit the client's response to the support person's comments:

"Of these things your sister has mentioned, which concern you the most?"

"How important do you think it is for you to deal with these concerns that your wife has raised?"

Recommendation (★★)

Couples/families therapy can be useful for drug and alcohol clients in improving communication skills, addressing drug and alcohol-related issues, and managing drug and alcohol relapse. Couples/family therapy within the drug and alcohol setting should not address entrenched relationship difficulties, aggression/violence, or non- drug and alcohol-related issues, as these should only be addressed by trained and experienced family therapists.

4.1.5.4.2 *Solution-Focused Approaches*

Solution-Focused Brief Therapy (SFBT) arose from the family therapy approach in the early 1980s (126). In contrast to other approaches, SFBT assumes that the client is motivated and willing to make changes, and treatment concentrates on helping the client to imagine they would like things to be different and what needs to happen to bring this about (126). The focus is on solutions, rather than problems, and as such little time is spent taking histories, etc (126, 127).

SFBT assumes that the client is the expert in the experience of their problem (128). As such, they have the skills, insights and solutions they need to attain the goals they see as relevant to them (126-128). The task of the clinician is to ask questions that encourage the client to think about actions and solutions they can take in managing problem behaviours, while focusing on the client's strengths, competencies and successes (129). For example, clinicians can ask (pg 137, 128):

"When you do this, how will things be better?"

"Tell me about a time when you were not using... How did you manage to stay straight for so long?"

When clients relapse, again the focus is on solutions (pg 137, 128):

"How did you manage to stop?"

As the name suggests, SFBT is brief, usually lasting around six sessions (126).

The Solution-Focused Approach (pgs 343-344, 129)

- all people have strengths, resources and competencies
- change is happening all the time
- engage in solution talk rather than problem talk
- clients are the experts
- emphasise the present and future
- only small change is all that is necessary for larger changes to occur.

SFBT has been used in the context of case management activities (see Section 6), and has been evaluated among clients with mental health problems (Level 3-b evidence, 126, 129). However, very little evidence exists to test the effectiveness of SFBT among drug and alcohol clients. One study reported the results of a single case of the use of SFBT with a client with alcohol use issues preventing him from attending to his work commitments (126). Results indicated an implied improvement in problem drinking, as measured by an increase in the client's work attendance (Level 4 evidence, 126). Drug and alcohol use outcome were not directly measured in this study.

> **Recommendation (★)**
>
> SFBT can be used in the treatment of problematic drug and alcohol use by suitably trained and experienced drug and alcohol professionals. There is evidence for the use of SFBT as a generic therapeutic technique, although specific evidence in treating problematic drug and alcohol use is lacking at this time.

4.1.5.4.3 *Systemic Approaches*

Systemic approaches examine a client's presenting problem in terms of the 'system' of relationships, activities and parts that make up the client's problem (125). Joining together the individual parts of the 'system' will lead to a greater understanding of the whole problem, which is more than just the sum of the parts (125).

Typically, clients are viewed in terms of their relationships with key others in their lives, with family members and extended families all taking active roles in the treatment (130). The systemic therapist works with each of the family members willing to take part in treating an identified 'problem' (125). Treatment is typically between 5-20 sessions (125).

During treatment discussions, the clinician focuses on how the people within the system communicate with each other, what they communicate and how these translate into the various roles and expectations the system has for its individual members (130). D&A professionals take an active questioning approach in therapy, and attempt to enable individuals within the system to decide where and how change might be needed (130). Importantly, what happens in between therapy sessions is regarded as at least as vital to treatment as what happens during the treatment session (130).

The main targets for treatment using a systemic approach are suggested to be the serious psychiatric disorders, including addictions (125). These approaches may be particularly useful for the treatment of adolescents clients, and could be used in isolation or as an adjunctive approach to other psychosocial treatments (125, 130). However, currently there are no treatment trials or case studies describing how systemic approaches relate to drug and alcohol use outcomes.

> **Recommendation (★)**
>
> Systemic approaches to treatment may be of use in the treatment of problematic drug and alcohol use, and should only be used by suitably trained and experienced drug and alcohol clinicians. There is evidence for the use of systemic approaches as a generic therapeutic technique, although specific evidence in treating problematic drug and alcohol use is lacking at this time.

4.1.5.4.4 *Narrative Approaches*

Narrative Therapy is based on the assumption that people use stories to make sense of their lives and relationships (131, 132). As people mature, these stories govern how they see themselves, and their behaviour will be either consistent or incongruent with these stories (132). It is of little relevance whether these stories are accurate, rather the emphasis is on the impact these stories have on the client's life (132).

Narrative Therapists encourage clients to talk about their problems in terms of these 'stories' and asks the client to consider how these stories might act as a barrier to overcoming their presenting problems (131). The Narrative Therapist then assists the client to re-author their story in a way that might assist this process (133). In addition, narrative approaches see problems as very separate from the people experiencing the problem, which can often make the problems seem more manageable (131). The

> **Summary of Narrative Therapy Techniques (CAREE, 132)**
> - **C**urious stance
> - **A**lternative stories
> - **R**eframe the problem
> - **E**xpert knowledge from the client about own situation
> - **E**nvisioning a preferred future.

key strategies used by narrative therapists are summarised using the CAREE acronym (132).

Narrative Therapy has not been evaluated formally in terms of its impact on treatment outcomes, such as mental health, quality of life, functioning, etc. No study currently exists that examines the use of narrative therapy among drug and alcohol clients. However, proponents of the therapy suggest that it is very useful in working with clients presenting with a wide range of problems.

> **Recommendation (★)**
>
> Narrative approaches to treatment may be of use in the treatment of problematic drug and alcohol use, and should only be used by suitably trained and experienced drug and alcohol clinicians. There is evidence for the use of narrative approaches as a generic therapeutic technique, although specific evidence in treating problematic drug and alcohol use is lacking at this time.

4.1.6 Self-help groups

A self-help group is any group that has the aim of providing support, practical help and care for group members who share a common problem (134).

12-Step groups are the most common form of self-help groups available for clients with substance use problems (eg. Alcoholics Anonymous, Narcotics Anonymous) and are often broadly available within the community (16). Very few treatment studies exist to support the effectiveness of 12-step programs as stand-alone interventions. However, for some clients they can provide an adjunctive support and benefit in maintaining changes brought about by other drug and alcohol treatments (28, 135). One major randomised trial (project match, Level 2 evidence, 136) indicated that a 12-step program for alcohol use problems resulted in equivalent improvements in alcohol use to CBT and motivational interventions.

However, several limitations exist with this study and, while encouraging, this result awaits further replication. This is particularly the case when other research exists to suggest that the benefits of 12-step programs only come into effect when clients attend more frequently than once weekly, and usually only in conjunction with concurrent formal drug treatment programs (135). Importantly, if a client has previously benefited from 12-step approaches to their problematic drug and alcohol use, then it is essential

that goal setting within the current treatment plan is coherent with this philosophy (eg. abstinence-oriented approach rather than modified use).

> **Recommendation (★★)**
>
> D&A professionals should be aware of local 12-Step groups and provide this information to interested clients.

More recently, SMART (Self Management And Recovery Training) groups have commenced in Australia, targeted specifically at recovery from problematic drug and alcohol use. Groups are available face-to-face or on-line (see http://www.smartrecoveryaustralia.com.au/).

There are very few clinical trials looking at the effectiveness of self-help groups (16). However, they are considered an important tool in assisting people to achieve and maintain their goals in relation to substance use.

4.1.7 Self-help material

Self-help material (books, information pamphlets, computer programs, etc) have been used as an adjunct to ongoing face-to-face treatment and as a stand-alone intervention since the 1970s (28). Self-help materials are thought to have some advantages over other modes of treatment, as they can be made widely accessible and are flexible enough to be used as necessary by the individual client (137).

In the drug and alcohol treatment arena, a correspondence-based CBT program for problematic drinking produced a 50% reduction in alcohol use over a 12-month period (controlled drinking by correspondence, Level 2 evidence, 138, 139). In addition, research has suggested that approaches such as bibliotherapy may be preferred for people with alcohol use problems, who may be reluctant to seek treatment given stigma or other adverse consequences associated with admitting to problematic drug and alcohol use (140). For example, self-help booklets aimed at reducing drinking behaviours and the negative consequences of problematic drinking resulted in increased treatment seeking for alcohol problems relative to a control group. This is particularly the case when 'drinking diaries' are included as a means of encouraging the client to monitor their problematic drinking patterns (65). A further review of the effectiveness of self-help material for alcohol problems

discussed several studies that indicated it was associated with a decrease in alcohol consumption (141). Very little evidence exists to examine the impact of self-help material on other problematic drug and alcohol use.

CBT has been adapted for delivery via computer programs and/or the internet for the following conditions: anxiety (142); panic (143); agoraphobia (144); smoking cessation (145); and eating disorders (146). However, very few computerised or internet-based interventions exist for substances other than alcohol or nicotine (147). For example, one small-scale study has been conducted using computer-based therapy among people with problematic alcohol use in the US (148). An eight-session windows-based computer intervention was developed and trialled among 40 problem drinkers.

Although the study lacked an alternative treatment control condition, the intervention resulted in clinically significant reductions in alcohol consumption that were maintained at 12-month follow-up (148).

Level 1 evidence exists for the use of self-help material in the treatment of problematic alcohol use.

Although self-help materials are an important clinical tool in managing problematic drug and alcohol use, it is important to remember that they are not always associated with a change in behaviour (28).

Recommendation (★★★)

D&A professionals should encourage the use of self-help materials, particularly for alcohol use problems among clients with problematic drug and alcohol use.

A range of on-line self-help resources and useful websites are available to clients and D&A professionals. These include (but are not limited to) the following:

■ Centre for Drug and Alcohol, NSW Health, fact sheets and guidelines: http://www.health.nsw.gov.au/public-health/dpb/publications.htm

■ Australian Drug Foundation: www.adf.org.au

■ Australian Drug Information Network: www.adin.com.au

■ Family Drug Support at: www.fds.org.au

■ Make a Noise: www.makeanoise.ysp.org.au

■ Community Builders: www.communitybuilders.nsw.gov.au

■ NSW Health: www.health.nsw.gov.au

■ Counselling On-line: www.counsellingonline.org.au

■ Australian National Council on Drugs: www.ancd.org.au

■ National Drugs Campaign: www.drugs.health.gov.au

■ Turning Point Alcohol and Drug Centre: http://www.turningpoint.org.au

■ Alcoholics Anonymous: http://www.aa.org.au

■ Narcotics Anonymous: http://www.na.org.au

■ Beyond Blue (national depression initiative): http://www.beyondblue.org.au

■ Black Dog Institute: http://www.blackdoginstitute.org.au

■ Moodgym (on-line counselling for depression): http://www.moodgym.anu.edu.au

■ Bluepages: http://www.bluepages.anu.edu.au

■ Reach Out (advice for young people): http://www.reachout.com.au/home.asp

■ Beyond Blue (young people): http://www.beyondblue.org.au/ybblue/

4.1.8 Sleep and dietary issues

Problematic drug and alcohol use will harm the body in several ways, including the direct affect of the substance on the client, and the associated negative lifestyle changes that often accompany problematic drug and alcohol use. In particular, sleep problems, poor diet/exercise and hydration issues will emerge, and require intervention from the D&A professional.

Encouraging clients to eat regularly and healthily will help them to resume an active and healthy lifestyle commensurate with a reduction/cessation in problematic drug and alcohol use. Often, hunger can

be mistaken for cravings for drug and alcohol and so it is important to educate clients about the importance of eating regularly to achieve their drug and alcohol use goals. In addition, this will also assist the client to better cope with the demands that withdrawal from problematic drug and alcohol use places on their bodies. Developing a meal plan with clients that focuses on low-fat, increased protein, complex carbohydrates and fibre is recommended (149). Specific advice regarding dietary recommendations according to drug type is provided at http://www.umm.edu/ency/article/002149.htm. Finally, during withdrawal and recovery from problematic drug and alcohol use, dehydration is common. Therefore, it is important for clients to also ensure they are drinking plenty of fluids during and in between meals (149).

Sleep disturbances are also common among clients with problematic drug and alcohol use, and can also be associated with withdrawal from some substances. Although sleep problems can be among the most difficult to address, there are various strategies to help clients increase their chances of a reasonable sleep. Such strategies involve developing a routine or ritual around going to sleep at night, and include the following tips (150):

- Avoid sleeping unless tired

- If client is not asleep after 20 minutes, get out of the bed

- Begin rituals that help the client relax each night before bed

- Encourage the client to set an alarm clock and to get up at the same time every morning

- Encourage the client to get a full night's sleep on a regular basis

- Avoid taking naps if the client can manage this

- Ask the client to keep a regular schedule (mealtimes, sleep times, activity times)

- Avoid reading, writing, eating, watching tv, talking on the phone, or playing cards in bed

- Avoid caffeine after lunch

- Avoid alcohol within six hours of bedtime

- Avoid cigarettes or any other source of nicotine before bedtime

- Do not go to bed hungry, but avoid eating a big meal near bedtime

- Avoid any strenuous exercise within six hours of bedtime

- Avoid sleeping pills, or use them cautiously

- Try to get rid of or deal with things that the client is worried about

- Encourage the client to make their bedroom quiet, dark, and a little bit cool.

These strategies are described in more detail at http://www.sleepeducation.com/hygiene.aspx

4.1.9 **Continuing care**

Generally, continuing care is regarded as the system of continuing contact between a client and D&A professional once the initial (or acute) treatment phase is completed (28). Continuing care programs can take many forms, and often includes the following components (151, 152):

- 'Pinch hitting' (a service provider steps outside their regular role to undertake another task)

- Trouble shooting (anticipating and planning for problems likely to be encountered by clients)

- Smoothing transitions (such as between services, and moving back into the community)

- Speeding up the system (such as repeated phone calls to update other professionals on aspects of the client's care)

- Contextualising (communicating the history of a client to other health care providers).

In addition to these activities, continuing care can also include assisting the client to establish a social system to enhance and support their long-term recovery, including ways in which they can engage in employment, meet educational needs, and undertake recreational activities that are non-drug related (153). Providing information to general practitioners and other service providers is integral to this process, as is the engagement of families, peers and other social supports. Continuing care can also extend to providing the client with assistance in relapse prevention (154), using the '4As' framework:

- **Awareness**: of problematic drug and alcohol use and other issues and factors affecting health and wellbeing

- **Anticipation**: self-management approaches, continuity of care and crisis planning

- **Alternatives**: availability of a range of services to address risk and protective factors for problematic drug and alcohol use

- **Access**: early, easy and equitable access to services that meet these needs.

Several well controlled trials exist supporting the use of structured continuing care programs, particularly among clients with alcohol use problems (Level 2 evidence, 155) and opioid addiction (Level 2 evidence, 156, 157). The key features of these programs were that the content and format was highly structured, and negotiated with the client and D&A professional. The evidence from these studies indicate that pre-planned continuing care appointments, which the client attends regardless of drug and alcohol status, are associated with significantly lower rates of relapse, crime and unemployment relative to having this assistance provided only upon request (28).

Continuing care can be provided in person or via telephone contact initiated by the D&A professional (28), and should be regarded as part of the overall psychosocial intervention.

Recommendation (★★★)

A structured program of continuing care should be organised for drug and alcohol clients, which includes trouble shooting, smoothing transitions, relapse prevention, and assistance with other lifestyle concerns.

4.1.10 **Management of crisis situations**

A range of crisis situations can confront a client whilst engaged in treatment for problematic drug and alcohol use. These include those associated with the problematic drug and alcohol use itself (intoxication states, overdose/ heavy use, withdrawal, risky drug use behaviours) and those associated with other areas of the client's life (children, welfare issues, homelessness, pregnancy, cultural background, mental health co-morbidities, suicide risk, etc). Each D&A professional should regularly assess

and monitor the risk factors affecting each client and adapt the treatment plan accordingly. This will include referral to relevant and available services designed to address particular risk factors (eg. mental health services, family services, etc) when these issues become more pressing for a client than the agreed upon treatment plan. Risk management is an important component of a psychosocial intervention, and can be used to enhance the therapeutic alliance and treatment program (158).

The management of intoxication of a client should be guided by the local service policy of the D&A professional. Broadly, however, intoxicated clients need to have access to a safe, well-monitored environment, with low levels of external stimulation, and access to reassurance, reorientation and reality testing (16). Acute intoxication may require medical intervention, to remove the substance/s from the client's body. Clients using multiple substances simultaneously will need to have the effect of each substance considered when deciding on a management plan (16). Psychosocial interventions should not be attempted with an acutely intoxicated client.

Overdose among drug and alcohol clients can be accidental or deliberate (see suicide risk management below). Typically, the D&A professional needs to maintain a supportive stance for the drug and alcohol client who has overdosed and mobilise emergency medical treatment as soon as possible (44). Local service policies should also guide the management of clients who have overdosed in the drug and alcohol setting.

Risk factors associated with increased risk of suicidal behaviour (suicidal, pg 25, 4)

- **S** (sex: women attempt more than men, but men complete more than women; lack of significant others, stressful life events)

- **U** (unsuccessful previous attempts, unemployment, unexplained improvement in symptoms)

- **I** (identification with others who have suicided)

- **CI** (chronic illness or severe illness of recent onset)

- **D** (depression, decision that suicide remains a possibility)

- **A** (age: older at increased risk, alcohol/other drug intake, availability of means to suicide)

- **L** (lethality of previous attempts and of method selected for future attempts).

In general, D&A professionals perform one of two roles in managing the suicide risk of clients (4). In the first instance, D&A professionals may need to address an actual suicide attempt, and should refer to their service-based guidelines for this event.

Secondly, the D&A professional will need to recognise and assess suicidal thinking among their clients. This involves having a good basic understanding of the risk factors associated with suicidal behaviour (as indicated on the previous page).

If a client is exhibiting several of these risk factors, the D&A professional has sufficient cause for concern about the wellbeing of the client. Typically, the use of a suicide contract has been used by health professionals to safeguard against suicidal behaviours in clients (158). However, the evidence suggests that the presence of a contract (i.e. A formal agreement between client and D&A professional that the client will not harm themselves within a given time period) is not associated with a reduction in subsequent suicidal behaviours (158).

A suicide contract should not be seen as replacing a thorough suicide risk assessment, regular monitoring and supportive/engaging practices.

The management of suicidal clients is usually governed by agency policies and procedures. D&A professionals should also be familiar with the requirements of the mental health act, and the NSW health framework for suicide risk assessment and management (9).

4.1.11 Summary of evidence and recommendations

The table below summarises the above evidence regarding the use of psychosocial interventions among clients of drug and alcohol services. Clinician judgment is central to planning the use of particular interventions with particular clients, especially in the absence of research data to support these decisions. However, D&A professionals should also use the results from studies on the effectiveness of treatments, where available, to supplement this process (159).

Table 4.1 Summary of evidence and recommendations regarding psychosocial interventions for drug and alcohol clients

Psychosocial Treatment	Level of Evidence for Use with Problematic Drug and Alcohol use	Strength of Recommendation for Use with Drug and Alcohol Clients
Brief Interventions	Level 1	★★★
Motivational Interviewing	Level 1	★★★
Contingency Management	Level 2	★★★
CBT	Level 1	★★★
Psychodynamic Approaches	Level 2	★★★
Emotional Regulation		
MBSR	Level 3b	★★
DBT	Level 2	★★★
ACT	Level 2	★★
Family Approaches		
Couple/Family Therapy	Level 3a	★★
SFBT	Level 4	★
Systemic Approaches	Nil	★
Narrative Approaches	Nil	★
Self-Help Groups	Level 2	★★
Self-Help	Level 1	★★★
Continuing Care	Level 2	★★★
Management of Crisis Situations	Level 4	★

4.2 Considerations for specific drug types

Marsh and Dale (2) provide a detailed description of the range of substances and related difficulties that clients will present with to the D&A professional. Additional information on these issues is provided at the Australian drug foundation website (www.druginfo.adf.org.au) and from a number of additional texts and reports (see 4, 68, 135).

4.2.1 Tobacco

Tobacco contains nicotine, which is a highly addictive stimulant that temporarily increases alertness, concentration, memory and mood, but quickly forms a strong physical and psychological chemical dependence in regular users (160). Evidence suggests that smoking tobacco increases the levels of dopamine in the brain, resulting in abnormally high levels of this 'feel-good' chemical similar to that experienced by clients using heroin and/or cocaine (160).

Smoking is one of the most preventable causes of premature death and morbidity worldwide (161, 162). It is responsible for 20% of all deaths in the US and 45% of smokers will eventually die of a tobacco-induced disorder (163). Cigarette smoking is also linked to lung cancer; other lung problems such as emphysema; other cancers such as lip, mouth, oesophageal and breast cancers; and complications in pregnancy such as miscarriage, and birth defects (160).

Cigarette smoking causes neurochemical changes in the brain (164) and as such, researchers have examined the use of pharmacological treatments, such as nicotine replacement therapy (NRT) with a view to improving outcomes for people with nicotine dependence. of the four available forms of NRT (gum, patches, inhalers and sprays), nicotine gum has been the most extensively examined (Level 1 evidence, 165, 166). However, the other forms of NRT are also consistently associated with high rates of abstinence among heavy smokers. Generally, the use of NRT is associated with double the rates of abstinence from smoking compared with placebo or no-medication conditions (167).

Other non-nicotine based pharmacotherapies have also been used to address smoking cessation. These include antidepressant medications (such as nortriptyline and bupropion), anxiolytics and some anti-psychotic medications (167). Importantly, the addition of psychosocial treatments (eg. CBT) to these pharmacological approaches, increases the quit rates reported by smokers by 50-100% (167).

A range of support services are available to assist smokers effectively and affordably make a quit attempt (168). In NSW, a telephone-based counselling service is available to all smokers who would like support for a quit attempt. The Quitline also provides assistance to the family and friends of smokers and others requesting information about smoking.

Callers to the Quitline receive a free quit kit, along with 24 hour access to advice about quitting smoking, nicotine dependence, strategies on preparing to quit, preventing relapse and staying a non-smoker, as well as information on products and services to help with a quit attempt. Up to six follow-up phone calls can be scheduled throughout the most difficult period of quitting.

Quitline: 13 QUIT (13 7848) is a confidential telephone based service designed to help smokers quit smoking.

4.2.2 Alcohol

Alcohol is a central nervous system depressant (169), with effects that vary according to the concentration of alcohol in the blood, prior use of alcohol, genetic susceptibility, and the situation (170). It also presents the client with the most diverse range of additional problems of all the drugs of abuse (15).

Low-risk drinking guidelines (171)

■ Males: two to four standard drinks* per day with two alcohol-free days per week, avoid binges.

■ Females: One to four standard drinks* per day with two alcohol free days per week, avoid binges.

Binge drinking guidelines: (171)

■ Males: no more than six standard drinks* on any one drinking occasion.

■ Females: more than four standard drinks* on any one drinking occasion.

*Standard drink = 10g of alcohol
(Eg one middy of full strength beer, one schooner of light beer, one nip of spirits, 100ml wine)

Aside from developing alcohol abuse and/or dependence disorders, many clients will engage in unsafe drinking practices, consuming alcohol outside the recommended guidelines for non-hazardous use.

Drinking outside these guidelines (see above) can be associated with both short- and long-term problems. Short-term risks include the risks of harm such as falls, assaults and car accidents, increased likelihood of engaging in risky behaviours while intoxicated (driving, unsafe or unwanted sex), exposure to verbal or physical abuse, etc continuing to drink in excess of these levels can also increase risk of medical or health-related problems.

There are also the risks of developing emotional problems, such as depression, and problems at school, work and with relationships. Even if clients do not have a strict alcohol use disorder (abuse or dependence), risky or unsafe drinking should be assessed by the D&A professional. Steps need to be taken to control drinking within these guidelines and manage any of these additional problems associated with unsafe alcohol use.

The American Psychiatric Association (16) indicates that the majority of alcohol abuse/dependence problems can be treated in the outpatient setting, with the exception of clients showing signs of alcohol withdrawal. In these cases, detoxification is recommended. However, once the physical symptoms of withdrawal are managed, it is important to follow up with some form of psychosocial treatment (28). Indeed, one of the key ingredients in successful alcohol treatment is engaging the client in a longer-term program of psychosocial treatment, emphasising relapse prevention and management strategies (Level 1 evidence, 16). This is particularly important in managing the more enduring symptoms of alcohol withdrawal such as cravings for use (170).

Withdrawal syndrome can occur in clients who are dependent on alcohol within 6-24 hours of their last drink, and is potentially fatal if not recognised and managed appropriately (4). Symptoms usually include tremors, hypertension, increased pulse and respiration rates, sweating, nausea/diarrhoea, sleeping problems, anxiety and decreased appetite (28, 170). The syndrome tends to peak approximately two to three days following abstinence, and symptoms subside within one week following abstinence (170). In severe cases of dependence, seizures can be experienced, usually one to three days following abstinence (170). In these clients, major withdrawal syndrome (which could include

delirium tremens) may be present, emerging around three to ten days following the client's last drink (170). Symptoms include disorientation, high fevers, paranoia, tactile, auditory or visual hallucinations and extreme agitation (28, 170).

Approximately 5% of clients will experience major withdrawal syndrome, and it is rare in people under 30 years of age (170). Withdrawal symptoms should be monitored, using formal withdrawal scales to supplement clinical judgment (see 28), and medical advice should be sought for moderate-high level drinkers prior to commencing a period of abstinence. D&A professionals should obtain a thorough history of past withdrawal symptoms in clients, as this profile of symptoms is most closely associated with future withdrawal symptoms, more so than the current number of drinks consumed by the client.

In cases where abstinence is not a realistic or desired goal for the client, a goal of controlled drinking may be more feasible. A controlled drinking goal is a legitimate harm reduction strategy, and needs to be clearly articulated for the client (eg. specific number of drinks, specific number of days per week when they will drink). One option may be to recommend a reduction of drinking to within the low-risk levels. Evidence suggests that controlled drinking goals are most effective among clients with low-level alcohol use through to hazardous or harmful use (172). There is less evidence that clients with severe alcohol dependence are able to maintain a reduced level of drinking (as opposed to abstinence) without relapsing to pre-treatment levels. However, chances are increased significantly when the client believes that a controlled drinking goal will be able to be achieved and maintained (172).

CBT, Motivational Enhancement Therapy and Brief Interventions have a strong evidence base for their effectiveness in treating alcohol use problems (Level 1 evidence, 16). Psychodynamic, Interpersonal Therapies and 12-step treatments have received less research attention, but may well be effective for some clients with alcohol use disorders (eg. suicidality, acute psychosis, etc, 16).

A number of pharmacotherapies are available to assist a client in working toward abstinence, manage withdrawal symptoms and to prevent cravings. In particular, naltrexone, acamprosate (Campral) and disulfiram (Antabuse) have shown benefits in treating alcohol

use problems over the short-term, if combined with a psychological intervention (173). Naltrexone in particular, if combined with coping skills training, is useful in preventing relapse to alcohol use (16).

Naltrexone is an anti-craving drug that acts on the brain's opiate receptors and reduces the likelihood of relapse to alcohol dependence (28). Acamprosate is thought to reduce drinking by moderating the brain's response to withdrawal from alcohol, and may be most suitable for people who are moderately to severely alcohol dependent and medically stable, provided they are also willing to comply fully with the medication regimen and engage in regular counselling (28). There is less evidence for the use of disulfiram among people with alcohol dependence. It is most commonly indicated for clients who are highly motivated to abstain from alcohol, and good outcomes can be achieved with close supervision. Disulfiram works by interacting with alcohol to create an intensely aversive reaction when alcohol is consumed (28), however is not currently subsidised by the pharmaceutical benefits scheme.

4.2.3 Cannabis

Cannabis is the most commonly used illicit drug in Australia (174), with sedative, euphoric and (in high concentrations) hallucinogenic actions (169). There are several major health risks associated with cannabis use, including psychosis, memory and attentional problems, respiratory disease, etc (15). The risk of these complications increases with increasing quantity and frequency of use. There is no 'safe' level of cannabis use, and abstinence should be recommended in order to avoid complications and longer-term health consequences. However, research suggests that these harms are minimised if use is limited to once a week or less (175).

Generally, withdrawal from cannabis is considered straightforward and mild (135), and is suggested to occur in clients who smoke two or more units of cannabis per day for three weeks or more (176). Upon cessation of cannabis use, these clients will experience a range of withdrawal symptoms, such as anxiety, disturbed sleep, irritability, nausea, increased body temperature, tremor, stomach pain, etc (176). These symptoms will usually subside without complication. Tobacco is also often used among clients smoking cannabis, and withdrawal from tobacco will need to be managed appropriately by the D&A professional in assisting clients to reduce their cannabis use.

Evidence suggests that the symptoms of cannabis use disorder are best managed on an outpatient basis, unless hospitalisation is indicated for another condition (16). Whilst very few studies exist suggesting an optimal psychosocial approach with clients using cannabis, treatment that combines motivational enhancement, and elements of CBT such as relapse prevention and the development of coping skills, is likely to be successful (Level 2 evidence, 16, 135). The effect of CBT on cannabis use problems is also more enduring than other psychosocial therapies (Level 2 evidence, 135). No specific pharmacotherapies can be recommended with any clinical confidence for cannabis withdrawal or dependence (16).

4.2.4 Amphetamines and other stimulants

Amphetamines are central nervous system stimulants, often producing feelings of well-being, euphoria, increased energy and confidence and decreased appetite (177). Other stimulants will include cocaine and ephedrine/pseudoephedrine. Acute and chronic stimulant use (including amphetamines) is associated with increased risk of psychosis, hyperactivity, delirium, and cardiac problems (15). Heavy stimulant users may become violent for no apparent reason, and experience constant sleep problems, anxiety and tension, high blood pressure and rapid, irregular heartbeat (135). Another common side effect is depression (70). The greater the stimulation effects reported by clients using stimulants, the greater the negative effects and rebound will be when they stop using (169). There is no 'safe' level of amphetamine use, and abstinence should be recommended in order to avoid complications and longer-term health consequences. However, research suggests that these harms are minimised if use is limited to once a week or less (175).

Upon abstinence, acute withdrawal symptoms include lethargy and fatigue, cravings, increased appetite, insomnia (or excessive sleep), and bizarre dreams (4). Depression is also common, placing these clients at an increased risk of suicide (177). Withdrawal symptoms can last for hours in the case of cocaine use, up to around three weeks for amphetamine use (177).

As with cannabis, stimulant dependence, particularly cocaine, is also best managed in outpatient clinical settings, using a treatment approach that encompasses a variety of modalities (16). A combination of motivational interviewing and CBT has been shown to be effective in reducing amphetamine use and other

side effects of use (eg. depression, Level 2 evidence, 70). However, an important factor in the success of these psychosocial approaches with this population has been efforts to engage amphetamine users in therapy (70). As such, the D&A professional should spend time properly engaging the amphetamine use client with the treatment plan/service.

There are currently no evidence-based medication regimens for reducing or managing amphetamine use (178). However, the use of dexamphetamine as a substitution therapy has recently increased as a clinical tool in many drug and alcohol treatment programs (179). Very few studies of the use of dexamphetamine in the treatment of problematic amphetamine use have occurred to date. However, one small-scale study reported that the use of dexamphetamine prescriptions among oral- and injecting amphetamine users was reasonably safe, and associated with some reductions in amphetamine use (179).

Clearly, more research into this treatment needs to occur. In response to this, NSW Health have established two specialist amphetamine clinics across the state to explore the potential of a range of amphetamine treatments, including substitution therapies. The clinical outcomes of these centres will contribute to the evidence base for treatment among this important group of drug and alcohol clients. In lieu of these results, any medications (eg. antidepressants, dexamphetamine) should be integrated within a psychosocial treatment program, which emphasises CBT, 12-step and other self-help approaches (16).

4.2.5 Heroin and other opioid drugs

Opioid drugs, including heroin, stimulate the opioid receptors in the central nervous system, and produce drowsiness, reduced pain perception and euphoria (180). Overdose among heroin/other opioid users is more common than for any other illicit drug (15). Opioid overdose is associated with neuropsychological damage. However, the primary complications of opioid use will often arise from the psychosocial problems associated with use (eg. poor nutrition, menstrual irregularities, poor hygiene, etc) in addition to the risks associated with injecting drug use (15).

Withdrawal from heroin and other opioids includes cravings, sneezing, muscle aches or cramps, nausea or vomiting, diarrhoea, recurrent chills, heart problems, yawning and restless sleep (4). These symptoms are not

fatal, except in newborn children (180). Rather, it is the client's perception of the severity of these symptoms that presents the most concern (180).

Abstinence is an ideal goal for clients with heroin use problems. However, from a harm reduction perspective, focusing on safe injecting and sexual practices can be an early and important treatment focus (4).

Two main pharmacotherapies are recommended for use among people with opiate dependence: Methadone Maintenance Treatment (MMT) and buprenorphine (181). Other forms of pharmacological treatment for opiate dependence include naltrexone (182). Of these, MMT is the most thoroughly studied and widely used treatment (183). Relevant NSW Health policy documents and guidelines include: *Clinical Guidelines for methadone and buprenorphine treatment* (5), and *Drug and Alcohol Withdrawal Clinical Practice Guidelines* (in print) (8).

CBT has been shown to reduce illicit drug use among people on a methadone maintenance program, as well as other risk-taking behaviours (184, 185), and in decreasing the psychosocial problems associated with heroin use (eg. depression, risk taking, criminality, etc, Level 1 evidence, 16). In addition, CBT and motivational interviewing increases the effectiveness and adherence to MMT (Level 1 evidence, 135). Intensive inpatient programs have been shown to be no more effective than weekly psychosocial treatment as an adjunct to mmt (Level 2 evidence, 135).

4.2.6 Ecstasy (MDMA, 3, 4-methylenedioxy-N-methylamphetamine) and other club drugs

Hallucinogens (such as Ecstasy) produce thought distortions, and alter perception and mood (186). They differ from the other classes of drugs in that they are not usually associated with a clear dependence syndrome, and hence few withdrawal symptoms are present upon cessation of use (186). Ecstasy is chemically similar to amphetamines and mescaline, resulting in both stimulant and hallucinatory properties, such as euphoria, pleasant emotional effects, and increased energy (186).

The primary effects of Ecstasy and other hallucinogen use is psychiatric, including anxiety, hallucinations (psychosis-type state), and poor decision making (15). Although Ecstasy is often regarded as a 'safe' drug by clients, use has been associated with renal failure, hyperthermia (overheating) and cardiovascular collapse (186). These side effects are unpredictable and can result in death (186).

As with stimulant use, there are currently no approved medication regimens for reducing or managing hallucinogens (178). An evidence base for the use of motivational interviewing and CBT is beginning to emerge and is thought to be associated with a decrease in associated harms, although final results on these trials are not yet available (see National Drug and Alcohol Research Centre, University of NSW, http://ndarc.med.unsw.edu.au/ndarcweb.nsf/page/current).

4.2.7 Poly-drug use

It is common for drug and alcohol clients to be using more than one drug at the one time. This 'poly-drug use', or hazardous use of more than one drug, is associated with increased risks and harms compared with single-drug use (187).

Clients may use multiple drugs in a variety of ways (187):

■ To increase their intoxication by using different drugs with similar effects at the same time (eg. alcohol + benzodiazepines + cannabis)

■ To offset the 'undesirable' effects of one drug (eg. sedation) by using an additional drug at the same time that diminishes this effect (eg. stimulant)

■ To manage withdrawal by using drugs in a sequence (rather than all at once) to regulate their withdrawal symptoms, improve mood, sleep, etc

Poly-drug use is associated with higher rates of psychiatric co-morbidity, increased risk of overdose, and risks associated with the interaction effects of different classes of drugs (187). For example, combining alcohol and heroin can fatally depress heart rate and breathing; combining amphetamines and ecstasy can result in severe dehydration, dangerously high body temperature, heart seizures and even death; and combining alcohol and amphetamines can result in dangerous amounts of the drugs being used without the client realising. (188). Additionally, withdrawal is likely to be more complicated if the client is ceasing use of several drugs simultaneously.

A comprehensive assessment of poly-drug use is essential for every drug and alcohol client presenting for treatment. This will help to highlight for the D&A professional which drugs are being used problematically, which drugs the client is abusing and which drugs are being used at the level of dependence.

D&A professionals should take extra time engaging clients with poly-drug use issues, and should assess the individual and combined effects of poly-drug use on the client. Clients with poly-drug use issues will consider each drug differently in terms of its impact on their lifestyle and potential to cause harm in their lives (187). Treatment plans need to consider this, and tailor interventions to the relative concern expressed by clients about the different drugs they are taking.

More information on the management of poly-drug use in drug and alcohol clients is available at http://www.turningpoint.org.au/library/lib_ctgs.html#7 (prescribing for drug withdrawal, and working with polydrug users).

SECTION 5

Co-morbidity

'Co-morbidity' may refer to multiple, co-existing physical, mental health and problematic drug and alcohol use issues, which may meet formal diagnostic criteria for a defined disorder such as in the diagnostic and statistical manual of mental disorders (38). However, mental health/problematic drug and alcohol use/other symptoms do not need to meet this formal criteria in order for co-morbidity to be present, and for these conditions to impact significantly on client functioning and thereby be worthy of treatment (189).

Co-morbidity is an important issue when considering treatment for substance use problems. Indeed, co-morbidity is more common than would be expected by chance, with the presence of one disorder significantly increasing the risk of developing additional disorders (184, 190-192). For example, epidemiological surveys indicate that adults with lifetime mental disorders are twice as likely to experience alcohol use disorders than are their counterparts without mental disorders (14).

It is imperative that a co-morbidity-specific treatment plan is developed for clients presenting with co-morbid problematic drug and alcohol use and other conditions, as failure to effectively treat one condition will impact on the other present conditions (189, 193). In addition, co-morbidity is associated with an increased burden of illness and disability. If left untreated, it will also result in an increased use of emergency and other high-cost services more often than would otherwise be necessary (59, 194). The risk of HIV infection, medical complications and early mortality are also significantly increased among clients with co-morbid mental health and problematic drug and alcohol use (53). Clients with co-morbid issues are also the most likely to consistently miss appointments with health professionals (53). It is important that D&A professionals realise that compliance with treatment and management plans among clients with co-morbidity is often low (191). Therefore, additional efforts to engage and retain clients in treatment will often be required.

On the other hand, outcomes are improved when these clients are engaged within an integrated system of mental health and drug and alcohol treatment (195). This is particularly the case when psychosocial treatments are part of this treatment plan, given that a multitude of psychosocial problems will likely be present in a client with co-morbidity (53). The onus is on the D&A professional to develop local links with mental health services to improve collaboration between the two systems of care, as clients with co-morbid issues will experience a range of barriers negotiating through health services on their own (38, 53). In addition, D&A professionals can encourage the development of supportive activities and relationships outside of the helping-related context, by supporting and maintaining client involvement in regular activities such as sport, music, art, social clubs etc engaging and activating a range of supports outside the helping relationship (eg. with families, schools, friends, carers, teachers, other role models) can also help provide the client with co-morbid issues with stability and 'normalcy' in other areas of their lives. This will have a flow-on effect to their wellbeing.

5.1 Models of co-morbidity

Given the frequency with which problematic drug and alcohol use co-occurs with other conditions, population-based surveys have been used to more closely examine the various environmental, genetic and neurobiological factors that may explain this co-morbidity (196, 197). As a result, several different models have been proposed to explain the co-occurrence of any disorder with a substance use disorder, and these can be applied with a view towards planning treatment approaches for these co-morbid conditions. The main models of co-morbidity are (198):

1. Primary substance use disorder with psychiatric consequences (assumes that treatment of the problematic drug and alcohol use will resolve the mental health symptoms)

2. Primary psychiatric disorder with secondary substance misuse (assumes that treatment of the mental health symptoms will resolve the drug and alcohol problem)

3. Dual primary disorders (assumes that problematic drug and alcohol use acts as a trigger and maintaining factor for the other co-occurring disorder, and vice versa)

4. Common aetiology (assumes that one or more factors, such as genetic predisposition, antisocial personality disorder, social difficulties, stressful events etc contribute to an increased risk of both problematic drug and alcohol use and mental health problems).

Little firm evidence exists to support the adoption of one co-morbidity model over another (199), and experts have suggested that the primary/secondary distinction between co-morbid disorders is immaterial once the two disorders have surfaced (15, 200). Moreover, clinical practice suggests that the relationship between substance use and mental health disorders in particular will change over time. For example, depression may trigger alcohol use at some times and the reverse may occur at other times (201).

Schuckit and colleagues (201) also suggest that the pattern of mental health symptoms in primary and secondary substance use problems is so similar that it is difficult for D&A professionals to use the presence of certain key symptoms as a guide when planning treatment programs for co-morbidity. Thus, D&A professionals may not be able to identify from the outset which clients are more likely to have a mental health problem that persists beyond abstinence from problematic drug and alcohol use (15, 202). Instead, experts recommend that treatments for co-morbidity should focus on the impairment and distress experienced by the client, rather than primary/secondary diagnoses (Level 3-a evidence, 203, 204). Such an approach means that treatment can proceed in absence of formal diagnosis and even when substance use is active, thereby facilitating earlier engagement in treatment, and encouraging multi-disciplinary input from a range of health professionals.

In line with this recommendation, the concept of integrated treatment was developed for co-morbid problematic drug and alcohol use and mental health disorders (205). Integration of treatment for co-morbidity can occur at the level of the service or organisation that does not necessarily specify a particular defined clinical approach to treatment, or can refer to treatment that is offered by the one D&A professional, simultaneously targeting co-occurring substance use and mental health

conditions, using techniques drawn from evidence-based treatment approaches across mental health and substance use domains (16). This "clinical" integration of treatment for co-morbidity may provide superior outcomes, as treatment can additionally target the mutual relationship between conditions in a meaningful, consistent way, potentially encouraging the client to develop better management skills for both conditions (38). Indeed, in its revised practice guidelines for treatment of substance use disorders, the american psychiatric association (16) suggests there is sufficient evidence currently available to support the efficacy of integrated treatments for co-morbid substance use and mental health disorders, particularly when psychosocial approaches to treating substance use problems are combined with psychosocial treatments for mental health problems.

Integrated treatments can be tailored more easily to the particular needs of the client with co-morbidity, targeting areas of high distress and priority as they identify, addressing both acute and non-acute symptoms (205). In addition, clinically-integrated treatments provide clients with a coherent treatment plan that can arguably be delivered in a manner that is cost- and time-effective for service providers and clients themselves (16, 202).

Recommendation (★★)

Principles of practice for co-morbidity (38)

1. Focus treatment on the impairment and distress experienced by the client, rather than trying to establish a diagnosis of primary/secondary substance use disorder

2. Use a 'clinically-integrated' treatment approach, incorporating psychosocial strategies for both substance use and mental health problems into the same intervention

3. Conduct a thorough assessment of all presenting conditions, and manage those symptoms that are the most severe first

4. Ensure the development of good rapport and the use of strategies to actively engage clients in treatment

5. Professionals working with co-morbid clients should seek training to ensure they possess skills to incorporate psychosocial strategies for both drug and alcohol and mental health problems into a treatment plan.

5.2 Specific co-morbidities

A general approach to managing co-morbidity should be to conduct a thorough assessment of the substance use and additional conditions, and to organise treatment according to the most distressing issues for the client at that point in time. In line with a stepped care approach to treatment, further intervention can be tailored to client need, and can focus on issues that remain problematic for the client following the initial intervention. Specialist input will be necessary for specific mental health issues, and this should be co-ordinated by the D&A professional, who can continue to offer drug and alcohol treatment.

At a minimum, D&A professionals could offer five key interventions to clients with co-morbid mental health problems (198):

1. Screening for mental health and other co-morbid conditions

2. Engagement of the client in the process of treatment (see Section 3)

3. Enhancing motivation and working towards change (see motivational interviewing, section 4)

4. Active treatment, including goal setting, education and awareness about interaction between drug and alcohol use and mental health symptoms and, if suitably trained, a more intensive psychosocial intervention (see Section 4)

5. Relapse prevention and management, including triggers for both drug and alcohol use and mental health symptoms.

5.2.1 Depression

Of the 6% of Australians with an alcohol problem, 40% also experience at least one other co-morbid disorder such as depression (184). Equally, among people with depressive disorders, 34% of men and 15% of women also experience concurrent alcohol use problems (16).

Given the overlap in the symptoms of depression and substance use/withdrawal profiles, it is recommended that antidepressant treatment not commence as a first-line treatment option, unless indicated by the presence of severe depressive symptoms, high levels of suicidal ideation, and evidence of prior mood disorder (16). A delay of one to four weeks is recommended, during which a program of psychosocial treatment can be commenced to encourage a reduction in substance use and depressive symptomatology without pharmacological intervention (16). In particular, CBT and IPT have been associated with improvements in depression, along with other psychosocial strategies discussed in Section 4.

Sleep and anxiety problems are also common among people with co-morbid depression and substance use problems, and these issues can be targeted using behavioural psychosocial techniques (see Section 4.1.8, 207). In addition, given that situations involving negative mood are among the most commonly cited reasons for relapse across a range of substances (16), the relationship between the two co-morbid conditions should also be examined.

The APA Practice Guideline for the treatment of clients with depression provides more detailed information on evidence-based treatments for this condition (208).

5.2.2 Anxiety

Epidemiological research indicates that anxiety disorders will occur in around 50% of clients who are misusing substances (16). Clients with co-morbid anxiety and substance use disorders will benefit from an integrated approach to treatment that uses both pharmacological and psychosocial strategies. In particular, CBT has been successfully evaluated among a range of specific anxiety disorders, such as obsessive-compulsive disorder, social anxiety disorder and panic disorder (see section 4.1.5.1, 16). Post-traumatic stress disorder will also commonly co-occur with substance use problems, and clients will benefit from a range of psychosocial treatment approaches, particularly when the relationship between the two conditions is examined (16).

The APA Practice Guideline for the treatment of clients with panic disorder (209) provide more information on the evidence-based treatments for this specific condition.

5.2.3 Psychosis

Approximately 40-60% of people with schizophrenia will have a co-occurring substance use problem at some stage in their lifetime (16). This rate is even higher when conditions such as bipolar affective disorder are considered. Given the typically limited training of D&A professionals in treating schizophrenia and other

psychotic disorders, treatment usually occurs within the mental health system (16). However, D&A professionals can often supplement this care, by offering psychosocial support that emphasises optimism, empathy, assertive outreach and case management, as described in Sections 3 and 6. The evidence suggests that these approaches are effective for between 50-60% of clients with co-morbid psychotic and drug and alcohol use disorders (16).

Information about evidence-based treatment approaches for the psychotic disorders can be found in the APA Practice Guideline for the treatment of clients with schizophrenia (210) and the APA Practice Guideline for the treatment of clients with bipolar disorder (211).

5.2.4 Personality disorders

Problematic drug and alcohol use and personality disorders frequently co-occur (16). The combination of a substance use problem and a personality disorder (such as borderline personality disorder, antisocial personality disorder, etc) places a client at extremely high risk for suicide, engaging in other high-risk behaviours and a poorer prognosis (16). An approach that emphasises engagement and rapport building, structure and firm boundaries between the D&A professional and the client will enhance treatment outcomes (16). DBT (see Section 4.1.5.3.2) Is also a helpful approach for clients with personality disorders, and can have an effect on problematic drug and alcohol use.

The APA Practice Guideline for the treatment of clients with borderline personality disorder (212) provides more detailed information on evidence-based treatments for this condition.

5.2.5 Trauma

Traumatic events can take many forms, including community disasters, road accidents, through to sexual abuse, exposure to violent situations, etc experience of these events is often associated with increased rates of problematic drug and alcohol use (213). For example, hospital statistics indicate that between 20-40% of injured clients admitted to trauma units have current or lifetime alcohol abuse/dependence (214). Further, among clients with heroin dependence in Australia, trauma exposure and post-traumatic stress disorder are highly prevalent, occurring at rates of 92% and 41% respectively across drug and alcohol settings (215). Other research suggests that, among women seeking

treatment for problematic drug and alcohol use, up to 80% report a lifetime history of sexual assault, physical abuse, childhood abuse or a combination (216).

In a similar way to other co-morbidities, problematic drug and alcohol use within the context of trauma is viewed as either being a coping strategy (self-medicating the distress associated with the trauma), or as increasing the likelihood that a client is exposed to a traumatic situation (eg. Intoxication can increase risk of injury, exposure to violence, etc 214).

Some research exists to suggest that, particularly in the early stages of treatment, specific drug and alcohol treatment should occur concurrently with treatment for the trauma issues (with or without post-traumatic stress disorder, 217) in an integrated treatment program (216, 218). Such treatment could focus on engagement and rapport building, motivational interviewing, CBT strategies and relapse prevention (217).

The APA Practice Guideline for the treatment of clients with acute stress disorder and posttraumatic stress disorder (219) provide more information on the evidence-based treatments for these conditions.

5.2.6 Anger/aggression

The occurrence of angry and aggressive behaviours is significantly increased among clients with problematic drug and alcohol use (16). Such behaviours include verbal abuse and intimidation, physical and sexual aggression, domestic violence (including child abuse) and in some cases homicidal behaviour (2). The likelihood of these behaviours increases with increased intoxication.

A range of factors will increase the potential for 'reactive' violence in drug and alcohol clients, that is, violence that arises from fear or frustration (4). These factors may include a noisy waiting room, a long wait to see a D&A professional, fear of unknown people or environments etc. In these cases, an empathic approach that attempts to build rapport and decrease the threat or unpleasantness in the environment will usually help de-escalate the situation (4). If the client feels they have been 'wronged', it may be possible for the D&A professional to calm them down enough to explore the situation and determine how to rectify these thoughts/feelings.

In some cases, however, clients will not be calmed, and it may be necessary to ask them to leave the service, or

for the D&A professional to leave the session and seek support from peers/supervisors within the service (4). Personal safety of the D&A professional, other staff and clients is of key importance in these situations and a range of strategies can be used to minimise aggressive and violent outbursts.

Tips for Enhancing Personal Safety and Minimising Aggression with Potentially Violent Clients (pgs 640-641, 4)

Prior to the therapy session:

1. Structure the environment (communicate with other team members, protocol for alerting others to violent behaviours, staff passing by the appointment room, lockable doors, etc)

2. Inform clients about anticipated delays

3. Avoid excess stimulation (noisy waiting rooms, bright lights, etc).

During the therapy session:

4. Use warm, empathic, therapeutic skills

5. Provide supportive feedback (*"you seem to be a bit agitated...Perhaps you can tell me why you're feeling agitated, then I may be able to help you in some way..."*)

6. Never turn your back on an agitated or aggressive client

7. Let an aggressive or agitated client talk without interruption

8. Ensure a safe escape route (both drug and alcohol professional and client have equal access to the door, or if not possible, then drug and alcohol professional sits closest to the door)

9. Look for anger (rising voice, tensing muscles, red face, etc)

10. Do not try to handle a violent client on your own

11. Never try to disarm a client who has a weapon

12. Remove 'dangerous' items/clothing you may be wearing (scissors, knives, items that could be thrown, glasses, earrings, necklaces, neckties, cigarette lighters, etc).

5.2.7 Pain

Pain is the most common reason medical treatment is sought, and is often under-treated (220). It is estimated that, among clients engaged in a Methadone Maintenance Program, up to 60% may also have a concurrent chronic pain condition (221). Pain also alters the presentation of problematic drug and alcohol use, with an increased risk of using non-prescribed analgesic medications or cannabis use often evident (221). Suicidality is also likely to be elevated among drug and alcohol clients with co-morbid pain issues (221).

Co-morbid pain and problematic drug and alcohol use complicate treatment for both conditions, especially given opioids are commonly used to treat pain (221). It is often difficult to tell whether the client is only using opioids in response to pain (therefore not necessarily requiring drug and alcohol treatment) or whether a drug and alcohol use problem is evident. Some research has presented tips for distinguishing between these clients in practice (see below). However, the use of drug and alcohol to manage pain does not necessarily mean that clients do not need or will not benefit from treatment for drug and alcohol use.

Treatment of drug and alcohol clients with pain, particularly those engaged in Methadone Maintenance programs, requires skills that complement best practices in opioid prescribing (see *NSW Health Guidelines*, 5, 222). However, the presence of pain will often result in increased drug and alcohol seeking and heightened cravings for drug and alcohol (221). Also, because pain reduces well-being and quality of life experiences, drug and alcohol may be sought as a way of increasing euphoria, if only for a limited time (221). These issues should also become targets for drug and alcohol treatment.

Instead of deferring treatment for pain, particularly if drug and alcohol abstinence is not a realistic goal for clients with co-morbid pain, treatment programs need to be flexible and assist the client to work toward a goal of moderated drug and alcohol use while working with other health professionals to better manage the client's chronic pain. It may be appropriate, for example, to treat the client's problematic drug and alcohol use within the drug and alcohol setting, and seek agreement to have the client's prescription medications dosed by providers in that setting (223). Taken together, it is suggested that clients with concurrent chronic pain and

No drug and alcohol use issues (pg 28, 220)	Drug and alcohol use issues (pg 28, 220)
■ Not out of control with medication (ie. Only uses in response to pain)	■ Out of control with medication
■ Medication improves quality of life	■ Medication decreases quality of life
■ Aware of side effects	■ Medication use continues/increases despite side effects
■ Concerned about medical problems	■ Minimises medical problems
■ Follows agreed treatment plan	■ Difficultly following treatment plan
■ Has medications left over from previous prescriptions	■ Does not have medication left over (always a 'story')

problematic drug and alcohol use need to be engaged in an integrated treatment model of pain management and drug and alcohol treatment (221, 224).

5.2.8 Blood-borne viruses

Human Immunodeficiency Virus (HIV), Hepatitis B and Hepatitis C are common blood-borne viruses associated with problematic drug and alcohol use. Injecting drug use remains the largest risk factor for Hepatitis C infection (225), and unsafe injecting practices, increased risky sexual behaviours, etc places clients at high risk for developing these conditions.

Testing for blood-borne viruses such as Hepatitis and HIV is important among clients with problematic use of illicit substances, and involves a blood test. Prior to recommending this test, D&A professionals should discuss the implications of a positive and negative test result with drug and alcohol clients, and provide feedback on the outcomes of testing in person rather than via non-face-to-face modes (225). Testing should only be carried out with the full informed consent of the client, and should occur when they are relatively stable (ie. not during a phase of withdrawal or acute use/intoxication). Further information about pre- and post-test counseling strategies for D&A professionals is outlined in: NSW Health Policy Directive PD2005_048: *Counselling Associated With HIV Antibody Testing - Guidelines*. Vaccinations are available and should be recommended for clients with non-positive blood tests.

Drug and alcohol professionals can assess the risk of Hepatitis and HIV by asking clients about the following (64):

■ Frequency of injecting drug use

■ Frequency of sharing needles

■ Needle cleaning/sterilising practices if re-used

■ Number of sexual partners in past month

■ Frequency of unsafe sexual practices (eg non-use of condoms).

Care co-ordination and case management

Marsh and Dale (2) highlight the importance of focusing psychosocial treatments for problematic drug and alcohol use on issues that are important to the client. In the short term, this may involve addressing very practical concerns for the client such as housing, economic, legal or social problems, and adopting a 'case management' or care co-ordination approach to treatment (226). Addressing these pressing issues for the client presents the D&A professional with an ideal opportunity to build strong rapport and engagement, potentially setting the scene for psychosocial and other treatment strategies.

This section draws heavily on the position paper on case management developed by the NSW Health Drug and Alcohol Council Case Management Sub-Committee (227).

Case management grew out of community service models in the 1960s, in response to rapid service growth and the need to facilitate client care through uncoordinated and fragmented service systems. The development of case management approaches in conjunction with treatment for problematic drug and alcohol use is associated with the need to overcome fragmented treatment systems, inadequate service funding, service waiting lists, barriers between services (eg. drug and alcohol and mental health services), and admission criteria that exclude some clients. Case management is employed with substantial variety across treatment settings, with descriptions in the literature including:

■ A process to access ancillary services for clients to enable specialist clinicians to focus on clinical activities

■ Delivery of service linkages and co-ordination across a variety of service systems

■ Establishment of co-ordinated care partnerships through the establishment of close working relationships across the health system

■ The employment of designated case managers to ensure assessment, case planning, integration of responses to treatment needs, facilitation of access to substance abuse treatment places and engagement with clients throughout the treatment process.

6.1 Definition of case management

For the purposes of these guidelines, case management can be defined as the following:

■ A direct client service in which case managers and clients collaborate in comprehensive assessment, individual care planning, service facilitation, outcome monitoring and advocacy.

■ Case management is not a profession or discipline, but an area of practice employed across the range of professions in drug and alcohol programs. Case management is distinct from, however may overlap with, evidence-based clinical interventions employed in the management of problematic drug and alcohol use. The key distinction is that the case management provides a central process of co-ordination of individual client care and works to overcome obstacles in service access. The delivery of case management services within drug and alcohol programs should be established to maximise communication between professionals and agencies involved in the care of the individual and to minimise duplication of services where overlap occurs.

■ The case management approach is particularly useful for clients with complex needs and for those involved in ongoing care management. The case management approach assumes that clients with complex and multiple needs will access services from a range of service providers. The goal of case management is to provide seamless delivery across organisational boundaries.

6.2 Evidence for case management

Case management is thought to encourage positive changes in the drug and alcohol client by enabling them to form a trusting, strong, and enduring relationship with a D&A professional (159). Over the longer term, by co-ordinating care for the client and organising ongoing support services, case management is thought to reduce the intensity with which drug and alcohol treatment will be required (159).

The importance of case management in the treatment of clients with problematic drug and alcohol use has been agreed upon by many experts in the field, however very little actual research exists to suggest what the role of case management is in determining client outcomes (128, 228). Rather, studies of case management have largely focused on describing aspects of the treatment approach (159).

No controlled trials exist to test the effectiveness of case management approaches among clients with substance use problems (2). A few cohort studies do exist to suggest that case management is associated with increased retention in treatment (Level 3-b evidence, 229), but this has not been directly related to improved drug and alcohol use outcomes. Rather than the number of hours spent with the client, the active ingredient in these cohort studies is suggested to be the implementation of a case management model that is based on a theoretically sound, structured standard of care (229).

Shortcomings in evidence reflect that:

■ Investment in clinical drug and alcohol research has primarily focused on clinical interventions including medical interventions (opioid treatment services, detoxification etc), cognitive-behavioural and behavioural interventions, psychotherapy and counselling, mapping, family and relationship interventions, and welfare and employment interventions.

■ No controlled trials have been conducted on the effectiveness of case management in conjunction with opioid treatment services.

■ Research is difficult to conduct because case management is poorly defined, is applied inconsistently and it is therefore difficult to establish clear methods and goals.

■ Published studies suffer from inadequate research design and fail to control for non-experimental variables.

■ International studies examine case management practices that differ substantially from the Australian experience as they relate principally to the case manager's role in the direct purchase of substance abuse treatment.

Five models of case management have generally been used for drug and alcohol clients (7, 230):

1. Brokerage Model (brief approach whereby case workers 'broker' support services within one-two sessions; no evidence for effectiveness on retention in treatment or drug and alcohol outcomes, but associated with increased access to drug and alcohol services)

2. Generalist/Intensive Model (Level 3-b evidence for effectiveness on retention in treatment, preliminary evidence for improved drug and alcohol outcomes)

3. Assertive Community Treatment Model (Level 2 evidence for effectiveness on mental health outcomes, but no drug and alcohol studies to date)

4. Clinical Case Management (Level 2 evidence for effectiveness on mental health outcomes, but no drug and alcohol studies to date)

5. Strengths-Based Case Management (Level 2 evidence for effectiveness on mental health outcomes, but no drug and alcohol studies to date).

The three latter models (Assertive Community Treatment, Clinical Case Management, Strengths-Based Case Management) also involve significant clinical/therapeutic input as described in section 4. The Generalist/Intensive model uses the seven strategies most commonly suggested by experts in the case management area as the most effective case management approach (Level 3-b evidence, 53, 128, 229, 230).

Several groups have carried out studies examining the benefits of Brokerage Case Management approaches to clients with a range of difference problematic drug and alcohol use issues. For example, case management providing assistance in accessing required services, including drug and alcohol treatment, was compared

to receiving information about referral services, among a group of 360 injecting drug users who were randomly allocated to each condition (Level 2 evidence, 231). Results indicated that the case management group were significantly more likely to be admitted to treatment for drug dependence, had significantly lower periods between initial contact and admission, were retained in treatment for significantly longer than the comparison group and demonstrated better treatment outcomes. These results should be considered within the context that case management was provided externally to treatment services, and treatment places were purchased for clients in the experimental group where necessary.

In a descriptive study (Level 3-b evidence), case management (Brokerage) services were provided to 310 drug and alcohol clients presenting to a public health clinic for homeless, mentally ill and HIV positive issues (232). Results demonstrated that referrals to primary health care services reduced, drug and alcohol treatment services remained stable, and referrals to mental health services increased substantially over the three-year pilot study.

In another descriptive study (Level 3-b evidence), an enhanced model of case management was provided to 51 postpartum drug and alcohol clients over a 12-month period (233). The Generalist/Intensive program, described as an advocacy model, included the establishment of a therapeutic relationship, identification of client goals, establishment of linkages with service providers, written agreements, skills training and evaluation. The authors reported improvements across the clinical population including reductions in drug and alcohol use, increased involvement in treatment for drug and alcohol problems, increased use of birth control and increased involvement in parenting classes. It should be noted that the study design did not establish a control group.

Considerable research has been undertaken in the delivery of case management in mental health services, highlighting controversy over the value of the intervention. In a Cochrane collaboration review of seven published randomised controlled trials on case management services for people with severe mental health disorders, over the preceding 20 years (234), case management was associated with increased client contact with psychiatric services and a two-fold increase in admission/readmission to a psychiatric institution compared to those not case managed. Case

management was not associated with improvements in clinical or social outcomes and cost data was inconclusive.

The authors' conclusions express concern that "case management is an intervention of questionable value, to the extent that it is doubtful whether it should be offered by community psychiatric services". However, this review has since been criticised (235) for not including randomised controlled trials on Assertive Community Treatment (ACT) in the review of case management, and for focussing exclusively on passive Brokerage Case Management Models.

It should be noted that Assertive Community Treatment, as a form of case management, is defined by a number of service conditions that, in general, NSW drug and alcohol services could not meet (227) including:

■ Longitudinal care

■ Provision of services on a 24 hour per day, seven day per week basis in a fully mobile, fluid system

■ High intensity service provision, generally provided in the client's own setting

■ ACT teams are generally highly resourced and become self sufficient across the spectrum of care (including prescription and administration of medication) and are generally not required to refer clients to external services

■ Client to staff ratios should generally be established in a range from eight-to-one to ten-to-one.

For drug and alcohol clients, the core principles of case management are that client outcomes are improved where individual treatment or care plans are developed based on comprehensive assessment of the broad spectrum of biological, social, familial and behavioural factors. Although many models of case management currently in use are based on an accepted theoretical paradigm, in practice, these models have usually been adapted to suit the local conditions of the service and the individual needs of the client (128).

This client-centered approach is indeed a strength of case management, however this also means that the strategies used within a case management approach will vary a great deal between individual professionals and between services, geographic locations, etc (228). Consequently, within the drug and alcohol setting, case management is not well defined or operationalised (228, 229).

Recommendation (★★)

Core activities in Generalist/Intensive Case Management should include (53, 128, 227, 229, 230):

■ Screening and assessment of individual clients including assessment across all factors relating to the client's presentation

■ Development of comprehensive, individual treatment or care plans

■ Co-ordination of treatment or care plan implementation

■ Facilitation of access to specialist treatment for substance use disorders

■ Facilitation of access to other health services including mental health, hepatology, emergency etc as required

■ Facilitation of access to a broad range of community services

■ Maintenance of contact with and support for the individual client

■ Monitoring progress and outcome across the care plan

■ Review and revision of individual care plans.

Intervention for special groups

This section describes some additional considerations for important groups within the community to whom psychosocial interventions could be delivered. In general, many of these principles could be applied to any drug and alcohol client, however some additional practice tips provided here may assist the D&A professional to better engage with the target group.

7.1 Aboriginal people and communities

A range of additional psychosocial issues are associated with high levels of problematic drug and alcohol use among Aboriginal and Torres Strait Islander people in Australia. These include increased risk of exposure to violence, risk of depression, anxiety, high rates of suicidality, increased risks of poor nutrition and other medical complications (236). In treating a client of Aboriginal or Torres Islander descent, these additional issues should be considered.

D&A professionals need to take a proactive role in engaging additional services in the care of a client, acting as an advocate for them particularly if they are experiencing system-level barriers to treatment (eg. if co-morbidity issues are present). The onus is on the D&A professional to find out which local Aboriginal/Torres Strait Islander services are available, and actively seek out relationships and clinical partnerships with these services. This will include services within the drug and alcohol setting and those external to it.

In treating a client of Aboriginal or Torres Strait Islander descent, it is important to understand that the D&A professional is not just engaged with the individual client. Rather, the D&A professional is treating a client in the context of a close-knit Community. With client consent, consultation should occur with the individual client, other health providers (including indigenous support services), with family and Community members to determine the most appropriate course of action for the client (237). Realistic treatment plans should be developed, which can be incorporated into the wider social and cultural context of the client (238). In addition, the D&A professional must be sensitive to the possibility that the level of respect, rapport, trust and skill with which they treat any client will be evaluated by the larger Community, highlighting the need to manage these encounters appropriately.

Given that the experience of many Aboriginal and Torres Strait Islander people with the health and welfare system is unsatisfactory, it is unrealistic for the D&A professional to expect members of the Community to access their service in the same way that other groups may do. D&A professionals must be aware of and confront any stereotypes they may hold, and be aware of how they are perceived by the Community by virtue of their association with the health system (238). As such, the D&A professional needs to take time to engage with the Community, building a respectful and trusting relationship with them over time, which may then make the service more 'accessible' to members within the Community.

Clear, effective and culturally appropriate communication is an essential component in providing care to people of Aboriginal and Torres Strait Islander descent (238). For example, just as different drugs have different 'street' names, Aboriginal and Torres Strait Islander languages have their own words for alcohol, and other drugs (239). It is important for the D&A professional working with these groups to be mindful of this, and to attempt to understand how alcohol/other drugs are referred to within the Community. Conversely, the D&A professional should avoid the use of technical and/or medical jargon when interacting with Aboriginal and Torres Strait Islander people as this may affect their understanding of discussions, treatment plans, etc, which in turn will impact negatively on engagement. D&A professionals should speak slowly, clearly and non-judgementally, and use culturally-specific labels for words only when appropriate and without condescension (238). Again, taking the time to develop a relationship with the Community, learning social cues, body language cues, etc, is the key (238).

Finally, in the context of a therapeutic interaction with a client, the D&A professional should allow additional time for key messages to be communicated and discussed, and source culturally appropriate and sensitive documents that reinforce any advice or treatment plans involving the client (see 239 as a good example of this).

> **Tips for working with Aboriginal and Torres Strait Islander people:**
>
> ■ Be proactive in establishing relationships with Aboriginal/Torres Strait Islander services and take responsibility for maintaining these relationships
>
> ■ Be proactive in engaging with the local Community, rather than waiting for them to access the drug and alcohol service
>
> ■ Understand that a client needs to be treated in the context of their Community
>
> ■ Community views of health professionals will likely be judged according to the Community's experience with an individual drug and alcohol professional
>
> ■ Work with the local language for alcohol/other drugs
>
> ■ Avoid using technical or medical jargon
>
> ■ Reinforce key treatment messages with suitable documentation
>
> ■ Understand that relationships (including therapeutic relationships) will take time to develop and that this is often a necessary precursor to engaging in treatment and learning culturally appropriate ways of interacting with clients.

7.2 Services for domestic violence/ family violence

The *Policy and Procedures for Identifying and Responding to Domestic Violence* (http://www.health.nsw.gov.au/policies/pd/2006/pdf/pd2006_084.pdf) provides a framework for informing domestic violence responses for staff in hospitals and community health services in NSW. All D&A professionals should be aware of and follow the guidelines presented in this policy directive.

Domestic violence refers to abusive or violent behaviour that occurs between adults who are partners or former partners (see NSW Policy Directive PD2006_084, and 240), and often occurs in the context of problematic

drug and alcohol use. Drug and alcohol use does not cause or provide an explanation for domestic violence. However, it may exacerbate underlying problems and add an additional layer of management and intervention when responding to domestic violence situations. It is important to remember that episodes of domestic/family violence are one of the key notifiable issues for D&A professionals, particularly if children are involved.

The D&A professional should be aware of local services currently available to assist perpetrators and victims of domestic/family violence, and make appropriate referrals to these specialised services rather than attempting to treat them in the drug and alcohol context. If it is identified that issues of anger management are related to problematic drug and alcohol use, then these issues could also be the focus of treatment (if the D&A professional is suitably skilled) or referral.

Clients may request a court report from the D&A professional to assist with any legal matters arising from their involvement in domestic/family violence situations. These requests should be clarified as early as possible in treatment, and need to be managed with care. The D&A professional should clarify their role in this process, and ensure that treatment and thus their report remains focussed on the problematic drug and alcohol use issues of the client. D&A professionals should also clarify their role with the client (eg. case co-ordination, treatment, advocacy) and be aware of the different legal and ethical responsibilities associated with each of these roles in situations of violence.

If asked to provide a court report relating to domestic/family violence situations, D&A professionals need to be clear that the report can only be related to their drug and alcohol work with the client and not the violent situation, if this has been the focus of their work with the client.

7.3 Child protection services

The *NSW Interagency Guidelines For Child Protection Interventions 2006* (http://www.health.nsw.gov.au/pubs/2006/iag_childprotection.html) outlines NSW Health's and other government agencies' roles and responsibilities in relation to the safety, health and wellbeing of children and young people. All D&A professionals working in these agencies should be familiar with and follow these guidelines. In particular, these guidelines provide information about:

■ How to identify child abuse, neglect, domestic violence, sexual abuse, physical abuse and psychological harm

■ When and how to make a report to Department of Community Services (DoCS) helpline

■ Important contacts including web addresses.

Information about these issues is likely to benefit D&A professionals working in the private sector. However, these professionals should also refer to the guidelines provided by their own professional bodies.

Effective service delivery to families is dependent on the provider of drug and alcohol interventions, DoCS and other agencies involved working collaboratively, cooperatively and with a clear understanding of each other's roles and responsibilities.

> **Reports to DoCS are mandatory if:**
>
> ■ A child reports that they have witnessed (seen/heard) abuse/violent behaviour, or if they have been the victim of such behaviour
>
> ■ A drug and alcohol client reports that their child has witnessed or been the victim of abuse/violent behaviour. In these cases, the child becomes the client by proxy and drug and alcohol professionals have a responsibility to that child to notify DoCS.

If a decision to make a report is made, the following process will occur:

■ The D&A professional should contact DoCS in accordance with state legislation and mandatory report requirements

■ The information will be passed onto a "professional" person who may then speak with the D&A professional about more specific details of the case

■ This person will then consult with other members of the DoCS team about the case and a decision will be made that same day about how to proceed. The options are:

a) The report will be treated as an "intake only". This means that no information will be recorded against the client/child

b) The report will be filed as an "active case". This means that the information will be recorded on the client's file and on the DoCS database

c) The report is considered serious enough to warrant follow-up by the local DoCS office. In this case, DoCS will make contact with the client/child and conduct a thorough risk assessment to determine the need for further intervention with the child. During this assessment, individual interviews will be conducted with the child and his/her parents. Open-ended questions are asked, and where possible specific incidents involving abuse will not be mentioned. In addition, no mention will be made about who reported the abuse to DoCS.

■ The D&A professional, when talking with DoCS, may need to provide a recommendation as to what the course of action should be for a particular client. Information can also be provided to DoCS about how best to manage the client's problematic drug and alcohol use.

It is important that the decision to report suspected cases of abuse should not be based on whether or not the D&A professional believes that their report will be followed-up by DoCS. The consequences of not reporting incidences of abuse/violence against or witnessed by children are serious. Risk to the child can be re-assessed as more information comes to light about the family situation. One report to DoCS does not absolve the D&A professional of reporting requirements, and it is extremely useful for DoCS to have any new information about the same client, particularly if it is to establish a pattern of behaviour.

A therapeutic relationship should be maintained with the client (carer/parent) throughout this process, however duty of care to the child overrides duty of care to the client. Where appropriate, there are harm reduction suggestions that can be discussed with clients, such as not using in front of children, etc. Further, for many clients, a large proportion with children will cite their

children as primary reasons for reducing/ceasing use. An effective D&A professional can use this to motivate change, along with techniques to improve the client's parenting skills and capacity to be positively involved with their children. This can have a flow-on effect to mental health and drug and alcohol use.

If something worthy of notification is raised during a session with a client, the D&A professional needs to address that issue within that session (eg. client reveals he/she is having thoughts of killing self and children):

"What you are telling me is important information, and as a responsible professional I can't let it pass. I feel really bad about this, but I am required by law to inform welfare about this to see if you can get some helpIn all likelihood, the welfare people will be pleased to know we are currently involved in treatment and will see that as good enough - they may not need to do anything else, but they do need to be told."

Supervision can assist the D&A professional to make decisions about when and how to manage these types of difficulties with clients.

7.4 Sexual and gender diverse groups

Some evidence exists to suggest that a higher incidence of problematic drug and alcohol use may occur in gay and bisexually active men and lesbian women than for women and men in exclusively heterosexual relationships (16). This is particularly true for cannabis and tobacco use (16). The percentages of same sex attracted young people injecting drugs dropped from 11% in 1998 to 4% in 2004. Nevertheless drug use still remains substantially higher than for heterosexual young people, with double the number of same sex attracted young people having injected drugs.

Despite any improvements that may have occurred within society in terms of attitudes towards sexually and gender diverse groups, discrimination and stigma still exists in many situations, communities and workplaces. Clients of sexual and gender diverse backgrounds will often have experienced overt forms of violence and abuse, and also quite subtle forms of abuse and discrimination. This has important consequences for clients, given national and international research indicating a strong relationship between homophobia, heterosexism, social exclusion and the health status of individuals. As such, D&A professionals may need to provide this client group with additional support

and intervention related to disrupted peer/family relationships, harassment and violence, and anxieties about sexual behaviour.

Fundamentally, drug and alcohol treatment for clients of sexual and gender diverse backgrounds is the same as for any other client group, with the focus remaining on the client being treated. Small modifications in language will need to be made, particularly for the way in which family members and partners are referred to. Importantly, the D&A professional should take the client's lead in discussing the importance of issues related to their sexuality and treatment.

Of particular importance to D&A professionals providing treatment for clients of sexual and gender diverse backgrounds, is the increased proportion of HIV experienced by this group. Given the higher incidence of drug and alcohol use among drug and alcohol clients of these backgrounds, their risk of engaging in risky sexual practices is also significantly higher than for other groups in the Community. D&A professionals need to be aware of these issues, and provide support and information about harm reduction strategies to clients of sexual and gender diverse backgrounds. Such information and support will not be limited to problematic drug and alcohol use. This should also include safe sexual practices and information or access to appropriate role models to provide support and acceptance around same-sex relationship issues. Evidence suggests that internet use among clients of sexual and gender diverse backgrounds is common, particularly given the anonymity associated with accessing this media and the access to information and on-line support. D&A professionals can also then provide this client group with relevant and appropriate web addresses for these purposes.

7.5 Ageing population

As the age of the Australian community increases it is necessary to recognise the needs of the elderly. Elderly people with problematic drug and alcohol use have greater need for support services. Their increased age, coupled with the effects of drug or alcohol misuse, make them less able to cope in the community. Older people are also more vulnerable to the effects of alcohol/other drugs and to the deleterious side effects and illness associated with problematic drug and alcohol use (241). They will be more susceptible to complications in withdrawal phases of treatment, and more likely to experience falls and associated injuries (28, 241). The

relevant clinical guidelines are the *NSW Health Drug and Alcohol Withdrawal Clinical Practice Guidelines* (6).

In assessing older clients, a lifespan problematic drug and alcohol use history is essential, although this can be difficult if memory problems are present (241). Very few assessment instruments exist to assist this process. However, problematic drug and alcohol use is likely in older people exhibiting the following signs (pg 350, 241), and these issues could be raised by the D&A professional in their assessment:

■ Falls or accidents

■ Poor nutrition

■ Family problems and social isolation

■ Medical problems

■ Inability to perform everyday activities

■ Unfit to drive a car.

Once a psychosocial treatment program has commenced with an older client, it is reasonable to expect that a significant and sustainable change in problematic drug and alcohol use is possible (241). Older people will likely have experienced a range of losses that could be targets for psychosocial treatment (eg. retirement, loss of spouse/friends, loss of health/mobility, etc). For clients with memory problems, any treatment strategy should be adapted sensitively, with the D&A professional offering written information to support key messages, and working with the client to develop strategies to remember important activities, tasks, etc. Suicidality is often high among people over 65, and attempts are usually more lethal by virtue of the potential for medical complications in older people (241). Regular suicide risk assessment should form part of routine practice for D&A professionals treating this client group.

7.6 Coerced clients

The concept of "coerced" clients takes in a wide variety of presentations that can include court referrals, requirements of employment, requirements of schools and educational facilities and finally partner or family pressure (2). It is likely that the numbers of coerced clients seen by D&A professionals and agencies will increase in coming years in part due to changes of government and industry

policy. This section will look first at therapeutic issues that are common to most presentations with coerced clients and then focus on some specific issues relating to criminal justice coerced clients.

Some of the key general issues relate to special care than needs to be taken in establishing and negotiating the treatment framework and plan. These include: (242, 243):

■ Confidentiality, which needs to be clarified, negotiated and agreed upon by all key stakeholders from the outset of treatment

■ Conflicts of interest between the views of the D&A professional and the conditions under which the client accesses treatment

■ Client resistance to change, given motivation to engage in treatment is usually external rather than internal

■ The client goal regarding substance use and how that relates to agency, employer, court and family requirements or concerns. It is here that goals of abstinence or harm minimisation can often prove problematic when there are differing views from the client and the other stakeholders involved.

If a coerced client is motivated to engage in a psychosocial treatment program, treatment should proceed as per any client (see Sections 3 and 4). However, if a client is unmotivated and unresponsive, then a brief motivational, educational intervention is indicated as a first step, prior to any more intensive treatment being commenced (50, 54).

7.6.1 Coerced clients from criminal justice settings

D&A professionals may see coerced clients in at least three broad categories:

■ When a client is referred without any apparent coercion but on assessment or during treatment it emerges that legal or court issues are in fact an issue for the client. There may or may not be expectations of feedback or reports to the courts or legal stakeholders

■ When a court or legal stakeholder refers to a D&A professional or agency with a view for an assessment or treatment to be provided. There is usually a strong expectation that feedback or a report will be provided

- When a court or legal stakeholder refers to a drug court or court diversion programme, which is governed by formal protocols including the reporting framework.

The key point here is that while the psychosocial treatments that are provided will remain broadly similar in all three situations, the establishment of the therapeutic framework and the process of negotiating coordinated care and the agreed reporting process may differ. D&A professionals need to ensure they are clear what service it is that they are providing and how they will communicate this with courts and related agencies.

There is good evidence that drug court and court diversion programs, with their associated psychosocial elements, can produce beneficial treatment outcomes in terms of reduced substance use, better psychological functioning and reduced criminal activity. There is also evidence that programs that address social and environmental factors, in addition to focussing on the substance use, will be more successful. Evidence also exists that outcomes are better when clients complete programs (244). Outcomes from these types of programmes indicate that good outcomes can occur when a partnership occurs between health, legal professionals and the offender client ('therapeutic jurisprudence', 245). The implication is that similar results may also be obtained in more general settings providing that a partnership, with client's consent, is formed by the D&A professional and the court related agencies.

When treating coerced clients and/or those involved with the criminal justice system, drug and alcohol professionals need to be aware of the legal implications of treatment they provide to the client including questions of whether the court has mandated treatment or a form of treatment and what occurs if the client completes or does not complete treatment. Obtaining clear information about things such as bail conditions, court orders, court dates, solicitor contact details and prior criminal history are often extremely helpful when formulating treatment plans and providing treatment. Drug and alcohol professionals also need to be mindful that court processes are usually stressful for clients and may themselves influence current behaviour and self-report.

When treating clients involved with the criminal justice system, it may be necessary for the D&A professional to provide a formal report to the courts regarding client progress. In these cases, the following guidelines can be helpful:

- Keep all reports and clinical records factual rather than speculative or reflective

- Verify the facts of the client's case and behaviours by checking to make sure what the client claims is actually correct

- Avoid offering suggestions for client sentencing

- Avoid the use of jargon and opinion unsupported by facts.

7.7 People from diverse cultural and linguistic backgrounds

There can be diversity in the patterns of use within cultural groups, as well as differences in usage patterns between difference cultural groups. For example, people from a European background are more likely to have used alcohol and cannabis than those from an Asian or Arabic background (246). Each cultural group will also have its own norms and values in relation to drug and alcohol use and, whilst it is important for D&A professionals to be aware of these norms, it is also important to understand that a client's drug and alcohol use may not necessarily be in accordance with these norms.

Very little firm evidence exists to suggest any culturally bound variables that are associated with problematic drug and alcohol use among people from culturally and linguistically diverse communities in Australia (247). However, immersion in Australian culture may play a role in the initiation and maintenance of problematic drug and alcohol use among people from diverse cultural backgrounds, as they try to adapt to life in Australia. For example, for people immigrating to a new country, problematic drug and alcohol use may be used as a stress-reduction strategy adopted in response to the pressures of adapting to a new environment, or as a means to 'fit-in' with the new community (245). This experience will often be compounded for those people who are refugees (i.e. Involuntary migrants), who may also struggle with issues of family separation, socio-economic disadvantage and the impact of traumatic events experienced or witnessed

in their home country (248) these issues will increase risk of drug and alcohol use.

It may also be that the strong anti-drug and alcohol messages that people in the general community in Australia have been receiving via the media for decades have been missed or not understood by those immigrating to Australia, particularly those from non-English speaking backgrounds (249). As such, there remains a key role for D&A professionals to ensure that health promotion messages targeted to the english-speaking population are applied in an accessible and appropriate format for people from culturally and linguistically diverse backgrounds (246). Strategies could include translation of written materials, and the provision of alternatives to written materials such as audio, visual, or theatrical resources. A range of multicultural information is also available via the internet, including the following websites:

■ Druginfo clearinghouse – http://www.druginfo.adf.org. au/multicultural/

■ NSW Multicultural Health Communication Service - http://www.mhcs.health.nsw.gov.au

■ National Drugs Campaign – http://www.drugs. health.gov.au/internet/drugs/publishing.nsf/content/ languages-other-than-english

■ QUIT (tobacco) – http://www.quit.org.au/browse. asp?containerid=1643.

It is suggested that psychosocial approaches to problematic drug and alcohol use (see Sections 3 and 4) can be used with people of different ethnic backgrounds (250). However, very little research exists that directly tests the application of these approaches to people from culturally and linguistically diverse backgrounds. It is not immediately clear how the needs and perspectives of people from culturally and linguistically diverse communities fit within these approaches, nor whether doing so will influence problematic drug and alcohol use (246). Some experts suggest that traditional treatment approaches may not be appropriate for use among people from culturally and linguistically diverse backgrounds, and that seeking out or engaging with external agencies (i.e. those outside the family or community) may not be culturally acceptable (251). Additional efforts may need to focus on engaging with the community in general, with the aim of establishing trust and rapport.

For the D&A professional working with people from culturally and linguistically diverse groups, engagement with the community is vital. Messages regarding the impact of problematic drug and alcohol use should be presented in a language that the target audience can understand easily and be reinforced by prominent members within the cultural community, instead of being imposed from the outside (246). The influence of the cultural community of the client might be important in strengthening the messages delivered in treatment, perhaps in the same way that the community plays an important role in the health and well-being of clients of Aboriginal and Torres Strait Islander descent.

Being aware of local migrant health services within and external to drug and alcohol services is essential, as is access to a professional interpreting service when issues of language arise. NSW Health has provided a policy directive governing when and how professional interpreters should be used (see http://www.health.nsw. gov.au/policies/pd/2006/pdf/pd2006_053.pdf). Such situations include: assessments, explanations of treatments/ medical instructions, obtaining consent for treatments, at discharge, counselling (including psychosocial interventions), high risk and life threatening situations, etc when a professional interpreter cannot be present in person, telephone or videoconferencing may be used.

NSW Health Care Interpreter Service is available at all NSW public health facilities, free of charge, seven days a week, 24 hours a day. See the NSW Health Policy Directive PD2006_053. The relevant Area Health Service contact numbers are listed in Appendix C of this document.

A general telephone-based translating and interpreting service is also available: 131 450

7.8 Rural communities

People living in rural/remote communities report particular difficulties accessing psychosocial treatments because of limited available services and geographic isolation (242, 252). In addition, attitudinal or cultural barriers to treatment for substance misuse may be more prominent, affecting a rural client's likelihood of engaging in self-help meetings or treatment more generally (16). The utility of self-guided approaches, such as bibliotherapy or computerised treatments, in these settings cannot be overstated, along with the potential

for psychosocial treatments to be offered via alternative methods to face-to-face (eg. telephone, email, internet, etc, see section 4). Telecommunications and the use of technology in service delivery have a special role to play in making services accessible to these populations.

As with other communities, D&A professionals working in rural/remote areas need to spend time networking with local health providers, and fostering trust, non-judgemental acceptance and confidentiality in their engagement with rural clients. In small rural communities, anonymity is very difficult to maintain, presenting a range of additional challenges for the D&A professional in maintaining professional boundaries with the client group.

7.9 Parents with drug and alcohol issues

The Department of Corrective Services Families First has received drug summit funding for innovative prevention and early intervention projects to support families, communities and individuals with problematic drug and alcohol use. In a number of area health services, this funding has been used to implement projects to support substance-using mothers during pregnancy, and during the child's early infancy.

For clients who already have children, assessment should cover family functioning and how the children function and develop, even when there are no child protection concerns present for the family. D&A professionals should be able to provide basic parenting advice to clients with families, however should refer to specialist services such as family support in cases where more intervention is required.

7.9.1 Drug and alcohol use in pregnancy

The American Psychiatric Association (16) highlights the potential for problematic drug and alcohol use to impact negatively on the developing foetus. Accordingly, D&A professionals should be encouraged to work with pregnant women on a plan to manage/reduce/ abstain from substances during pregnancy and while breastfeeding, with psychosocial approaches central to this process. It is vital that partners/significant others of pregnant women be engaged in the drug and alcohol treatment process to assist in reinforcing messages provided during treatment and in encouraging treatment adherence and attendance. Treatment may also be offered to partners/significant others for problematic drug and

alcohol use (if present) as this will impact significantly on the pregnant woman's drug and alcohol use (253).

Tobacco has long been considered harmful to the developing child, and is associated with increased risk of miscarriage, premature birth, low birth weight and longer-term health effects (253). Pregnant women who smoke should be encouraged to engage with a smoking cessation program to mitigate these risk factors. The national clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn (253) recommend that five steps be taken to assess and manage smoking in pregnancy clients.

The '5 As' (brief intervention for smoking cessation in pregnant women, 253)

- ASK all women if they smoke tobacco and record smoking status (including recent quitters).
- Provide ADVICE regarding smoking cessation to continuing smokers.
- ASSESS stage of change for continuing smokers.
- ASSIST continuing smokers to modify use (eg via motivational interviewing, CBT), with abstinence recommended in all cases.
- ARRANGE follow-up after a quit attempt.

It is unclear whether Nicotine Replacement Therapy is safe in pregnancy, and psychosocial options should be tried as a first line treatment option (253).

Alcohol consumed by mothers during pregnancy can seriously affect the health and development of their unborn child. For example, some babies will be born with foetal-alcohol syndrome, which can include weighing less than expected at birth and having unusual facial features. Foetal-alcohol syndrome is more prevalent in indigenous than non-indigenous infants. Secondary effects of this disorder, such as behavioural, learning and mental health problems may not manifest in babies until well after birth. The World Health Organisation has stated that foetal-alcohol effects are the commonest cause of congenital developmental delay.

The World Health Organisation suggests that there is no safe level of drinking alcohol during pregnancy and that abstinence from alcohol is the safest approach (254).

Pregnant drug and alcohol clients should be encouraged to reduce alcohol consumption as much as possible, if not eliminate it completely. Psychosocial treatment approaches are potentially of most benefit in reducing alcohol consumption, however pregnant women should also be offered priority access to the range of treatment options where indicated (253). At the very least, only small amounts (eg. One drink less than once a week) should be consumed (254). These levels should be maintained while the mother is breastfeeding, as the infant's brain continues to develop over the first 12 months and can be affected by alcohol crossing into the mother's milk (254).

Mothers using heroin during pregnancy and whilst breastfeeding are also placing their babies at increased risk of a range of abnormalities and developmental problems, including HIV, HCV, HBV and other infections associated with injecting drug use. Heroin dependent pregnant women are strongly advised to enrol in methadone maintenance program for their pregnancy and following birth to reduce these risks, particularly given the improvements in health, diet and other lifestyle factors that often coincide with engagement in Methadone Maintenance Programs (253, 254). However, methadone does cross the placenta, so neonates will still have a risk of developing a neonatal opiate withdrawal syndrome. Importantly, pregnant mothers using heroin are advised against an unsupported attempt at withdrawal as the effects on the mother and unborn child include miscarriage and premature labour(254). Managing/reducing heroin use and/or methadone treatment should be closely monitored by a range of medical and D&A professionals. The first-line treatment for opioid-dependent pregnant women is methadone maintenance treatment (253). However, if a woman is already established on a buprenorphine maintenance program, then this can be continued during pregnancy and while breastfeeding.

Much less research has been conducted on the effects of cannabis, amphetamines and other illicit drugs on the developing foetus. However, drugs will cross the placenta and be excreted in breast milk, resulting in a range of infections, breathing problems, and developmental issues in babies (254). Pregnant and breastfeeding mothers are advised to reduce their use of cannabis, amphetamines, etc. To reduce these effects on the baby, with abstinence being the ideal goal during this time (253). Psychosocial treatment approaches are central to this reduction process.

In general, breastfeeding mothers who are using drug and alcohol should be advised to express breast milk prior to using to minimise the amount available to the baby through breast milk (254).

It is a given that problematic drug and alcohol use in pregnancy is associated with a range of risks for the mother and developing child. However, such behaviour also highlights the potential need for education and training in parenting skills, and a range of socioeconomic issues that may need to be addressed (16, pg 43).

The goals of treatment for pregnant women should be to (16):

1. Provide treatment for the substance use problem

2. Provide treatment for any co-occurring psychiatric or medical conditions

3. Monitor the pregnant mother's behaviour and risk taking activities during and following the pregnancy

4. Encourage the development of effective parenting skills

5. Encourage the mother to keep to drug and alcohol goals following childbirth.

More information about pregnancy, breastfeeding and drug and alcohol use is available from the Australian Drug Foundation (http://www.adf.org.au) and the Drug Info Clearinghouse (http://www.druginfo.adf.org.au). NSW Health has published national clinical guidelines for the management of drug use during pregnancy, birth and the early development years of the newborn, which are available at http://www.health.nsw.gov.au/pubs/2006/ncg_druguse.html. In addition, D&A professionals are encouraged to make use of the range of strategies and treatment programs available within NSW Health to assist pregnant women address these issues.

7.10 Young people with emerging problems

D&A professionals and services need to tailor their treatments differently to young clients with emerging problems (2). This will not be necessarily in terms of the content of psychosocial interventions offered to young people (eg. brief interventions, CBT, motivational enhancement, systemic/family therapy, psychodynamic

therapy, see Section 4), rather the process of engagement and providing treatment will need to consider the young client differently from an adult client (16).

Firstly, experimentation, including with drugs and alcohol, forms a relatively normal part of adolescence (255). Indeed, for some adolescents, this experimentation and experience with trial and error processes may be their way of developing a fully formed, healthy personality. While many young people do not use drugs and alcohol at dangerously high levels, there are known harms associated with all levels of misuse. It is also recognised that some young people will develop chronic patterns of drug use and engage in frequent harmful binging. As with adult clients, when drug and alcohol use becomes habitual and/or normal functioning is affected, it is cause for concern.

The assessment and diagnosis of problems among young people is difficult, given adolescence is a time of potentially tumultuous growth and change (255). However, the first presentations of psychosis will be emerging for vulnerable clients at this time, and this is often associated with cannabis and amphetamine use. Depression and anxiety disorders also first emerge during adolescence, which can also be exacerbated or 'self-medicated' with problematic drug and alcohol use. Characteristic of these emerging conditions will be obvious changes from previous levels of functioning, and treatment will also need to target these changes and symptoms in addition to problematic drug and alcohol use.

It is important that the D&A professional understands that the adolescent drug and alcohol user is not just a younger version of an adult drug and alcohol user (255). Adolescence is a time of establishing independence (especially from parents and adult authority figures), where relationships with peers are exceptionally important (255). D&A professionals working with young people need to recognise this, and use strategies such as humour to assist in the rapport and engagement process (255). Encouraging the development of 'normal' peer-related activities outside of therapy, such as playing sports, joining various social groups, playing music, drawing/artistic expression, should also be the focus of treatment sessions with adolescence. Or, at least these activities, when they are already occurring for some young people, should be strongly reinforced during therapy.

Young people also typically have higher energy levels than older adults, and as a therapist, the D&A

professional must also be prepared to take on a more active, energetic role in treatment, rather than relying on some of the more passive, reflective skills to promote engagement and build rapport. In addition, having a 'youth-friendly' environment in which to see young people is important. Simple strategies such as setting up a waiting room to indicate that young people are welcome can be useful in promoting engagement with a young client population. This might include photos of young people, images of activities relevant to young people displayed, etc.

Marsh and Dale outline several key strategies to consider when working with young people (pgs 290-294, 2):

■ Limit use of scare tactics

■ Take longer to establish rapport and trust within therapy

■ Ensure confidentiality is maintained

■ Provide structure, and set and reinforce clear limits

■ Allow the young client some freedom to choose their own goals for behaviour

■ Young people learn best when they try out experiences for themselves

■ Take a harm reduction approach

■ Use concrete, behavioural strategies

■ Remember that the young client operates within the context of a family, so they should also be involved where possible.

Clinical Governance issues

The NSW Health clinician's toolkit defines clinical governance as:

" The framework through which health organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish" (pg 2, 256).

Excellence in clinical care will therefore involve integration between individual D&A professionals, the team within which they are operating, and the wider service in which their team sits. Individuals working at each of these levels will have differing roles and responsibilities in ensuring that high quality clinical care is being consistently delivered to clients engaged with drug and alcohol services.

This section focuses on clinical governance at the managerial, team and clinician level. Note however that clients, and sometimes significant others, are also important partners in the clinical governance process, most often as active participants in individual clinical reviews. More detailed discussion of client collaboration, the engagement of significant others, communities and other support people are outlined in Sections 3, 4 and 7.

8.1 Suggested responsibilities of D&A professionals

Individual D&A professionals are responsible for their individual clients, and need to have sufficient skills, training and competence regarding the treatment of presenting complaints of clients accessing their service. However, no single D&A professional is expected to be an expert in the treatment of every issue or problem a client presents with, nor is any one team or service. Knowing one's limitations, or those of the team or service, is important in providing effective, quality and helpful clinical interventions (4).

Before proceeding, it is important to acknowledge that private practitioners usually develop their own clinical governance system, be it in individual or group practice. This can usually be tailored to the individual needs of the professional involved. Private practitioners are able to consult with local drug and alcohol agencies and the specialist advisory service over individual cases. For other forms of skills development or training, private practitioners may need to talk to the local drug and alcohol agencies, local or regional professional groups, or attend courses offered by training organisations and universities in order to see what is available that might meet their needs.

As described in previous sections, one component of good clinical care involves the implementation of a range of assessments and evidence-based treatment strategies by the D&A professional to assist clients work towards their identified goals. At a broader service level, formalised clinical reviews of client progress through treatment, including the core activities of regular consultation, supervision and clinical review/measurement of outcome will also be central to the provision of good clinical care (4, 256). The ways in which these activities are routinely incorporated into a team or service context should be determined at a local level, in line with policies and the needs of the clinical team.

Once a client has been accepted into a service, completed the assessment and treatment planning processes and has engaged in a treatment program, review and monitoring processes become important in determining how well the client has responded. From the perspective of the individual D&A professional, accurate clinical record keeping is an essential component of good clinical practice in these circumstances. Clinical/medical records also serve the broader purposes of teaching, as clinical audits, and providing evidence in the event of medico-legal issues. They are also a vital source of statistical and managerial information for the day to day running of the service. Core components of clinical/medical notes for drug and alcohol clients are suggested below.

■ Contain clinically relevant information only

■ Judgements of a personal nature should not be used. Comments about a client should be objective, factual and be relevant to their clinical assessment and treatment

■ Record presenting symptoms, diagnosis, and treatment (document each episode of care including telephone calls, consultation with other professionals etc.)

■ Summarise the following issues: what are your goals in treatment, why did you choose that treatment, have you provided informed consent by talking with the client about risks involved and alternatives to that treatment, and what are your rationales for referrals you've provided?

■ Any release of information obtained

■ Details of any risk assessments conducted (eg assessment of suicide risk, justification of level of risk assigned to client, etc).

Common problems with clinical notes include the following issues (257):

■ Absence of clarity eg the meaning of 'had a good day' and 'slept well' is not clear

■ Failure to record action taken when a problem is identified, eg 'is suffering increasing pain' then no record of action taken

■ Failure to document conversations

■ Failure to document care given

■ Failure to document special needs

■ Failure to record telephone calls, eg, on risk of suicide.

8.2 Suggested responsibilities of clinical teams and services

Where possible, D&A professionals should not work in isolation, and so responsibility for client welfare will also rest with the service team and the larger drug and alcohol agency, where there is more than one team. In practice, all these levels provide input into the consultation, supervision and management process. This can be complex, as staff involved at each level need to communicate well, and have an understanding and respect for the tasks required by each member of the team/service.

Within a clinical team, a range of disciplines will be represented, and each professional will have a defined role in addressing a client's problematic drug and alcohol use. D&A professionals working in a team environment need to acknowledge these different roles, particularly of those with different professional backgrounds and training from the D&A professional. In communicating with other D&A professionals, good clinical practice continues to apply. For example, a D&A professional should be aware of psychological questions that may be asked by a psychologist, and aware of medical questions that may be asked by a medical professional, etc, in consulting with medical professionals, non-medical D&A professionals should also appreciate the need to present them with facts, figures and particulars of a client, make a hypothesis about the problem situation, and be direct and specific about the questions requiring input.

8.2.1 Clinical supervision

Regular clinical supervision and review is important to good clinical practice, and is not a process meant to undermine practice or confidence, but rather to support the D&A professional and the client. The *NSW Drug and Alcohol Clinical Supervision Guidelines* (10) and the *Clinical Supervision Resource Kit* for the alcohol and other drugs field published by the National Centre for Education and Training on Addiction (NCETA, 258) provide detailed information about the process of clinical supervision and the roles of key players in the supervision process. In particular, clinical supervision is considered to be a tool for workforce development, can be used to review and maintain quality and clinical safety, and is a method by which D&A professionals can provide and receive support and debriefing for what is often a difficult and complex client group (10). These guidelines define clinical supervision in the following terms (pg 6-7, 10):

"A formal and ongoing arrangement between one worker and a (generally) more experienced practitioner whereby the clinical practice of the worker is reviewed and discussed in confidence for the purposes of:

■ *Further developing the worker's professional identity and practice*

■ *Ensuring workers are operating within relevant clinical, organisational, ethical, professional boundaries*

■ *Monitoring and supporting the worker's wellbeing and coping capacity in relation to their work."*

Broadly, clinical supervision could cover the following issues (pg 9, 10):

■ Methods and modalities of clinical practice

■ Concerns the drug and alcohol professional has about client progress, establishing or maintaining boundaries, etc

■ Any negative impact a client is having on the drug and alcohol professional

■ Skill and knowledge development

■ Ethical and professional practice

■ Workload issues.

Clinical supervision can be conducted individually or in groups, and is usually conducted by experienced clinicians. Supervision with peers is more frequent with senior staff. There is agreement that, except in special circumstances, clinical supervision should not be provided by the D&A professional's clinical line manager, as this may affect the supervision process.(10). Clinical line managers still have an indirect role in the clinical supervision process, by allowing the supervisor and supervisee time within the work day to conduct supervision sessions (10).

Clinical supervision is often characterised by a high but not absolute degree of privacy for the supervisee(s), which distinguishes it from most clinical review and clinical line management processes. Another feature of clinical supervision is that it should be adaptable to the needs of the professional. For example, a highly structured approach that may be necessary with a novice professional may be inappropriate for a professional of 20 years' standing.

8.2.2 Clinical review

The concept of clinical review can relate to a range of clinical governance activities. For this section, "client" and "clinical" review will be combined. While there are many variations on clinical review, the following strategies highlight the key ways in which this process may be carried out:

■ A form of clinical supervision whereby clinical line management is excluded and the focus is on professional development for each participant (10)

■ A team activity that forms part of the clinical governance procedures for a team (4). Usually this activity ensures that most, if not all, clients of a service team have some discussion regarding their entry, progress and discharge. Clinical line managers and sometimes staff from other teams or disciplines may be involved in this type of clinical review. Documentation from this type of review will be apparent in the individual medical records, client review pro-forma and team summaries capable of audit

■ A review of an individual client between the treating D&A professional and the clinical line manager or a senior clinician. The features of this type of review is that it often leads to re-formulated treatment plans that can be documented and is usually used when complex issues are identified with a particular client (4)

■ A review to look at a particular client, sentinel event or a clinical issue impacting on a class of clients (256).

D&A professionals need to be knowledgeable about the differing types of clinical review in addition to clinical supervision. Good clinical practice is indicated by a well thought out mix of clinical review and clinical supervision practices.

The clinician's toolkit (256) makes many valuable suggestions about the differing approaches a review meeting can take, although some adaptation may be required as some of the suggestions are more relevant to hospital rather than community health based settings. The toolkit provides some detail on how to review and discuss one's own and others' clinical practices; adverse events and the team's performance; morbidity and mortality meetings to review deaths and other adverse outcomes in clients; or ad hoc reviews/audits of specific practices, case notes to identify any general problems with the team/service in providing care (256). Importantly, clinical indicator data such as local activity data, minimum data set and IIMS data can be used to highlight possible problems or opportunities for improvements in client management of individual clients and client groups.

For client reviews to function well, there needs to be a culture where D&A professionals can talk about successes, near misses and mistakes within the context of trying to improve individual client care, and fix problems that might be occurring at a service level. An often-delicate balance needs to be struck between the

need for individual accountability within a team dynamic that encourages both transparency, support, and learning, so that client care is improved.

> **Suggestions for clinical review sessions (pgs 3-16, 256):**
>
> ■ Client reviews on presenting, complex and discharged clients
>
> ■ Facilitated incident monitoring (in response to event)
>
> ■ Sentinel event monitoring (prospectively or in response to event)
>
> ■ Effective use of clinical indicators (as required)
>
> ■ Peer review meetings;
>
> ■ Morbidity and mortality meetings
>
> ■ Ad hoc audits/reviews.

8.2.3 Clinical line management

All D&A professionals will report to a senior person or clinical line manager. Just as the knowledge base and competencies for a D&A professional is varied and takes many years to learn, so it is that the management of psychosocial services requires learning. At a minimum, the management of psychosocial work/teams needs to be done by managers who are themselves knowledgeable about the range of psychosocial treatments and the often-complex issues that are involved in delivery of these treatments. In contrast to clinical supervisors (who are only responsible for addressing matters raised within clinical supervision sessions), clinical line managers carry the overall clinical accountability on behalf of the agency (10). Clinical line managers usually have the following tasks:

■ Provide consultancy and at times direction to D&A professionals. This can include sharing medico-legal risk

■ Ensure that procedures are happening in line with service- and state-wide policies

■ Ensuring the workforce development issues for D&A professionals and service teams are being met, such as in facilitating attendance at professional training, clinical supervision, quality improvement activities and research

■ Ensure D&A professionals and service teams have the opportunity to work in a harmonious and supportive environment, where the employer demonstrates care for the staff and encourages self-care from the staff. Good clinical outcomes with clients will be impaired when D&A professionals and teams suffer from low morale, poor workforce development, lack of consultation and a culture of aggression or neglect.

SECTION 9

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Nurse Practitioner, *Drug and Alcohol Services*, *Northern Sydney Central Coast Area Health Service*

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Chief Executive Officer, *Odyssey House*

■ Mr. Barry Evans
Director, *the Buttery*

■ Mr. Steve Ella
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NSW Health Care Interpreter Service

Below are the Area Health Service contact telephone numbers for the *NSW Health Care Interpreter Service*. The numbers below are valid as at 5th March 2008.

Sydney South West (Western zone)
02 9828 6801

Sydney South West (Eastern zone)
02 9515 9516

SESIAHS - Northern Sector
02 9515 9516

SESIAHS - Southern Sector
02 4274 4211

Greater Southern Area Health Service
02 4274 4211

NSCC - Northern Sydney sector
02 9926 7690

NSCC - Central Coast sector
02 4924 6286

Hunter New England
02 4924 6286

Sydney West
02 9840 3697

To contact the *Translating and Interpreting Service* (TIS):
131 450

See also NSW Health Policy Directive PD 2006_053 dated 11 July 2006