1

General principles

What is Aboriginal alcohol and drug work?

OVERVIEW

Aboriginal alcohol and drug issues can crop up in many different settings and with people of any age. Some people work face-to-face with clients. Others work with communities to help prevent alcohol, drug and other problems from happening in the first place, or in policy or as advocates. So a wide range of professionals need to be comfortable to identify alcohol and drug issues and to help clients, their families and sometimes whole communities to address these. This section considers some of the key parts of what makes up Aboriginal alcohol and drug work.

TEAMWORK

To pick up problems, we work together with general health workers, general practitioners (GPs), corrections and sexual health officers, mental health workers and others. To prevent problems from happening, we work with whole communities, sport and recreation officers, art groups, elders and others who can help keep communities and young people strong. If a client is hooked on a particular substance (dependent), we might work with different services to get them the best help, or to reduce the harm if they cannot or will not stop using. As workers we need to know when and how to seek assistance from other services.

CONFIDENTIALITY

Confidentiality is an essential part of the relationship between any health professional and a client. It is very important that both the worker and the service are very careful about confidentiality in every part of the day's work. Fear of having their problems spoken about in the community can turn a person off seeking help. The client needs to know that you will never share their story with a family member without their permission. There are small ways that a person's story can accidentally be released. For example, if a worker phones a client's house and says, "Can you ask Tom to call me back? This is John from the drug treatment unit", then Tom's family will instantly guess that he has a drug problem. It is important to not accidentally release information about a person's alcohol or drug use without their consent.

STRONG RELATIONSHIPS

Building and maintaining strong relationships with clients, their family, whole communities and related agencies is central to doing this work well. This can happen in both formal (e.g. in case management meetings) as well as more informal settings (e.g. community events, cultural days, youth week). We need to listen and take things in and remember what we have been taught (professionally and culturally), so we can walk alongside our clients and help them develop the skills to make a better life. For example, rather than asking lots of questions, sometimes it may be more appropriate to listen to stories and to let the answers slowly unfold. These strong relationships are important so we can make sure clients have the skills they need to solve their own problems, as they are the only ones who can do it in the end. This means not doing everything for the client, but instead trying to empower and educate clients so they have the tools to make positive changes in their own lives.

KNOWING THE SCOPE OF THE ROLE

In different settings, alcohol and drug workers may have very different roles and responsibilities (e.g. outreach, counselling, linking clients with other health professionals, acting as advocates and informing policy). It is important to be aware of what your unit's policy allows you to do, and, if the policy seems wrong, to talk with your manager to see if it can be changed.

KEEPING SAFE

Ensuring your own safety and the safety of your client and those around is always a key issue. This is particularly important when doing outreach work, when you may have little support (see Aggressive clients, p. 399). It is important for a worker to be aware of their own limitations (see Looking after yourself, p. 416) and the policies of their workplace. Knowing when to seek help or to refer on is a critical skill. A range of opportunities is available to help you constantly update and refine your skills (see Keeping up your skills, p. 406).

Why people become dependent on alcohol or drugs

OVERVIEW

When people start taking drugs (including alcohol and tobacco) they do so because of the pleasure they get from using them. When they get unwanted effects from drug use (e.g. getting into fights while intoxicated, accidents, panic attacks or psychosis, or unwanted pregnancy), people who are not hooked (dependent) can usually learn from the experience and change their behaviour to reduce the chance of something like that happening again. However, for people who are dependent, it can be very hard to stop using. They feel a strong desire to use (cravings) even though they know this is harming their body, their mental wellbeing or their family and community. Continued use can be distressing to the client, their family, and the broader community. In this section we look at why people get dependent on drugs, and what are the factors that put a person at risk of becoming dependent.

WHO DEVELOPS DEPENDENCE AND WHO IS AT RISK?

No one is free from the risk of becoming dependent on drugs – rich or poor, happy or sad, black or white. But some people have a higher chance of becoming dependent than others. This might be because of illness, family history, where they live, their life experiences and their opportunities. On the other hand, there are many other factors that can help protect us from becoming dependent.

Factors that increase or reduce a person's risk of developing a drug problem

Things that put us at risk

- Family history (30–50% is probably genes)
- Mental illness as a child or as an adult
- Separation or major trauma as a child or as an adult, grief and loss
- Living in a disadvantaged area. This may go along with neighbourhoods with disruption, crime, limited opportunities, higher unemployment and readily available alcohol or drugs
- How early a person starts using drugs (the earlier the start, the greater the risk of developing problems)
- Risk taking – people who enjoy risks (including young men) are more at risk

Things that protect us

- Growing up in a happy, connected and loving family
- Feeling connected to some 'community' (e.g. through school, sport, arts, culture, religion)
- Having alternatives to drug use (e.g. jobs, opportunities, something to do)
- Friends who do not use drugs (or do not use a lot)

Some people are more at risk of dependence because of their genes (their 'make-up')

The way our brain is made up is strongly influenced by the genes we inherit from our parents, and also how healthy our mother was while she was carrying us. This affects the way our brains respond to different drugs. For example, some people really like the feeling of alcohol intoxication, while others do not like it at all, and some feel sleepy when they drink. People with ADHD may feel calmer with stimulant drugs and so keep using drugs like cocaine and speed and go on to develop problems. For other people, some drugs might make them feel terrible so they are unlikely to use them again (e.g. some people feel very paranoid when they use even a small amount of cannabis).

It is not just brain differences that affect whether or not a person will like a drug, it can also be the way our body breaks down the drug. For example, some people from Japan and China do not have an enzyme that helps break down alcohol so they get very sick when they drink. It acts exactly the same as Antabuse tablets (see Antabuse, p. 99). These people are very unlikely to develop alcohol dependence.

Mental illness

People with mental illness usually have higher rates of drug dependence, are more sensitive to the unwanted effects of drugs, find it harder to stop, and experience more problems (e.g. higher rates of violence, suicide, hep C, HIV, and being sent to prison). They may use substances to relieve distress from their mental illness, or in the case of bipolar disorder (manic depressive disorder), people may use drugs because they are more likely to take risks.

Dependence on one drug can lead to dependence on another

Sometimes a person uses one drug to relieve the withdrawals of another. This can lead to problems; for example:

- A person uses alcohol to help 'come down' after a methamphetamine binge and then develops a problem with alcohol.
- A person uses cannabis to replace alcohol when stopping drinking, but then becomes dependent on cannabis.

Some drugs are more addictive than others

In general, drugs that come on quickly (quick onset of effect) are more addictive. That is because when a person uses, they get an almost immediate 'reward' for their behaviour. This encourages them to go back for more.

How the drug is taken (route of use) is also very important

Smoking and injecting delivers the drug to the brain most quickly and most dangerously. People who smoke or inject drugs are also more likely to become dependent because the effect of the drugs comes on after five seconds (with smoking or injecting). In contrast, when drinking or swallowing a drug, it can take 30 minutes for it to have an effect.

As well as the speed of onset, the bigger and more intense 'high' or 'buzz' that a person gets from using a drug will also increase the chance of them becoming dependent. That is why more people get dependent on smoking ice (crystal methamphetamine; about 1 in every 4 users) compared with smoking cannabis (about 1 in every 10 users).

The shorter the drug lasts the shorter the withdrawal, but the more severe it will be. So a heroin withdrawal is shorter and more severe than a methadone withdrawal.

THE PLEASURE/REWARD PATHWAY IN THE BRAIN

Drugs that cause dependence do so because they 'hijack' our brain reward pathway. The reward pathway is the part of our brain that makes sure that the most important things for our survival are given the most attention. It is located deep in the brain (see Reward centre, p. 196). Our brain makes those essential things more rewarding than other things. Rewarding means that the experience gives you pleasure and makes you want to do it again (e.g. drinking water, eating food or having sex).

Everything in life that gives us pleasure and that we want to do again and again causes release of a chemical called dopamine in the reward centre of our brain. So exercise (in a fit person), music or feelings of love can all release dopamine. Alcohol or drugs (including tobacco) can all powerfully cause our reward pathway to release dopamine.

So, dopamine is a 'feel good' chemical, and makes a person want to repeat a behaviour. The problem is that, with continued use, drugs hijack the reward pathway. The desire to use alcohol or other drugs can then become even stronger than the desire to eat, or to care of yourself or family. After years of dependent use, our brain's wiring may change so that it is harder to get pleasure from things not related to drugs.

How chemicals transmit messages between nerve cells in our brain

The nerves in our brain and other parts of our body function like insulated electrical wiring (see Nerve cell, p. 197). They carry signals or messages from one part of the body to another. When a signal comes to the end of one nerve cell, it has to cross the gap (or synapse) to reach the next cell. The nerve cells use chemicals like dopamine ('neurotransmitters') to send the message across the gap. Once that neurotransmitter reaches its matching receptor on the next nerve cell, it activates the receptor like turning the key in a lock. This triggers a signal to be sent along that nerve. Nerves in the reward centre link to other parts of the brain, and so the reward of drugs can drive our behaviour.

TOLERANCE AND WITHDRAWAL

It usually takes months and even years to develop dependence. As a person continues to use, they need to use more of the drug to get the same effect (develop tolerance). Moreover, if they do not use the drug, they get sick and experience withdrawal. So while the person might start out taking a drug to make them feel good, in time they may need it to live normally.

What happens in the brain in dependence?

When a person uses alcohol or another drug again and again, it starts to have less effect, and they have to use more. This is because the brain tries to adapt so that it can function normally, even in the presence of the drug. So, for example, when a person first drinks alcohol, they may feel drunk after two cans of beer. But if they keep drinking regularly, and drink greater and greater amounts, they may not feel drunk even when they drink a case of beer. This is called tolerance.

Tolerance happens because the brain adapts its natural chemistry to help it to cope with the drug. So the first time someone drinks, if they drink enough, the alcohol makes them very sleepy (even unconscious). If they drink a large amount often, the brain fights back, so that it can keep awake, even when the person drinks a lot. The brain does this by increasing its natural stimulation to balance out the sleep making (sedating) effect of alcohol (see Tolerance, p. 198). The trouble is that, when the person stops drinking (perhaps because of the harms that alcohol is causing), they are left with far too much natural stimulation (e.g. they cannot sleep, feel edgy, cannot sit still and may even have seizures).

So as well as the person being drawn back to drug use by the reward of using, a dependent drinker or drug user is 'punished' by withdrawal if they stop. They know that using the substance will instantly relieve the withdrawal, and this increases their desire for it (craving).

HOW CAN PEOPLE COPE WITH AN INCREASED RISK OF DEVELOPING ALCOHOL OR DRUG PROBLEMS?

No one is immune from becoming dependent on drugs and so we all need to take care. Some people have a higher chance of developing alcohol or drug problems because of past traumas, their make-up or because there are many people using alcohol or drugs in their area. However, we can help support individuals, families and communities to break the cycle of alcohol and drug use and trauma:

- Strengthening family, community and culture can help reduce a person's chance of developing an alcohol and drug problem.
- If an alcohol or drug problem does start, as workers we play an important role in helping the person think about change and to support this process.
- We know that treatment can be effective and there are more treatments being researched and developed, based on our understanding of how the brain changes in dependence.

What type of drug is it?

OVERVIEW

Each drug can be grouped into three main categories: 'downers' (sedatives or depressants), 'uppers' (stimulants') and 'sideways'. Sedatives (or depressants) such as alcohol, benzos or heroin typically slow a person down, make them feel calmer, and may make them sleep better. But sedatives also carry the risk of slowing a person down so much that (in overdose) their breathing slows down or stops. Stimulants such as ice or cocaine make a person feel more lively and awake. Other drugs such as cannabis or LSD change the way a person sees or experiences the world.

Where each drug fits into these three categories is shown below:

'Downers'

- Alcohol
- Sleeping tablets (benzos)
- Heroin and other opioids
- Kava
- Inhalants
- Some designer drugs like GHB

'Uppers'

- Amphetamines
- Ecstasy
- Cocaine
- Nicotine

'Sideways'

- Cannabis
- LSD and 'magic mushrooms'

For most addictive drugs, the withdrawal is the opposite of feeling intoxicated. So, for a sedative, the withdrawal involves trouble sleeping and feeling anxious, while for a stimulant the 'crash' or withdrawal can involve having no energy or feeling 'down'. The details on each drug are covered in the specific chapters.

To find out about new drugs, see www.easyread.drugabuse.gov/drugs-of-abuse.php.

Assessment

It is important to understand your client's alcohol or drug use well if you are to engage them in making change. It is also important to look after the client's safety; for example, when they are intoxicated or going through withdrawal. In this section we look at the general principles of how to take an alcohol or drug history. In the chapters that follow, there is more detail about how to take a history for different substance types.

YOUR APPROACH IN ASSESSING THE CLIENT

When assessing your client you are doing a number of important things:

- Listening well and showing you care (empathy)
- Gathering information that will help you and the client choose a safe and effective approach to tackle the issues
- Helping the client become more aware of the problems that substance use is causing them, and to become more motivated to change.

How you do the assessment will depend on your setting. However, wherever you are, often an assessment works best if you first spend some time talking with the client so they can feel more relaxed. After getting a feel for what is going on and for the client's main concerns, you then usually need to ask some specific questions.

If you can, avoid writing at first, so the client can see that you are really listening. They will often use slang words to describe all the experiences around illegal drug use. If you are not sure what the client means, they are usually happy to explain.

Asking about your client's alcohol and drug use in a remote setting

If you are not from the local culture, get advice from a local health worker on the best way to take an alcohol or drug history. In more traditional areas, it may be best to avoid direct questions at first. A 'yarning' approach can work better. Instead of questions, you can sometimes suggest two alternative scenarios: "Some people get the shakes when they stop drinking; some people are fine. What is it like when you stop?"

! Confidentiality

It is important to be clear and open with the client at the beginning about what you can and cannot promise in terms of confidentiality. So, for example, you can reassure them that you will not talk to anyone about their story without their permission. However, you can tell the client that you have certain obligations by law. So if you have concerns about the safety of children, or if the client tells you he is about to go and commit a serious crime, then you have no choice – you have to report this.

What is the problem right now?

Why has the client come for help right now? Was it a health problem that triggered them coming? Or pressure, for example, from their family, community or the courts?

The alcohol and drug use history

Find out about the client's main drug of concern:

- How much they use each time (e.g. number of drinks, 'hits', cones, tablets, money spent each day)
- How often they use it (e.g. every day, on certain days)
- How they use it (e.g. eat or drink, smoke, snort, inject)
- Get a picture of their use (including who they use with) as this can help you see ways to help them tackle the problem.

Is the client dependent on that substance?

Not everyone who is having troubles with a drug is dependent on it. For example, a person may use ice once a fortnight, and have some problems from it, but still keep using by choice. However, some other people want to stop using but cannot. You need to be clear on whether or not the person is hooked (dependent) on the drug they are using.

If a person has come to ask you for help to stop, most often they feel they cannot control their drug use on their own. Loss of control is one key feature of dependence. Withdrawal is another feature of dependence (though not all dependent users experience withdrawal).

When is a person dependent on a drug?

People who are dependent on a drug usually have at least three of the following features:

- *A strong desire to use (craving) or need to use (compulsion)*
- *Hard to control use:* They may have tried to cut down but failed. Or you can ask: "How easy would it be to stop?"
- *Withdrawal:*
  - Ask: "What happens if you stop or run out? Do you become unwell or is it uncomfortable? Do you have any problems with your sleep?"
  - Or if the person has never stopped, ask: "What are you like when you are nearly ready for your next drink or 'hit'?"
  - Try to understand the nature of any withdrawals, as it will be important in helping the client find a safe way to stop.
  - For most drugs the withdrawal is the opposite of the effect of intoxication. So if a drug like alcohol or benzos makes you sleepy, then in withdrawal you will have trouble sleeping. If a drug like heroin relieves pain, then you are likely to experience pain in withdrawal.
- *The person needs more of the drug just to feel its effects (tolerance):* Can the person walk and talk normally after using a large amount? How much does your client need to drink get the effect they are after? Did they always need that much?
- *The drug becomes 'number one':* Is the client still doing other activities they used to do (e.g. work, or spending time with family and friends), or have these things become less common or been given up because of their alcohol or drug use? Ask the client to describe their typical day, and see if most of their time is spent on the drug.
- *Continued use in the face of clear harms.*

What are the chief problems the drug is causing? (e.g. to their body, mental health, family or community).

Overview of a client's lifetime substance use

- What age did they start using?
- How much of their life has been spent using their main substance(s), and how many years have they been 'dry' or 'clean'?
- What are the major harms that the drug has caused (e.g. to physical health, mental health, family and community)?
- Past treatment or approaches to stopping. In the past, has your client managed to stop? If so, what worked for them to achieve this and what did not work? This information will help in making a treatment plan.

Consider local culture and views on causes of sickness

In some communities, traditional beliefs may lead people to think that sicknesses are not caused by alcohol or drug use but happen because of sorcery and black magic.

How ready is your client to change right now?

There are pictures available to help you and your client think about how ready they are to change (see Stages of change, p. 199 and p. 423).

Other drug use

It is important to also ask the client about their other drug use. By the end of the assessment you should know about their use of:

- Alcohol
- Tobacco
- Cannabis
- Heroin and other opioids (e.g. Oxycontin, codeine or other strong pain killers, methadone)
- Stimulants (e.g. 'ice' or 'speed', cocaine, ecstasy)
- Use of other prescribed medicines that might be addictive (e.g. benzos like Diazepam, Serepax, Xanax)
- Any other substance use (e.g. petrol, paint, kava or newer 'party drugs').

General health and other issues

Are there major issues going on at present that will impact on their substance use, or that their substance use will affect (e.g. physical, mental health, family, community, cultural or legal issues)?

- Do they have a major health condition such as diabetes, asthma, heart disease, kidney failure?
- When did they last have a medical check-up? (e.g. for liver disease related to alcohol or injecting drug use; for high blood pressure related to alcohol; or for blood-borne viruses for injecting drug users)
- For injecting drug users: When did they last have tests for hep C, hep B, HIV and liver enzymes; and have they had a sexual health test recently?

Seeking extra information from family or others

Some people who use alcohol or drugs may be ashamed to tell the full story about their substance use. They might also be worried about getting into trouble with the law or child protection agencies. You can try to make the person feel comfortable, and they will see by your behaviour that you are not judging them and that you are not shocked by what they tell you.

If the client agrees, it is helpful to talk with a family member to ask them a bit more about the situation. You can also see if the family needs any support. Family may also be able to support your client to make a change.

Your observations

What you observe tells you some more about your client's substance use. Is your client:

- Intoxicated
  - Slurred speech, unsteady (e.g. from alcohol or benzo use), smells of alcohol or petrol
  - Restless, agitated, is talking fast (e.g. from stimulant use)
- In withdrawals
  - Restless, tremor, sweaty palms (e.g. from alcohol or benzo withdrawal)
  - Slowed up, tired, looks depressed (e.g. from amphetamine withdrawal)
- Showing signs of damage from substance use
  - For example, liver damage from alcohol misuse or viral hepatitis (yellow 'whites' of the eyes, swollen legs or belly, many bruises)
- Experiencing other urgent medical problems
  - For example, confusion or seeing things that are not there
- Experiencing mental health problems
  - For example, anxiety, depression, or suicidal thinking.

If you are trained to do a physical examination, check for the harms of long-term alcohol use, or the harms of injecting drug use, such as:

- Enlarged liver
- Raised blood pressure (heavy drinker or alcohol withdrawal or from stimulant use)
- Raised pulse or temperature (as in alcohol withdrawal or from stimulant use)
- Signs of needle use.

Summing up after your assessment

After assessing a client you should be able to sum up:

- Whether their substance use is:
  - Likely to give them problems in the future (risky or hazardous)
  - Already causing significant harms (harmful) or
  - Dependent, and if so, whether they need withdrawal management
- The sorts of help they have tried in the past
- Other key health issues (physical and mental)
- Other key family, community or cultural issues that is relevant to their drinking.

Overviews of ways to help

After your assessment you will be better able to help the client choose the treatment that is right for them. For most alcohol or drug problems, these are the key steps in treatment.

ENGAGING THE CLIENT

This might be just brief intervention if the problem is less severe (see p. 19); but, for a person with dependence on a drug, it may be trying to build the client's motivation to change, and linking them into further treatment. Elements of motivational interviewing can also be used to help the client weigh up the good and the not-so-good things about their substance use (see Counselling, p. 24).

MANAGING ANY WITHDRAWAL

- If the client is likely to experience a withdrawal, do they need specific treatment?
  - Alcohol and benzo withdrawal can be potentially life threatening, so a careful assessment of how severe a withdrawal may be is important (see Alcohol, p. 86; Benzos, p. 179). You will need to link the client with a doctor if medicines are needed.
  - Some withdrawals are unpleasant but not usually life threatening (e.g. heroin, cannabis, amphetamine withdrawal).
- Whatever substance the client is detoxing from, you can help them work out where is the best place for them to go through withdrawal. Some people cannot get to the point of stopping while living at home, because there are people around them using. You may be able to help them find a safe house with relatives, or they may feel a detox unit is best for them, where they will have professional support.

HELPING THE PERSON STAY DRY OR CLEAN (ABSTINENT)

Detox is an important step in getting on top of an alcohol or drug problem, but staying dry or clean is a bigger challenge. Once the client is safely detoxed, they should be offered support to help them stay abstinent. This can include:

- Counselling (see Counselling, p. 20)
- Group support (see Mutual support groups, p. 54)
- Some clients find that they relapse back to alcohol or drug use when they try to go straight from detox back to the community. They may prefer or need to go to rehab (see Resi rehab, p. 58).
- Medicines to prevent relapse: for alcohol, benzos and heroin (and other opioids), get advice from a doctor to see if there is a role for medicines to help prevent relapse (see Role of medicines, p. 50).

HELPING THE CLIENT GET TREATMENT FOR ANY PHYSICAL OR MENTAL HEALTH PROBLEMS

The client may have complications from their substance use (e.g. alcohol-related or viral liver disease). Or the client may have other medical or mental health conditions (comorbid), which could be made worse by their substance use. You can support the client to link with a doctor for treatment of these conditions.

REDUCING THE HARMS OF SUBSTANCE USE IF THE PERSON CANNOT OR WILL NOT STOP

Even if a person cannot change their alcohol or drug use, or does not want to change, there are things we can do to improve their health, and to reduce the impact of their substance use on those around them. This may include simple measures like encouraging thiamine to reduce the chance of alcohol-related brain damage, or encouraging the client to organise childcare if they are planning to drink or use a drug.

Getting a person thinking about their substance use (brief intervention)

Sometimes you may see a person in a general hospital or clinic or out in the community, and that person may not be aware they have an alcohol or drug use problem. Or they may know they have a problem, but are not yet ready for change. If you have a conversation with a person about their substance use, this can give them a chance to step back and think about whether they would like to change their use. This sort of short conversation about alcohol or drug use is often known as 'brief intervention'.

The steps of a brief conversation around substance use (brief intervention) can be summarised by the word 'FLAGS'

F	*Feedback*	Listening to the client's story, and reflecting back with them, on what harms alcohol or drug use might be causing.
L	*Listen*	What stage of change are they at?
A	*Advise/assist*	Share information that you have which might help your client make a decision about their substance use.
G	*Goals*	What goals is your client prepared to accept? Cutting down? Stopping? Having someone care for the kids when they are using?
S	*Strategy*	Help your client identify steps or strategies to reach this goal. Is further support or treatment needed?

More information on how to do a brief intervention is on p. 82.

Counselling

OVERVIEW

In alcohol and drug work we can help people tackle their own alcohol or drug use, and we can help family members cope with someone's use and to support that person to change. How much counselling and the type of counselling you give will depend on where you work, how much contact you have with the client, your training and skills, and what other services are available.

There are some straightforward counselling approaches that many workers can do. These include helping to build motivation, and helping a client to reflect on their own thinking and behaviour, and to make choices and changes about their substance use. There are more complex forms of counselling that can be effective but are best provided by a specifically trained counsellor or psychologist (for example, in-depth counselling for major past trauma).

This chapter talks about the range of counselling approaches available. Some parts have been adapted from the Strong Spirit Strong Mind resources with the permission of the WA Drug and Alcohol Office. Other parts have been written specifically for this book.

HOW YOU APPROACH COUNSELLING

There are more complex forms of counselling that can be effective but are best provided by a specifically trained counsellor or psychologist (for example, in-depth counselling for major past trauma).

They way you do counselling is just as important as what you talk about in it.
Here are some tips:

- Stand in the client's shoes – get a feel for what is important to them, and what is concerning them (empathy)
- Respect the client's right to choose if they use alcohol or other drugs
- Never be judgemental
- Listen well
- Most often you will help the client to reflect, think and decide, and not tell them what to do
- It is vital that the client has a sense of owning any goals, and of owning any plan to change.

Some of the skills of counselling involve working out:

- How do you, as a counsellor, manage your own feelings?
- How do you find empathy and understanding for the client without necessarily agreeing with them?
- How do you understand your client's world and their point of view?
- How do you work with clients who are not easy to get along with?

Clinical support and supervision are very important to keep improving your skills in ways of working with clients (see Looking after yourself, p. 418).

Remember the 'circle of change'

When working with clients it is important to remember:

- Everyone is different in how ready they are to change, and in how long it may take them to become ready.
- People may move between trying to change, becoming dry or clean, then relapsing back to use. People may move back and forth through this cycle many times before they finally become free of the drug (see Stages of change, pp. 199 and 423).
- You need to listen well and be aware of where your client is up to now, in their change process. Adjust your approach to fit this. Also remind them that change can be a cycle. This can encourage them to keep trying (or to try again).

It does not matter how ready to change the client is, there will be something you can do to try to help them to get a better life (or keep life good).

Trying to change thinking as well as behaviour

Most counselling in some way focuses on helping people to understand their behaviour, thinking and feelings around substance use and related issues. It also supports the person to try different ways to change behaviour and the thinking and feelings that go with it. It often builds strengths and gives clients a sense of empowerment.

WORKING WITH A PERSON WHO IS STILL USING ALCOHOL OR DRUGS

Sometimes a person may be happy with their substance use, or they are thinking about or planning change. Perhaps the client has never tried to change before, or perhaps the client has had good periods, but has relapsed back to use.

Assessment as a way to help bring about change

Doing a careful assessment, and showing that you care, can be the first step to helping a client (see Assessment, p. 11). In your assessment you will find out about the harms and risks for your client from:

- Getting a supply of alcohol or drugs to use (e.g. from a bottle shop or dealer)
- Using
- Running out of alcohol or drugs (withdrawal).

While the client is talking, they get a chance to think about the not-so-good parts of their substance use.

Trying to engage the person with the idea of change

How you talk with a person about their substance use will depend on how much they have already thought about change:

- The person may not see that any trouble happens from their alcohol or drug use.
- The person may see lots of trouble from their substance use but believe there is nothing that they can do to change things.
- The person may believe that the good bits about drinking or drug use outweigh the harms, and they will lose too much from changing (e.g. lose drinking friends).

Even a short conversation on their substance use may help them start thinking about change.

The section on brief intervention (p. 19) talks about how you can handle this conversation.

! *Note:* you may disagree with your client's choices. It is important to tell them if you believe their decision is risky or harmful to them (or their family or community). However, in the end the decision is theirs.

Working with someone who is prepared to think about change

It may be that in your conversation about drinking, you find the client is prepared to talk more with you about their alcohol or drug use, either that day or on another day. Counselling can help support the client to move towards making decisions about their substance use.

You can help the client build motivation, understanding, strengths and confidence to change their alcohol or drug use, for example:

- A person may be not happy with their drinking or drug use, but has not yet decided to do anything about it.
- A person may want to change but is not sure that they can get on top of their alcohol or drug use.
- A person may be actively preparing to make a change in their substance use.

Sometimes people have mixed feelings about their alcohol or drug use, for example:

- They enjoy it, find that it takes away painful feelings or gives them something to share with friends or family.
- They experience some not-so-good things from using, e.g. problems with family, community, health, Aboriginal Law, legal issues, work and money, grief and loss, and country and cultural responsibilities (these are described by the seven 'Ls' in Strong Spirit Strong Mind training).

They may still be undecided about their alcohol and other drug use. This can be an uncomfortable feeling. Sometimes it can feel so stressful that it stops the person from being able to make any change – and they remain stuck.

A range of approaches can be used to help a person move towards making a decision to change or to change successfully. These include:

- Building motivation
- Assessing whether the client believes they can make change, showing them the strengths they have and empowering them to believe in themselves
- Checking that the client is aware of the support or treatment that may help them manage any withdrawal and then stay dry
- Helping the client to clarify their problems and set goals. This can include identifying any fear the client has about change, and barriers to change. You can explore how they can still maintain their social and cultural obligations whilst cutting down or stopping.
- Helping the client to identify their support network (you can map this on paper or on a story-telling board).

BUILDING A CLIENT'S MOTIVATION (MOTIVATIONAL INTERVIEWING)

Because clients often feel in 'two minds' about their alcohol or drug use, try to help them weigh up the good and not-so-good things about their use so they can make a decision about whether they want to cut down or stop. This approach is known as 'motivational interviewing'. This can help them decide whether they want to make changes.

Start by asking the client to list the good things and then the not-so-good things for:

- Themselves (body, and mental, emotional and spiritual wellbeing)
- Their family
- Their community.

Ways to approach motivational interviewing

There are six basic principles:

1 Express empathy

- Hear what the client is saying (this does not mean you approve of their behaviour or agree with their choices) but helps to build rapport.
- Listen respectfully even if you disagree; do not be judgemental.
- Reflect back what the client has been saying to show that you understand.
- Summarise the client's story to make sure you have the facts.

2 Work with the client's discomfort about being in two minds

- Clients are often in two minds about their alcohol and/or other drug use.
- They are more likely to change their behaviour when they present their own reasons for changing without feeling pressured.
- The reason to change needs to be meaningful to them.
- Track the good and not-so-good things about their alcohol or drug use.
- Get the client to think about how they would like to be and how they are currently behaving.
- Remember even small changes in attitude are a positive outcome and need to be acknowledged.

3 Avoid arguments

- Do not argue with your client as it will create barriers and undermine your relationship with them. Angry clients are unlikely to hear what you are saying.
- If you find yourself arguing with the client, then it is time to change direction or shift attention to something else.

4 Work with resistance

Resistance is common and can take many forms including: arguing, interrupting, denying, ignoring, self-harm, and acting aggressively towards staff members and not showing up for appointments. There is usually a reason for the resistance. Your job is to understand the reason and assist clients to overcome it. Some strategies that are useful in working with resistance include:

- Review the client's story.
- Change track.
- Review the good and not-so-good things.
- Ask about and support their preferred choices.
- Empower the client to believe they can do it and support them to do so.

5 Support the client's belief that they can complete a task or meet a challenge (self-effectiveness)

- Encourage clients to take personal responsibility for making a change.
- Encourage clients to talk and think positively about themselves (positive self-talk).
- Set realistic short-term goals and focus on the client's achievements.
- Acknowledge successes like cutting down or not giving in to cravings.

6 View life as a whole (holistically)

Any change in one area of life will impact on other areas of life. Any changes in their alcohol or drug use will impact on their relationships with family and community.

Adapted from Strong Spirit Strong Mind

In helping a client weigh up the good and the not-so-good things about their substance use:

- Have accurate information about the harms and risks related to their use. Pictures or visual aids can help with this. But if this does not quickly build their motivation, then move on. Counselling is not about hammering a client with facts. It is about encouraging a person to reflect and think.
- Identify how cutting down or stopping will have positive effects on the client's physical, psychological, emotional and spiritual wellbeing; this may include better relationships with family, friends and community.

Using visual aids when talking with your client

Many workers use visual aids to help them in their counselling work. Choose what resources, if any, suit your setting, your style and each client. Several visual aids are available and simple pen and paper can be helpful. You can use:

- Pictures to help a client work out what harms alcohol or drugs might be causing (to the person, their family and community) or to see how life would be better after tackling substance use.
- Draw on a piece of paper to help map-out the good and not-so-good things about your client's alcohol or drug use. For example, you can map-out the drinkers who the client likes spending time with, the people (including children) who might experience harms from the client's drinking, and the people (like an aunty or uncle) who might be concerned about the client's drinking. This mapping process can help give a clearer picture in the client's mind (and in yours) about what's going on, and about their reasons to change. A 'story-telling board' (from Strong Spirit Strong Mind training) is used in this way too.
- Use pen and paper (or a story-telling board) to help the client make a map of the people who might be able to support them to change, and the people who might make them feel like drinking or using drugs.

SUPPORTING CHANGE

You have an important role in making change easier and supporting the change process. For example, you may be able to:

- Help the client to identify appropriate treatment supports, including medicine or help for managing withdrawal symptoms)
- Help your client to develop an action plan for making changes
- Start planning for relapse prevention: help your client identify high-risk situations/ triggers and develop a plan to cope with these, and to cope with cravings.
- Link clients to other services if they have other needs, e.g. finding suitable housing, a court case coming up, or child protection issues (see Case management, p. 44).

WORKING WITH A CLIENT WHO HAS MANAGED TO CHANGE

If your client has successfully changed their alcohol or drug use, you have an important role in helping them maintain that change. For example, you can:

- Acknowledge and encourage positive thinking and positive behaviours:
  - Acknowledge their decision to change by identifying positive outcomes (such as better emotional, spiritual and mental health, better physical health, better relationships with family and community).
  - Acknowledge and identify ways to avoid substance use that have worked well for the person. For example, encourage behaviours that the person is using as alternatives to alcohol or drug use (e.g. exercise, music, seeking support).
- Identify and manage high-risk situations, help plan approaches to cope with cravings and to manage any lapses (slip ups).
- Encourage the client to accept ongoing support from family, friends and community, and from you.
- Try to be sure that all parts of treatment and help are pulling together:
  - e.g. Support your client with the treatment they are receiving, and link them in with a mental health team or other services as needed.

RELAPSE PREVENTION

Things that can lead to relapse are different from person to person, and may be beyond the control of the person:

- Stressful events, e.g. funerals
- Strong emotions – both good and bad
- Arguments and conflict
- Pressure from family and friends
- Using other drugs
- Being reminded of their drug use.

Things that help prevent relapse include:

- Understanding yourself (sometimes called mindfulness)
- Learning to cope with cravings and urges to use again
- Learning to be aware of and how to cope in high-risk situations and triggers
- Lapse/relapse management skills: what to do if a slip-up occurs
- Sorting out lifestyle issues and coming up with new living skills.

Coping with cravings

Cravings are a normal part of cutting down alcohol or drug use. In time, cravings will reduce, and become less intense and less frequent if they are not reinforced by using.

! The 3Ds approach can help clients manage cravings

- *Delay:* delay the decision to use – the urge will pass.
- *Distract:* distract from thoughts of using – help the client create a list of alternative behaviours. The intensity of the craving will reduce if the client's attention is focused on another activity.
- *Decide:* review the reasons for deciding to stop or reduce use.

Identifying and tracking high-risk situations and triggers

A high-risk situation is one that challenges a person's sense of control and increases the risk of relapse. A trigger is a reminder or cue that may lead the client to consider engaging in the substance use that they are trying to avoid. Triggers can be physical things like walking past a pub, smelling cannabis or getting dehydrated. Sometime triggers are things like feeling down, having an argument or feeling really happy. Triggers are specific to the client, and can be anything that increases the possibility of a lapse.

The first step in developing a relapse prevention plan is to help the client identify the high-risk situations and triggers. To do this it is useful to get the client to keep a record, and then explore this in a session to identify risk situations and triggers and their consequences. It is also really useful to explore situations where the client encountered a high-risk situation or trigger but had a positive outcome. This can help identify coping strategies. Pen and paper or the story-telling board can help the client to map-out the high-risk situations in their community.

Tips to identify high-risk situations and triggers

- Explore with the client the social setting – where they were, who were they with, what they were doing.
- Ask what they were thinking when the lapse occurred.
- Ask about their mood and feelings and their physical state.

- What did they do? What was the outcome? More regular client contact may allow regular review of the plan and a reflection of events, and a safe family mentor/friend support may assist this process.

Dealing with high-risk situations and triggers

In the initial stages the client may benefit most by avoiding high-risk situations. This is sometimes difficult for our people who are expected to maintain family, social and cultural obligations. Some Aboriginal people also experience overwhelming pressure from their family/friends to have a drink. Therefore it is important to assist the client to:

- Connect with safe family/friend support systems so the client can maintain their sense of belonging to their people
- Think about times when they can be with their family without the pressure to use. For example, if a client wants to avoid drinking, maybe it would be better not to visit family members who drink on their payday, as there may be a lot of grog about. Visit another day.

While initially avoiding high-risk situations may be a useful strategy, over time this may need to be replaced by a range of skills and coping strategies. The client can confidently use these approaches when high-risk situations and triggers emerge. These skills can be identified, learned and rehearsed during sessions with their AOD worker as well as practised by the client in their own environment.

Working with the client to develop coping strategies

- Be specific about the high risk situation or trigger: a coping strategy that works well in one situation may not be useful in another.
- Have the client identify why that situation is risky for them.
- Brainstorm with the client to generate a coping strategy or number of coping strategies.
- Identify other family, friends or community members who can help the client manage the situation and keep them safe.
- If the risk situation or trigger occurs, try out the strategy – if it works, use it again; if it does not work, explore what went wrong and think about a new coping strategy.

Adapted from Strong Spirit Strong Mind

WORKING WITH CLIENTS WHO HAVE HAD A LAPSE OR RELAPSE

Relapse can happen at any stage. In the circle of change this is sometimes called an 'oops' moment. People can have a little slip and then get back on track without too many difficulties. For others, they may return to using at their old patterns and levels.

People may relapse many times before they finally stay changed. Clients can learn from their relapse and this can help them find new ways to stay changed. Help your client:

- Understand that a lapse is normal and does not mean they have failed
- Be aware that they may feel shame about the lapse
- Try to identify any high risk situations or triggers that led to the lapse
- Develop relapse prevention strategies to keep them safe next time
- Strengthen their motivation and remind them of the positive reasons they wanted to change
- Strengthen confidence and increase their sense of effectiveness
- Acknowledge and build on past successes
- Prepare for what to do if they have a slip or lapse again (e.g. seek help early)
- Address other lifestyle issues (e.g. try to make themselves stronger, healthier and happier in all parts of their life).

Lapse versus Relapse

- A lapse means your client has had an 'oops' moment in their plan to cut down or stop using. They then get back on track.
- A relapse is a return to old patterns of use that leads the client to give up trying to not use (abstain) or cut down their use.

Understanding cultural aspects of a situation

This can be an issue in any setting, but more so in traditional settings. If your client has grown up with different cultural values than you, you may need to get help from a knowledgeable local person to understand the meaning of a situation. Aboriginal people can travel around a lot, so you can also get help from their local medical service.

PLANNING WHAT YOU WILL COVER IN COUNSELLING SESSIONS

If you offer counselling you should be clear on what you want to achieve through counselling, and how you will try to achieve it. Develop a counselling plan that meshes with the client's plan and gives a focus to each session. If, further down the track, the client and you agree to vary the client's plan, you should both follow this new way forward.

Alcohol and drug use will always be a key focus of the plan; but the counselling plan will always attend to other issues – for example, what the client also wants to address. Other common issues that might be part of a counselling plan include working on:

- Mental health comorbidities; for example, mood (including depression and anxiety)
- Relationships and communication – helping communicate where they are up to with the people around them, in a way that is more productive for everyone
- Employment, education, other activities.

Your counselling may also involve helping the client develop new skills e.g. goal setting, planning, problem solving, managing anger and other strong emotions.

Engaging the client in planning and reviewing how counselling is going

Throughout the counselling process, the client should be engaged in reflecting on their thoughts and behaviour, and in trying to change these where necessary. Review points are important. For example, have a burst of counselling, then step back, and with the client review if the counselling is meeting the client's needs. Is it on track or off track? Does your counselling plan need to vary? Or does the client have needs that you cannot meet, but another health professional can meet better?

SOME SKILLS THAT YOU CAN HELP YOUR CLIENT LEARN

One of the most important things in counselling is helping a client reflect on their behaviour and their thinking, and helping them reshape these to make life simpler and better. You can also help the client develop skills that may be of assistance to them, such as:

- Problem solving
- Goal setting
- Coping, including managing emotions
- Staying strong and being able to speak up for what they believe (assertiveness)
- Relaxation and recreational skills
- Activities to strengthen culture
- Communication skills to improve relationships

Problem solving

Everyone comes up against problems in life, and some clients can have such complex lives that these issues can seem overwhelming to them. Help them learn or practise the skills to handle problems.

Seven steps to problem solving

Step 1: Look at the problem as if it is happening to someone else

Everyone experiences problems and these are part of everyday life. Problems need to be seen as challenges rather than thinking of them as catastrophes. Encourage your client to take a step back and look at the problem as if the problem is happening to someone else, like they are standing on the outside looking in. Many people respond to problems with the first idea that comes into their heads. This is often not the best solution and sometimes can make things worse. Encourage your client to step back and think rather than act immediately with a decision that may set them up to fail.

Step 2: Identify the problem

Have a clear understanding of what the problem is. Our people often experience multiple problems and so prioritising problems may be necessary. The problem needs to be clearly and exactly stated. Assist the client to clarify the problem by using good listening skills and gently asking questions to get more information. Work with the client to break a bigger problem down into small parts.

Step 3: Brainstorming ideas to address the problem

This is the fun part of problem solving where you and the client can come up with a range of ideas no matter how wild they might be. Here you both generate ideas, possibilities and alternative courses of action that may assist the client to address the problem. Use pen and paper or a whiteboard to write these down. There are three rules that help this technique work:

- No criticism or 'put downs' of any suggestion are to be used. Judgement is delayed until a later stage.
- Think broadly. Any idea is acceptable at this stage.
- The more ideas the better as this increases the possibility of finding useful solutions.

Step 4: Select the best idea (decision making)

Help the client cross off the list any ideas that do not seem practical. Assist the client to consider the good and the not-so-good things from the remaining options that they have brainstormed. Ideas may be combined or added to. Finally, assist your client to select the one strategy that they consider will be the most effective, realistic and achievable.

Step 5: Develop an action plan

Once the best strategy is selected, develop a concrete and specific action plan. How exactly are they going to carry out their selected plan? What time frame are they working in? What are they going to do first? When will they do it? How will they do it?

Step 6: Try it out

To assist the client to put their plan into action they may need to think through or practice the plan. Then try it out.

Step 7: Evaluate and review how it went

Whatever happens, evaluate the results carefully. Did it resolve or go part the way to resolving the problem? What were the consequences for the client? If it was only partially successful, or not effective at all, consider whether the plan can be improved (go back to Step 5), or whether a new strategy is needed (go to Step 4).

Adapted from Strong Spirit Strong Mind

Helping a client to set short-term goals

Working with clients to develop short-term goals can help them experience success. This success can boost their confidence and help them keep trying. A staged approach, of setting a series of short-term goals that your client can achieve, will support your client to reach their long-term goal.

Here are some tips for helping a client set goals:

- Goals should be suggested and 'owned' by the client.
- Goals need to be specific, solution focused, positive and support change.
- Step back and review if the goals have been reached. Any goals that are not fully achieved should be used to provide valuable insight for future goal setting.

Questions your client can work through in goal setting

Your client can answer and write down their responses to these points when setting goals:

- My long-term goal is:
- My short-term goal is:
- The specific changes I want to make are:
- These changes are important to me because:
- How will these changes affect my family and my community?
- The steps I plan to take to achieve my goals:
- Some of the things that could get in the way of my plan
- People who can help me:
- I know my plan is working when:

Adapted from Strong Spirit Strong Mind

Forming an action plan

It is not enough to develop some goals and then go away and expect them to happen. Clients need to think through how they are going to achieve these goals (i.e. come up with a plan for 'action'). You can help your client to develop an action plan, which includes identifying potential barriers and alternatives to reaching their goal.

How to set an action plan

An action plan needs to be realistic, time limited, detailed and flexible. It should consider:

- The goal
- The steps needed to achieve that goal
- Strengths and resources that the client has that will assist them in reaching the goal
- The potential pressures and barriers that may make it hard for the client to achieve their goals (or interrupt them from achieving their goals).
- Additional resources (if any) that your client may need to achieve their goals – including where and how they can get help if difficulties come up
- Reviewing and evaluating how things are going.

Adapted from Strong Spirit Strong Mind

COUNSELLING APPROACHES TO HELP THE CLIENT CHANGE THEIR THINKING

An important part of counselling is to help people understand and learn to manage any thoughts and feelings that may get in the way of change.

In talking to people about their thoughts you will often come across thinking that does not make sense in some way. For example, a person who is dependent on alcohol may say: "I know drinking's bad for me and I'll never get into a heavy binge again. I'll just have one or two drinks because I will be able to stop". But everyone around knows that this person has never been able to stop at one or two. Often clients cannot see anything wrong with their own thinking. Counselling can try to help the person identify the parts of their thinking that make sense and the parts that need challenging.

Challenging irrational thinking – an example

A person who is dependent on alcohol may say, "I just want to go back to just have a couple of quiet drinks with my mates." But this person has never been able to stop at one or two drinks.

Gently challenge this thinking by asking the client to reflect on their own drinking experience: "Can you tell me how many times you've been able to stop at just one or two drinks in the last year? And how many times have you got drunk in that time?"

If the client persists with thinking they can control their drinking, you can gently ask:

- "You say it's easy to stop, but you came to ask me for help? Can you explain a bit more what problem you would like to talk with me about?"
  or
- "What do you think people around you see? Do they think you have a problem? What problem do they see?"

What is CBT?

The counselling approaches we have talked about in this chapter focus on helping people make change. Many of these approaches also help people to understand their behaviour, thinking and feelings around substance use and related issues. They then support the person to try to change their behaviour, thinking and feelings. The approaches that aim to tackle thinking as well as behaviour are known as CBT (cognitive-behavioural therapy).

Some of the common counselling approaches that are based around CBT are goal setting, treatment planning, problem solving, relapse prevention, assertiveness training and anger management.

These CBT-based approaches can be combined with other forms of counselling such as motivational interviewing, building strengths and focusing on solutions. There is also a wide range of other counselling approaches available, including narrative therapy and advanced CBT that are used by counsellors. These can work well alongside basic CBT.

CLIENTS THAT ARE HARD TO GET ALONG WITH

Some clients are easier to get along with that others. If you find a client hard to get on with, it is important to remember that both the client and the counsellor bring baggage with them into the relationship.

- Sometimes a client will 'arc up' and get angry with you for no obvious reason. This may be because something about you, or about the situation, reminded them of something very unpleasant. For example, if the client thinks you are telling them what to do, it might remind them of being 'bossed around' in prison or as a child (perhaps living with an abusive parent). Without the client realising it, this situation triggered all the same emotions (anger, resentment) that they experienced back then. Because the emotions and behaviour from a past 'relationship' seem to be transferred onto this new relationship with you as a counsellor, this is known as *transference*.
- Sometimes the reverse happens: something the client says, or the way they say it, 'gets under your skin'. You find yourself getting irritated, upset or angry. Or you may feel afraid of a client with an angry attitude, even though there is no real threat to you. If this happens you may find that you avoid working with that client; or you may find you agree to do things that you do not want to do. It may be that something about the client reminds you of a past conflict (e.g. with a teenage son, with an unpleasant bully, or with a partner). Because you seem to be transferring the feelings from that past situation onto this new situation, this is known as *counter-transference*.

Being able to recognise the baggage that both you and the client bring into counselling can help you understand what is going on if things get tense. Also recognising these issues makes them easier to deal with. Sometimes you may find you just cannot work with a certain client. Then you may need to accept that you are not the best counsellor for that client, and you may be able to help identify someone else to take over from you. Clinical supervision or professional support can help you understand how to manage these issues better (see Looking after yourself, p. 418).

WORKING WITH CLIENTS WHO DECIDE THEY DO NOT WANT TO CHANGE, OR WHO CANNOT CHANGE: HARM REDUCTION

This can be hard, but there are often ways you can help clients reduce the harms to themselves, and to those around them. If the client will engage in a discussion on their drinking or drug use, you can help them reflect on the impact of their use on others. Work with them to develop a plan to reduce the harms (review the plan when your client is ready and willing to do so).

Some tips to developing a harm reduction plan:

- Ask your client to think about the potential risks to their children. Is there any way that they can see to reduce those risks? (e.g. is there someone that could help look after the children; after a nights drinking, can they stay at a friend's place till sober?)
- Are there ways they can reduce the impact of alcohol or drugs on themselves? (e.g. can they take thiamine to reduce the chance of brain damage; can they eat before drinking?)

WORKING WITH FAMILY

You have an important role in supporting family members who are distressed by a person's substance use. Some counsellors have training to do family therapy, to try to improve relationships between family members. But many other people who work in the field may also called upon for advice by distressed family members. You may be able to teach the family ways that they can help the person who is using or trying to stop using (also see What can families do?, p. 62).

Ways family or friends can help a person who is trying to change their substance use:

If the person is still trying to change:

- If the person is in two minds about their alcohol or drug use, talk with them about the good and not-so-good things about their use for themself, their family and community
- Remind the drinker of the benefits they will get from change
- Encourage and support the person to find alternatives to using alcohol or drugs
- Be able to go with a client to get treatment or other help. Family and friends can also find out about different types of treatment that are available.

If the person has made a change:

- Encourage them by:
  - Talking about the positive changes that have been made since cutting down or stopping
  - Talking about what has been working well for them in avoiding alcohol and drug use.
- Help the person to develop a plan to cope in situations where they may feel pressured to use
- Develop a family support network that can help their family member during high risk times, e.g. funerals
- Try to make changes to their own alcohol or drug use.

If the person has relapsed:

- Understand that relapse is a normal part of changing, and the person can still get back on track.
- Remind the person of the reasons they wanted to make change for themselves, their family and community.
- Remind the person of the success they have had so far and look at the benefits of continuing to make changes.
- Encourage them to get professional help.
- When the person is back on track, they can help the person think through what led up to the relapse and help the person see it as a learning experience, rather than a failure.

If the person does not want to or cannot change:

- Be sure the person understands the harms and risks of using, but do not lecture or nag.
- Do not put the person down or judge them for continuing to use.
- Talk about ways to reduce the harms from using and do practical things to help reduce the harms (e.g. look after kids when parents are using, encourage the drinker to eat and to take thiamine tablets to help reduce brain damage).
- Offer to support the person if they want to make changes to alcohol or drug use.
- Get support for themselves if the person's alcohol or drug use is causing family and community problems. This could be from friends and community, and some agencies also offer help for families of problem users.

Adapted from Strong Spirit Strong Mind

WHEN TO REFER

Many different health professionals can do some of the practical aspects of counselling that we have talked about so far. If your duties mainly include case work and you do not have enough time for detailed counselling, your clients may benefit from also seeing a counsellor. There is a range of other counselling approaches available that require special training. And some clients – for example, those with complex mental health problems – may benefit from seeing a psychologist or mental health counsellor as well as having alcohol and drug counselling. Support your client to see a counsellor who is the right match for their needs.

Examples of clients who may need to be linked in with mental health services include those who:

- Have serious mental health issues (e.g. major depression, psychosis, or experience of complex or severe trauma), which may benefit from medicines or specialised counselling.
- Are a risk to themselves or others (e.g. has suicidal thoughts or is at risk of harming others).

It is important to recognise your strengths and limitations

- If you are not trained to do something, do not do it, if there is a better alternative.
- In a setting where there is no one to refer a client to, seek expert advice and support. Tread lightly, and listen more than direct. It may be better to provide general support rather than counselling.
- Clinicians should not push people to talk about past traumas if the client is not comfortable to go there. Trauma issues with clients need to be handled with great sensitivity and workers need to be aware that clients speak about trauma in different ways. Most clinicians (including doctors and nurses) do not have much training in dealing with major past traumas. If your organisation does not follow a particular program for helping people with trauma, or if you do not have specific training, act carefully.

Working in partnership with mental health professionals or other specialised counsellors

Some clients have complex needs and may benefit from the help of several different clinicians at different times. It is important not to overload the client with appointments, but to work out the priorities, and a plan for how the care can fit together (see Case management, p. 43). For example, talk with the psychiatrist or counsellor, and ask when is the best time for them to see the client. If the mental health problem is not urgent, they may suggest first getting the alcohol or drug problem under control. Then the client will be better able to take part in mental health counselling. However, if there is a risk to the client or others, there may be urgent need, for example, to see a psychiatrist, and this may need to happen even while they are trying to tackle their alcohol or drug problem.

Explaining the role of different mental health professionals to your client

Many clients get confused about the role of the different mental health professionals. Below is a brief summary of some common roles:

- A psychiatrist is a doctor who has specialised in mental health. Psychiatrists can prescribe medicines (e.g. for psychosis or major depression) and offer some counselling. Many do not have time to provide in-depth counselling. They can be particularly useful in advising whether any medicine can help your client, and in working out the correct diagnosis.
- A psychologist has studied human thinking and behaviour at university. Many psychologists have gone on to do further study in providing talking therapies or assessment services.
- Counsellors come from a wide range of different backgrounds, and have usually studied how to provide talking therapies (at a Certificate level or at university). Some counsellors specialise in mental health, some in drug and alcohol, some in family therapy or in another field.

You can learn who is good in your area to refer clients to and sometimes you can arrange to share the care of client. Other times you may arrange for a counsellor to take over from you for a period of time to help with a specific problem.

Not all general counsellors are good at alcohol or drug counselling, but they may be able to help the client with mental health issues. Work with a local counsellor (e.g. for the client's anxiety), so that the counsellor deals with the anxiety and you deal with the alcohol or drug use. How this all fits together needs to be part of a treatment plan and it is important not to overload the client with too many appointments.

CONTINUING TO DEVELOP YOUR COUNSELLING SKILLS

If you are to be involved in counselling, you should be constantly expand your skills, knowledge and understanding. Counselling is an ongoing learning curve. Having someone to go to for clinical advice and support is essential. This could be face-to-face or by phone if necessary. Finding a clinical mentor or supervisor can greatly help you increase your skills. In addition, for one-off advice on challenging situations, the specialist advisory service in each state or territory may be able to help (see Specialist advice, p. 435).

FURTHER READING

Casey W & Keen J. (2005). Strong Spirit Strong Mind, Aboriginal Alcohol and Other Drugs Worker Resource: A guide to working with our people, families and communities. WA Alcohol and Drug Authority trading as the Drug and Alcohol Office. Perth WA.

NSW Health (2008). Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines. Sydney: NSW Health. Available from: www.health.nsw.gov.au/policies/gl/2008/pdf/GL2008_009.pdf.

Case management

OVERVIEW

Aboriginal drug and alcohol workers aim to bring together all the aspects of care for our clients ('case management'). In doing so, we walk beside an individual who needs support, and also offer to help and guide them during challenging times in their life. Part of this involves helping clients to access the services they need and to get the most out of these services.

For case management to be successful, two key elements are required:

- Knowing your client (that also means knowing the client's family and the local community)
- Knowing the services in your local area and other relevant services within your state or territory.

ASSESSING YOUR CLIENT'S NEEDS

For any client, it is essential to do a full assessment using your organisation's assessment form so you have a clearer understanding of your client's needs. The form is completed after you have spoken with your client. Some clients may feel like there is a barrier if they are speaking to a health professional who is taking notes or filling out forms as they are speaking with them. Make sure you have a strong understanding of what is on your assessment form so that you can 'weave' the questions into a conversation when conducting an assessment (see Assessment, p. 11).

Forming a treatment plan

When developing a treatment plan for your client, there are several aspects that you will need to take into account after you have completed the initial client assessment:

- Speak with your client about what their treatment goals are and what areas they would like your support with, such as: housing, support letter to help them with a court case, rehab, transport, or counselling.

! *Note:* make sure treatment goals are achievable (see Counselling, p. 34)

- Once you and your client have identified the areas they would like to address, work out what services would best be suited to them and if they are available. For example:
  - Do they simply want some ongoing support from you?
  - Would they benefit from a mental health referral?
  - Do they need to link up with a doctor for withdrawal management, relapse prevention or a health check?
  - Do they need a residential program? If so, which is the best for them?
    - An 18 year old might be referred to an adolescent rehab program rather than a program where the average age is over 30.
    - A parent who is required to attend a long-term resi rehab facility could be referred to a program where the client can attend with their children.
- Review the treatment plan made with your client on a regular basis to check they are still achieving the agreed goals. Make changes to the treatment plan if needed.
- Update the client's records after each visit. Note: client notes are legal documents and may be requested by a lawyer during a court case ('subpoena').

COORDINATING AND SUPPORTING TREATMENT

Many clients have a range of health or support workers that they have regular contact with. These services might include: mental health, social workers, child support services and probation and parole. It is important that the services offered are not duplicated, and one way to coordinate this is to arrange case management meetings with all of the service providers involved with your client. This can help a clear case management plan to be developed with input from each service provider about the areas they are working on with the client.

ADVOCATING FOR YOUR CLIENT

It is essential to have your client's written permission before you advocate on their behalf with any services.

If your client is dealing with Centrelink

Not all clients will require assistance from Centrelink. However, for many clients, dealing with Centrelink can be overwhelming. Some clients may also have had negative experiences with Centrelink in the past. Talk with your client about what support they need from Centrelink and how you might help them to get this support. Some types of support clients can get from Centrelink include:

- *Centrelink benefits* – all clients will be assessed individually by Centrelink to work out if they are eligible to receive benefits. For example:
  - *Youth Allowance:* can assist if your client is a young person aged 16 to 20, is studying, doing training or an apprenticeship, is looking for work, or is sick.
  - *Newstart Allowance:* clients need to be 21 years and older, be actively looking for paid work and be prepared to enter into an Employment Pathway Plan.
  - *Disability Support Pension:* clients requesting a Disability Support Pension will be required to provide a report from their treating doctor or specialist for their disability, injury or illness. The client may be asked to complete a Job Capacity Assessment.

Birth certificate

If a client is applying for a Centrelink payment, they need to have a 'Commencement of Identity' in Australia. A birth certificate is the best way to cover this. Your client may need your help to complete the required paperwork and submit the birth certificate application to the local courthouse.

- *Release from correction payment*
  - If a client has been in jail for 14 days or longer, they will be eligible to apply for a crisis payment. This payment is equal to one week's payment of the client's basic pension or benefit. Your client can arrange this payment 25 days prior to their release or within seven days after their release. Clients may also apply for an advance on their regular payment ('Hardship Advance').

- *No pressure to apply for jobs while in rehab or detox (with medical certificate)*
  - If your client is a resident in a detox or rehab unit and cannot seek paid employment during this time, they may be eligible to have a medical certificate to cover them while they are receiving treatment. A doctor who works in conjunction with the detox or rehab usually writes this medical certificate, but it can also be written by a GP in consultation with detox or rehab.
  - Clients can continue getting Newstart Allowance if they get sick or have an accident and are temporarily unable to work. They do not have to meet the activity test or hand in your fortnightly application form in person while you are unfit for work. To do so, a medical certificate will be needed from the client's doctor that states they are unfit to do at least eight hours work a week. See: www.centrelink.gov.au/internet/internet.nsf/payments/newstart_circumstances.htm
- *State debt recovery payments*
  - Some clients may be unable to pay their court costs or fines, and failure to do so could result in loss of their driver's licence. You can help the client by making sure all the necessary paperwork is completed with Centrelink so that regular fortnightly payments are arranged to pay off this debt. This can also help lessen the client's fear of losing their licence.
- *Centrepay*
  - Centrepay is a free direct bill-paying service offered to clients who are receiving payments through Centrelink. You can help the client by assisting them to arrange to have regular amounts deducted from their Centrelink payments (e.g. rent, electricity, loans, court fines, and sometimes chemist bills).

If your client does not have stable housing

For many clients, having stable and suitable accommodation is a high priority (e.g. for after discharge from rehab or after release from prison). Many clients will ask for help to find and relocate them to suitable accommodation. However, finding suitable and stable accommodation can be very difficult. Often there are lengthy waiting lists. Writing a letter of support for your client can be helpful.

Letters of support for housing usually highlight the need for accommodation to be located in suitable surrounds and not in areas that are: close to pubs, known for drug dealers, high density housing or near people they used to use alcohol or drugs with. The support letter also might talk about the effort the client has shown to change the drug-taking behaviour and to make a better life.

- *Emergency housing*
  - Emergency housing organisations are in each state/territory across Australia. See www.australia.gov.au/topics/family-home-and-community/housing-and-property
  - You can help your client by writing a support letter stating the reason why suitable accommodation is essential for your client at this time in their recovery.
  - Centrelink Community Engagement Officers provide services to people who are homeless or at risk of homelessness. Contact these workers through your local Centrelink office.
  - Department of Housing and Homelessness Services are in each state and territory. You can help your client by helping them to fill out the written application for housing and providing supporting documents (e.g. a letter of support).
- *Tenant Advice and Advocacy services*
  - Tenant Advice and Advocacy services are in each state or territory. These services can provide advocacy for your client if there has been a past rental dispute. You can provide support by arranging appointment times to go along with your client to discuss their housing issues, supporting your client at a rental dispute hearing and writing supporting documents about locating suitable accommodation for your client.

> ! *Note:* try to get extra support for your client from any Aboriginal workers who may work for these service providers.

If your client is going to court

Attending court can be an overwhelming and anxious time for anyone. There are several ways to support your client before and during their court case.

- *Before the court case*
  - Talk with your client about whether they would like you to write them a referral letter to an Aboriginal and Torres Strait Islander Legal Service (if available in your community).
  - If your client is currently in treatment and unable to attend court on the day, you can provide the court with a letter requesting an adjournment on your client's behalf because they are in a rehab/detox program. A copy of the letter will need to be sent to the client's lawyer. Sometimes an adjournment will not be given and the client will still need to attend on the day. Make sure you and your client remain in contact with their lawyer.
  - You (or a senior staff member of your service) could send a letter of support to the court providing information on your client's effort to address their drug and alcohol use since being discharged from a program.

  - As your client's advocate you can refer them for assessment into an alcohol and drug court diversion program. These programs operate throughout Australia. The main aim of these programs is to divert alcohol and drug users from prison and into treatment programs (see Programs to reduce re-offending or avoid prison, p. 328).
- *On the day of the court case*
  - If possible, offer to attend the court case to support your client. Having someone there with them prior to their appearance could help them feel less anxiety.

Probation and parole services are often involved with our clients. You may be requested to provide written reports to them on the progress of your client's participation in treatment. Ensure that your client gives written permission so you can provide relevant information to this service.

If your client is dealing with child protection services

If your client is currently in a rehab program and their child is under the care of child protection services, it is important for both the parent and child to maintain either face-to-face and/or phone contact.

- Contact the child protection service on behalf of your client to arrange visits while the client is in treatment.
- Some rehabs let young children be with their parents during treatment. Make sure you know where these services are located in your state/territory.
- Some child protection services will provide financial assistance to a parent to attend rehab.

If your client needs food or money urgently

Charities can also be very helpful. Charities such as St Vincent De Paul, Anglicare and the Salvation Army provide financial assistance to attend rehab, travel vouchers to help get to rehab, and assistance with admission fees.

- *Admission and travel costs into treatment*
  - You can write a letter of support for your client to request financial help from a charity. This will also give the charity written evidence about how the money will be used (e.g. travel assistance and admission fees). Request that a direct deposit or cheque be sent directly to the treatment service as this will help prevent any loss of money or money being spent inappropriately by the client prior to their admission. Travel vouchers can also be requested instead of cash.
  - Many charities provide food and utility vouchers to clients who have been finding it hard to pay for bills or to have enough money to buy food. This can be especially difficult after release from prison or on discharge from rehab.

- *Budgeting*
  - If your client is having problems with budgeting, refer them to a financial counselling service for advice on budgeting. Many of these services operate within charities such as the Salvation Army.

Above all, remember 'one size' does not fit all, and individually-tailored assistance should be offered to all clients to guide and support them through their alcohol or drug issues.

FURTHER READING

Definition of case management: www.cmsa.org.au/definition.html.

Substance and Mental Health Services Administration (SAMHSA) (1998). Applying case management to substance abuse treatment. Available from: www.ncbi.nlm.nih.gov/books/NBK64857.

The role of medicines

OVERVIEW

Medicines are used in a number of ways to help people who use alcohol or drugs. For example:

- To reduce cravings
- To block the effects of drugs or alcohol (an 'antagonist')
- To make taking alcohol a very unpleasant experience (an 'aversive agent')
- To replace a drug with a safer medicine ('replacement therapy')
- To relieve symptoms of alcohol or drug withdrawal
- To treat mental or physical health issues that happened because of alcohol and other drug use.

REDUCE CRAVINGS

Some medicines act on the reward centre or other areas of the brain to reduce cravings. An example is Campral (acamprosate) that may be prescribed to people who are dependent on alcohol. This drug damps down the part of the brain that is overactive and causes alcohol cravings.

BLOCK THE EFFECTS OF DRUGS OR ALCOHOL ('ANTAGONIST')

Some medicines 'block' the effects of drugs (called 'antagonists'). This means that the person will not get as 'high' if they use the drug, because the medicine stops the drug from working as well on the brain.

Medicines that block the effects of opioids

Naltrexone is a medicine that blocks the effects of heroin (or other opioids) so people do not get high. As a result, they tend to stop seeking out heroin because it no longer 'works' for them or feels good.

Medicines that block the effects of alcohol

Naltrexone also reduces the 'feel good' effects of alcohol and is used to help people control their drinking. When people drink alcohol on naltrexone they still get 'drunk' (e.g. their coordination and memory do not work as well, they slur their words) but they get less of a high. This is because naltrexone blocks the effects of alcohol on the brain's opioid receptors.

MAKES TAKING ALCOHOL VERY UNPLEASANT ('AVERSIVE AGENT')

The only medicine in this category is Antabuse (disulfiram). Antabuse changes how alcohol is broken down in the body. So, if someone taking Antabuse drinks even a few mouthfuls of alcohol they become very sick with nausea, vomiting, flushing (red in the face), a pounding headache, diarrhoea and a racing heart. Knowing that this will happen if they drink can help some people stay away from alcohol completely.

REPLACEMENT MEDICINES

Some medicines may be the same, or very similar, to the drugs that are being misused. But replacing the drug with medicines is a safer and legal way to satisfy cravings.

Some examples of replacement medicines are nicotine patches or gum for people who are dependent on tobacco. Another example is methadone or buprenorphine for people who are dependent on opioids.

Opioid substitution treatment

Medicines such as methadone or buprenorphine are prescribed to replace heroin or morphine in people who are dependent on opioids. They have similar effects to heroin or morphine, so they work to reduce cravings and stop the symptoms of withdrawal. Although buprenorphine has some opioid effects, these are not as strong as heroin. Any heroin taken will not have its full effect, but will be blocked by the buprenorphine, which has a weaker effect.

Only available on prescription, methadone and buprenorphine also:

- Offer a chance for the person to get other types of help (e.g. from doctors or nurses)
- Reduce or stop people from injecting
- Reduce the person's need to spend a lot of money on drugs
- Are pure, whereas street drugs can contain many impurities
- Remove the person from their regular drug-taking environment (e.g. involvement with drug dealers and other people who use drugs).

Nicotine replacement therapy (NRT)

Another example of replacement medicines are those taken to help someone cut down or stop smoking tobacco (e.g. nicotine patches, gum, lozenges, under-the-tongue tablets, inhaler). These medicines give the nicotine that the body is craving, and so help to reduce cravings.

RELIEVE SYMPTOMS OF ALCOHOL OR DRUG WITHDRAWAL

Some medicines are used to relieve withdrawal symptoms or other symptoms (e.g. side-effects or after-effects of alcohol or drug use). For example:

- If someone who is dependent on heroin or morphine suddenly stops using these drugs, they may get stomach cramps or diarrhoea. The cramps could be relieved by taking Buscopan (hyoscine) and diarrhoea could be reduced by taking Gastrostop (loperamide). Maxolon (metoclopromide) can be used to reduce nausea and vomiting.
- Sleeping tablets (benzos) are sometimes prescribed for people who have recently stopped using cannabis, stimulants, alcohol or opioids.

! Note: when medicines are taken to provide relief from symptoms of alcohol or drug withdrawal, it is important to check that the person does not:

- Switch from being dependent on one drug to being dependent on another (e.g. from needing cannabis to sleep to needing benzos to sleep).
- Become dependent on a second drug (e.g. someone who is dependent on stimulants starts using benzos regularly to deal with anxiety and sleep problems from their stimulant use, and gets hooked on benzos as well as on stimulants).

TREATMENT OF RELATED MENTAL OR PHYSICAL HEALTH PROBLEMS

Many medicines play a role in treating other health issues that happen because of using drugs or too much alcohol. For example, for:

- *People who drink alcohol regularly:* thiamine (vitamin B1) may be taken to reduce or treat the harmful effects of low thiamine on the brain and nerves.
- *People who inject drugs:* antibiotics may be prescribed to treat infected injecting sites.
- *People who are dependent on painkillers taken because of chronic pain:* medicines that do not lead to dependence, like amitriptyline or gabapentin, may be prescribed instead of opioid painkillers.
- *People with major depression or anxiety:* anti-depressants may be useful for people who drink or take drugs as a way to help with these mental health issues.
- *People who experience psychosis:* anti-psychotics may be needed for those with ongoing signs of psychosis after using drugs or alcohol (drug-induced psychosis).
- *People who smoke tobacco:* medicines may be prescribed to help with heart disease or lung disease in long-term smokers.

FURTHER READING

NSW Health (2007). *NSW Drug and alcohol withdrawal clinical practice guidelines*. North Sydney: Mental Health & Drug and Alcohol Office, NSW Department of Health. Available from: www.health.nsw.gov.au/policies/gl/2008/pdf/GL2008_011.pdf.

Mutual support groups

OVERVIEW

Mutual support groups are made up of people who share their experiences about how their lives have been affected by alcohol and other drugs. They may share their progress, success and hopes for the future. Volunteers typically run these groups to help members support each other. The groups are 'recovery' focused, and provide social and emotional support and other information.

The availability of mutual support groups may differ depending on whether the client is living in a city, or in a regional or remote area. Some of the mutual support groups available include 12-step groups like Alcoholics Anonymous (AA), SMART Recovery, and also Aboriginal men's groups and Aboriginal women's groups.

What is recovery?

Recovery is an individual's unique and personal process of change. Through the process, the individual may regain health, hope, and a sense of wellbeing. Mutual support groups provide a place where people may feel acknowledged and encouraged by others who understand their past and current experiences, and also the challenges faced in maintaining recovery. Mutual support groups are an important part of recovery, not only for the individual, but also for their family and the wider community.

12-STEP GROUPS

12-step groups include Alcoholics Anonymous (AA), Narcotics Anonymous (NA), Marijuana Anonymous (MA) and groups for family and friends (Al Anon, Al Teen).

Alcoholics Anonymous (AA)

Alcoholics Anonymous (AA) is one of the oldest and longest running recovery groups. This group has 12 core 'steps' to help people recover from alcohol dependence. The steps focus on taking responsibility for recovery, listening to and sharing personal stories, and recognising and accepting a spiritual higher power.

AA operates worldwide, and regular meetings are held in community halls, churches and public buildings. It is free to attend, but people may give a small donation. The format of the meetings can vary. The main focus of the meetings is to share stories with

people attending the group, to consider the effect alcohol has had on their lives, and explore the efforts people are making to not drink (i.e. to stay 'abstinent').

AA encourages people to attend meetings regularly. The suggestion for new members is to attend 90 meetings in 90 days, but people may attend as many or as few as they wish.

People can find out about local meetings in their area at www.aa.org.au or through their local Alcohol and Drug Information Service (see p. 435).

Narcotics Anonymous (NA)

A group of people who share their experiences about recovery from drug dependence. For more information, see www.naoz.org.au.

Marijuana Anonymous (MA)

A group of people who share their experiences about recovery from cannabis dependence. For more information, see www.marijuana-anonymous.com.

Family and friends (Al Anon, Al Teen)

A group of adults and young people who share experiences about how their lives have been affected by a family member or friend's alcohol or drug dependence. For more information, see www.al-anon.alateen.org/australia.

SMART RECOVERY

SMART Recovery is a self-help group for people seeking practical skills and strategies to assist with recovery from alcohol and other drugs, or other addictions like gambling. It is run by volunteers who have had problems with alcohol and other drugs ('peer-led' programs).

SMART Recovery started in the United State of America as an alternative to 12-step groups and is now available throughout Australia. The focus is on the here and now, and, unlike AA participants, people attending the meetings do not share their life stories. It may appeal to people who prefer a non-spiritual focus. The SMART Recovery model is based on cognitive behavioural therapy (CBT; see Counselling, p. 36).

The program provides common-sense information to help people change their behaviour and encourage a healthier lifestyle. It is made up of four key principles:

- Enhance and maintain motivation
- Cope with cravings
- Problem solving
- Lifestyle balance.

People are welcome to attend for as long or as little as they choose. People who attend talk about their goals, challenges and practical skills to help with their recovery.

People can find out about local meetings in their area at www.smartrecoveryaustralia.com.au or through their local Alcohol and Drug Information Service (see p. 435).

ABORIGINAL MEN'S GROUPS

What does a men's group offer?

A men's group is a culturally safe place where men can deal with their alcohol and other drug use as well as other issues like spirituality, identity, anger management, domestic violence and employment. Groups aim to empower men so they can have better relationships with their families and communities and take control of their lives again. Places you might find a men's group could be in the community, in a prison, rehab or health clinic, and anywhere else men face difficult situations.

How to start a men's group in your area

Step 1: Seek out elders and other men in your community and discuss which issues are important (e.g. alcohol and other drugs, domestic violence, better parenting skills).

Step 2: Get advice from elders and other men in your community and from men's groups in other communities to work out how best to get the group up and running (including ways to seek funding and find people with the right skills to run the group).

Step 3: Organise a 'get away' (e.g. might be a workshop, bush camp or fishing trip) to get men together and to start talking about what issues are important to them.

Step 4: Find funding to help cover costs of running a men's group. Now this is the tricky part as there is no national coordination run by any one specific government department. You could try to get government funding from your local council, or even from state, territory, or federal governments. Another way to get funding is to approach local businesses in your area, church groups, or other non-government organisations.

ABORIGINAL WOMEN'S GROUPS

What does a women's group offer?

A women's group is a culturally safe place for women where they can meet and talk about health or other private issues that they would not want anyone else to hear. In these groups, other women are going through the same issues – so people attending the group do not have to worry about stigma or feeling discrimination because of their alcohol or drug issue. The group usually decides what happens in each group and there is always food and a cup of tea or coffee available. Sometimes a speaker might be invited to talk about a particular issue, or the group might go on an outing or do arts and crafts or other activities – anything that the women would like to do. The group may also spend some time coming up with rules for the group. Groups can vary in length from two or more hours – depending on childcare availability. Ladies are welcome and encouraged to bring their kids. Some groups might also have volunteers to look after kids so women can have their own 'time', and the kids look forward to going as well.

Where are groups typically held?

Groups might be run in the community, at a health centre or women's centre, or in treatment settings (e.g. drug and alcohol service).

How to start a women's group in your area

The most important thing to do is to get advice from elders and other strong leaders who are from the community about whether they think it is a good idea to start a group. If these people are supportive of the idea, they can help promote it to women, men and the rest of the community.

HELPING YOUR CLIENTS ACCESS MUTUAL SUPPORT GROUPS

It is important to help clients think about seeking help from mutual support groups in their area. This may involve you as a clinician learning about the different types of support groups available and how they are run. This can help you to find the most suitable support group for your client.

The availability of mutual support groups may differ depending on whether the client is living in a city, or in a regional, rural or remote area.

Residential rehabilitation

WHAT IS RESIDENTIAL REHABILITATION?

Residential rehabilitation centres ('rehabs') provide a supportive treatment environment where people can live for a period of time to work on their issues with alcohol and other drugs. This involves the person getting away from their day-to-day life, away from friends and family that they normally drink or use drugs with, and away from their usual habits and routines. Alcohol and other drugs are not allowed in these centres.

Different centres offer different services. They generally provide individual and group counselling, skills development (e.g. living skills, managing finances, parenting), and other relapse prevention measures. This helps to prepare people for re-entry back into their community and for a life without alcohol or other drugs and the harms that can result from ongoing use.

WHEN CAN A CLIENT BENEFIT FROM REHAB?

Rehab is one of many treatment options available to people with substance misuse. Clients will often be offered outpatient or home-based treatment before trying rehab. This can include: counselling, withdrawal management and support ('detox') as an outpatient or inpatient, support groups (e.g. men's and women's groups, Alcoholics Anonymous or Narcotics Anonymous) and outpatient drug and alcohol groups (e.g. SMART Recovery, narrative therapy day groups, day rehabilitation programmes; see Mutual support groups, p. 54).

Rehab provides intensive and supportive treatment and is often good for clients when other treatments have not been successful. It should be considered if the client:

- Has not found outpatient treatment helpful
- Is unable to reduce or stop their substance use
- Has relapsed following treatment.

For some clients, rehab may be the best treatment for them to start with. This might be when clients have other social issues such as:

- Being homeless
- Being isolated from their community
- Many people in their community drink or use drugs (e.g. family and friends)
- They could benefit from learning other skills in rehab as well as stopping their substance use (e.g. parenting skills, work skills, general living skills).

WHAT DO REHABS OFFER?

Rehab centres vary in a number of ways. Some centres provide both detox and rehabilitation, but most will insist that the client has gone through detox before entering the centre. This can create a barrier as places in detox units are limited. For some people, home detox may be appropriate (e.g. see Alcohol, p. 88).

Some centres offer a comprehensive treatment program including things like AA/NA meetings, relapse prevention groups, and individual and group cognitive behavioural therapy (CBT).

Other centres use 'a therapeutic community model'. This means that clients work with staff to actively help other residents (mutual support) and to help themselves (self-help). They try to create a safe space where change can happen and clients can learn to live without alcohol and other drugs.

Aboriginal-specific rehabs

Some communities may have access to rehabs that are set up for Aboriginal clients only. These centres offer the same services as other rehabs, but also focus on providing a culturally safe place for clients to go through rehab. Some rehabs may also be able to have family members and even children stay while the client goes through their treatment program.

HOW TO HELP YOUR CLIENT CHOOSE A REHAB CENTRE

It is good to know about rehabs nearest to your area and what clients they will take. If you have any trouble finding out, call the Alcohol and Drug Information Service (ADIS) in your state or territory (see p. 435).

Talk with your client about what they are looking for and what their needs are. Questions to ask include:

- What do you want to achieve in rehabilitation?
- How long do you want to go to rehabilitation for?
- What are your family commitments?
- If there is a cost involved and can you afford this?

You can make a recommendation based on what you know about the client and the rehabilitation centres in your area. For example, the needs of a young male client with an alcohol problem and mental illness who wants short-term treatment will differ from a homeless mother who is looking for longer-term treatment where she can take her baby and learn some parenting skills.

Some other important things to consider when choosing a rehab centre are:

- Cost:
  - Some government rehabs are free.
  - A number of rehabs are run by religious charities, non-government organisations and government health services. Clients usually have to pay for these services (and some government services), by signing over a proportion of their Centrelink payments.
  - Some private rehabilitation centres are very expensive and difficult to pay for without private health cover.
- Medicines: some centres will not allow medicines such as sleeping tablets or methadone to be taken during the client's stay. Others provide medicines such as diazepam to treat alcohol withdrawal.
- Gender: some centres are male or female only, some are mixed.
- Length of stay: varies widely from short-term (e.g. one month) to long-term (e.g. 12 months).
- Mental health issues: some centres will not accept clients with a diagnosis of a mental health problem, while others specialise in helping people with mental health issues.
- Children: some centres will allow children to stay, but many do not. This can be a barrier for parents who need rehabilitation.

How do I refer a client to rehab?

Once you and your client have decided on the centre that they want to go to, the client can call each centre themselves to find out more information. Usually the client is assessed for suitability over the phone and often there may be a waiting list before the client can attend treatment.

For some services, the health worker can ring on behalf of the client, and this can help the client gain a place in the centre.

It is also good to check if there are any requirements for your client. For example, some centres will need a referral letter from you (the health worker) or from a doctor or nurse.

! Organising transport to rehab

In some communities there may be limited or no options available to transport a client to rehab safely. For example, when a client is referred to rehab by a magistrate ('conditional release into rehab'), without transport the client may remain in prison until transport is arranged. Then, if the client does not get to the rehab safely, this might result in them getting into trouble, perhaps using drugs or alcohol, and maybe even breaking their bail conditions. Try to talk with the relevant agencies about a plan to make sure the client gets to rehab safely. Arranging transport is a priority – this should be sorted out from the point of departure to the point of collection.

FURTHER READING

NSW Health (2007). *Drug and alcohol treatment guidelines for residential settings*. North Sydney: NSW Department of Health. Available from: www.health.nsw.gov.au/pubs/2007/pdf/drug_a_guidelines.pdf.

What can families do?

OVERVIEW

Families are important to our people and they play a big role in our lives. As we do not function as a 'nuclear' family – with 2.5 children – typically our families, including extended families, are very much a part of each other's lives. In traditional times, each person, even children, had a specific role to play in the family. This structure helped keep life in order, but, with the changing world that we live in now, these roles have changed a lot.

If a family member has a problem with alcohol or drugs, this affects everyone in the family. This is even harder if more than one person is using. Working together as a family to deal with these situations can sometimes be the best way to go. This section talks about what families can do to help if they are worried about a family member's alcohol or drug use. There is more information on ways of talking with families in the section on counselling (see p. 38).

HOW TO HELP A FAMILY MEMBER THINK ABOUT CHANGING THEIR ALCOHOL OR DRUG USE

If a person is worried about a family member's alcohol or drug use, there are things that they can do to help.

! Tips for families to help their family member think about changing alcohol or drug use

- Talk with that family member and help them weigh up what they like and what they do not like about their substance use (see Counselling, p. 24).
- Go with that family member to ask at your local Aboriginal Medical Service, health clinic or hospital to get some information about stopping or reducing alcohol or drugs, and to find out what treatment programs may be suitable.
- If there is an alcohol and drug treatment service in your area, try to take your family member to visit this service to see what it is like. The family member can find out whether this service might suit them, and how comfortable they are in getting help from this service.
- Try to get the family member to go with you to see your local GP. The GP may be able to provide some help with alcohol and drug treatments, or make a referral to another service.

SUPPORTING A FAMILY MEMBER TO STAY IN TREATMENT

Living with someone with a problem can be hard and can affect every family member. Sometimes family may feel like their loved one is not the same person they used to be, and it can be easy to feel frustrated because of this. It is important to make sure that family know what help and support is available to help the person address their alcohol and drug use. They will need to remember that it will most likely be hard for the person to make changes. It is important that they work together as a family to support the person through the changes they are trying to make in their lives.

! Tips for family to help them support their family member to stay in treatment

- Give encouragement and practical support to the family member when they are getting help.
- You can help the family member remember why they wanted to change, and help them remember the balance between things they did like and did not like about using (see Counselling, p. 24). Reassure your family member that you, as a family, will help them during and after their treatment. Going with the family member to treatment is another option; most of our people do not like doing things like this by ourselves so having someone go with them can help them take the first steps towards change.
- For family members who are receiving treatment away from home (e.g. in a live-in rehab), regular contacts with family such as phone calls and visits can help the client feel confident and supported in what they are doing.
- Always approach the family member positively and try not to be negative. This can help them to stay focused to complete their treatment and maintain abstinence.
- There are support groups and services out there to help families affected by alcohol or drugs. Sometimes it can be as simple as you sitting and talking over a cup of tea, or it may be a chance for you to talk to someone in more depth about how you are all feeling, either by yourselves or as a family (counselling – group, family or individual).

SUPPORTING A FAMILY MEMBER WHO CANNOT OR WILL NOT STOP USING

If family are worried about the amount of alcohol or drugs being used by their family member and that person is not going to give it up, they could try the following:

- Suggest that they have a couple of alcohol and other drug free days during the week.
- Make sure they have a feed before they start drinking (or using drugs).
- Suggest they cut down how much they use each day (e.g. drinking less beer/wine or smoking less cones each day).
- Go with them and visit an alcohol and drug treatment service or other health service to talk about their use.
- Help them find ways to reduce the harms of their alcohol or drug use. For example, the family may be able to help ensure children are safely cared for; and help the drinker take thiamine to lower the risk of brain damage.

PREVENTING FAMILY MEMBERS FROM STARTING ALCOHOL OR DRUG USE

It would often be better if we could stop family members from using drugs in the first place. A good place to start is with young people.

We can teach young people about the harms of drugs and alcohol and let them know, for example, that alcohol can hurt your mind and your body. We can tell them that alcohol can harm the kidneys, liver, brain and heart – these are all important parts of the body that keep us alive. We can also tell them that smoking can damage the lungs, heart, throat and mouth as well as other parts of the body.

Where to find educational resources for young people

If you are interested in educating young people, you could talk to your local schools who may have an age-appropriate program with information about drugs and alcohol. Local drug information agencies or health departments may have information programs for young people. Other agencies like ADAC (Aboriginal Drug and Alcohol Council Inc. SA) have Aboriginal-specific resources (www.adac.org.au).

But more important than what we say about alcohol or tobacco or drugs is what young people see. We can encourage family to try to set a good example in their own alcohol or drug use. Families can work together to try to get the community to tackle alcohol or drug problems.

Perhaps the most important thing that family can do is helping young people to feel cared for and feel connected (e.g. to family, community, culture, sport or art). This can make them stronger, and help protect them against later problems with alcohol or drugs (see Young people, p. 378).