

An introduction to working with alcohol and other drug issues

(2nd Edition)

Helen Mentha

2002



Eastern Drug and Alcohol Service

**A service of the Eastern Community Health Consortium:
Eastern Access Community Health • Inner East Community Health Service • MonashLink Community Health Service
Melbourne, Australia**

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Purpose of this Handbook

The Eastern Drug and Alcohol Service (EDAS) offers specialist drug and alcohol counselling to residents of the Eastern Metropolitan Region of Melbourne. EDAS also provides secondary consultation and training to other professionals.

EDAS is a service of the Eastern Community Health Consortium, comprising the Inner East Community Health Service, Eastern Access Community Health and MonashLink Community Health Service.

This handbook was developed as an introduction to working with alcohol and other drug issues, and presents some simple, practical strategies that may be applied in many different settings. The handbook was produced as a resource to assist other professionals to address drug and alcohol issues in their work. This resource may be used in conjunction with individual secondary consultation with one of our counsellors.

The handbook was written for workers in the Eastern Metropolitan Region of Melbourne and services mentioned in the handbook may not operate in other regions. The Additional Resources section at the back of the handbook provides sources of further information.

The handbook has been written by Helen Mentha B.A.(Hons), M.Psych (Clinical), M.A.P.S., who is a registered psychologist and a drug and alcohol counsellor with EDAS.

The handbook has also been published on the Internet. As the Internet version was developed for a broader audience, it contains fewer specific references to alcohol and drug services in the Eastern Metropolitan Region of Melbourne. The web site address for the handbook is: <http://www.edas.org.au>.

We hope you find this handbook a useful resource and please do not hesitate to call us if you require further assistance.

If you would like further information about EDAS or would like to speak with a drug and alcohol counsellor for secondary consultation, please phone our duty worker 9 am to 5 pm, Monday to Friday, on:

1300 650 705.

For twenty-four hour information about other drug and alcohol services in Victoria, phone Direct Line on **1800 888 236**.

To order additional copies of this handbook, please contact EDAS on **1300 650 705** or contact Helen Mentha, c/o Boroondara Community Health Centre, 378 Burwood Rd, Hawthorn, Victoria, 3122; phone **(03) 9818-6703**; fax **(03) 9818-6714**; or email **helen.mentha@iechs.org.au**.

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Table of Contents

<u>Secondary Consultation</u>	6
<u>Alcohol and Other Drugs</u>	7
<u>Types of drugs</u>	7
<u>Why people use drugs</u>	8
<u>Problematic drug use</u>	8
<u>Drug and Alcohol Services: The Treatment Options</u>	10
<u>Counselling</u>	10
<u>Withdrawal</u>	10
<u>Residential rehabilitation</u>	11
<u>Methadone</u>	11
<u>Naltrexone</u>	12
<u>Buprenorphine</u>	13
<u>Self-help groups</u>	14
<u>Twenty-four hour telephone counselling</u>	14
<u>Principles of Drug and Alcohol Counselling</u>	16
<u>Harm minimisation</u>	16
<u>Stages of change</u>	17
<u>Working with Clients with Drug and Alcohol Issues</u>	19
<u>Assessment</u>	19
<u>Evaluating pros and cons of substance use</u>	19
<u>Interventions</u>	20
<u>Coping with cravings</u>	21
<u>Strategies to cut down</u>	21
<u>Replacing the substance use</u>	22
<u>Rewarding effort</u>	23
<u>What not to do</u>	23
<u>When the strategies don't seem to work</u>	24
<u>Working with Specialist Client Groups</u>	26
<u>Cultural, linguistic and lifestyle diversity</u>	26
<u>Involuntary clients</u>	26
<u>Clients with a mental illness</u>	28
<u>Young people</u>	29
<u>Parents and other carers of people using substances</u>	31
<u>Workers dealing with alcohol and other drug issues</u>	32
<u>Additional Resources</u>	34
<u>Further reading</u>	34
<u>Further information</u>	34
<u>Other drug and alcohol web sites</u>	35
<u>Additional booklets and pamphlets</u>	35
<u>Substance use diary</u>	36
<u>Dealing with cravings</u>	36
<u>Strategies to cut down</u>	36
<u>How to say no</u>	36
<u>Things to do</u>	36
<u>Something to say?</u>	43

Secondary Consultation

Secondary consultation occurs when one professional seeks the advice of another professional regarding a client or general client-related issue. The nature of secondary consultation varies depending on the needs of the professional making the enquiry, including one-off consultations, ongoing consultations over a period of time and attendance at a case conference.

Secondary consultation may occur in conjunction with the client being referred to another agency or may take place instead of a referral. Secondary consultation may be more appropriate than referring a client for individual counselling when:

- The client does not want to see a drug and alcohol counsellor.
- The client does not want to see a new worker.
- The client would have difficulty getting to a drug and alcohol counsellor.
- The drug and alcohol issues are secondary to other difficulties the client is experiencing.
- The consistency of care would be compromised by involving too many workers.
- There is uncertainty about whether the client is suitable for referral.

This handbook is intended to facilitate the consultation process and provide an additional resource for professionals who encounter drug and alcohol issues in their work.

If you would like secondary consultation with a drug and alcohol counsellor, please call the EDAS duty worker on **1300 650 705**.

Alcohol and Other Drugs

Types of drugs

Alcohol and other drugs are often classified according to how they affect the person using the drug. The commonly used drugs fall into three categories: depressants, stimulants and hallucinogens. Depressants slow down the central nervous system and the person may experience relaxation, less pain and poorer coordination and judgment. Stimulants speed up the central nervous system and are associated with increased energy, confidence and sometimes paranoia. Hallucinogens distort the user's experience of reality, including sensory experience, sense of time and sense of self. Some drugs may have more than one effect. For example, cannabis is both a depressant and an hallucinogen, while most other hallucinogens have stimulant properties.

Often it is not possible to know what is in a drug, particularly if the drug is illegal and unregulated. For example, "ecstasy" is the street name for MDMA, a stimulant with hallucinogenic properties. However, a tablet sold as "ecstasy" may contain little or no MDMA, but may contain varying amounts of amphetamines or caffeine, other hallucinogens or other substances. Illegal drugs often have other cheaper substances added, such as glucose, to make the amount of the drug seem larger, which also makes it difficult to judge the strength of the drug.

Examples of Types of Drugs

Depressants	Stimulants	Hallucinogens
Alcohol	Amphetamines (speed)	Dissociative anaesthetics (e.g. PCP and Ketamine – also a depressant)
Inhalants (e.g. solvents, aerosols, petrol and glue)	Caffeine (e.g. cola, coffee and tea)	LSD (acid)
Minor Tranquillisers (e.g. Valium, Serapax, Rohypnol and Temazepam)	Cocaine	Mescaline
Opiates (e.g. heroin, morphine, methadone and codeine)	MDMA (ecstasy – also an hallucinogen)	Psilocybin (magic mushrooms)
Cannabis (also an hallucinogen)	Nicotine	

A person's subjective experience of a substance will also depend on the meaning they attribute to their experience. For example, one person smoking cannabis may enjoy the feeling that they are thinking about things from new perspectives, while another person may feel a sense of rising panic from the feeling of confusion and loss of control that can accompany altered perception of their world. The impact and experience of the substance can be influenced by three main groups of factors:

- Person:** This includes factors such as mood, physical health, body size, expectations about the effects of the drug, tolerance to the effects of the drug, allergies, mental health issues, and idiosyncratic differences in the way the body reacts to the substance.
- Drug:** Effects of a drug depends on factors such as the chemical composition, purity, amount taken, frequency taken, interactions with other substances and impact on core functions such as memory, emotional regulation, decision making, co-ordination and basic physiological regulatory systems.
- Environment:** The environmental factors include those of the immediate environment such as the safety of the place where substances are being used, the potential support available from others and the availability of medical help if needed, through to social and cultural factors such as socioeconomic conditions, levels

of unemployment and availability of other meaningful sources of pleasure and escape from pressures.

Why people use drugs

People use drugs for a wide range of reasons. Think about the last time that you used a drug. It may have been a cup of coffee with breakfast, an aspirin for a headache or a few drinks with friends. Why did you use the drug? You probably expected a rewarding experience of some kind. For example, you may have looked forward to an enjoyable taste, increased energy, relief from pain, relaxation or a sociable time.

People use alcohol and other drugs, both legal and illegal, for much the same reason. In the short term, drugs are rewarding for the pleasure they bring and/or the relief from physical or emotional pain. Their effects are usually relatively predictable and fast acting, and therefore can be appealing compared with the alternatives.

People also use drugs to varying degrees. They may use a drug in any of the following ways:

Abstinence: The person does not use the drug at all. For example, the person may drink alcohol but decide to abstain from cannabis.

Experimental: The person tries a new drug and may only use it once or a few times. For example, using LSD twice in the person's life.

Recreational: The person uses the drug for leisure. The use is usually planned and controlled, and may be specific to particular social situations or settings, such as parties, clubs or at home with friends. For example, taking ecstasy at a dance party or rave.

Regular: The person uses the drug as part of their lifestyle but use may still be controlled. For example, a glass or two of wine with dinner.

Dependence: The person uses the drug a lot and needs it to feel "normal", to cope with day-to-day problems or to stop the symptoms of withdrawal. For example, using heroin three times a day and feeling physically sick if heroin is not used.

Hazardous: The person takes serious risks when using the drug, such as taking excessive amounts of the drug or using a combination of drugs that may interact with each other, or taking other risks, including sharing injecting equipment or driving under the influence of the drug. For example, using a combination of large amounts of alcohol and prescription pills without anybody else present, risking both interaction between the drugs and overdose.

One type of use does not necessarily lead to heavier or more regular use. People may also use different drugs to different degrees, such as drinking alcohol on a regular basis but only occasionally using ecstasy. Experimental and recreational use of drugs is relatively common amongst young people and is associated with their developmental stage of risk taking and seeking new experiences.

Problematic drug use

Excessive use of alcohol or other drugs may lead to more problems in the long term, particularly if they are used as the main solution for meeting a range of needs. Problematic use may include:

- Always using a substance to deal with a particular problem (e.g. dealing with conflict).
- Continued use despite known negative consequences (e.g. continuing to drink despite liver damage or relationship problems).
- Using in situations where the person is at risk of other harm (e.g. accidents, unwanted sex or assault).

- Relying on a substance to regulate emotions (e.g. coping with negative feelings through substance use).
- Unsafe using practices (e.g. sharing any injecting equipment).
- Repeatedly engaging in risky behaviour while under the influence of the substance (e.g. drink driving).
- Frequent use in excess of the intended amount or inability to stop using while under the influence of the substance (e.g. “I’ll just have one” becomes a binge).
- Difficulty in saying “no” even when the person has decided that they do not want to use (e.g. when the substance is offered to them or is readily available).
- Ongoing difficulty fulfilling responsibilities for work, home or school as a result of use (e.g. taking time off work to recover from substance use).
- Recurrent legal problems arising from the substance use, behaviour while intoxicated or criminal acts committed in order to acquire the substance.

Further problems arise when the person becomes dependent on the substance – that is, they need the substance to feel normal and feel sick when they do not have it. If you suspect that your client may be dependent on a substance, it is advisable to seek medical advice on the risks associated with cutting down or stopping the substance use. It can be dangerous for some people to undergo withdrawal without medical supervision, particularly if there is a history of seizures in previous withdrawals.

For information on withdrawal, please read the section on withdrawal services in this handbook. Sources of further information have also been included in the Additional Resources section at the end of this handbook.

Drug and Alcohol Services: The Treatment Options

There is a range of treatment options for clients seeking help with alcohol and other drug related issues. Some clients will be able to be given appropriate assistance by their current worker and will not need further support from specialist drug and alcohol services. Both secondary consultation with a drug and alcohol counsellor and this handbook are intended to facilitate such work.

Every drug and alcohol service is able to provide secondary consultation. The needs of the client will determine which agency would be the most appropriate to provide secondary consultation, but most agencies can provide general information and suggest which agency would be the most useful for more specialised assistance.

Sometimes, however, more intensive interventions are required. This section is an introduction to the typical drug and alcohol services available to clients and when it is appropriate to refer clients to these services.

Counselling

Specialist drug and alcohol counsellors are able to bring both knowledge about drug use and interventions, and the experiences of many other clients who have been through similar experiences, to help clients to meet their goals. Drug and alcohol counsellors mainly focus on the drug-related issues, although they do assess the range of other issues with which the client is experiencing difficulty.

Sometimes these other issues are central to the substance use and must be addressed before substantial progress is made in the drug use. Depending on the nature of the client's problem and the counsellor's skills in this area, the counsellor may address these issues directly in counselling or may refer the client to an agency that specialises in that area. Common co-existing problems include grief and loss, trauma, childhood abuse, sexual assault, relationship and family break-ups, low self-esteem and overwhelming emotions, such as anger, anxiety and depression.

Drug and alcohol counsellors largely provide individual counselling to people experiencing difficulty regarding their alcohol or other drug use. However, drug and alcohol counsellors do offer a range of services including counselling for individuals, couples, families and groups. In addition, counsellors will see people who care for someone with an alcohol other drug issue, including parents, partners and friends. Drug and alcohol counsellors are also available for secondary consultation and training for other professionals.

Withdrawal

Withdrawal services offer assistance to people who are physically dependent on a substance. Dependence means that the person has been using the substance on such a regular basis, usually daily, that their body has adapted to having the substance in the system and that the person needs the drug to feel "normal".

If the person stops using that substance, they may experience withdrawal symptoms – that is, they feel sick without the substance but will feel better if they use the substance again. Typical withdrawal symptoms include:

- Difficulty sleeping
- Nausea
- Headaches
- Hot and cold flushes
- Sweating
- Lethargy
- Mood swings
- Irritability
- Increased anxiety
- Tremors

- Vivid and often distressing dreams.

Withdrawal services typically deal with the immediate physical and emotional aspects of withdrawal. These services provide medical supervision and support on a short-term basis while the person experiences withdrawal. Typically, the worst of the withdrawal is over between four days to two weeks, depending on the substance.

Medical support is highly recommended for clients experiencing withdrawal from a drug as it can be dangerous, and even life-threatening, to undergo withdrawal unsupervised. It is especially important that clients with a high level of drug use or a history of seizures during withdrawal are supervised during this time. It is also recommended that women who are dependent on a substance and pregnant seek specialist medical support from a hospital-based ante-natal chemical dependency unit.

However, physical withdrawal is only part of dealing with dependence, as physical withdrawal will not necessarily address the person's psychological dependence on the substance. Psychological dependence refers to the reliance on a substance to face day to day life, including: dealing with painful emotions, alleviating boredom, satisfying cravings, managing pain, and use of the substance in the person's social circle. These underlying issues often can only be addressed once worst of the withdrawal symptoms have passed and the person is able to focus their attention on issues other than the immediate experience of withdrawal.

Residential withdrawal services: Residential withdrawal services offer an average of six days of supervised accommodation and support while the person withdraws from the substance. There is always a registered nurse on duty as well as welfare workers. Residential services usually have a structured program, including duties, group attendance and discharge planning. As the client is usually feeling unwell during this time they may not be in the condition to fully engage in counselling for much of the stay.

Home-based withdrawal: Clients may also be supported through mild to moderate withdrawal in their own home. In most cases, this service requires that the client have a support person within the home and a drug-free environment for withdrawal. This option is particularly worth considering for mothers with children in their care, young people who live in the family home, and clients who work in the health or welfare field and who are concerned about confidentiality issues.

Outpatient withdrawal: The third withdrawal option is outpatient withdrawal, where the client attends appointments at the site where the withdrawal service is based. As with home-based withdrawal, this option is more appropriate for clients expecting to undergo mild to moderate withdrawal and who prefer to stay at home rather than go into the residential program.

Youth withdrawal services: Specialist youth withdrawal services include residential withdrawal and respite units as well as home-based withdrawal.

Residential rehabilitation

Rehabilitation programs are a further option for clients to consider, especially if they have difficulty adjusting to life without substance use and continue to relapse back into use. These programs are long-term residential programs that usually last between three and twelve months. Rehabilitation programs are staffed twenty-four hours a day, and have a structured format, which usually includes life-skills training and counselling for personal issues. Most programs require that the client has undergone withdrawal with a recognized withdrawal service and are drug-free at the time of entry into the program. Some programs exclude clients who are currently on methadone maintenance.

Methadone

One option available to clients who use opiates such as heroin, morphine or codeine is to substitute the opiate with a legal, supervised alternative. Methadone is a synthetic opiate, which is prescribed by a doctor who has completed a methadone training program. Methadone is taken orally under the supervision of a pharmacist. It is important to note that, being an opiate, methadone is still

addictive and people reducing or ceasing their methadone treatment will most likely experience withdrawal, and that this withdrawal takes longer than withdrawal from heroin.

The advantages of methadone treatment include:

- Reduced cost – clients only pay a dispensary fee at the chemist.
- Regulated dose – clients know exactly how much they are using.
- Oral administration – methadone is taken orally and reduces the health risks from intravenous drug use.
- More stable lifestyle – the inexpensive, regular dose can help some clients to get other areas of their lives back in order, such as health, work, relationships, accommodation, parenting or study.
- Reduced crime – without needing to support a daily heroin habit, methadone users may feel less need to commit crimes, such as theft or prostitution.
- Longer lasting – methadone stays in the person's body for much longer than heroin and only requires one dose per day, usually at a regular time.
- Does not give the same high – methadone can cause the client to feel “drug-effected” but the effect comes on more slowly and does not cause the same high as heroin, breaking the link between opiate use and the reinforcing “high”.
- Allows client to make long-term changes – recovering from opiate addiction can mean a complete change in lifestyle for some people and no matter how determined the person is to stop using, these changes can take time. Some people may need to: move to new accommodation or to a completely new area, end significant relationships, leave entire networks of friends and acquaintances and form new supports and friendships, change work, change routines, learn new skills, learn how to deal with strong emotions and develop a new role in a society that often does not understand substance dependence.
- Use heroin less frequently – for clients who are not yet ready or prepared to cease heroin use, methadone maintenance can reduce the amount and frequency of heroin use and allow the client to reduce the cost and risks associated with high frequency heroin use.

However, methadone is not the ideal treatment option for all people experiencing opiate addiction. There are a number of disadvantages with methadone maintenance that need to be considered:

- Daily dose – clients usually need to attend a specific pharmacy for at least six out of seven days per week as “take-away” doses are limited and require the doctor's authorisation. In addition, travel must be planned well in advance to organize a temporary transfer to a chemist who dispenses methadone (not all chemists do) in the area where the client is going.
- Drawn-out withdrawal – as methadone stays in the system for much longer than heroin, the withdrawal lasts for much longer than that of heroin. Some symptoms, such as disturbed sleep, may still be experienced a month after ceasing or significantly reducing use. Reducing methadone is usually best done as part of a long-term plan where the client reduces their dose in stages and then stabilizes on the new dose before decreasing the dose again. Some clients choose to reduce their dose in tiny amounts on a regular basis in order to minimize the withdrawal and subsequent disruption to their life, such as reducing the dose by one or two milligrams per week.
- Side effects – some clients may experience one or more of the following side effects: lethargy, sweating (especially at night), constipation, aching muscles and joints, reduced sex-drive, rashes or itching, fluid retention, appetite disturbance or stomach cramps.
- Methadone is an opiate – methadone does not “cure” addiction to opiates, but reduces some of the problems inherent in illegal, expensive, and unsupervised opiate use.
- Risk of overdose – it is common for people using methadone to continue to use heroin at reduced levels and overdose is possible when the person does not allow for the methadone already in their system.

Naltrexone

Naltrexone is another option available to clients who have been using either opiates or alcohol. It can be used in three ways: rapid detoxification from opiate use; maintenance treatment for opiates; and maintenance treatment for alcohol. Naltrexone is not a miracle cure for addiction and is most

successful when used in combination with counselling and other approaches to overcoming dependence on opiates or alcohol. Naltrexone is not appropriate for all clients but increases the range of options available to individuals wishing to change their substance use.

Rapid detoxification for opiate dependence: Naltrexone can be used in specialist clinics to shorten the duration of the withdrawal after stopping opiate use. However, this only deals with the physical dependence, and any psychological dependence on opiates may still need to be addressed following the withdrawal process.

Maintenance treatment for opiates: Naltrexone is an opiate-antagonist, which means that it blocks the receptors in the brain that detect opiates so that the client would not feel the effects of opiates if they took them. Like methadone, Naltrexone is taken daily and is prescribed by a doctor. As Naltrexone stops the body from detecting opiates, the person must be free of all opiates, including methadone, for at least seven days prior to commencing treatment, otherwise the person may experience sudden withdrawal symptoms.

There are a number of advantages with Naltrexone, including:

- Reduces “craving” for opiates.
- Using opiates has no rewarding effect and reduces the desire to use them.
- Gives clients another option, especially if other options have not been successful.
- While not using opiates, clients have the chance to make lifestyle changes and find healthier alternatives to substance use.
- Does not require daily visits to the pharmacist, unlike methadone.

There are disadvantages with Naltrexone as well, including:

- Risk of overdose after ceasing Naltrexone – clients may underestimate how much their tolerance has decreased once they cease using Naltrexone. It is also possible to overdose after ceasing Naltrexone if the person uses opiates before the Naltrexone has worn off, then uses more opiates to feel an effect and then floods the receptors with both the original dose and the additional dose when the Naltrexone wears off.
- Inappropriate option for clients who want to use opiates still, even if “only a little”.
- Naltrexone does not necessarily stop the desire to use opiates and underlying issues may need to be addressed.
- Naltrexone alone is usually not enough –clients tend to benefit from a combination of Naltrexone and counselling.
- Side effects – some clients experience side effects, including: nausea, dizziness and drowsiness.
- Clients must be fully withdrawn from all opiates.

Maintenance treatment for alcohol: Naltrexone does not block the effect of alcohol, but reduces the euphoria of drinking and may be used to assist clients to be either abstinent from alcohol or to maintain controlled drinking. As with opiates, clients may still need to address the psychological factors that led them to use alcohol excessively in the first place.

Buprenorphine

Buprenorphine is one of the newer treatment options to be made available to clients. It is both a partial agonist (has opiate effects, like methadone) and partial antagonist (blocks or reduces the effects of further opiate use, like naltrexone). Doctors must have a licence to prescribe buprenorphine, as with methadone. Buprenorphine is taken at the chemist like methadone, but is administered as tablets that are dissolved under the tongue. Buprenorphine can be used to assist a person to withdraw more gently from heroin or methadone, or may be used as a maintenance treatment. As buprenorphine is still a relatively new option, the advantages and disadvantages for clients are still being established.

The advantages include:

- Long-acting properties mean that clients may receive their dose every second day or three times a week, increasing flexibility of lifestyle and reducing dispensing costs, although some clients still prefer daily medication.
- The opiate effect is reported to be less sedating than methadone, morphine or heroin.
- At appropriate doses, the opiate effect can be sufficient to prevent withdrawal or “hanging out” and reduces cravings to use heroin.
- Clients report the withdrawal from buprenorphine is milder and easier to tolerate than withdrawal from methadone or heroin.

The disadvantages include:

- Longer dispensing time (approximately 3-5 minutes) than methadone, as the tablets must be dissolved under the tongue. Some clients also report that this is a somewhat awkward or uncomfortable experience while it lasts.
- Clients usually need to be on 30 ml methadone or less before being able to transfer to buprenorphine, although transferring from higher doses of methadone may be negotiated under some circumstances.
- Chemists still charge a dispensing fee, similar to that of methadone.
- At the time of writing, clients who are pregnant or breast-feeding are not recommended for treatment with buprenorphine.
- Overdose is possible, but more likely if combined with other depressants.

Self-help groups

Another treatment option available to clients is self-help groups. Self-help groups are run by people who have also experienced problems with alcohol or other drugs. Some clients find it useful to talk with someone who has had similar experiences to them and understands the obstacles they face in making their recovery. Self-help groups will usually offer the option of having a sponsor or mentor, who the person can call on in times of need or cravings.

Anyone can attend self-help groups and people can attend as many different meetings as they like. For example, when some people are experiencing strong cravings to use, they may attend up to three meetings a day for support and to occupy their time. Self-help groups have meetings in the evenings as well, when many of the professional services are closed. Some areas also have specialist self help groups for particular groups of people, for example, based on gender, sexual orientation, age or profession.

The main disadvantage of self-help groups is that the people who attend can end up making contacts that will make it easier to return to their substance use, particularly if they are feeling vulnerable. Different groups also vary in the mix of personalities attending the group, and clients may wish to attend a few different groups before finding one they are comfortable with. Some clients are not comfortable with the references to religion in 12-step programs such as Alcoholics Anonymous or Narcotics Anonymous. Some clients may not feel comfortable in a group setting.

Oxford Houses of Australia offer accommodation for people recovering from alcohol and other drug problems. These houses are intended to provide a safe, alcohol and other drug free environment. The houses are self-run and self-supporting with the aim of helping the residents to develop a fulfilling role in the community without the use of substances.

Twenty-four hour telephone counselling

Another option available to clients is to call the twenty-four hour telephone counselling services. These services can be particularly useful at times when other services are closed, or the client feels it is too late at night to call friends or family. Although some clients have to wait on hold for a while before they can speak with a counsellor, calling one of these services may make the difference between coping with cravings and going out and using the substance.

Phone lines specialising in alcohol and other drug issues are a useful resource for both workers and clients. In addition to counselling, they also provide information and contact details for the various alcohol and other drug services available.

Principles of Drug and Alcohol Counselling

Drug and alcohol counselling is much like other counselling. It is important to:

- Listen
- Be non-judgmental
- Help the clients to find their own solutions.

Different drug and alcohol counsellors work in different ways, and there can be differences in the philosophical approach taken by various agencies. Typically, however, the counselling will include an assessment of the substance use history and current patterns of use. Counsellors then assist individuals to find strategies to cut down or quit and replace the substance use with other solutions or activities.

Harm minimisation

EDAS counsellors work from a principle of harm minimisation. Our first aim is to help the person to survive their drug use and reduce the damage associated with the drug use.

Harm minimisation does not encourage drug use and is not in opposition to abstinence. Abstinence is one of a range of harm minimisation strategies available to us. However, some clients are either not able to stop using despite repeated attempts or do not want to stop using at this point in time. Therefore, we need to consider a range of other interventions.

Harm from substance use can come from a range of different sources, not just the type of drug and how much is used. There are five main sources of harm from drug use. They are listed below, with an example of both a type of harm and a harm minimisation strategy.

Sources of Drug Related Harm

Source of Harm	Definition, Harm and Intervention
Acquisition	How you get hold of the drug, including getting the money and the drug itself Harm: committing criminal offences to fund a heroin habit Harm minimisation: methadone maintenance to reduce the need to use heroin or as much heroin – this may create an opportunity to get other areas of one’s life back under control – e.g. relationships, finances, work.
Administration	How you put the drug into your body – e.g. smoke, inject, snort, drink, or eat it Harm: contracting HIV or Hepatitis C from sharing injecting equipment, including syringes, spoons, swabs, filters, tourniquets and any other possible source of blood-to-blood contact Harm minimisation: use of needle exchange and safer injecting practices, smoking or snorting instead of injecting
Intoxication	What the drug does to your body Harm: e.g. cirrhosis of the liver Harm minimisation: education on standard drinks and safer levels of drinking

Source of Harm	Definition, Harm and Intervention
Intoxicated behaviour	<p>What you do while the drug is affecting you</p> <p>Harm: drink-driving</p> <p>Harm minimisation: drink-drive campaigns, breath testers in pubs</p>
Crash/ Withdrawal	<p>What happens when you are recovering from the drug</p> <p>Harm: keep using to stop withdrawal symptoms or post-pone the “crash” of the effects of the substance wearing off</p> <p>Harm minimisation: support and medical supervision if needed</p>

Stages of change

People experiencing alcohol and other drug problems typically go through a series of stages in dealing with their use. These stages were identified by Prochaska and Di Clemente (references and suggestions for further reading can be found at the back of this handbook). The stages are as follows:

Precontemplation: The person does not believe they have a problem or does not want to change.

Contemplation: The person is beginning to evaluate their use and starts to think about changing their pattern of use.

Determination The person decides that they do want to change their pattern of use.

Action: The person changes their use by cutting down or quitting.

Maintenance: The person tries to keep to their reduced level or abstinence.

Relapse: The person returns to increased use.

Clients may only experience one or two stages of the model while others may go around the cycle many times. It is important to be aware that it is common for people to swing back and forth between particular stages. For example, a person may be ambivalent about their drug use and swing between precontemplation and contemplation many times before they decide to change their pattern of use. It is also common for people to retreat back into contemplation or precontemplation at a time when they appear very motivated to make change and may even have already taken action to reduce or cease use. This can be bewildering or frustrating for the worker, as the client had appeared to be making good progress, and may indeed be frustrating for the client as well.

The diagram on the following page represents the different stages of change. The diagram may be used as a handout with clients to identify which stage the client is in. It can also be helpful for clients who have lapsed back into increased use to see that they are simply going around the cycle one more time, as they can often feel that they have made no progress at all. The diagram illustrates the stages involved in quitting the drug, but the process applies equally to reducing use as well.

Stages of change
Prochaska and Di Clemente



Working with Clients with Drug and Alcohol Issues

Assessment

If you are already working with the client, you will probably be familiar with their general history and current issues. For each drug used it is useful to get a history of the pattern of use and what was going on in the client's life when:

- The substance use started
- The substance use became more regular or more of a problem
- The substance use reduced or ceased, even if only temporarily.

This information may help to identify what issues are associated with the substance use and may still need to be addressed, especially where grief or trauma is involved. Information about what was going on when the substance use reduced or ceased may be useful in developing strategies to cut down or quit this time.

As always, it is important to assess for risk as well. In addition to assessing risk of harming oneself or others, it is also important to check for risks commonly associated with substance use, including:

- Sharing any injecting or preparation equipment (including syringe, spoon, swab, filter and tourniquet)
- Unsafe sex
- Drink driving
- History of overdoses
- History of seizures during withdrawal.

It can be useful to have the client record their drug use on a daily basis. Substance use diaries can give valuable information about the person's pattern of use, triggers to use and any changes or improvements in use over a period of time. A blank example of such a diary is included in the back of this handbook to use with clients. The examples recorded in the diary can be examined with the client to identify whether there are patterns in the way the person uses the substance. It can be useful to look for patterns with the following factors:

- Time of day (e.g. preparing evening meal and the children are demanding a lot of attention)
- Day of the week (e.g. pay day)
- Type of situation (e.g. after having an argument or relaxing in front of the television)
- Location (e.g. feeling cravings to use after walking past the dealer's house)
- Presence of, or encounters with, particular people (e.g. an ex-partner)
- Particular thoughts (e.g. "just one won't hurt" or "I can't bear this anymore – I have to use")
- Particular emotions (e.g. anxious or bored)
- Precursors (e.g. when tired, run-down, hungry, haven't slept well or ongoing stress).

Evaluating pros and cons of substance use

Although there can be many negative consequences from drug use, people also experience a range of positive experiences from their substance. They will still want those positive experiences even if they quit using the substance and will need to find other ways to meet those needs.

For example, if the substance helps someone to relax, it will be important for that person to find other ways of relaxing. Likewise, if a person tends to use a substance to help to deal with unpleasant emotions, it will be important to develop other ways to deal with those feelings.

It can be valuable to ask the client about the good and bad things about both using the substance and cutting down or quitting the substance. Often clients will think about either the good things or the bad things, while looking at both at once helps to build a more complete picture of their substance use and what it means to them. It can also be a positive experience for clients to find that you are interested in finding out what they enjoy about their substance use, as they may have been expecting

you just to focus on the negative aspects of their use. However, we also need to balance discussion about the benefits of the substance use with the client’s perception of the benefits of change.

The “good things about using” and the “hard things about cutting down” in the following table are particularly useful in identifying what needs may have to be met in other ways. Replacing the drug use with healthier alternatives decreases the client’s need to go back to the drug use to meet those needs. Sometimes the underlying needs require more intensive intervention and may involve referral to another professional.

An example of a completed table of pros and cons

	Using	Cutting Down or Quitting
Good	<p>“What are some of the things you like about using the drug?”</p> <ul style="list-style-type: none"> relaxation forget problems feels good deal with anxiety deal with boredom 	<p>“What would be good about cutting down or quitting – what are you looking forward to?”</p> <ul style="list-style-type: none"> more money healthier less conflict with family
Not Good	<p>“What don’t you like about using the drug?”</p> <ul style="list-style-type: none"> expensive poor health problems in relationships cravings 	<p>“What would make it difficult to cut down or quit – what would be hard about it?”</p> <ul style="list-style-type: none"> resisting cravings dealing with problems withdrawal finding other things to do

Interventions

It is important to identify what stage the client is in before deciding what intervention to use. For example, if a person is in the precontemplation stage, it may be unrealistic to attempt to get them to quit. It may be more useful just to explore their use with them, including looking at both the advantages and disadvantages of their substance use and the role it has in their life. It can also be useful to leave the topic of their substance use for a while and discuss other issues that they identify as being more relevant. Trying to address too much too soon may be overwhelming, so it is important to try and work at a pace that is comfortable for the client.

Precontemplation: Information and education, harm minimisation, exploration of issues, including the pros and cons of substance use.

Contemplation: Evaluate pros and cons of the substance use, start to develop strategies to cut down or quit, start to develop alternative solutions and activities.

Determination: Plan the change in drug use, select strategies and prepare for change.

Action: Put strategies into place and reward effort.

Maintenance: Evaluate strategies and improve them, plan ahead for danger times, reward effort.

Relapse: Evaluate which strategies worked and which strategies need to be modified, use the information to plan ahead for the continuing process of making change.

Coping with cravings

Often when a person tries to cut down or stop their substance use they will experience strong urges to use that substance again. The following range of suggestions have been found to be useful by other people experiencing cravings but some strategies may suit some people more than others. Discussing these strategies with your client may also help them to think of additional ideas that will work for them. The strategies have also been included as a client handout at the back of this handbook:

- Identify when the craving starts – knowing what is going on is the first step in doing something about it.
- Remind yourself that cravings are a normal part of cutting down and that they will pass with time – the more you give into cravings the stronger they become.
- Remember that cravings are like a hungry cat – the more you feed it the more the cat comes back. If you don't feed it, the cat eventually stops coming back.
- Try to find something to distract yourself with - even if you only delay using the substance
- Try to work out when you are more likely to crave the substance - e.g. in certain situations, with particular people, when you feel a certain way - and plan ahead how you will deal with each situation when it comes up.
- Delay using for an hour, or even five minutes. When the time is up, delay using for another hour, and then another and so on. It is easier to resist cravings for a manageable period of time than to stop “forever”.
- Talk to someone supportive when you start to get cravings.
- Do something relaxing and enjoyable instead.
- Have a bath or shower.
- Have a massage.
- Go for a walk or run, or do other physical exercise.
- Visit friends who don't use the substance or won't while you are there.
- Watch a video or go to the movies.
- Listen to relaxation tapes.
- Reward your efforts to cut down, even if you ended up using more than you meant to - it takes time to make change and being hard on yourself will make it more difficult to change your habits
- Talk to friends who have been able to cut down their use and find out what worked for them.
- Talk to friends about how they enjoy themselves or relax to get some more ideas.

Strategies to cut down

Some people choose to reduce their use rather than stop it altogether. As with the strategies for resisting cravings, different strategies will suit different people. The following list of options for cutting down may be presented to clients and discussed in order to evaluate which strategies they would like to try. The suggestions in this section are also included as a client handout in the back of the handbook:

- Plan the substance use.
- Set limits on the day, time and amount used (e.g. only after 8 pm).
- Try to have at least two substance free days per week.
- Delay the first use and each use after that.
- Find something else to do as a distraction from wanting to use more.
- Arrive later.
- Leave earlier.
- Spend time with someone who will support your efforts to cut down.
- Try to avoid situations where you are likely to use or use a lot.
- Try to plan what days will be “normal” use and what days will be heavier use.
- Only prepare a little bit of the substance at a time, even if you intend to use more.
- Place the drug in a place that is hard to get to, or give it to someone who is supportive.
- Reduce your tolerance - you will need less.

- Keep a record of how much you are using and check whether you are meeting your goals.
- Do not try to keep up with other people - go at your own pace.
- Only take as much cash as you need when you go out.
- Leave your ATM card at home.

Replacing the substance use

As stated previously, substance use can be rewarding in many ways for the person, even when there are considerable negative consequences as well. To increase the likelihood that changes in substance use will be long-lasting changes, it is important to identify what needs the substance use is meeting and replace the substance with other ways of meeting that need.

One difficulty many clients experience in trying to replace their substance use with healthier alternatives is that few alternatives work as quickly or effectively as a chemical that directly alters the brain's processes. Instead of looking for one solution that will replace the substance, it is usually more effective to try and replace the substance with a variety of alternatives, so that the person can select the option most appropriate for each situation.

In addition, many clients will feel that their substance use is "second nature" and all too easy. It can be useful to ask the client to think back to when they first started using the substance. When a person uses a new substance for the first time, there is often some uncertainty about:

- What to expect from the experience
- How to use special equipment (e.g. how to roll a joint, or use a bong or syringe)
- Substance use "etiquette" (the often unspoken "rules" of how to use the substance in a social setting)
- How to behave or control certain behaviours (e.g. uncontrollable giggling while smoking cannabis, loss of balance while drinking, or dealing with the "outside world" while using LSD)
- How to cope with unexpected experiences (e.g. anxiety or paranoia while smoking cannabis or possible overdose by another person present).

People who use substances to excess have plenty of opportunities to practice the skills required in using the substance and learn ways to compensate for difficulty in carrying out normal activities. When the substance use becomes easier, it is common for people to forget that it wasn't always so simple or easy.

The same principles apply when learning how to replace the substance use with alternatives. At first, the new activity may feel awkward or unsatisfying, but with practice may become more rewarding and a more effective alternative to the substance use. It is worth reminding clients that just as it probably took them a while to develop a substance use habit, it will probably take a while to develop a range of alternatives that will effectively meet the needs that the substance use met.

Often clients will experience difficulty in thinking of alternatives to substance use, especially if the use and use-related activities dominated their lives. For some clients, it can be helpful to ask them to think about what they used to do before the substance use became a problem. However, for some clients the substance use prevented them from developing alternatives. This is particularly the case for people who started to use substances at an early age, before they developed well-established, alternative ways to deal with difficulties or to spend time.

Replacing the substance use with viable alternatives can sometimes be a process of trial and error. Solutions will differ according to the individuals' needs, abilities and preferences. There are, however, common themes in the kinds of areas that clients want to work on in finding alternatives to the substance use, including:

- Finding ways to relax and unwind
- Developing assertiveness
- Dealing with unpleasant feelings, such as anxiety, depression, guilt, anger and grief
- Coping with trauma
- Finding enjoyable ways to spend time

- Developing self-esteem.

These are familiar themes in any counselling setting, regardless of whether the client uses substances or not and the counsellor can work with these issues as they would with any client.

Given that substance use and related activities can consume a lot of clients' time, finding alternative ways to spend time is a very common focus of drug and alcohol counselling. A list of ways to spend time has been included in the back of this handbook to help clients to think of new ways to experience pleasure.

Rewarding effort

An important part of trying to change substance use patterns is to acknowledge and reward the effort it takes to make those changes. Often clients fall into the trap of taking any change for granted, because they feel that they should not have developed the problem in the first place. Far from feeling proud of their achievements, they may be hard on themselves for experiencing difficulty in making those changes.

Many people in our society believe in the myth that you just need enough will power to stop or cut down, and that those who cannot are somehow weak or aren't trying hard enough. Relying on will power alone is a difficult and often ineffective way to make changes in substance use. It is more effective to take the time to examine what the substance means to the client and finding alternative ways to meet those underlying needs.

There is also a widely held belief that returning to increased levels of use is a sign of failure or weakness. Often clients will be critical of themselves when they lapse back into increased use, and such criticism may risk further substance use to relieve unpleasant feelings this criticism creates. Sometimes it is not the client but the people around them who view the lapse as a problem. It is useful to examine the meaning of the lapse for the client, as it may have been planned or it may have become a source of further motivation to keep making change. Changing any behaviour often involves a degree of trial and error and lapses back into use are a natural part of making those changes.

Rather than view the lapse as failure, it is far more useful to use the lapse as a learning experience and gain better information about what situations are likely to trigger substance use again in the future. Ask the client what they would have done differently and what they would still have done the same way, and use this information to develop more effective strategies to change their substance use.

Given that clients usually experience some pleasure or benefit from their use, it is important to replace the reward of using with rewards for not using or for cutting down. Even if the client experiences lapses into increased use, the effort they are putting into changing their use should be rewarded.

If the client's experience of trying to make change is one of difficulty and emotional or physical pain, they will have all the more reason to want to return to their substance use to feel relief and to feel normal again. Therefore, it is all the more important to help the client to plan pleasant events or activities into their week to provide some relief from the pain that making changes often brings. The list of enjoyable and relaxing things to do at the back of this handbook can be useful in helping clients to identify rewards that are meaningful for them.

What not to do

There are few "right" or "wrong" ways to do counselling with clients, as different approaches will suit different people. However, there are some approaches that seem less useful than others in terms of achieving positive outcomes.

Telling the client what to do - for example telling them to "Just say no" - tends not to be effective, despite its popularity in some anti-drug campaigns. If the client is not sure that they want to stop or

are unsure why they should stop, telling them to be abstinent will not be a very powerful motivator to resist temptation to use. The belief that making change is just a matter of will power is inaccurate and may reinforce a sense of failure or inadequacy in the client.

Helping the client to set their own goals and find their own solutions is more effective as it allows the client ownership of a solution that is tailored to their own needs. In addition, the client is better able to learn the skills in making change rather than simply focussing on the outcome of that change. They then may be able to apply those skills again in the future, whether in relation to substance use or other issues.

Confronting and criticising the client regarding their substance use may only succeed in alienating the client and limiting future access to otherwise beneficial support. Similarly, labelling the client as an “alcoholic”, “drug user” or “junkie” may reinforce the idea that they cannot change – e.g. “I drink because I am an alcoholic”. Labelling the client also ignores the other qualities and roles that the client has in their life and implies that whatever else they may do well, it doesn’t matter because they are primarily defined by the fact that they use substances.

Many clients will use substances when they feel unpleasant emotions, and criticism often leads to feelings such as guilt, failure, hopelessness, or resentment. Therefore, criticism and harsh judgements may provide more incentive to keep using rather than to make change, particularly if they have not yet developed alternative ways of dealing with unpleasant feelings.

Threatening clients with negative consequences may also alienate the client and simply result in them withholding information and withdrawing from potential support. Like most people, clients with substance use issues will be more open to making long-term change when they are aware of the benefits of such change rather than simply fear certain consequences. Counselling is always more effective when it is a collaborative, rather than a coercive, process.

Ultimately it is useful to keep in mind that substance use can occur anywhere and that there are many techniques that people can use to avoid detection. Due to the stigma attached to substance use, clients may already be very practiced at concealing their use or minimising the extent of it. The approach most likely to be met with acceptance and co-operation by the client is to listen, be non-judgemental and to focus on the client’s needs and finding alternative ways to meet those needs.

When the strategies don’t seem to work

The strategies suggested in this handbook work for some people but some clients continue to experience difficulty. This can be a frustrating time for professionals, especially when they feel that the person now has a range of strategies to change the alcohol or other drug use.

At this stage it can be useful to go back to exploring the person’s motivation to change and the positive experiences that the drug provides. It may be that the drug still continues to provide a reward that the client does not yet find anywhere else. Sometimes clients find it hard to change their drug use when they are motivated by reasons other than their own desire to change. For example, they may be trying to change to please a partner, to reduce conflict with their parents or to co-operate with an agency such as Child Protection. It is important to try to understand the client’s substance use in the context of their whole life.

Clients often have mixed feelings about changing their drug use. They may be very aware of the difficulties their use has caused, yet still desire to feel the way the drug makes them feel. It is common for people changing their drug use to feel a sense of loss or grief over cutting down or quitting. They may miss the feeling of the drug, the ritual of using, the lifestyle surrounding the drug or the social network related to their drug use. Some people may dislike the drug-related lifestyle yet feel a sense of belonging with other people who use the drug. They may feel alienated from “straight” or “normal” people and may feel unsure of who they are without the drug lifestyle to define who they are and what they do.

Issues of confidentiality may also interfere with the change process. Clients may be withholding information if they are unsure what will happen with that information. There are many reasons why a client may be wary about the information they disclose including:

- Involvement of agencies such as Child Protection or the Office of Corrections, who are able to impose significant negative consequences on the client
- Use of illegal substances, and the risk of criminal charges
- Paranoia, which is relatively common with substances such as cannabis and amphetamines
- Social stigma and fear of negative consequences such as being ostracised or losing employment
- Use of interpreters, especially when the client comes from a small community, such as the deaf community or from a culture that speaks a language other than English
- Fear that parents, children or partners will somehow find out
- Difficulty in admitting the extent of the problem, even to themselves
- Fear of negative judgement from the worker regarding use or lapses back into use
- Involvement in current or pending legal processes, such as facing criminal charges or going to the family court.

When initial interventions do not seem to be effective, it may be useful to refer the client to a drug and alcohol counsellor or to seek secondary consultation with a drug and alcohol counsellor regarding the particular client as different solutions will suit different people.

Sometimes people take time to commit to making change and this may not be the right time for the client. If this seems to be the case, it is important to return to harm minimisation strategies to reduce the negative consequences of the drug use until the client is ready to make more change.

Working with Specialist Client Groups

Cultural, linguistic and lifestyle diversity

As with all counselling it is important to be aware of our own values and assumptions, and to recognise that they may not hold true for other people. This is particularly the case with substance use, which raises issues on many levels, including: moral, legal, health, social, religious and cultural aspects.

People's attitudes toward substance use can be influenced by their cultural background or context. The cultural group or groups with which a person most identifies can be determined by a range of factors including: ethnicity, nationality, religion, language, sexual orientation, disability, occupation, location, education, income. For example, excessive use of alcohol may be seen as shameful in a religious community that favours abstinence from alcohol and yet be seen as normal, if not necessary, in a university residential college.

If a person identifies with more than one cultural group, which is often the case, there may be conflict between the different groups' "typical" views toward drug use, and the person may in turn experience conflict or ambivalence within themselves over their substance use.

Alternatively, the person's attitudes towards substance use may differ from the majority of members of their identified social or cultural group, even if they share attitudes toward other issues. It is important to try to identify the meaning of the substance use to both the individual and the culture with which they identify themselves.

Attitudes may also differ depending on the drug in question. For example, some groups of people who smoke cannabis together may, overall, feel that heroin is a dangerous drug that should not be used. In some subgroups of people using heroin, it may be another drug, such as alcohol or amphetamines that is seen as unacceptable or dangerous.

As substance use often carries a social stigma, confidentiality is particularly important. Naturally, confidentiality is important in any counselling setting and professionals have ethical standards that they must uphold. Just as important, though, is the client's perception of whether the counselling setting is a confidential and safe environment in which to discuss sensitive issues, especially if they fear negative consequences from others finding out about their substance use. These concerns are often justified, given that workers can breach confidentiality if they believe the client is in serious danger of harming themselves or someone else, if they are subpoenaed to appear in court or if their profession requires mandatory reporting of child abuse.

Confidentiality becomes particularly relevant when a third person is involved in the session, whether they be an interpreter, another health or welfare worker, family member, partner or a counselling student. Use of interpreters may raise confidentiality concerns for the client if they know the interpreter from other settings, including socially, or if the client is a prominent or active member of their community. This is particularly relevant for small or close communities, such as the deaf community or people from a culture that speaks a language other than English.

The client may feel more comfortable if they have the opportunity to select their own interpreter or have the guidelines of confidentiality explicitly discussed and agreed to by all involved. If a client does not feel a sense of trust in the counselling process, then they are less likely to benefit from the experience or may not even participate at all.

Involuntary clients

Often when we see clients with alcohol and other drug problems, it has been someone other than the client who is advocating change in the client's drug use. Agencies such as Child Protection, the Office of Corrections and mental health services, for example, regularly work with clients who do not want to attend the agency but are required to by law.

The case management plans for these clients often involve the requirement that they cease or substantially reduce their alcohol or other drug use, and this requirement is often linked with an important consequence. For example a client of Child Protection may be informed that they need to change substance use that is seen to be affecting their parenting ability before they will have their children returned. A client of the Office of Corrections may be told that they must refrain from using illegal substances and supply drug-free urine samples or return to court for breaching their parole conditions. A client of mental health services may be told to stop using substances that could interfere with the effect of psychiatric medication or risk experiencing another episode of their psychiatric illness.

Motivation to change is one of the key factors in whether change will occur and yet the involuntary client may not have much, if any, desire to change. There may be more motivation to keep using than to change their use, despite the possibility of negative consequences. Working with clients on alcohol or other drug issues can be difficult in these circumstances, as the worker and the client may have very different goals.

The potential for the agency to impose negative consequences on the client for not changing their drug use may encourage some clients to present their past or current use in the most positive, but not necessarily accurate, light. This is particularly the case when clients do not trust that the agency is “on their side” or fear that they will be judged harshly for their continued use. The client may even want to cut down or stop, but continue to experience difficulty in doing so.

Engaging a client in counselling under these conditions is particularly difficult, as counselling relies heavily on client motivation to change and on the openness and trust of the therapeutic relationship. When working with an involuntary client regarding alcohol and other drug issues, it is important to:

- Openly discuss the goals of counselling and acknowledge that the therapist’s or referrer’s goals may be different from the client’s goals.
- Acknowledge that the client may not agree with the goals that have been set for them, such as ceasing substance use.
- Ask the client how they feel about being told to change their use.
- Acknowledge that changing drug use can be a slow and difficult process, even for those who do want to change.
- Acknowledge that the client may experience positive outcomes from their substance use (e.g. relaxation, relief from emotional distress, enjoyment or feeling in control of the difficulties they face), even if there are also negative consequences.
- Discuss what else might need to change in their life before they would consider changing their drug use.
- Ask the client what they believe the problem to be, if it isn’t their substance use.
- Focus on the progress and effort the client has made, and encourage your client when they experience success, even if that success seems small or temporary – a lot of small successes can lead to more permanent change than big, dramatic changes.
- Help the client to set small, achievable goals that are meaningful to them – trying to get the client to quit straight away may be too overwhelming or confronting even for clients who want to quit, let alone those who do not.
- Always maintain a non-judgmental approach – you may not agree with the client’s behaviour but can respect their right to make their own choices in life.

Prochaska and DiClemente’s model of the Stages of Change is particularly useful for involuntary clients. It is important to identify which stage of the model the client is in, before deciding what approach to take in counselling. The therapeutic goal is to engage the client and help them move from one stage to the next, rather than to look at solutions before the client is ready.

As stated previously, a useful way to gauge what stage the client is in is to evaluate the pros and cons of both using and not using. This allows the client to acknowledge that their use may have both positive and negative consequences in their life.

The counsellor can also encourage the client to look at both the direct and indirect consequences of the drug use. For example, the client may feel that the drug is not harming their health but may admit that their drug use contributed to a relationship break-up. Evaluating the pros and cons of use

enables both the client and the therapist to examine the full impact of the drug use on the client's life and to develop a realistic picture of the role the substance use plays in the client's life.

It can be frustrating for a clinician to work with a client who chooses to risk negative consequences from drug use, whether that risk relates to their health, the custody of their children, or going to prison. However, ultimately, we must respect that clients have the right to make their own decisions and the responsibility to face the consequences of those decisions. Sometimes the most important outcome from counselling is that the counselling was at least a positive experience in which the client felt listened to, respected and not judged. The client will then be more open to the possibility of seeking counselling in the future, should they decide that they would like to address their substance use.

Some involuntary clients are required to undergo urine screens, which can be done by GPs and specialist pathology services. Phone services such as The Drug and Alcohol Clinical Advisory Service (DACAS) in Victoria can be contacted for assistance in interpreting urine test results. This service is for professionals only and can be contacted on **(03) 9416-3611** or toll free on **1800 812 804** for professionals in rural Victoria.

Clients with a mental illness

Clients who have both a mental illness and substance use problems are referred to as having a dual diagnosis. Working with this group of clients can be difficult for a number of reasons, not least of which is trying to work out which problem is the primary problem. Some of the dilemmas facing service providers include:

- Did the substance use cause the mental illness symptoms (e.g. paranoia from excessive amphetamine use)?
- Is the substance use making the mental illness symptoms worse (e.g. becoming more depressed from alcohol use)?
- Is the substance being used to “self-medicate” for the symptoms of the mental illness (e.g. using cannabis to relieve anxiety)?
- Is the substance interfering with psychiatric medication (e.g. alcohol and anti-depressants)?
- Is the substance use protecting the client from dealing with painful issues that they are not yet ready to face (e.g. using heroin to block out distress from traumatic memories of sexual abuse)?
- Is the substance use independent from the mental illness and not necessarily a problem?
- Is the substance use helping the client in other ways (e.g. building social networks with other cannabis smokers when they would otherwise be isolated)?

When there is a substance use issue with a client with a mental illness, the focus of counselling can often be on getting the client to stop using. This focus often arises from fears that the substance use will make the mental illness worse or the difficulty in working with the client while they continue to use.

As with other clients, it is important to identify the role of the substance use in the client's life and the client's attitude toward changing their level of use. For some clients, their substance use may be both a positive and a negative factor in their lives. If the positive aspects of the substance use are acknowledged, the client may be more willing to consider the negative aspects as well. For example, substance use may help clients to:

- Feel relief from upsetting symptoms or emotions
- Develop social networks when they may otherwise be isolated
- To develop a sense of identity independent from the often distressing label of “mental illness”
- To maintain a level of interest in other activities, particularly if the client is unable to participate in work, study, or other ways of structuring the day
- To feel like a “normal” person or do what “normal” people do.

If the client does not want to change their substance use or is having difficulty doing so, the first issue to be addressed is the risk of harm from the client's current pattern of use. If you are not sure of the risks a client is taking with their use, ask a drug and alcohol counsellor or a specialist service for further advice. This stage can be educational for the client, particularly if they have a limited understanding of the ways in which alcohol and other drugs may be harmful to them. For example they may not have connected their use with ongoing symptoms of mental illness, loss of employment or difficulties in relationships. Helping the client to connect the substance use with various important issues in their life can help a client to gain some insight into the impact of their substance use.

Even if the client is not willing to stop, they may be able to change what substances they use and how they use them. The most important priority in working with clients is helping them to stay alive, with the minimum of long term negative consequences, until they reach a point in their lives when they are able to consider making greater changes to their use. For example:

- Switch from straight spirits to lower alcohol drinks
- Smoke joints instead of "bongs" (water pipes)
- Swallow Valium tablets but not inject Valium (which is very damaging to the veins)
- Inject heroin but use safe injection practices
- Never use alone.

Again, it is important to identify how motivated the client is to change and to help them move to the next stages of change, rather than go straight into developing strategies to stop. Helping the client to find alternatives to substance use, that meet the needs that the substance use met, is particularly important if the client has few coping strategies or alternative interests, as the loss of the substance from their lives will be all the more keenly felt.

Simple strategies to cut down may be more appealing to the client than quitting straight away. A list of strategies for cutting down can be found in the back of this handbook.

For many people having difficulty with substances, one of the hardest temptations to resist is having money in one's pocket. This is particularly likely if the client has a history of impulsive behaviour or poor planning skills. Looking at the client's financial arrangements can be useful to limit the amount of spare cash available to them. Some of the following strategies are useful in limiting the temptation of having ready cash:

- Have income diverted to a safe person or bank account, with limited access to cash
- Leave ATM cards at home
- If the client gets paid cash for casual work, see if they can be paid by cheque instead
- Help the client to find another use for the money, such as paying off lay-by.

It can be difficult working with clients who engage in seemingly self-destructive behaviours, especially when their judgment appears to be impaired by either mental illness or substance use. Often workers are caught between respecting the client's right to make their own decisions, and wanting to intervene when the client continues to behave in a way that seems detrimental to their own interests or seems to undermine opportunities for other progress to be made. There are no simple solutions in these cases and a great deal of patience and persistence may be required. It is particularly important for the worker to feel supported in order to continue with such work, as it can be draining and disheartening at times.

Young people

When working with young people, it is important to keep in mind the developmental stage they are in. The adolescent years are typically a time of testing limits, experimenting with new behaviours and developing a sense of independence. It is a time when dependence on parents decreases and young people increasingly turn to their peers for information and a sense of where they belong. It can be a turbulent time, while young people juggle the many aspects of developing an adult identity, such as:

- Developing a sense of one's place in a broader social context than the family

- Separating from parents and parents' values and opinions
- Developing their own sense of morality or ideals
- Developing sexual identity, dealing with puberty, sexual orientation and negotiating the unpredictable world of relationships
- Developing self-reliance, moving from solutions that lie in the outside world (e.g. parents) to their internal world (e.g. own problem solving)
- Experimenting with new behaviours and ideas, and learning from those experiences
- Developing more self-awareness and the ability to engage in more abstract and complex thinking
- Developing a sense of self-worth and belonging.

As a result, adolescence can be a source of stress and confusion for both the young person and the adults who care for them. Adolescents' behaviour can change at this time and may include behaviour that could be confused with signs of drug use, such as:

- Being rude
- Testing limits
- Demanding more privacy
- Having mood swings
- Having sudden changes in appetite or energy levels
- Being uncommunicative
- Being sensitive and taking things to heart.

As outlined in the section on Alcohol and Other Drugs at the beginning of this handbook, there is a range of ways in which a drug may be used, from abstinence to hazardous use. Young people who use alcohol and other drugs are most likely to do so in an experimental or recreational way, consistent with their developmental stage of experimenting with new behaviours and sensations, testing limits and risk-taking.

Far fewer young people will move on to be dependent on alcohol or other drugs or use them in an on-going, hazardous manner. However, young people who do use alcohol or other drugs may be at risk of increasing their use to a more harmful level if they are having difficulty coping with the challenges of adolescence or other significant life events.

When carers suspect or know that the young person is using alcohol or illicit drugs, there are often deep concerns about the young person's well-being and future. There is often a strong tendency to want the person to cease using substances, at least until they are older, from fear that the young person will experience significant negative consequences through inexperience or ignorance. However, just telling a young person not to use alcohol or other drugs often proves ineffective. Given the developmental needs of developing independence and separating oneself from parental opinions or behaviours, it is not so surprising that orders or pleas to stop from carers of the person may be ignored or minimised.

When talking with young people about drug use, it is essential to try to develop a two-way discussion about the topic, rather than a one-way lecture. Like anyone, young people appreciate being listened to and feeling that their opinion is respected, even if the other person does not agree with their opinion.

It is important to be non-judgemental and to try to explore what the drug means to them, which includes acknowledging the positive aspects of the substance as well as the negative. If you want the person to change their pattern of substance use, give a good rationale for the request.

Some young people may have more knowledge about some substances than the people who work with them, but may also believe in a number of myths about substance use. Unless the young person feels comfortable enough to speak about their use and beliefs about their use, these myths may go unnoticed and may be a source of future harm to them. This is particularly relevant given the developmental stage of adolescence which often involves swinging between extremes, such as feeling indestructible and knowing everything, to feeling helpless and having no future ("I'll be dead by the time I'm thirty anyway so who cares?").

It is helpful to assist the young person to make informed decisions, so that they have accurate information about the effects of substances, the risks and the safest way to use them. This may include looking at areas not directly related to drug use itself, such as dealing with emotions, problem solving, setting goals, and self-esteem. If the person is better equipped with a range of skills for dealing with life's difficulties and pain, they are less likely to become overly dependent on one solution, such as substance use.

Ultimately, it is up to the young person to decide whether they will use substances or not. There will always be opportunities when carers are not present when young people can engage in any number of experimental or risky behaviours, many of which are a normal part of growing up. Most young people will either grow out of using substances or develop safer limits for their use through trial and error. As young people expand their range of interests and sources of stimulation, substances also tend to become less of a priority as they are just one of many options.

Parents and other carers of people using substances

Sometimes the client presenting with an alcohol or other drug issue is not the person using the substance themselves, but a parent, partner, child or someone else who cares for them. It can be very difficult watching a loved one use substances known to be harmful to one's health and carrying the risk of further harm while under the influence of the substance, imprisonment, loss of employment or relationships, or even death.

Parents and other carers may feel a range of emotions in response to the person's substance use, which may include:

- Guilt and self-blame
- Anger
- Fear and anxiety about the person's well-being and future
- Betrayal and loss of trust
- Confusion
- Shame
- Frustration
- Helplessness.

Carers may be concerned about their lack of knowledge about what the substance is or how it affects the body. They may also feel responsible for the well-being of the person using the substance, particularly if the carer is a parent, and yet find their efforts to intervene are unsuccessful or even unwanted.

By the time carers present to community agencies for assistance, they are often experiencing relatively high levels of distress and may feel desperate for some direction or solutions to help them deal with the situation. It is important not to slip into giving advice as the carer, not the worker, has to live with the consequences of those decisions. Although neither the carer nor the worker can directly change the behaviour of the person using substances, there are interventions that may help ease the carer's distress and may even help to create an environment in which the person using substances begins to initiate change.

It is important to work gently with carers as they often blame themselves to a degree for the person's substance use. Parents may fear that they somehow caused the substance use by being a "bad parent". Partners may wonder what they are doing wrong for their partner to continue using. Children, in particular, have a tendency to personalise family problems and may believe that their parent's use, or behaviour while intoxicated or withdrawing, is "all my fault". Carers may even have been told by others, including the substance user, that they are indeed to blame.

Reinforcing that sense of guilt is unlikely to help anybody in the situation, and carers are equally entitled to receive the same compassionate, non-judgmental approach that is advocated for working with people using substances themselves. However, it is not helpful to simply reassure the client that they have nothing to do with their loved one's substance use, as such platitudes may well be dismissed. It is more helpful to acknowledge that we all do things that we later wish we had not done, despite the fact we usually acted with good intentions. If we did not make what we end up calling

“mistakes”, we would not be able to learn, adapt and develop as our needs and events around us change with time.

No single person can be responsible for another’s behaviour either. Feeling responsible for another person’s behaviour is an endless source of frustration and guilt. We are all influenced by many sources and must ultimately be responsible for the decisions we make and accept the consequences of our decisions. Therefore, it is unrealistic for carers to label themselves the “cause” of another’s substance use.

As with most problems, it is more useful to focus on the future and what may yet be done, rather than to dwell on the past as the past will not change, no matter how much we want it to. It can be useful to help the carer to identify what they are responsible for (i.e. their own behaviour) and what they cannot be responsible for (i.e. another person’s behaviour). The carer can then focus their energy on those aspects of the situation they can realistically have some control over.

If the person using substances is not prepared to stop, the carer still has the right to negotiate limits on behaviour that also affects them. It is useful for the carer to think about what behaviour is acceptable to them (e.g. coming home late) and what behaviour is not acceptable (e.g. smoking cannabis in the family home). As in any negotiation process, it is helpful to offer acceptable alternatives (e.g. if the person is going to smoke cannabis, they do so away from the family home). It is also important to identify realistic consequences for the unacceptable behaviour that the carer is willing to enforce consistently. There is no point in making threats that will not be put into place. The person using the substances is then in a position to make an informed decision about what they will or will not do.

As is the case with any ongoing problem between two people, it is important for carers to talk about neutral or positive topics of conversation as well. If the main topic of conversation is one involving conflict, it can easily lead to feelings of resentment on both sides. No matter how extensive the substance use may be, there is always more to a person using substances than just their substance use. Talking about other matters can help to keep open the lines of communication, and may lead to more effective outcomes when the topic of substance use is actually discussed.

Finally, and most importantly, ask whether the carer is looking after themselves and encourage them to attend to their own needs as well as to the needs of others. Some carers are relieved to hear that the worker appreciates how difficult it is for them. Other carers may find it hard to acknowledge their own needs, and may feel guilty for thinking about themselves when someone they love is putting themselves at risk through their substance use.

It can be helpful to explain that supporting someone experiencing substance use problems can be draining, and may be a long-term situation. In order to support another person, it is vital to nurture oneself and keep oneself strong. It also sets a positive role model for the person using substances, demonstrating that there are other ways to deal with distress and to feel good than by using substances. The list of activities for fun and relaxation at the back of this handbook can be used to help carers find ways to look after themselves and find some relief in an often distressing situation. Drug and alcohol services offer counselling to carers as well as people using substances.

Workers dealing with alcohol and other drug issues

This last section focuses on you, the worker. If you have read this handbook, it’s likely that you have to deal with alcohol and other drug issues in your work and possibly in your personal life, as alcohol and other drug use is present in all walks of life and affects most people in some way.

Maybe you have tried to apply the interventions suggested in this handbook. You may have seen some clients make improvements. You are likely to see others make no noticeable change whatsoever. When clients do not appear to make changes in their substance use, despite obvious harm the substance use is doing, it can be frustrating or demoralising for the worker. You may be wondering what you could have done differently. You may be wondering what the author knows about the topic anyway, because the strategies obviously aren’t working.

Keep in mind the nature of alcohol and other drugs. They are chemicals that directly influence the way our brains and bodies function. Once you learn how to use a substance, it is a simple, fast-acting and fairly predictable way to achieve certain results. In other words, they work – at least in the short term. There are few alternatives offered by counsellors, physicians or other professionals that come anywhere near the success rate of substances to achieve the desired aim – again, in the short term.

Usually, the various approaches advocated by counsellors require practice and patience, and aim for long-term improvement. Medication alternatives, such as antidepressants, also take a while to work effectively, require patience and may have unpleasant side-effects. While most people understand that long-term solutions are more effective than short-term solutions, we tend to find that we reach for the short-term solution when our immediate needs become too intense or overwhelming. In short, if you are working with alcohol and other drug issues, you are up against some fairly tough competition.

As a result, it can be draining to work with alcohol and other drug issues, especially if the client appears to make little improvement or continually slips back into previous levels of use. It is useful at this stage to step back and look again at what role the substance plays in the client's life and whether at least some of the harm may be reduced even if the substance use itself is not.

Just as important, though, is to step back and think about your own well being. Just as we encourage clients to look after themselves, seek support when they are emotionally troubled, and give themselves credit where it is due, it is just as relevant for workers to listen to our own messages to clients and learn to apply them to ourselves as well. Try to focus on what you can realistically do as a worker and try to accept that there will be things you cannot change, no matter how much you want to. You deserve to be compassionate and non-judgemental with yourself, as well as your clients.

Finally, while it can be difficult working with alcohol and other drug issues, it can be rewarding as well. Clients teach us a great deal about life and ourselves, and it seems only fair that such knowledge comes at a price - it can be hard work when clients are experiencing the pain and frustration of trying to let go of a drug that has helped them in difficult times. If you take the substance use out of the picture, people who use substances are people like everyone else, feeling the same emotions and often trying to meet the same basic needs – they may just be going about it in a different way.

Additional Resources

Further reading

Allsop, S. (2008) *Drug Use and Mental Health: Effective Responses to Co-Occurring Drug and Mental Health Problems*. I.P. Communications

Burrows, C. (1994) *Clued up too: Helping young people with drug issues*. Melbourne: Australian Drug Foundation.

Fanning, P. & O'Neill, J.T. (1996) *The Addiction Workbook: A step-by-step guide to quitting alcohol and drugs*. Oakland: New Harbinger Publications.

Hamilton M., Kellahear A., & Rumbold G. (1998) *Drug Use in Australia: A Harm Minimisation Approach*. Melbourne: Oxford University Press.

Hawks, D. & Lenton, S. (1995) Harm reduction in Australia: Has it worked? A review. *Drug & Alcohol Review*, 14, 291-304.

Marsh, A. & Dale, A. (2006) *Addiction Counselling: Content and Process*. I.P. Communications

Miller W.R. & Rollnick S. (2002) *Motivational Interviewing: Preparing People to Change Addictive Behaviour*. (2nd Edition) New York: The Guilford Press.

Prochaska J.O. & DiClemente C.C. (1982) Transtheoretical therapy: Toward a more integrative model of change. *Psychotherapy: Theory, Research and Practice*, 20, 161-173.

Prochaska J.O., DiClemente C.C. & Norcross J.C. (1992) In search of how people change: Applications to addictive behaviours. *American Psychologist*, 47, 1102-1114.

Ryder, D., Walker, N. & Salmon, A. (2006) *Drug Use and Drug-related Harm: A delicate balance*. (2nd Ed.) I.P. Communications.

Further information

Eastern Drug and Alcohol Service (EDAS) provides drug and alcohol counselling in the Eastern Metropolitan Region of Melbourne. This handbook, *An Introduction to Working with Alcohol and Other Drug Issues*, is also available online at the EDAS web site.

<http://www.edas.org.au>

The Australian Drug Information Network (ADIN) is a valuable internet resource on a wide range of drug and alcohol issues, with access to databases and very comprehensive links to evaluated websites.

<http://www.adin.com.au>

Australian Drug Foundation is an independent, non-profit organization providing information on alcohol and other drugs. They have an excellent library of alcohol and other drug resources as well as a catalogue of resources for purchase, ranging from pamphlets on specific substances to books and videos.

<http://www.adf.org.au>

Alcohol and other Drugs Council of Australia (ADCA) is a non-government national organization representing the interests of the Australian alcohol and other drugs field. ADCA provides a free email service, keeping workers in the field up-to-date with news on various

aspects of alcohol and other drug use (including clinical, legal, policy, and law enforcement issues, as well as information on up-coming workshops, lectures and conferences).

<http://www.adca.org.au>

Alcoholics Anonymous

<http://www.alcoholicsanonymous.org.au/>

Narcotics Anonymous

<http://www.naoz.org.au/>

Other drug and alcohol web sites

There are many alcohol and other drug sites available on the internet, representing all points of view, and containing information of variable reliability. The sites listed here are intended to provide a sample of the range of information available. Many of these sites have a useful list of links to other sites for further information.

The Drug Policy Alliance is a policy research institute with a harm reduction focus. The site has an on-line library with an extensive range of articles and good links.

<http://www.lindesmith.org>

The Lycaenum Drug Archives provide a diverse range of information on alcohol and other drugs, including personal accounts.

<http://www.lycaenum.org>

Erowid also provides comprehensive information on a wide range of substances.

<http://www.erowid.org>

Media Awareness Project (MAP) is a site dedicated to drug policy reform providing access to media articles and good links to other sites.

<http://mapinc.org>

Additional booklets and pamphlets

For good, basic information on specific substances, the Australian Drug Foundation (ADF) has produced a series of pamphlets on the most commonly used substances, as well as more comprehensive booklets on alcohol and amphetamines. Turning Point Alcohol and Drug Centre Inc has very good booklets available on withdrawal from heroin (Vietnamese version available), methadone, alcohol and amphetamines. Contact details for both the ADF and Turning Point are listed in the previous section.

Client Information

The following pages contain forms that may be photocopied and used with clients where appropriate.

Substance use diary

This diary can be used to record substance use on a daily basis. It is useful to look at the entries in the diary with the client and try to identify patterns in the use. There may be some consistency in times of day, situations, presence of particular people or feelings. This information can then be used to identify high-risk triggers and to generate strategies to cut down or cease use that are tailored to the person's individual patterns of use.

It can also be useful for clients to keep a record of their progress, as our memories are not always reliable. It can also provide encouragement to clients who tend to minimise their successes and focus on what they have not yet achieved or on lapses back into increased use.

Dealing with cravings

This handout can be given to clients who have difficulty dealing with cravings, or the urge to use, even when they have decided not to. It can be useful to draw the analogy between a craving and a hungry cat. If a hungry cat comes to your back door and you feed it, the cat is most likely going to keep on coming back. If you don't feed the cat, it eventually loses interest and goes away. Cravings work in much the same way – the more you give in to them, the worse they tend to get. If you can resist the cravings, they gradually reduce in both intensity and frequency.

Strategies to cut down

This handout can be used with clients who want to reduce their use rather than cease their use altogether. It may be useful to go through the list with the person and select the strategies that they feel they would like to try. If these strategies are not successful, other options on the list may be reconsidered.

How to say no

Many people with alcohol or other drug problems find it hard to refuse the substance when it is offered to them. It can help to think of a way to say no before entering a situation where they may be offered the substance, and to practice saying the phrase until they feel more comfortable or natural saying it. Sometimes other people will not accept a simple refusal and will insist that the person uses. It may be handy to prepare a back-up statement, to deal with people who are more insistent that they use.

Things to do

As this list is fairly long, it can be useful to go through the list with the client and to encourage them to select a small number of activities that they would like to start with. Otherwise, it can be just as difficult to know what to do when there are too many options, as when there are too few.

Substance use diary

Cost	
How much was used	
Feelings	
Situation	
Time	
Day	

Dealing with cravings

- Identify when the craving starts - knowing what is going on is the first step in doing something about it.
- Remind yourself that cravings are a normal part of cutting down and that they will pass with time - the more you give into cravings the stronger they become.
- Remember that cravings are like a hungry cat - the more you feed it the more the cat comes back. If you don't feed it, the cat eventually stops coming back.
- Try to find something to distract yourself with - even if you only delay using the substance.
- Try to work out when you are more likely to crave the substance - e.g. in certain situations, with particular people, when you feel a certain way - and plan ahead how you will deal with each situation when it comes up.
- Delay using for an hour, or even five minutes. When the time is up, delay using for another hour, and then another, and so on. It is easier to resist cravings for a manageable period of time than to try to stop "forever".
- Talk to someone supportive when you start to get cravings.
- Do something relaxing and enjoyable instead.
- Have a bath or shower.
- Have a massage.
- Go for a walk or run, or do other physical exercise.
- Visit friends who don't use the substance or won't while you are there.
- Watch a video or go to the movies.
- Listen to relaxation tapes.
- Reward your efforts to cut down, even if you ended up using more than you meant to - it takes time to make change and being hard on yourself will make it more difficult to change your habits.
- Talk to friends who have been able to cut down their use and find out what worked for them.
- Talk to friends about how they enjoy themselves or relax to get some more ideas.

What else helps you to deal with cravings?

Strategies to cut down

- Plan the substance use.
- Set limits on the day, time and amount used (e.g. only after 8 pm).
- Try to have at least two substance free days per week.
- Delay the first use and each use after that.
- Find something else to do as a distraction from wanting to use more.
- Arrive later.
- Leave earlier.
- Spend time with someone who will support your efforts to cut down.
- Try to avoid situations where you are likely to use or use a lot.
- Try to plan what days will be "normal" use and what days will be heavier use.
- Only prepare a little bit of the substance at a time, even if you intend to use more.
- Place the drug in a place that is hard to get to, or give it to someone who is supportive.
- Reduce your tolerance - you will need less.
- Keep a record of how much you are using and check whether you are meeting your goals.
- Do not try to keep up with other people - go at your own pace.
- Only take as much cash as you need when you go out.
- Leave your ATM card at home.

What else could you think of trying?

How to say no

- No thanks.
- I'm right, thanks.
- I'm driving.
- No thanks, doctors orders.
- I have to work tomorrow.
- I quit.
- Sorry, liver problems.
- Not tonight, thanks.
- I can't with the medication I'm on.
- I'm on the wagon.
- I've had enough, but thanks anyway.
- No thanks, I'm not feeling too good.
- I don't enjoy it any more.
- I'd rather have a coffee (or whatever).
- I'm cutting down.
- It doesn't seem to agree with me any more.

If someone continues to insist:

- No thanks.
- Tempting, but no thanks.
- No, I really don't feel like it.
- I would have thought you would be more supportive.
- If it is a problem for you, I can leave and catch up with you later.
- I'd rather not go into detail, but I really can't because of my health.
- No, but you go right ahead.
- Hey, I'm still the same person!
- This is hard enough - please don't make it harder.
- No thanks - is it a problem for you if I don't?
- I really would prefer a coffee - I don't mind making it myself.
- Hey, what's the big deal?
- No, but what about that game of footy last night... (changing the topic)

Things to do

Activity	Enjoy this	Would try it	Not interested
Reading a newspaper, magazine or book	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wearing something that feels good	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Laughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Playing a sport	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having a massage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being with children or pets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Making presents for friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doing a craft or art	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Singing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking a bath or shower	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being with friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Playing music	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having a hair cut or a facial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going for a drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Completing a task you've been meaning to do	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Playing pool, cards or other games	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Planning something good for the future	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going camping or bushwalking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping or window shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doing a short course	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Redecorating your room or home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gardening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going to the zoo, park, museum or gallery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Buying/preparing food you like or haven't tried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ringing or writing to a friend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going to the movies or a concert	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking along a beach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking the dog	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Activity	Enjoy this	Would try it	Not interested
Asking for a cuddle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going to a restaurant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking a holiday	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going to a sports event	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Giving time or money to a cause you believe in	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Working on your car, motor bike or bicycle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Writing stories, poetry, or a diary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being with relatives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dancing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going on a picnic or having a barbecue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going fishing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Taking photographs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going to see a stand-up comedian	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Playing computer games or surfing the Internet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kissing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being alone	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reminiscing about happy memories	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Getting up early in the morning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Praying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doing yoga or meditating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Having a good night's sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Doing outdoor work or housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going running, swimming or surfing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Riding a bike or going to the gym	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smiling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Going to markets, garage sales or op shops	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

What other things could you think about trying?

Something to say?

If you have any comments about this handbook, we would like to hear from you! If you found the handbook useful or incorrect in any way, or if you have suggestions about what else you would like to see added, please let us know. Our aim is to provide a useful resource for you, and the only way we will know if we have done that is if you give us your feedback. Please fill in the relevant sections of this form and fax it to **Helen Mentha**, c/o Eastern Drug and Alcohol Service, on **(03) 9818-6714**.

What did you like about the handbook?

What would you like to see changed?

What else would you like to see added?

Mailing List

Would you like to be sent up-dates on projects and services being offered by the Eastern Drug and Alcohol Service? If yes, please fill in the following information:

Name: _____
Agency: _____
Address: _____
Phone: () _____ Fax: () _____
Email: _____

For agencies in the Eastern Metropolitan Region of Melbourne, Victoria:

If you would like to express interest in attending EDAS training related to the issues covered in this handbook, please fill in the following details:

Which of the following general topic areas would you be interested in:

- What drugs do, how people use them and what the treatment options are
- Practical interventions: assessment and treatment
- Working with specialist client groups: are there any specialist groups you would want to focus on?
If yes, please specify: _____
- Other: (please specify) _____

How many people from your agency would be interested in attending training? _____

Name: _____
Agency: _____
Address: _____
Phone: () _____ Fax: () _____
Email: _____